OFFICE OF THE INSPECTOR GENERAL

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BUREAU OF AUDITS AND INVESTIGATIONS

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QUARTERLY REPORT
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INTRODUCTION

The Office of the Inspector General (OIG) investigates and audits the California Department of Corrections and Rehabilitation (CDCR) to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses. This quarterly report summarizes the OIG's audit and investigation activities for the period October 1, 2007, through December 31, 2007. 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 our inspectors' activities and findings, this report also summarizes audit activities, warden and superintendent candidate evaluations, and facility inspections completed during the fourth quarter of 2007. All the activities reported were carried out under California Penal Code section 6125 et seq., which assigns the OIG responsibility for independent oversight of the CDCR.

EVALUATION OF WARDEN AND SUPERINTENDENT CANDIDATES

With the enactment of Senate Bill 737, which took effect on July 1, 2005, the Legislature assigned the Inspector General responsibility for evaluating the qualifications of every candidate the Governor nominates for appointment as a state prison warden. In 2006, California Penal Code section 6126.6 was amended to also require the Governor to submit to the Inspector General the names of youth correctional facility superintendent candidates for review of their qualifications. Within 90 days, the Inspector General advises the Governor whether the candidate is "exceptionally well-qualified," "well-qualified," "qualified," or "not qualified" for the position. To make the evaluation, California Penal Code section 6126.6 requires the Inspector General to consider, among other factors, the candidate's experience in effectively managing correctional facilities and inmate/ward populations; knowledge of correctional best practices; and ability to deal with employees 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 that pertain to the Inspector General's evaluation of warden and superintendent candidates are confidential and absolutely privileged from disclosure.

During the fourth quarter of 2007, the Governor submitted one warden candidate to the OIG for review.

FACILITY INSPECTIONS

Pursuant to California Penal Code section 6126, the OIG has implemented semiannual inspections of adult correctional institutions and youth correctional facilities. The inspection program's purpose is for our inspectors to identify unsafe conditions, become more familiar with the institutions, develop contacts with staff members, and identify conditions needing further audit or investigation.

Since October 1, 2007, our inspectors have inspected the following institutions:

- Baker Community Correctional Facility
- California Medical Facility
- California State Prison, Corcoran
- California State Prison, Los Angeles County
- California Substance Abuse Treatment Facility
- Calipatria State Prison
- Centinela State Prison
- Central Valley Community Correctional Facility
- Chuckawalla Valley State Prison
- Claremont Custody Center

- Delano Community Correctional Facility
- Golden State Community Correctional Facility
- Ironwood State Prison
- McFarland Community Correctional Facility
- Mesa Verde Community Correctional Facility
- Mule Creek State Prison
- N.A. Chaderjian Youth Correctional Facility
- Richard J. Donovan Correctional Facility
- San Quentin State Prison
- Shafter Community Correctional Facility
- Sierra Conservation Center
- Southern Youth Correctional Reception Center and Clinic
- Valley State Prison for Women
- Wasco State Prison

During this reporting period's inspections, there was one use-of-force incident reported at a community correctional facility that we are now reviewing. In addition, two institutions submitted confidential information to our inspectors. The information is currently under review.

SUMMARY OF AUDITS DIVISION ACTIVITIES

During the fourth quarter of 2007, the OIG completed a special review into the CDCR's release of inmate Scott Thomas, provided comments to the CDCR on its revised Armstrong Accountability Proposal, issued a letter to Senator Perata on the results of the newly completed Board of Parole Hearing's workload study, finished an audit of the California Institution for Women, and issued peer review results of the Texas Health and Human Services Commission's Office of Inspector General, Audit Section.

Special Review into the California Department of Corrections and Rehabilitation's Release of Inmate Scott Thomas

In October 2007, the OIG issued its special review into the release of inmate Scott Thomas. The special review, initiated at the request of the Governor's Office, revealed that a series of mistakes, oversights, and failures to follow CDCR policy resulted in San Quentin State Prison staff failing to identify and treat Thomas' needs while he was incarcerated, as well as improperly releasing him on parole on May 18, 2007. The day after his release, Thomas entered a San Francisco bakery and allegedly stabbed a 15-year-old girl and a man who came to her aid. We could not determine whether Thomas would have ultimately committed a similar act on his release from prison if the institution had followed CDCR policy.

We made 21 recommendations as a result of the special review. Eight of those recommendations appear in the public report. We redacted the other 13 recommendations from the public report because they contained personal health care information protected from public disclosure by various state and federal privacy laws. All 21 recommendations were included in a confidential report to the CDCR and the California Prison Health Care Receivership.

You can view the full text of the public version of the special review report by clicking on the following link to the Inspector General's Web site:
http://www.oig.ca.gov/reports/pdf/thomas_special_review-redacted.pdf

Review of Armstrong Accountability Proposal

As part of the *Armstrong* class action lawsuit, which pertains to the constitutional treatment of inmates with physical disabilities, the federal court ordered the CDCR to develop a system for tracking two areas: the record of each prison in providing services to physically disabled inmates and the conduct of staff members who were not complying with the court order. The order also calls for the department to refer repeatedly noncompliant staff members, including wardens and medical administrators, to the Office of Internal Affairs for investigation and discipline, if appropriate. The court required the CDCR to develop its system in consultation with the OIG. Accordingly, the department provided us its Armstrong Accountability Proposal for review and comment.

In a June 28, 2007, letter to the secretary of the CDCR, we pointed out numerous deficiencies with the department's proposal and recommended specific actions to correct those deficiencies. The department revised its Armstrong Accountability Proposal and again submitted the proposal to us. In an October 3, 2007, letter to the secretary, we stated that the revised proposal had adequately addressed all the deficiencies we had found in the original proposal. We advised the federal court of our finding.

Letter to Senator Perata on the Results of the Board of Parole Hearing's Workload Study

In November 2007, the OIG provided a letter to Senator Don Perata in response to his inquiry about a workload study conducted for the Board of Parole Hearings by CPS Human Resource Services. The study's purpose was to "provide a comprehensive time and workload analysis of commissioner and deputy commissioner positions and to provide the basis of a resource allocation and time management system." The study was necessary largely because we have found in past audits that the board does not maintain its own timekeeping system for these employees. Our review of the CPS study found that CPS used reasonable methodologies to

perform the study and develop its conclusions. Nevertheless, we continue to believe that the board should implement a contemporaneous time recording system.

While CPS' focus, as intended, was on board tasks as currently performed and not on identifying and analyzing inefficiencies in the staff's work processes, CPS did comment on certain obvious inefficiencies. CPS identified a limitation in the board's ability to accurately identify the future number of parole consideration hearings for inmates with indeterminate sentences. The board represented that this problem may be resolved with the November 2007 launch of the new Life Sentence Tracking System (LSTS). CPS also noted problems with the board's underutilization of its Revocation Scheduling and Tracking System (RSTS) and the scheduling of hearings that are subsequently postponed.

The California Institution for Women Quadrennial and Warden Audit

In December 2007, the OIG issued its audit report concerning the California Institution for Women (CIW) and the performance of its warden. We found that despite facing numerous challenges, the warden is devoted to the institution's mission, and she has made great strides in steering the institution in a positive direction. She brings a positive energy to the staff and inmates and has implemented several innovative programs, including California's first in-prison nursery for inmates' children. Overall, we concluded that the warden is hardworking and performs her duties well, but she could improve by requiring a greater degree of staff compliance with CDCR policy.

The report also contained the results of the OIG's review of CIW's operations and programs and presented seven findings and 23 recommendations. Specifically, CIW has ongoing building maintenance problems that result from age, overcrowding, and limited funding for maintenance projects. We also found that a lack of substitute teachers and inadequate air-conditioning in classrooms contributed to an attendance level of only 42 percent in the institution's education program. Other problem areas included follow-up medical care, inmate visiting, use-of-force incident documentation, and weapons training.

You can view the full text of the audit report by clicking on the following link to the Inspector General's Web site:
http://www.oig.ca.gov/reports/pdf/ciw_combo_audit_final.pdf

Peer Review of the Texas Health and Human Services Commission's Office of Inspector General, Audit Section

In December 2007, the OIG issued its peer review results of the Texas Health and Human Services Commission's Office of Inspector General, Audit Section, to the agency's deputy inspector general for compliance.

We conducted the review in accordance with the standards and guidelines contained in the *Peer Review Guide* adopted in June 2007 by the Association of Inspectors General. We reviewed the audit section's internal quality control system and tested a sample of audits and attestation engagements conducted by the audit section to determine whether its internal quality control system provided reasonable assurance of compliance with *Government Auditing Standards* issued by the Comptroller General of the United States.

We concluded that the audit section's internal quality control system was suitably designed and operating effectively to provide reasonable assurance of compliance with the 2003 revision of *Government Auditing Standards* for audit and attestation engagements during the period September 1, 2006, through August 31, 2007. We found that the quality control system included exemplary forms and checklists and that the audit section had an excellent process for tracking and monitoring the staff's continuing professional education training hours. However, for some of the audits and attestation engagements sampled, we noted the following quality control exceptions: documenting of auditors' independence; lack of procedures for detecting fraud, illegal acts, or violations of contracts or grant agreements in audit programs; cross-referencing of draft reports to supporting workpapers; and issuing of attestation engagement reports in a timely manner.

SUMMARY OF INTAKE AND INVESTIGATIONS DIVISION ACTIVITIES

The OIG received 944 complaints this quarter concerning the state correctional system, an average of 315 a month. Most complaints arrive by mail or through the Inspector General's 24-hour toll-free telephone line. Others are brought to our attention during audits, investigations, or inspections. We may also conduct investigations at the request of CDCR officials or other elected officials in cases that involve potential conflicts of interest or misconduct by high-level administrators.

Our staff responds to each complaint or request for investigation; complaints that involve urgent health and safety issues receive priority attention. Most often, our staff resolves the complaints at a preliminary stage through informal inquiry by contacting the complainant and the institution or division involved to either bring about an informal remedy or to establish that the complaint is unwarranted. Depending on the circumstances, we may refer the case to the CDCR's Office of Internal Affairs for investigation. Other complaints require further inquiry or full investigation by the OIG.

During the fourth quarter of 2007, the Intake and Investigations Division had 31 ongoing investigations and completed four investigations—two

administrative investigations and two criminal investigations. These completed investigations are summarized in the table that follows.

Cases referred to the Office of Internal Affairs may be monitored by the OIG's Bureau of Independent Review depending on whether the nature of the case meets applicable criteria. 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 semiannually in a separate report.

Intake and Investigations Division: Completed Investigations (4th Quarter)

Allegation	Investigation	Result
The OIG received a complaint that a CDCR executive involved himself in a multimillion dollar health care contract proposal where he had a financial interest as a subcontractor. A second CDCR executive authorized work by the same contractor without a contract.	We conducted an investigation and found sufficient evidence the first executive had a financial interest in the original contract proposal. The investigation also showed the second executive allowed work to be done without a contract.	We referred the report and supporting documentation to the hiring authority for appropriate action. In addition, we referred the case to the California Fair Political Practices Commission.
The OIG uncovered information alleging that a warden misused state equipment and personnel for personal gain.	We conducted an investigation and determined no evidence existed to support the allegation.	We closed the investigation.
The OIG received citizen complaints from a district attorney's office regarding an inmate who made several allegations against institution staff members and complained that his appeals were being ignored.	We conducted an investigation that included performing site visits at two institutions, reviewing and examining documentary evidence, reviewing the inmate appeals process, interviewing CDCR staff members, and reviewing applicable law. We noted some discrepancies with the inmate appeals process.	The hiring authority referred these allegations to the Office of Internal Affairs for investigation; therefore, we closed our investigation.
The OIG received a complaint from an institution that a construction project was initiated without going through appropriate authorizations and approvals.	We conducted an inquiry including interviewing the complainant and reviewing numerous documents relating to the construction project. We determined through the inquiry that there was insufficient evidence to support the allegations.	We closed the investigation.