QUARTERLY REPORT

BUREAU OF AUDITS AND INVESTIGATIONS

JANUARY–MARCH 2008

OFFICE OF THE INSPECTOR GENERAL

STATE OF CALIFORNIA

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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 January 1, 2008, through March 31, 2008. 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 and medical inspections completed during the first quarter of 2008. All the activities reported were carried out under California Penal Code section 6125 et seq., which assigns our office 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, 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 first quarter of 2008, the OIG was not provided any warden candidate names.

Facility Inspections

Pursuant to California Penal Code section 6126, the OIG carries out 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 audit or investigation.

For the first quarter of 2008, our inspectors visited the following institutions:

- Adelanto Community Correctional Facility
- Desert View Community Correctional Facility
- Preston Youth Correctional Facility
- Taft Community Correctional Facility
- Leo Chesney Community Correctional Facility
- N.A. Chaderjian Youth Correctional Facility
- San Quentin State Prison
- Deuel Vocational Institution

During this reporting period, our inspectors uncovered officer safety concerns at a correctional facility; specifically, correctional officers were carrying expired pepper spray canisters while performing their duties. We informed CDCR administration of the expiration of the issued pepper spray.

In addition, we received a complaint regarding the Community Correctional Facilities Administration (CCFA) policy on charging inmates for feminine hygiene products. As a result of this inquiry, tampons are now being provided to inmates free of charge.

Medical Inspections

In 2001, California faced a class action lawsuit (*Plata v. Schwarzenegger,* previously *Plata v. Davis*) over the quality of medical care in its prison system. The suit alleged that the state did not protect inmates' Eighth Amendment rights, which forbid cruel and unusual punishment. In 2002, the parties agreed to several changes designed to improve medical care at the prisons. Yet the court found in 2005 that the state failed to comply with its direction. Consequently, the court established a receivership and relieved the state of its authority to manage medical care operations in the prison system, handing that responsibility to the receiver. The court stated that it would remove the receiver and return control to the state once the

medical delivery system is stable and provides for constitutionally adequate medical care.

To evaluate and monitor the state's progress in providing medical care to inmates, the receiver requested that the OIG establish an objective, clinically appropriate, and metric-oriented medical inspection program. We agreed to this request and began to develop a comprehensive medical inspection program to annually inspect each of California's 33 institutions. To develop this program, we reviewed the CDCR's policies and procedures, relevant court orders, guidelines developed by the department's Quality Medical Assurance Team, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care, consulted with clinical experts, and met with stakeholders from the court, the receiver's office, the department, and the plaintiffs' attorney, the Prison Law Office, to discuss the nature and scope of the inspection program. This effort resulted in a 21-component medical inspection instrument that we will use to evaluate each institution. To make the inspection results meaningful to both an expert in medical care and a lay reader, we consulted with clinical experts to create a weighting system that factors the relative importance of each component compared to other components. The result of this weighting ensures that components that we consider more serious—or those that pose the greatest medical risk to the inmate-patient—are given more weight compared to those we consider less serious.

Although we are still in a pilot phase of the program development, as of March 31, 2008, we had already performed three medical inspections, and we plan to conduct another two inspections before we finalize the program. For the three pilot inspections, we obtained the institutions' inmate medical scheduling, tracking, pharmacy, and census data. We used the data to select random samples of inmates who receive or require specific medical services. We examined 180 to 200 inmate medical records (unit health records) at each of the three institutions we visited. In addition, we reviewed staffing level reports, medical appeals summaries, nursing protocols, results of medical care audits conducted by the institution, summaries of medical drills and emergencies, minutes from committee hearings, and assorted manual logs or tracking worksheets related to medical care delivery. We also conducted a live medical emergency drill and evaluated the adequacy of the responding staff. Finally, we interviewed various medical and custody staff members about the delivery of medical care to inmates, and we observed medical delivery at the institution during the inspection. We expect to begin statewide inspections in fall 2008.

Summary of Audits Division Activities

During the first quarter of 2008, the OIG issued its audit report on Folsom State Prison and the performance of its warden. In addition, we issued the report of our review of the California Prison Health Care Receivership Corporation's expenditures.

FOLSOM STATE PRISON QUADRENNIAL AND WARDEN AUDIT

In January 2008, we issued our audit report on Folsom State Prison and the performance of its warden. We found that during the first year of his appointment, the warden faced challenges requiring adverse personnel actions against members of his management team. He confronted these challenges and took action to restructure and rebuild the team. After an initial period of disruption, the prison's staff relations and general morale improved, and staff members credit the warden's actions for a turnaround in morale. Staff members praised his leadership skills and dedication to inmate rehabilitation and programming opportunities.

The report also summarized the results of our review of Folsom State Prison's operations and programs, presenting three findings and 11 recommendations to remedy certain safety issues. Specifically, in the medical area, inexperienced nurses and a lack of qualified nurse supervisors were a concern. Many of the new nurses had never worked in a prison, and their training and supervision was often inadequate. As a result, some new nurses unintentionally compromised the safety of staff members and inmates on several occasions by inadvertently allowing inmates access to controlled medications and syringes. Further, we found that some members of the prison's custody staff did not conduct the minimum number of daily cell searches required by CDCR policy, and they were not requiring inmates to stand during the daily "standing count."

Finally, we found that the prison's substance abuse treatment program for parolees is located at a facility that concurrently houses a similar program for inmates. Housing the two programs in the same facility exposes inconsistencies between the policies governing the two programs and presents the possibility for housing parolees formerly classified as "maximum custody" at the minimum custody facility.

You can view the entire report by clicking on the following link to the Inspector General's Web site:
http://www.oig.ca.gov/reports/pdf/Folsom_Combo_Audit_Final.pdf

REVIEW OF THE CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP'S EXPENDITURES

In February 2008, we issued a report on our review of the California Prison Health Care Receivership Corporation's expenditures. The purpose of the review was to satisfy the court order issued by the U.S. District Court for Northern California requiring the receivership to coordinate the OIG's periodic review of the receivership's expenditures. The review revealed that from April 2006 through June 2007, the receivership received over $33 million in state funds and expended $20.6 million for its operating costs and long-term capital assets purchased for the CDCR. The receivership's largest expense category was personnel services. Our review found that the receivership paid 64 percent of its employees salary and other compensation equating to a projected annual amount of more than $100,000—including 12 employees whose projected annual compensation exceeded $225,000. We also found that the receivership paid numerous employee travel claims that did not conform to its travel policy, which requires employees to provide original invoices or receipts and substantiate the amount, time, location, and business purpose of meal expenses.

In presenting the receivership's use of state funds, we did not include analysis or conclusions on the appropriateness of that use. Nonetheless, we presented three recommendations where the receivership could ensure that it uses public funds only for appropriate purposes. Specifically, our recommendations addressed employee compensation, use of corporate credit cards, and enforcement of the travel policy.

You can view the entire report by clicking on the following link to the Inspector General's Web site:
http://www.oig.ca.gov/reports/pdf/CPR_audit%20report_final.pdf

Summary of Intake and Investigations Division Activities

The OIG received 929 complaints this quarter concerning the state correctional system, an average of 310 complaints 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 or related investigations. We may also conduct investigations at the request of CDCR 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 establish that the complaint is unwarranted or to bring about an informal remedy. 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 first quarter of 2008, the Intake and Investigations Division had 54 ongoing investigations and completed six criminal investigations. Those 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 if 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.

Allegation	Investigation	Result
The OIG received a complaint that alleged a Board of Parole Hearings official failed to serve adverse action to an employee within the statutory time requirements.	We conducted an investigation that included a review of documentary evidence and interviews of pertinent staff members. We found sufficient evidence that the adverse action was served within the statutory time limit.	We closed the investigation.
During an investigation of excessive force, the OIG discovered that a medical doctor may have improperly administered a psychotropic drug following a cell extraction.	We conducted an investigation that included interviews of staff members and a review of key documents and policies. We found that the type of psychotropic drug ordered by the doctor was inconsistent with the emergency need and in violation of the Keyhea laws.	We forwarded the investigation report and supporting documentation to the hiring authority so it could take appropriate action.
The OIG's Fraud Investigations Unit reviewed the CDCR's process for ensuring that persons appointed to special boards and commissions disclose any financial conflict of interest.	We conducted an investigation that included interviewing witnesses and reviewing several documents. The review determined that the CDCR complied with the government code.	We closed the investigation, but we continue to monitor the conflict-of-interest process.
The OIG received information that alleged fraud, conflicts of interests, and improper accrual of leave credits by CDCR medical staff members at an adult institution.	We conducted an investigation that included interviews of CDCR staff members and a review of key documents and policies. We were unable to substantiate the allegations.	We closed the investigation.
The OIG received a complaint that alleged numerous first-watch CDCR staff members at a minimum security institution were sleeping on duty. The complaint also alleged that a correctional officer falsified inmate count documents.	We forwarded our information to the institution's warden. The institution's investigative services unit conducted an investigation.	The warden took direct action against two CDCR staff members who were charged with falsification of official documents and neglect of duty.
The OIG received a complaint from a health care professional who alleged that a correctional officer filed a false report against an inmate for assaulting a staff member.	We conducted an inquiry, including a site visit and review of several files and documents. We determined, as a result of the inquiry, that insufficient evidence existed to support the allegation of a staff member filing a false report.	We closed the investigation.