QUARTERLY REPORT

BUREAU OF AUDITS AND INVESTIGATIONS

OCTOBER - DECEMBER 2008

OFFICE OF THE INSPECTOR GENERAL

STATE OF CALIFORNIA

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 of October 1, 2008, through December 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 fourth 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 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 on 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 absolutely privileged and confidential from disclosure.

During the fourth quarter of 2008, the Governor submitted three warden candidates to the Office of the Inspector General. The Office of the Inspector General completed two warden vettings and submitted the findings to the Governor's office for final determination.

Facility & Parole Region Inspections

Pursuant to the Budget Act SB 77 (Chapter 171, Statutes of 2007), the OIG carries out semi-annual inspections of adult correctional institutions and youth correctional facilities. In addition, we inspected parole regions I, II, III, and IV this quarter and will continue to follow up on them semi-annually. The inspection program's purpose is for our inspectors to identify unsafe conditions, develop contacts with staff members, and locate areas needing audit or investigation.

During the third and fourth quarters of 2008, our inspectors visited the following institutions and facilities:

- Adelanto Community Correctional Facility
- Avenal State Prison
- Baker Community Correctional Facility
- California Correctional Institution
- California Institution for Women
- California Medical Facility
- California Rehabilitation Center
- California State Prison, Los Angeles County
- California State Prison, Sacramento
- California State Prison, Solano
- California Substance Abuse Treatment Facility and State Prison, Corcoran
- Calipatria State Prison
- Centinela State Prison
- Central California Women's Facility
- Central Valley Modified Community Correctional Facility
- Chuckawalla Valley State Prison
- Claremont Custody Center
- Corcoran State Prison
- Desert View Community Correctional Facility
- Deuel Vocational Institution
- Golden State Modified Community Correctional Facility
- High Desert State Prison
- Ironwood State Prison
- Lassen Community Correctional Facility
- Leo Chesney Community Correctional Facility
- McFarland Community Correctional Facility
- Mesa Verde Community Correctional Facility
- Mule Creek State Prison
- N.A. Chaderjian Youth Correctional Facility
- O.H. Close Youth Correctional Facility

- Pelican Bay State Prison
- Pleasant Valley State Prison
- R.J. Donovan Correctional Facility
- Salinas valley State Prison
- San Quentin State Prison
- Shafter Community Correctional Facility
- Sierra Conservation Center
- Southern Youth Correctional Reception Center
- Taft Community Correctional Facility
- Valley State Prison for Women
- Wasco State Prison

Also during the fourth quarter of 2008, our inspectors visited the following parole regions:

- Parole Region I
- Parole Region II
- Parole Region III
- Parole Region IV

Findings

At one institution, in the laundry area, our inspectors noticed a collage of photos of partly nude women on a back wall, in violation of California Code of Regulations, Title 15, Division 3, Section 3006 (c) 17. The laundry supervisor claimed that he had admonished the inmates to remove the photos the previous week and surmised that the inmates put the photos back on the wall without his knowledge. Before the inspector left the institution, the laundry supervisor escorted the inspector to the area to show that the photos had been removed and apologized to the inspector.

In the same laundry area, inspectors also found a room with about four large metal cabinets containing dark blue nurses' smocks. Each cabinet was equipped with a padlock, but the padlocks were unlocked and unsecured. Supervisors explained that the cabinets were unsecured because staff and inmates constantly removed or placed items in the cabinet, however, the cabinets are locked at the end of the day. The cabinets are within the secured perimeter. Because inmates have access to nurse's smocks, the smocks could be used in an escape, thereby, jeopardizing the safety and security of the institution and public.

During a previous institution inspection, inspectors learned that administrative segregation inmates were housed in an overflow building not designed for that purpose. The overflow building created a substantial added expense to the state. During the inspection this quarter, inspectors toured the building used to house administrative segregation overflows

and discovered no administrative segregation overflow inmates were housed in the building. In addition, there were vacant administrative segregation cells in the regular administrative segregation unit.

Medical Inspections

Background

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 prohibit cruel and unusual punishment. In 2002, the parties agreed to several changes designed to improve medical care at the prisons. Subsequently, the court established a receivership and relinquished the state of its authority to manage medical care operations in the prison system, handing that responsibility to the receiver.

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. In response, we developed a program based on CDCR's policies and procedures; relevant court orders; guidelines developed by the department's Quality Medical Assurance Team and the American Correctional Association; professional literature on correctional medical care; and input from clinical experts, the court, the receiver's office, the department, and the plaintiffs' attorney, the Prison Law Office. This effort resulted in a 20-component medical inspection instrument that we use to evaluate each institution.

The inspection process collects over 1,000 data elements for each institution using up to 162 questions on the following 20 component areas of medical delivery:

- Chronic care
- Clinical services
- Health screening
- Specialty services
- Urgent services
- Emergency services
- Prenatal care/ childbirth/post-delivery
- Diagnostic services
- Access to health care information
- Outpatient housing unit
- Internal reviews
- Inmate transfers
- Clinic operations
- Preventive services
- Pharmacy services
- Other services
- Inmate hunger strikes
- Chemical agent contraindications
- Staffing levels and training
- Nursing policy

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.

Results

During the fourth quarter of 2008, the medical inspection unit performed three medical inspections and issued its first public medical inspection report regarding the medical care provided at California State Prison, Sacramento. California State Prison, Sacramento, received 65.2 percent of the total 869 weighted points possible. Some of the highest scoring areas at California State Prison, Sacramento, were the prison's medical staffing levels and training, general clinic operations, and the handling of inmates exposed to pepper spray who are prescribed medication.

The lowest scoring areas were the prison's monitoring of inmate hunger strikes, cancer screenings and influenza immunizations, and effectiveness in filing, storing, and retrieving medical records.

We also conducted medical inspections of three additional correctional institutions. During the next quarter, we anticipate issuing the reports for the inspections completed during the fourth quarter of 2008 and conducting up to four more medical inspections.

Summary of Audits Division Activities

In the fourth quarter of 2008, the Audits Division issued audit reports of the Salinas Valley State Prison (SVSP) and the California Institution for Men (CIM). The purpose of these audits is to assess the wardens' performance one year after his or her appointment to the position and to evaluate the institutions' overall performance.

Salinas Valley State Prison Quadrennial and Warden Audit

In October of 2008, we issued our audit report on SVSP. Our audit found that Warden Evans is a knowledgeable, effective leader. With over 20 years of department experience and a reputation for integrity and professionalism, the warden has gained many supporters among the

employees at SVSP. Managers and staff members alike describe him as an effective administrator who provides strong leadership. Moreover, most of the employees we surveyed felt that SVSP was meeting its mission under his leadership.

The report also summarized the result of our review of SVSP's operations and programs, presenting six findings and 21 recommendations to remedy certain areas of concerns. Specifically, in the educational and vocational program area, SVSP assigned education and work program preference to inmates serving life without the possibility of parole. Eligible inmates can reduce their sentence in half when they participate in an education or work program, but lifers are not eligible for this time credit. Conversely, credit eligible inmates are being denied educational and work opportunities that would reduce their time in prison. As a result, credit eligible inmates are serving extra time in prison which results in a waste of taxpayer dollars. In addition, we found that SVSP canceled its education classes nearly 40 percent of the time because of security concerns, teacher absences, and other disruptions. This again results in inmates not earning time credits and negatively impacts their readiness for a successful parole. Further, in the prison safety and security area, custody employees rarely completed the required six daily cell searches, and many officers who work at armed posts did not demonstrate quarterly weapons proficiency, as state law and regulations require. These items reduce the safety and security of the institution, staff, and inmates.

California Institution for Men Quadrennial and Warden Audit

In November 2008, we issued our audit report of CIM. Our audit found Warden Poulos to be an experienced, effective administrator who has nearly 30 years of experience with the Department of Corrections and Rehabilitation. Interviews and surveys revealed that most employees feel he is an effective leader who is usually accessible to the staff and responsive to institution problems. Further, many staff members cited improvements at CIM under his tenure, such as the reopening of a gymnasium formerly used for inmate housing and rededicating the Marine Technology Training Center. Managers also praise his performance as warden, giving him an average rating of "outstanding" on our survey.

The report also summarized the result of our review of CIM's operations and programs, presenting six findings and 17 recommendations. In particular, the institution's poor infrastructure has caused significant problems which include an ineffective water treatment system, failing plumbing, dilapidated housing units, leaking roofs, and hazardous materials in need of removal. These items result in hazardous working and living conditions, and pose a threat to the safety of both staff and

inmates. Unfortunately, many improvement projects approved by the department remain unfunded. Besides the ongoing maintenance problems, we found safety and security problems in some areas. The most significant problem involved correctional officers inappropriately approving certain high-security inmates for open dormitory housing instead of celled housing. Such inappropriate assignments increase the risk of violence against staff and other inmates. Also, many officers who work at armed posts did not demonstrate the required quarterly weapons proficiency. The inappropriate assignment of staff who have not demonstrated quarterly proficiency also poses a risk for other staff and inmates, should the use of lethal force be necessary.

Summary of Intake and Investigations Division Activities

The OIG received 788 complaints this quarter concerning the state correctional system, an average of 263 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 CDCR's Office of Internal Affairs (OIA) for investigation. Other complaints require further inquiry or full investigation by OIG.

During the fourth quarter of 2008, the Intake and Investigations Division had 24 ongoing investigations and completed seven administrative investigations and six criminal investigations. Those completed investigations are summarized in the table that follows. Cases referred to the OIA may be monitored by OIG's Bureau of Independent Review (BIR) if the case meets applicable criteria. Such cases are not included in the quarterly report until the OIA investigation is complete. The BIR reports its monitoring activities semiannually in a separate report.

Allegation	Investigation	Result
The OIG received a complaint regarding potential fraudulent activity by staff members at a youth correctional facility.	The OIG conducted an investigation that included interviews with youth correctional facility staff and reviews of procurement and accounting documents. Although the investigation found insufficient evidence to support the fraud allegation, the OIG identified potential areas of risk that it will address during future audits of youth correctional facilities.	The OIG has closed its investigation.
The OIG received a request to investigate a possible conflict of interest concerning a member of a state board who is also a contractor for the type of services the board oversees.	The Office of the Inspector General conducted an investigation into a possible conflict of interest and referred its findings to a district attorney's office for consideration in the filing of criminal charges. The district attorney declined to accept the case for criminal prosecution. The OIG sent a letter to CDCR recommending they seek an opinion from the Fair Political Practices Commission concerning any possible present or future conflict of interests.	The OIG has closed its investigation.
The OIG identified a series of suicide attempts that occurred at one of the youth correctional facilities during May 2008.	The OIG conducted an investigation that included interviews with youth correctional and medical staff, and reviews of incident reports, logs, as well as other documents. Although no link between the suicides or evidence of foul play was established, several policy and procedure violations were found. These violations diminished the oversight and accountability of the living units operations.	The OIG informed the superintendent of the results of the investigation and recommended six corrective actions to strengthen living unit operations and improve his ability to hold employees accountable for failing to perform required duties.
The OIG received information alleging inmates at Salinas Valley State Prison, with the help of accomplices outside of the prison, were filing fraudulent income tax returns with the Internal Revenue Service.	The OIG conducted an investigation that included interviews with facility staff as well as inmates. The investigation found sufficient evidence to warrant referral of the case to the Internal Revenue Service for further action.	The OIG has referred the investigative package to the Internal Revenue Service.
The OIG received information alleging that a CDCR manager failed to initiate a request for investigation pertaining to management staff misconduct at a prison and showed preferential treatment.	The OIG conducted an investigation that included interviews with departmental staff, and the collection and review of evidentiary documents that determined the manager failed to initiate a request for an investigation showing preferential treatment.	The case was forwarded to the hiring authority for appropriate action.

Allegation	Investigation	Result
The OIG received information that a CDCR manager inappropriately drafted his own letter of instruction (LOI) for his misconduct, and inaccurately reported the facts of the incident.	The OIG conducted an investigation that included interviews of CDCR and the collection and review of evidentiary documents. The investigation showed that the manager drafted his own LOI; however, he was directed by senior management to do so. In addition, there was insufficient evidence to show he inaccurately reported the incident.	The OIG has closed this investigation; however, an investigation of the senior CDCR manager was initiated.
The OIG received information that CDCR's Internal Affairs Investigations, conducted by the institutions, may not be following proper DOM procedures regarding the proper handling of allegations of employee misconduct.	The OIG conducted an investigative survey of ten institutions to determine if their Internal Affairs investigations are following appropriate DOM procedures.	The OIG investigation revealed that all ten of the institutions failed to implement key aspects of the required DOM changes; therefore, the OIG recommended that CDCR adequately train and monitor institution staff regarding their responsibilities as described in the DOM.
The OIG received an anonymous complaint indicating that a prison had inappropriately released three inmates who required a high control-level of parole supervision without waiting for their assigned parole agent to pick them up at the prison. The complaint indicated a high ranking prison official had ordered the release.	The investigation revealed that staff releasing the high control parolees were unaware that the parole agents had attempted to schedule a pick-up. One of the parolees did not require parole agent pick-up. The evidence supported that the other two were not processed by staff appropriately due to misfiled documents and poor communication measures.	The OIG has closed its investigation. Case records processes in relation to the high control parolee process may be reviewed during future OIG audits of the prison.
The OIG received allegations that CDCR's correctional staff members conspired to facilitate the attempted murder of an inmate.	The OIG conducted a criminal investigation that included interviews with departmental staff and inmates, and the collection and review of documents.	The OIG found no evidence to support the allegations or warrant an administrative investigation.
The OIG received allegations that CDCR's staff members committed misconduct leading to the attempted murder of an inmate.	The OIG conducted an investigation that included interviews with departmental staff, and collection and review of evidentiary documents.	The OIG investigation found insufficient evidence to support that the staff members' actions contributed to the assault.
The OIG received allegations that CDCR staff members conspired to have an inmate murdered.	The OIG conducted an investigation that included interviews with departmental staff, and collection and review of evidentiary documents.	The OIG investigation found insufficient evidence to support that the staff members conspired to have the inmate murdered. However, the OIG opened an administrative investigation into potential staff misconduct.

Allegation	Investigation	Result
The OIG received a complaint that alleged staff used unnecessary and/or excessive force on inmates. Specifically, more than 30 correctional staff members were involved in an incident where oleoresin capsicum (OC spray) was used on inmates confined to their cells.	The OIG initiated a criminal inquiry into allegations that correctional officers violated California Penal Code Section 149 (Officer Unnecessarily Assaulting or Beating any Person) and Penal Code Section 182 (Conspiracy).	The OIG investigation found insufficient evidence to support the criminal allegations. However, the OIG is investigating violations of CDCR policies and procedures.