QUARTERLY REPORT

BUREAU OF AUDITS AND INVESTIGATIONS

APRIL–JUNE 2008

OFFICE OF THE INSPECTOR GENERAL

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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 April 1, 2008, through June 30, 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 second 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 second quarter of 2008, the OIG was not provided any warden candidate names from the Governor's office.

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 develop contacts with staff members, identify unsafe conditions, and uncover conditions needing audit or investigation.

For the second quarter of 2008, our inspectors visited the following 31 institutions:

- Avenal State Prison
- Baker Community Correctional Facility
- California Correctional Center
- California Institution for Women
- California Medical Facility
- California Men's Colony
- California Rehabilitation Center
- California State Prison, Corcoran
- California State Prison, Los Angeles County
- California State Prison, Solano
- California Substance Abuse Treatment Facility at Corcoran
- Calipatria State Prison
- Centinela State Prison
- Central California Women's Facility
- Chuckawalla Valley State Prison
- Claremont Custody Center
- Delano Community Correctional Facility
- El Paso de Robles Youth Correctional Facility
- High Desert State Prison
- Ironwood State Prison
- Lassen Community Correctional Facility
- Mesa Verde Community Correctional Facility
- Mule Creek State Prison
- North Kern State Prison
- Pleasant Valley State Prison
- R.J. Donovan Correctional Facility
- Shafter Community Correctional Facility
- Sierra Conservation Center
- Southern Youth Correctional Reception Center
- Valley State Prison for Women
- Ventura Youth Correctional Facility/Ventura Youth Conservation Camp

Inspections during the second quarter identified numerous issues that require corrective action by the individual institution or the CDCR. Specifically, our facility inspections disclosed the following issues:

- At one institution, the medical staff alerted us to problems with the pharmacy and medication delivery. Specific issues included incorrect medications, incorrect amounts of medications, or incorrect dosages. In addition, on some occasions the staff had to borrow medication from one inmate's supply to fill the needs of another inmate. These problems put inmate welfare at risk, reduce accountability and control over medications, and increase the potential for theft, waste, or abuse. We reported these issues to the chief medical officer and the federal receiver for California's prison health care system, and they prepared a corrective action plan to address the issues.

- One institution does not perform medical screenings before transferring Enhanced Outpatient Program (EOP) inmates to the Support Care Unit (SCU). Not performing medical screenings potentially exposes inmates and staff members to infectious diseases. In fact, during the inspection the SCU was in quarantine for tuberculosis exposure. We reported this issue to management for appropriate action.

- At multiple institutions, cell searches are not consistently performed or documented. Cell searches are an important method to find and confiscate contraband (including weapons), and the failure to perform these searches compromises institutional safety and security. We reported this issue to management for appropriate action.

- We discovered that staff members at two institutions were falsifying documents. Specifically, correctional officers were documenting cell checks of inmates in administrative segregation before the specified time. When the specified time arrived, our inspectors saw that officers did not perform the cell checks that they previously documented as taking place. These cell checks are performed to verify the health and safety of inmates in administrative segregation to ensure that they have not harmed themselves or their cellmate. We reported these incidents to the respective wardens for appropriate action.

- At one institution, we reviewed five inmate central files to determine if the classification staff was complying with regulations governing inmate placement in administrative segregation. We found that four of the five inmate cases did not comply with various regulations. Based on our initial review of each case, we determined that staff members may be retaining inmates in administrative segregation for months longer than necessary due to the improper use of tracking tools and the staff's failure to follow Title 15 requirements. We reported this issue to management for appropriate action.

- Further, during a 2007 inspection, we identified several safety and security concerns related to tool control at one institution's bicycle shop; we shared these concerns with the warden. During an inspection this quarter, we toured the bicycle shop to see what corrective action the institution took to make the shop safer and more secure. We found that tool control has improved, dangerous items are now stored in locked containers, and inmate supervision has been increased. Our inspectors noted that these positive changes were a direct result of the OIG's inspection program.

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 prohibit 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.

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 the 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 will use to evaluate each institution.

The inspection process collects over 1,000 data elements for each institution using 148 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.

As of June 30, 2008, we are still in the development and pilot phase of the program. However, we have already performed pilot medical inspections at the following institutions:

- California Institution for Men
- California State Prison, Corcoran
- Calipatria State Prison
- Mule Creek State Prison
- Valley State Prison for Women

For these five pilot inspections, we reviewed the institutions' data related to medical care delivery, and we examined random samples of inmates who receive or require specific medical services. In addition, we conducted live medical emergency drills and observed the adequacy of medical care delivered to inmates. We also interviewed medical and custody staff members about the delivery of inmate medical care.

As we move out of the development and pilot phase, we expect to automate the data collection and reporting process. We will begin statewide medical inspections with one inspection team in September 2008.

Summary of Audits Division Activities

During the second quarter of 2008, the OIG issued its accountability audit of the CDCR. In this accountability audit, we assessed the department's progress in implementing past recommendations from 37 audits and special reviews affecting the CDCR's Adult Operations and Programs, the Division of Juvenile Justice, and the Board of Parole Hearings.

ACCOUNTABILITY AUDIT: REVIEW OF AUDITS OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

In April 2008, we issued our annual follow-up audit of previous recommendations issued to the CDCR. The two-chapter audit analyzed 212 unresolved recommendations from 37 prior reports and special reviews.

Chapter 1 presented results from our first follow-up of the 41 recommendations in four special reviews completed during 2005 and

2006. We found that the department successfully implemented 65 percent of the 41 recommendations. However, the department failed to implement several critical recommendations. For example, the department still does not consistently ensure that all correctional officers at armed posts complete quarterly weapons qualifications. Ignoring this recommendation could endanger staff and inmates and expose the state to preventable litigation costs.

In another example, the department has yet to develop a process to properly account for leave time granted to employees for union activities, potentially wasting state funds. The department has also neglected to collect overpayments from contractors that coordinate substance abuse treatment services—nearly $5.6 million.

Chapter 2 summarized the results of the remaining 171 recommendations from 33 past reports that had been reviewed in previous accountability audits. In this chapter, we found that the department successfully implemented 41 percent of the 171 recommendations.

The CDCR's diligence in addressing our recommendations has progressed steadily since we performed our first accountability audit three years ago—from an initial success rate of 62 percent at the Division of Juvenile Justice, to an overall departmental success rate of 86 percent in 2008, as the following table shows.

Comparison of Initial Implementation Rates to 2008 Rates
Percentage of Recommendations Successfully Implemented

Report	Initial Success Rate	2008 Accountability Audit Success Rate	Change in Success Rate
Division of Juvenile Justice 2005 Accountability Audit	62%	86%	24 Points
Board of Parole Hearings 2005 Accountability Audit	41%	68%	27 Points
Adult Operations and Programs 2006 Accountability Audit	75%	88%	13 Points
Departmental Total	69%	86%	17 Points

Still, concerns remain for the 100 recommendations from prior accountability audits that have not been successfully implemented. Some of these recommendations have remained unimplemented for over seven years and represent problems that place staff members and inmates in danger or potentially waste millions of dollars in state funds.

For instance, in Adult Programs, we noted that inmates at California State Prison, Solano, who suffer from seizures continue to be placed in upper bunks, putting them at risk for injury—and putting the state at risk for litigation. In another example, California State Prison, Sacramento, inmates still do not receive dental exams within 90 days of arrival, as required by a federal court order.

And according to the Division of Juvenile Justice, it still has not ended the practice of isolating youthful offenders in their rooms for long periods. Our 2005 special review found that this practice of long periods of confinement might have contributed to a youthful offender's suicide.

The report presented 14 follow-up recommendations in Chapter 1 and three issues for ongoing review in Chapter 2 to address deficiencies identified during the course of the audit.

You can view the entire 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/2008_Accountability_Audit_WEB_FINAL.pdf

Summary of Intake and Investigations Division Activities

The OIG received 944 complaints this quarter concerning the state correctional system, an average of 315 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 either to 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 second quarter of 2008, the Intake and Investigations Division had 52 ongoing investigations and completed four administrative investigations and five 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 suspicious circumstances surrounding an inmate's suicide.	We conducted an investigation that included a site visit to the prison, interviews with staff members, and a review of documents, photographs, and county coroner's reports. We found no evidence to indicate foul play.	We closed this investigation.
The OIG received a complaint from a health care professional who alleged that unidentified correctional officers assaulted a disruptive inmate, causing serious injuries, and they failed to report the incident.	We conducted an inquiry, which included a site visit and review of several files and documents. We determined that the allegations required further investigation by the Office of Internal Affairs.	We referred the case to the Office of Internal Affairs.
The OIG received a complaint alleging that medical technical assistants employed by the Department of Mental Health used excessive force on a CDCR inmate during a cell extraction.	We conducted criminal and administrative investigations that included a site visit to the prison, a review of documents and photographs, and interviews with staff members from the Department of Mental Health and the CDCR.	We contacted the district attorney's office regarding the allegations, but the district attorney's office declined to pursue the case. We gave the administrative report and its supporting documentation to the hiring authority for appropriate action.
The OIG received a complaint alleging that the CDCR improperly awarded a purchase order for 18 x-ray machines.	We conducted an investigation into potential conflicts of interest between a contractor and CDCR personnel. The investigation found insufficient evidence to support the allegations.	We closed this investigation.
The OIG received a complaint alleging that CDCR correctional officers concealed and/or destroyed evidence related to an incident. It was further alleged that one of the officers, in his position as a firearms dealer, sold weapons from his vehicle while on prison grounds.	We conducted a criminal investigation that included interviews with staff members from the Department of Mental Health and the CDCR. The investigation also included a review of several evidentiary documents.	We forwarded the case to the district attorney's office for prosecution.
The OIG learned of potential misconduct by prison employees who had allegedly released an inmate in violation of department policies.	We conducted an investigation that included a review of the inmate's central file; a review of pertinent laws, policies, and procedures; and interviews with prison staff members. Our investigation found that the employees did not make appropriate arrangements for the inmate's release from prison, as required by department policies.	As a result of our investigation, the subject employees were disciplined by the hiring authority.

Allegation	Investigation	Result
The OIG received a complaint alleging that a parole manager inappropriately altered parole discharge papers with correction fluid. The complaint alleged potential violations of Penal Code section 115 and other statutes regulating the discharge of parolees under Penal Code section 3001.	We conducted an inquiry into the issues raised by the complainant. During the inquiry, we reviewed applicable California law and Division of Adult Parole Operations policy. Also during the inquiry, we reviewed documents, conducted interviews, and visited various parole offices. The inquiry revealed that there was insufficient evidence to support the allegations.	We closed this investigation.
The OIG received a complaint alleging that a CDCR manager failed to accurately report an incident of discourteous treatment.	We conducted an investigation that included interviewing the complainant, CDCR staff members, and the subject employees. The investigation also included a review of key documents and policies.	We gave the report and supporting documentation to the hiring authority, which took disciplinary action against the manager.
The OIG received a complaint alleging that a CDCR manager acted disparately in the issuance of corrective action to another CDCR manager.	We conducted an investigation that included interviewing the complainant, CDCR staff members, and the subject employees. The investigation also included a review of key documents and policies.	We closed this investigation.