QUARTERLY REPORT

OCTOBER - DECEMBER 2009

OFFICE OF THE INSPECTOR GENERAL

BUREAU OF AUDITS AND INVESTIGATIONS

AND

BUREAU OF CRIMINAL INVESTIGATIONS

Introduction

The Office of the Inspector General (OIG) investigates, inspects, 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, 2009, through December 31, 2009. These functions are performed primarily by the Bureau of Audits and Investigations (BAI) and the Bureau of Criminal Investigations (BCI). The BCI was created in September 2009 to help the OIG more effectively concentrate its resources and uncover criminal activity in California's prisons.

This 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 2009. 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 2009, the Governor submitted three warden candidates and one superintendent candidate to the OIG for evaluation. Also in this quarter, the OIG completed its evaluation of two wardens whose names were submitted to our office in the previous quarter, and we presented our recommendations to the Governor's Office for final determination. The CDCR withdrew one candidate's name for evaluation during the vetting process.

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, by being deliberately indifferent to their serious medical needs. In 2002, the parties agreed to several changes designed to improve medical care at the prisons. Subsequently, the federal court established a receivership and stripped 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. This effort resulted in a 21-part 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 165 questions on 20-component areas of medical delivery.

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 considered 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 2009, the medical inspection unit issued reports for medical inspections of five institutions: California Rehabilitation Center, California Institute for Women, Avenal State Prison, High Desert State Prison, and San Quentin State Prison. The attached schedule summarizes the weighted scores by component for the 16 institutions for which public reports were issued as of December 31, 2009.[1]

We also performed fieldwork for medical inspections at four institutions: California Conservation Center, North Kern State Prison, Folsom State Prison, and Kern Valley State Prison.

From September 2008 through November 2009, the Medical Inspection Program operated with only one team of inspectors. Starting in December 2009, the unit added a second team, resulting in doubling the number of inspections conducted to about two per month.

Audits

One-Year Reviews

In the fourth quarter of 2009, the Audits Division issued one-year reviews on the performance of the wardens at Chuckawalla Valley State Prison and Ironwood State Prison. The purpose of these reviews is to assess the warden's performance one year after his or her appointment to the position. During these reviews, the OIG:

- surveys employees, key stakeholders, and department executives;
- analyzes operational data compiled and maintained by the department;
- interviews employees, including the Warden; and
- makes an onsite inspection of the institution.

The reviews compile information and focus on four key areas: safety and security, inmate programming, business operations, and employee-management relations.

[1] Please refer to Appendix B at the end of this report for a detailed summary of our results.

Chuckawalla Valley State Prison (CVSP)

In December 2009, we issued a one-year review of Warden John Salazar. The review found Warden Salazar has successfully transitioned to his role and gained a reputation as an ethical, professional, and approachable leader. CVSP employees rated his management skills and qualities as 'outstanding' overall, and the employees we surveyed believe that he is an effective leader, given all of the institution's challenges. In addition, CVSP employees told us that morale and communication, in general, have significantly improved since Salazar became warden in August 2007.

Warden Salazar's performance in the areas of safety and security and employee-management relations was viewed favorably with 85% and 80% of employees giving him a positive rating, respectively. Factors contributing to Warden Salazar's success in the area of safety and security include his handling of the activation and deactivation of housing facilities necessitated by renovations to the living units, as well as the conversion of two yards from general population to sensitive needs yards.[2] With regard to employee-management relations, Warden Salazar's communication skills have helped to forge positive relations with the staff and bargaining units.

In the area of inmate programming, Warden Salazar has been successful at minimizing missed class time, which is consistently lower than the average both statewide and for similar institutions. Further, Warden Salazar's support for inmate programming was acknowledged by education and substance abuse treatment staff, as well as a representative from the Inmate Advisory Council. Rehabilitative initiatives supported by the warden include expanding self-help groups and moving a substance abuse program to more suitable space within the prison to improve program delivery and effectiveness. Specific programming accomplishments include establishing a weekly youth diversion program that inmates presented to more than 600 children from local schools, 200 inmates graduating from the institution's Alternative to Violence class programs, 154 inmates receiving General Education Development (GED) certificates, and 16 inmates receiving college degrees.

Nevertheless, there are items that Warden Salazar should address. First, the institution has a relatively high number of vacant positions – 17% across all classifications. In custody and support positions, the vacancy rate is at or close to 20%. While the location of CVSP makes recruiting difficult, the warden needs to work with CDCR headquarters to identify ways to attract needed staff to the institution. Second, only 56% of employees rated the institution's business operations favorably. Among

[2] Because of factors like commitment offense, notoriety, or gang affiliation, some inmates cannot be housed with general population inmates safely and therefore must be placed on sensitive needs yards.

administrative, plant operations, and other support staff, Warden Salazar's rating was only 39% positive. While it appears that the low rating is a result of staffing challenges at CVSP, the Warden should also work with staff to identify ways to mitigate the issues and concerns in order to improve operations and maintain staff morale.

Ironwood State Prison (ISP)

In November 2009, we issued a one-year review of Warden Debra Herndon. The review found Warden Herndon's managers and other employees rated her management skills and qualities as very good to outstanding, and employees view her as an effective leader. Almost all ISP employees we interviewed told us the institution's operations have improved since she became warden in October 2007.

Overall, 80% of employees gave Warden Herndon positive ratings in the areas of safety and security, inmate programming, and employee-management relations. One of Warden Herndon's accomplishments in the area of safety and security is reducing the backlog of use-of-force reviews/appeals. Whenever correctional officers use force to quell an incident or gain compliance from an inmate, that use of force must be reported and reviewed for appropriateness. Prior to Warden Herndon, there was a backlog in reviewing these incidents. Reducing the backlog is important as delays in this process jeopardize the department's ability to discipline or provide additional training to staff who may have not been in compliance with departmental policies and procedures. In the area of employee-management relations, Warden Herndon is viewed by staff as approachable and caring, indicating that she is an effective communicator.

Nevertheless, we found some areas that the warden could improve upon. First, in the area of administrative segregation, inmates at ISP have an average length of stay that is significantly longer than both the average statewide and for similar institutions. While the prison faces significant hurdles and special circumstances that may contribute to the longer average stay, ISP has also had instances where it did not meet timelines for preparing reports and conducting reviews of the inmate's administrative segregation placement. Warden Herndon needs to closely monitor administrative segregation, as procedural delays may unnecessarily lengthen inmates' stays, violate their due process rights, and increase cost to the state. Second, ISP's lost education time per inmate consistently exceeds the statewide average. Rehabilitation programs, such as education, can decrease inmates' time in prison and improve their chances for a successful parole. Therefore, Warden Herndon should make efforts to decrease lost educational time by judiciously using lockdowns, aggressively working to fill teaching vacancies, and exploring alternate ways of providing educational services to inmates during lockdowns.

Special Reports

In November 2009, the Special Investigations Unit released a special report on CDCR's supervision of parolee Phillip Garrido. Garrido was arrested along with his wife in August 2009 for the 1991 kidnapping and sexual assault of then 11-year-old Jaycee Dugard. During the course of the following 18 years, Garrido reportedly sexually assaulted Jaycee—fathering two children—while holding her captive on the grounds of his residence in Antioch, California.

For the last 10 years, Corrections' parole division supervised Garrido. This special report shined a public light on systemic problems that transcended parolee Garrido's case and jeopardized public safety. The investigation resulted in 11 recommendations to help Corrections address the deficiencies we identified in parolee supervision.

Among other findings, the special report reveals that during the time Corrections was responsible for Garrido, the department failed to supervise him as a high-risk sex offender, adequately train parole agents to conduct parolee home inspections, and use GPS information to determine that Garrido was violating the terms of his parole. The department's passive GPS monitoring program falls short of its potential and provides the public with a false sense of security, raising concerns about its current and future use.

Intake and Investigations

The OIG received 652 complaints this quarter concerning the state correctional system, an average of 217 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, inspections, 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 bring about an informal remedy.

Depending on the circumstances surrounding a complaint, we may refer cases to CDCR's Office of Internal Affairs (OIA) for investigation. Cases

referred to the OIA may be monitored by the OIG's Bureau of Independent Review (BIR) if they meet applicable criteria. The BIR reports its monitoring activities semiannually in a separate report.

Some allegations or incidents require preliminary or full investigation by the OIG. In addition to large-scale investigations, the OIG initiates routine preliminary investigations into critical incidents occurring within CDCR, such as inmate deaths, civilian homicides committed by parolees, civil rights violations, and major security concerns occurring in the department. When the OIG identifies a critical incident, a preliminary investigation is conducted to identify any misconduct by staff or inmates, potential policy violations, or systemic issues that may warrant further action by the OIG. During the fourth quarter of 2009, the Bureau of Audits and Investigations and the Bureau of Criminal Investigations had 146 ongoing investigations and completed one criminal investigation, six administrative investigations, and seven preliminary investigations. Those completed investigations are summarized in the table that follows.[3]

[3] Please refer to Appendix A.

Allegation/Incident	Investigation	Result
The OIG received a complaint alleging that CDCR contract psychiatrists were over-billing for hours that they did not provide services.	The OIG conducted a criminal investigation that included collection of volunteer/contractor logs, video tapes, GPS data, and medical invoices. Investigators also interviewed witnesses and the subject.	The OIG submitted its findings to the Monterey County District Attorney's office for criminal filing and closed this case.
The OIG received a complaint alleging that a prison's chief medical officer was not fulfilling his full time employment obligation because he was also working as a physician at a separate facility.	The OIG conducted a preliminary investigation that included a complainant interview, a review of personnel records, CDCR time sheets, and time sheets from a medical registry.	The OIG closed the case due to insufficient evidence.
The OIG received a complaint alleging that CDCR staff members assigned to a Division of Juvenile Justice facility were staging fights between wards.	The OIG conducted a preliminary investigation that included interviews with the CDCR Division of Juvenile Justice Headquarters and a review of policies, procedures, case records, and incident reports. Investigators also interviewed wards and staff.	The OIG found insufficient evidence to indicate any wrongdoing and closed this investigation.
The OIG received a complaint that alleged a correctional officer encouraged an inmate to commit suicide.	The OIG conducted an administrative investigation that included the collection and review of departmental policies and procedures and interviews of departmental staff.	The OIG found no evidence to support the allegations and closed this investigation.
The OIG received information from a confidential informant alleging that medical invoice processing errors were resulting in overpayments to medical providers and that staff were being directed not to review the claims for errors.	The OIG conducted a preliminary investigation that included interviews with the confidential informant and CDCR staff.	The OIG closed the investigation and combined the information with another review.
The OIG conducted a routine review of the circumstances surrounding a CDCR prison riot motivated by racial issues.	The OIG conducted a preliminary investigation into the riot participants housing assignments, classification factors, and rules violation reports from the riot.	The OIG determined that the institution did not violate policies or procedures and closed this investigation.
The OIG received a complaint that alleged managers violated California Government Code section 8547.3 by retaliating against an employee who participated in a protected activity.	The OIG conducted an administrative investigation that included interviews of departmental staff, collection and review of documents, and computer forensic examination.	The OIG closed this investigation due to a lack of evidence.

Allegation/Incident	Investigation	Result
The OIG received an inquiry from State Senator Darrell Steinberg questioning why a DJJ substance abuse treatment program (SATP) was being under-utilized based upon the program's budgeted capacity.	The OIG conducted a preliminary investigation that included interviews with employees at the youth correctional facility and headquarters staff. We also reviewed relevant documents and policies.	The OIG determined that the SATP had recently been established at the facility and was integrating youth into the program in intervals. The OIG forwarded the findings to Senator Steinberg, the CDCR secretary, and the DJJ chief deputy secretary.
The OIG received an allegation concerning possible fraudulent billing by a substance abuse community based provider that serves parolees.	The OIG conducted a preliminary investigation into the allegations, interviewing parole agents and other witnesses and reviewing billing documents.	The OIG has referred this matter to the California Attorney General's office and the California Franchise Tax Board to investigate a possible violation of tax laws concerning the provider's non-profit status.
The OIG received an allegation that a non-CDCR attorney falsified documents during a Board of Parole Hearings procedure.	The OIG conducted an administrative investigation that included the collection and review of documents and inquiries to the California State Bar.	The OIG's inquiry revealed that an attorney did inappropriately modify documents. The OIG referred the allegation and supporting documentation to the California State Bar for appropriate course of action and closed this investigation.
The OIG received an allegation that a CDCR correctional staff member was the victim of vandalism to his vehicle on prison grounds. The complaint indicated the vandalism was an act of retaliation.	The OIG conducted an administrative investigation to identify subjects and evaluate possible violations of department policy and/or administrative rules.	The OIG closed this case due to a lack of evidence.
The OIG received a complaint that alleged a high level prison administrator failed to initiate an investigation upon becoming aware of an allegation of potentially serious employee misconduct.	The OIG conducted an administrative investigation that included the collection and review of documents, interviews with departmental staff, and an evaluation of violations of department policy and/or administrative rule violations.	The OIG identified no administrative wrongdoing during its inquiry, and this investigation was closed.
The OIG received a complaint alleging an acting warden improperly influenced an institution's hiring of a member of the acting warden's family.	The OIG conducted an administrative investigation that included reviewing pertinent hiring documents and interviewing witnesses, who may have had information related to the alleged improper influence.	No evidence was found to support the allegations, and the OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received an allegation that a CDCR dentist was transferring guns from Arizona to California and possibly selling them illegally.	The OIG conducted an administrative investigation and monitored an interview conducted by the Bureau of Alcohol, Tobacco, Firearms and Explosives, where the subject admitted purchasing weapons in Arizona for personal use and maintaining them in his California residence.	The OIG identified no wrongdoing and closed this investigation.

Appendix B

Medical Inspection Results

	California State Prison, Sacramento	California Medical Facility	R.J. Donovan Correctional Facility	Centinela State Prison	Deuel Vocational Institution	Central California Women's Facility	California Men's Colony	Sierra Conservation Center	California State Prison, Los Angeles County	Pleasant Valley State Prison	California Correctional Institution	California Rehabiliation Center	California Instiution for Women	Avenal State Prison	High Desert State Prison	San Quentin State Prison	Average Score	Median Score
	Report issued Nov 2008	Report issued Jan 2009	Report issued Feb 2009	Report issued Feb 2009	Report issued Mar 2009	Report issued May 2009	Report issued May 2009	Report issued June 2009	Report issued July 2009	Report issued Aug 2009	Report issued Sept 2009	Report issued Oct 2009	Report issued Nov 2009	Report issued Dec 2009	Report issued Dec 2009	Report issued Dec 2009		
Chronic Care	62.7%	83.6%	48.8%	80.9%	73.5%	73.2%	57.3%	75.0%	70.1%	56.9%	61.8%	67.1%	69.6%	59.2%	45.0%	64.6%	65.6%	65.9%
Clinical Services	67.0%	87.1%	67.2%	80.1%	72.8%	74.1%	74.2%	71.1%	65.5%	46.7%	57.4%	70.2%	61.7%	64.4%	51.1%	46.6%	66.1%	67.1%
Health Screening	76.4%	86.8%	68.0%	77.8%	74.3%	84.3%	73.2%	61.0%	68.8%	67.1%	78.3%	74.2%	69.8%	80.7%	72.3%	76.5%	74.3%	74.3%
Specialty Services	47.4%	42.6%	62.3%	59.6%	53.4%	52.6%	63.4%	73.1%	70.3%	60.6%	57.3%	59.2%	63.1%	74.1%	53.2%	58.0%	59.4%	59.4%
Urgent Services	82.5%	79.1%	73.2%	80.2%	77.5%	89.4%	83.7%	89.1%	80.2%	80.5%	82.7%	81.2%	75.4%	70.2%	71.9%	62.9%	78.7%	80.2%
Emergency Services	47.5%	72.1%	89.7%	76.7%	71.0%	80.1%	85.5%	75.9%	84.0%	82.8%	77.9%	72.9%	80.0%	78.1%	72.1%	78.3%	76.5%	78.0%
Prenatal Care/Childbirth/Post-Delivery	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	61.3%	N/A	N/A	N/A	61.3%	61.3%
Diagnostic Services	68.1%	72.2%	64.0%	74.4%	73.7%	83.8%	70.0%	85.7%	54.0%	64.6%	60.4%	58.5%	70.6%	86.7%	42.9%	69.4%	68.7%	69.7%
Access to Healthcare Information	39.2%	58.8%	44.1%	82.4%	58.8%	53.9%	39.2%	82.4%	72.5%	62.7%	54.9%	77.5%	58.8%	19.6%	58.8%	53.9%	57.3%	58.8%
Outpatient Housing Unit	75.6%	85.5%	N/A	N/A	82.8%	N/A	N/A	75.2%	N/A	N/A	73.3%	74.8%	63.3%	71.3%	N/A	83.3%	76.1%	75.2%
Internal Reviews	70.4%	68.8%	100.0%	60.8%	93.3%	97.9%	70.4%	60.4%	73.0%	70.5%	60.0%	90.5%	95.1%	65.5%	62.5%	68.8%	75.5%	70.4%
Inmate Transfers	75.3%	50.0%	89.5%	100.0%	78.9%	100.0%	94.2%	95.3%	100.0%	76.0%	43.2%	100.0%	80.0%	100.0%	100.0%	100.0%	86.4%	94.8%
Clinic Operations	91.0%	82.8%	94.9%	81.8%	87.9%	85.9%	84.8%	87.9%	90.0%	92.7%	90.6%	86.4%	97.9%	93.9%	90.9%	100.0%	90.0%	90.3%
Preventive Services	32.1%	43.7%	24.0%	19.0%	21.7%	58.7%	53.0%	28.0%	20.0%	27.3%	7.3%	82.0%	32.6%	60.3%	24.0%	48.7%	36.4%	30.1%
Pharmacy Services	74.5%	75.9%	93.3%	57.8%	92.0%	92.0%	90.8%	90.8%	100.0%	72.4%	79.3%	79.3%	95.2%	92.1%	100.0%	86.2%	85.7%	90.8%
Other Services*	90.6%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	55.0%	100.0%	70.0%	85.0%	70.0%	57.1%	70.0%	72.7%	85.0%	84.1%	87.8%
Inmate Hunger Strikes	10.5%	31.6%	10.5%	31.6%	N/A	100.0%	71.1%	N/A	42.1%	36.8%	45.8%	N/A	N/A	N/A	44.2%	53.7%	43.4%	42.1%
Chemical Agent Contraindications	100.0%	86.8%	94.1%	89.4%	89.4%	64.7%	100.0%	100.0%	90.6%	66.3%	66.3%	100.0%	100.0%	100.0%	100.0%	89.4%	89.8%	92.4%
Staffing Levels and Training	95.0%	95.0%	100.0%	100.0%	95.0%	85.0%	100.0%	100.0%	90.0%	80.0%	90.0%	85.0%	85.0%	100.0%	100.0%	95.0%	93.4%	95.0%
Nursing Policy	78.6%	35.7%	88.6%	71.4%	35.7%	100.0%	78.6%	94.3%	57.1%	100.0%	50.0%	75.7%	64.3%	67.1%	88.6%	70.0%	72.2%	73.6%
Overall Score	**65.2%**	**72.4%**	**68.0%**	**74.4%**	**72.6%**	**77.9%**	**71.3%**	**76.1%**	**71.7%**	**64.5%**	**64.3%**	**74.3%**	**69.6%**	**70.4%**	**62.4%**	**68.2%**	**70.2%**	**70.9%**

* Other services include the prison's provision of therapeutic diets, its handling of inmates who display poor hygiene, and the availability of the current version of the department's Inmate Medical Services Policies and Procedures