QUARTERLY REPORT

BUREAU OF AUDITS AND INVESTIGATIONS

JULY - SEPTEMBER 2009

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 July 1, 2009, through September 30, 2009. 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 third 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 third quarter of 2009, the Governor submitted three warden candidates to the OIG for evaluation. The OIG vetted two warden candidates and submitted the findings to the Governor's Office for final determination.

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 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 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' attorneys. 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 162 questions on 21-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 considered less serious.

Results

During the third quarter of 2009, the medical inspection unit issued reports for medical inspections of three institutions: California State Prison, Los Angeles County; Pleasant Valley State Prison; and California Correctional Institution. The attached schedule summarizes the weighted scores for the 11 institutions for which public reports were issued as of September 30, 2009.[1]

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

Also during the third quarter of 2009, we performed medical inspections at three institutions for which results were not yet published. Inspection results are pending for the following inspections performed during the third quarter: Avenal State Prison, San Quentin State Prison, and High Desert State Prison.

Audits

California State Prison, Solano Quadrennial Audit

The OIG is statutorily required to audit each adult institution at least once every four years. In July 2009, we issued our audit report on California State Prison, Solano (Solano). The report presented four findings and 19 recommendations to remedy issues where the prison and/or department need to improve performance or achieve compliance with laws and regulations. One significant report finding related to wasteful procurement and warehousing practices. Despite state law that requires the department to minimize fiscal waste, we found 483 pieces of new equipment valued at $215,000 sitting unused in storage areas. Most of the new equipment – including computers and fan motors – was one or two years old, but some items were up to ten years old. Much of the unused equipment identified at Solano was part of larger statewide purchases, and similar equipment from those purchases has been noted at several other prisons. Therefore, it appears the procurement and warehousing problems extends beyond Solano and may have cost the department in excess of $6.8 million statewide.

In addition to the procurement and warehousing issues, we also found that Solano was not:

- effectively using its limited resources to rehabilitate inmates;
- ensuring that staff assigned to armed posts had met the required firearms qualification; and,
- adequately safeguarding inmate central files.

One-Year Reviews

In the third quarter of 2009, the Bureau of Audits and Investigations issued one-year reviews on the performance of the wardens at California State Prison, Corcoran, Sierra Conservation Center, and California Substance Abuse Treatment Facility and 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;
- interviews employees, including the warden; and,
- makes an onsite inspection of the institution.

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

California State Prison (CSP), Corcoran

In August 2009, we issued a one-year review of Warden Derral Adams. The review found Warden Adams has competently managed the large and complex maximum security prison, CSP Corcoran. Overall, many Corcoran employees we interviewed told us the institution's operations have improved since Adams became warden in July 2007. On average, Warden Adams was rated from very good to outstanding by managers and employees.

During his tenure as warden, Adams has affected several positive changes. For example, in the area of inmate programming and education, in order to improve inmate literacy, the warden implemented a requirement that all inmates must read at the ninth grade before they are eligible for a paying job in the prison. In addition, to minimize class cancellations, CSP Corcoran uses teachers affected by partial lockdowns as substitute teachers in other parts of the education program. In the area of business operations, the warden has overseen numerous facility and infrastructure improvements including adding exercise yard fence lines, making improvements to the sewage treatment plant, and purchasing new kitchen equipment.

Warden Adams' performance was rated positively in the area of safety and security. Based on available department data, under Warden Adams, the per capita use of force incidents at CSP Corcoran are consistently lower than similar maximum security prisons. Also, inmates' average length of time in administrative segregation at CSP Corcoran is consistent with other maximum security prisons.

Nevertheless, there are several items that Warden Adams should address. First, CSP Corcoran appears to have significant vacancies in administrative support positions, such as secretaries, analysts, etc. Second, only 51% of custody employees rated employee-management relations positively. This appears to the result of strained relations between a local union president and the warden. Therefore, the warden should work to increase and improve communication with custody staff.

Sierra Conservation Center (SCC)

In August 2009, we issued a one-year review of Warden Ivan Clay. Our review found Warden Clay has successfully transitioned to his role as warden of the minimum security facility and southern camps program. Warden Clay is considered knowledgeable and is well respected by his employees and superiors. SCC employees told us the operation of the institution has improved since Clay became warden in July 2007. Overall, Warden Clay was rated from very good to outstanding by managers and employees.

While warden, Clay has effectively dealt with challenges, such as implementing the department's integrated housing policy, and supported rehabilitative programs, including the establishment of an additional self-help program called Freedom of Choice. Further, under Warden Clay, SCC has been more effective than similar institutions in minimizing inmates' time in administrative segregation and use of force.

Challenges for Warden Clay included limited knowledge of business operations and addressing facility needs given limited resources.

California Substance Abuse Treatment Facility and State Prison (SATF)

In September 2009, we issued a one-year review of Warden Ken Clark. Our review found Warden Clark has competently managed SATF, which is the largest prison in California with approximately 7,000 male inmates. Overall, Warden Clark was rated from very good to outstanding by managers and employees.

In the area of safety and security, Warden Clark was rated positively. Clark is credited with making the institution more security conscious and is considered proactive. Warden Clark has tightened tool control, emphasized the checking of employee identification and authorization, and instituted security audits. Based on available department data, under Warden Clark, the per capita use of force incidents at SATF are consistently lower than prisons with the same mission and security level.

With regard to issues such as inmates' average length of time in administrative segregation, lost class time ("S-time), and employee grievances, SATF is performing similar to like prisons.

Nevertheless, there are several items that Warden Clark should address. First, some employees voiced criticism of Warden Clark's administration of the employee disciplinary process, stating concerns that discipline is unevenly applied. While we are not aware of any systemic issues

regarding the application of the disciplinary process at SATF, there appears to be an issue regarding some employees' understanding and perception of the process. Therefore, in order to maintain staff morale, Warden Clark should work to address this issue.

Other staff members were concerned about what they perceived as Warden Clark's lack of visibility in the prison's yards. He also acknowledged that communication with employees is very important and stated his intent to increase his visibility by visiting the yards more often. Notwithstanding these two items, most employees were positive about Warden Clark's overall performance and confident in his abilities.

Intake and Investigations

The OIG received 870 complaints this quarter concerning the state correctional system, an average of 290 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 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 third quarter of 2009, the Bureau of Audits and Investigations had 142 ongoing investigations and completed three administrative investigations and thirteen preliminary investigations. Those completed investigations are summarized in the table that follows.

Allegation/Incident	Investigation	Result
While conducting a criminal investigation into allegations that CDCR staff conspired to conceal misconduct, the OIG found insufficient evidence to support criminal activity. Evidence was discovered, however, to support an administrative investigation for the alleged misconduct.	The OIG conducted an administrative investigation that included seizing and forensically examining multiple CDCR computers, collecting and reviewing documentary evidence, and conducting interviews with numerous CDCR staff.	The investigation found that CDCR staff failed to fully investigate and document allegations of misconduct. The investigation also found that a former CDCR manager failed to appropriately supervise the staff member's activities. The OIG provided the results of our investigation to the hiring authority for appropriate disciplinary action.
The OIG received an allegation that a CDCR employee violated conflict of interest laws and destroyed public documents during a bid solicitation.	The OIG conducted a criminal investigation that included numerous staff interviews; review of bid, procurements and accounting documents; and consultations with the Office of the Attorney General.	The OIG presented the results of the investigation to a Deputy Attorney General assigned to the case. The Office of the Attorney General rejected the criminal filing of the case due to insufficient evidence. The OIG prepared a separate administrative investigation identifying potential administrative violations and forwarded the results to the CDCR for appropriate action.
The OIG conducted a routine preliminary investigation concerning the arrest of a parolee for driving while intoxicated and with a suspended license that resulted in the death of two people and one person critically wounded.	The OIG conducted a preliminary investigation into this case that included contact with the California Highway Patrol, CDCR parole staff, and CDCR records along with a review of numerous documents, parole agent case records, and the parolee's case history. The OIG determined that staff from the Division of Adult Parole Operations acted within CDCR policies and procedures.	The preliminary investigation found no issues regarding staff's actions to warrant further investigation. The OIG closed this investigation.
The OIG reviewed the placement of an inmate who murdered his cellmate.	The OIG conducted a preliminary investigation into the murder suspect's central file. Originally, one central file was believed to be incomplete or missing critical documentation. Our investigation determined the document was completed and only misfiled.	The preliminary investigation found no issues regarding staff's actions to warrant further investigation. The OIG closed this investigation.
The OIG received information alleging that doctors were operating private practices and/or working at other state facilities as contract doctors while being employed by CDCR.	The OIG conducted a preliminary investigation that included a review of documents and interviews with CDCR staff and staff from other state agencies.	The OIG closed the preliminary investigation after determining there was no evidence to support the allegations.

Allegation/Incident	Investigation	Result
The OIG initiated an investigation relating to the supervision of a parolee responsible for the homicide of a civilian while on parole.	The OIG conducted a preliminary investigation that included the collection and review of parole records, crime/incident reports, investigative reports, departmental policy, and state regulations.	The OIG found no violations of departmental policies, procedures, or state regulation and closed this inquiry.
The OIG initiated a preliminary investigation into the necessity for CDCR health care service to refer inmates to outside clinics for sleep studies.	The OIG conducted a preliminary investigation that included a review of CDCR health care cost and utilization data, expenditure information, and transportation and custody coverage estimates. The investigation found during a nine-month period ending in March, 2008, that CDCR conducted 90 in-house sleep studies and 206 studies in the community. The estimated total costs during that period were $839,721.	The preliminary investigation revealed that CDCR conducts sleep studies both on prison grounds and at community based clinics. The decisions to perform these studies are made by licensed physicians and are based upon medical necessity for conditions such as sleep apnea. The OIG closed this case; no further investigation is warranted.
The OIG received an allegation that an inmate clerk had access to other inmates' confidential information and that information was being divulged, putting those inmates at risk.	The OIG conducted a preliminary investigation that included the review of documentation to determine if any confidential information could have been available to an inmate clerk.	The OIG found no evidence to support the allegations that an inmate clerk had access to confidential information.
The OIG received an allegation that an institution's investigative services unit was providing assistance to outside law enforcement agencies without the approval of the warden.	The OIG conducted a preliminary investigation consisting of interviews with institution staff, including the Warden and investigative services unit staff.	The OIG found no evidence to support the allegations or warrant an administrative investigation.
The OIG initiated a routine preliminary investigation of a parolee suspected of committing murder while on parole.	The OIG conducted a preliminary investigation, reviewing the parolee's parole and field files and interviewing the involved parole personnel.	The OIG determined all policies were followed and the involved parole staff assisted the local law enforcement agency to apprehend the parolee after he was identified as a suspect in a murder.
The OIG received an allegation that a CDCR institution sends inmates to an outside medical provider for unnecessary procedures.	The OIG conducted a preliminary investigation that included a complainant interview, review of medical transportation logs, CDCR medical contracts, and medical invoices.	The OIG closed this case due to insufficient evidence indicating misconduct.
The OIG initiated an investigation that focused on whether CDCR staff failed to follow established policies and procedures while conducting an investigative inquiry.	The OIG conducted an administrative investigation that included the collection and review of documents, interviews with departmental staff, and an evaluation of violations of departmental policy and/or administrative rule violations.	During the investigation, the OIG identified a subject and discovered facts to support that administrative wrongdoing occurred. The OIG forwarded the report to the hiring authority for appropriate action and closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received information concerning an allegation of staff misconduct at a CDCR, Division of Juvenile Justice (DJJ) facility.	The OIG conducted a preliminary investigation that included a review of CDCR and DJJ policy and procedures, a review of the facility's records and video footage, and interviews with a ward and numerous staff members.	The OIG found insufficient evidence to indicate any wrongdoing by staff and determined that staff members from the DJJ acted within CDCR policies.
The OIG initiated a routine preliminary investigation of a parolee suspected of committing murder while on parole.	The OIG conducted a preliminary investigation by reviewing the parolee's parole and field files and interviewing the involved parole personnel.	We determined all policies were followed and the involved parole staff assisted the local law enforcement agency to apprehend the parolee after he was indentified as a suspect in a murder.
The OIG received an allegation that information technology (IT) equipment was being hidden in a prison's mail room to conceal the fact that surplus equipment was not being effectively managed and deployed.	A site visit to the prison concluded that IT staff appropriately utilizes a portion of the prison's mailroom as an IT equipment storage location for un-deployed and surplus equipment. The investigation also found that current up-to-date inventory records of the stored equipment were not available. As a result, we could not independently determine if all the stored equipment was accountable.	The OIG closed this preliminary investigation.

Appendix A

	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	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		
Chronic Care	62.7%	83.6%	48.8%	80.9%	73.5%	73.2%	57.3%	75.0%	70.1%	56.9%	61.8%	67.6%	70.1%
Clinical Services	67.0%	87.1%	67.2%	80.1%	72.8%	74.1%	74.2%	71.1%	65.5%	46.7%	57.4%	69.4%	71.1%
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%	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%	58.4%	59.6%
Urgent Services	82.5%	79.1%	73.2%	80.2%	77.5%	89.4%	83.7%	89.1%	80.2%	80.5%	82.7%	81.6%	80.5%
Emergency Services	47.5%	72.1%	89.7%	76.7%	71.0%	80.1%	85.5%	75.9%	84.0%	82.8%	77.9%	76.7%	77.9%
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	N/A
Diagnostic Services	68.1%	72.2%	64.0%	74.4%	73.7%	83.8%	70.0%	85.7%	54.0%	64.6%	60.4%	70.1%	70.0%
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%	59.0%	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%	78.5%	75.6%
Internal Reviews	70.4%	68.8%	100.0%	60.8%	93.3%	97.9%	70.4%	60.4%	73.0%	70.5%	60.0%	75.0%	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%	82.0%	89.5%
Clinic Operations	91.0%	82.8%	94.9%	81.8%	87.9%	85.9%	84.8%	87.9%	90.0%	92.7%	90.6%	88.2%	87.9%
Preventive Services	32.1%	43.7%	24.0%	19.0%	21.7%	58.7%	53.0%	28.0%	20.0%	27.3%	7.3%	30.4%	27.3%
Pharmacy Services	74.5%	75.9%	93.3%	57.8%	92.0%	92.0%	90.8%	90.8%	100.0%	72.4%	79.3%	83.5%	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%	90.1%	100.0%
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%	42.2%	36.8%
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%	86.1%	89.4%
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%	93.6%	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%	71.8%	78.6%
Overall Score	**65.2%**	**72.4%**	**68.0%**	**74.4%**	**72.6%**	**77.9%**	**71.3%**	**76.1%**	**71.7%**	**64.5%**	**64.3%**	**70.8%**	**71.7%**

* 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.