QUARTERLY REPORT

JANUARY – MARCH 2010

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, monitors 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 January 1, 2010 through March 31, 2010. These functions are performed primarily by the Bureau of Audits and Investigations (BAI) and the Bureau of Criminal Investigations (BCI).

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 medical inspections completed during the first quarter of 2010. 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 first quarter of 2010, the governor submitted three warden candidates to the OIG for evaluation. Also in this quarter, the OIG vetted one warden candidate whose name was submitted to our office in the previous quarter, and we submitted the findings to the Governor's Office for final determination. One warden candidate was withdrawn by CDCR and was not vetted.

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 medical inspection instrument that collects over 1,000 data elements for each institution in 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 first quarter of 2010, the Medical Inspection Unit issued medical inspection reports of four institutions: California Correctional Center, North Kern State Prison, Kern Valley State Prison, and Folsom

State Prison. The attached schedule summarizes the component scores for the four institutions for which public reports were issued during the first quarter.

	California Correctional Center	North Kern State Prison	Kern Valley State Prison	Folsom State Prison
	Report issued Jan 2010	Report issued Mar 2010	Report issued Mar 2010	Report issued Mar 2010
Chronic Care	45.7%	58.9%	37.6%	78.8%
Clinical Services	65.9%	64.0%	57.7%	75.8%
Health Screening	80.6%	71.9%	75.4%	88.8%
Specialty Services	70.7%	60.7%	61.7%	80.1%
Urgent Services	83.7%	79.8%	61.0%	87.6%
Emergency Services	89.7%	81.0%	71.9%	83.6%
Prenatal Care/Childbirth/Post-Delivery	N/A	N/A	N/A	N/A
Diagnostic Services	70.8%	67.9%	85.6%	80.4%
Access to Healthcare Information	77.5%	72.5%	72.5%	77.5%
Outpatient Housing Unit	82.3%	N/A	N/A	N/A
Internal Reviews	85.5%	85.0%	68.8%	98.0%
Inmate Transfers	92.6%	95.8%	100.0%	95.3%
Clinic Operations	97.0%	90.0%	96.6%	93.9%
Preventive Services	36.7%	55.0%	27.3%	56.7%
Pharmacy Services	69.0%	93.1%	82.8%	100.0%
Other Services *	100.0%	50.0%	50.0%	70.0%
Inmate Hunger Strikes	68.4%	N/A	46.3%	N/A
Chemical Agent Contraindications	100.0%	100.0%	60.0%	100.0%
Staffing Levels and Training	100.0%	95.0%	95.0%	100.0%
Nursing Policy	94.3%	71.4%	57.1%	74.3%
Overall Score	**73.4%**	**72.2%**	**64.0%**	**83.2%**

We also performed fieldwork for medical inspections at six institutions: Valley State Prison for Women; California State Prison, Solano; California Substance Abuse Treatment Facility and State Prison, Corcoran; Ironwood State Prison; Chuckawalla Valley State Prison; and California State Prison, Corcoran.

Audits

One-Year Review at California State Prison, Sacramento

In the first quarter of 2010, the Audits Unit issued a one-year review on the performance of Warden James Walker at California State Prison, Sacramento (SAC). The purpose of this review is to assess the warden's performance one year after his appointment to the position. During this review, the OIG surveyed employees, key stakeholders, and department executives; analyzed operational data compiled and maintained by the department; interviewed employees, including the warden; and inspected the institution.

Our review found Warden Walker had the skills necessary to manage a multi-mission institution like SAC and has successfully performed his job as warden. Most SAC employees we interviewed told us the institution's operations have improved under his stewardship. Warden Walker received mainly positive responses from SAC employees and other stakeholders regarding his performance. On average, the warden's managers and employees rated him between very good and outstanding.

Most notable from the SAC employee survey results was that 85 percent of the prison employees we surveyed had positive opinions about the safety and security of the institution - a high percentage considering that the prison houses maximum security level IV inmates serving long sentences or those who have proved to be management problems at other institutions.

In March 2010, Warden Walker retired from state service.

Intake and Investigations

The OIG received 740 complaints this quarter concerning the state correctional system, an average of 247 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 conduct investigations at the request of CDCR officials in cases that involve potential conflicts of interest or misconduct by high-level administrators. The OIG may also initiate investigations upon request by the Governor or Legislature.

Our staff responds to each complaint or request for investigation; complaints that involve urgent health and safety issues receive immediate attention. The OIG may also review other CDCR issues, including,

employee retaliation, allegations involving sexual misconduct by staff or inmates, fraud or financial waste, or physical abuse. 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 first quarter of 2010, the Bureau of Audits and Investigations and the Bureau of Criminal Investigations had 179 ongoing inquiries and investigations and completed three criminal investigations, two administrative investigations and 17 preliminary investigations. Those completed investigations are summarized in the table that follows.[1]

[1] Please refer to Appendix A.

Allegation/Incident	Investigation	Result
The OIG received an allegation that contract psychiatrists were billing CDCR for more hours than they provided on site.	The OIG conducted a criminal investigation against the first psychiatrist that included collection of volunteer/contractor logs, secured perimeter gate entry video tapes, GPS data, medical invoices, witness interviews, and a subject interview.	The case was submitted to the Monterey County District Attorney's Office for criminal filing. The OIG closed the case due to the District Attorney's successful Nolo Plea for GC6201 [Destroy/Alter/Etc Public Record/Etc], a felony. The subject received probation, paid court costs and made restitution to CDCR in the amount of $42,445.
The OIG received an allegation that contract psychiatrists were billing CDCR for more hours than they provided on site. As a consequence of the investigation into the allegation, the OIG opened a separate investigation against another physician.	The OIG conducted a criminal investigation against the physician that included collection of volunteer/contractor logs, GPS data, time sheets, witness interviews, and a subject interview.	The case was submitted to the Monterey County District Attorney's Office for criminal filing. The subject was indicted by a Grand Jury and pleaded Nolo Contender to PC 487(a), Grand Theft. The subject received probation, paid court costs and made restitution to CDCR in the amount of $16,875.
The OIG received an allegation that a contractor to the Women and Children Services Unit (WCSU) of CDCR was involved in a scheme to defraud the state. In order to participate in the WCSU program, which allows certain female offenders to live in a modified setting where they can raise their children, the inmate's children must surrender their public assistance funds to the contractor who manages the facility, who in turn uses these funds to finance part of the program. The allegation we received claimed the contractor received the public assistance funds and subsequently billed CDCR for one hundred percent of the treatment services it provided.	The OIG conducted a criminal investigation that included interviewing various witnesses and reviewing applicable documents.	The OIG found evidence to support the allegation and referred its findings to the California Attorney General's Office for consideration in filing criminal charges against the contractor.
The OIG received information concerning allegations that a CDCR employee acted in a rude and discourteous manner and presented false or misleading information to an administrative law judge during a State Personnel Board hearing.	The OIG conducted an administrative investigation that included the collection and review of documents, interviews with departmental staff, and an evaluation of department policy and/or administrative rule violations.	During the investigation, the OIG discovered facts to support allegations of administrative wrongdoing. The OIG forwarded the report to the hiring authority for appropriate action and closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee for attempted murder to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation that included a review of parole supervision records and the initial criminal report for the parolee's commitment offense.	The investigation found parole agents properly conducted home contacts and searches prior to the parolee's most recent offense. The OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received allegations that a CDCR correctional staff member was attempting to coerce fellow staff members to engage in a code of silence.	The OIG conducted an administrative investigation that included the collection and review of documents, interviews with departmental staff, and an evaluation of department policy and administrative rule violations.	During the investigation, the OIG discovered facts to support that the CDCR correctional staff member engaged in intimidation, coercion and discourteous treatment of others and failed to comply with the CDCR directive for the Code of Silence. The OIG forwarded the report to the hiring authority for appropriate action and closed this investigation.
The OIG conducted a routine review of the circumstances surrounding an inmate riot at a privately operated community correctional facility (CCF).	The OIG conducted a preliminary investigation to determine if the riot was preventable and if staff responded appropriately. The investigation included interviews of prison staff and a review of incident reports, as well as a digital video of the riot.	The OIG determined that CCF staff members responded appropriately to an unpreventable riot. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding a parolee suspected of murder to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation into the supervision of the parolee that included a review of the parole file and interviews of the involved parole personnel.	The OIG determined all policies were followed and the involved parole staff acted quickly to apprehend the parolee after he was identified as a suspect in the murder. The OIG closed its investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee suspected of carjacking, kidnapping and robbery to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation that included contact with CDCR parole staff and a review of documents related to the supervision of the parolee.	The OIG determined that CDCR parole staff acted within CDCR policies and procedures. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee suspected of vehicle theft and child endangerment to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation into this case that included contact with the CDCR parole staff and a review of documents related to the supervision of the parolee.	The OIG determined that CDCR parole staff failed to follow some CDCR policies and procedures regarding the location and documentation of a Parolee at Large (PAL). The OIG continues to monitor CDCR's progress in revising the method by which PAL's are supervised.
The OIG conducted a routine review of the circumstances surrounding a parolee's connection to the accidental death of two civilians to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation into the supervision of the parolee, which included the collection and review of parole records, crime/incident reports, investigative reports, department policy and state regulations.	No violations of departmental policies, procedures, or state regulation were found, and the OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received allegations that inmates at several different CDCR institutions were being unnecessarily transported for medical services, and that prison staff spent much of their time transporting inmates for minor medical issues.	After an initial review, the OIG narrowed its focus to contracted versus non-contracted air ambulance costs for inmate medical transportation. The OIG conducted a preliminary investigation into CDCR's referrals of inmates for outside medical treatment. During the investigation, OIG staff reviewed medical transportation data, personnel cost data for medical transports and medical custody coverage, and interviewed CDCR personnel involved with the medical transportation process.	The OIG determined that medical transportation costs have leveled off in recent years and the federal receiver is in the process of implementing a new procedure to standardize the process for physicians to refer inmates for outside medical services. In addition, non-contracted air ambulance providers charged less than contracted providers due to California Penal Code language that limits the amount reimbursed to ambulance service providers. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee as a suspect in a murder to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation into this case that included contact with CDCR parole and institution staff, along with a review of documents related to the conditions of parole.	The OIG determined that CDCR parole and institution staff acted within CDCR policies and procedures. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding a sexual assault of an inmate by his cellmate.	The OIG conducted a preliminary investigation into the possible sexual assault to determine whether institution staff members followed Prison Rape Elimination Act (PREA) protocols.	The OIG determined that all PREA protocols were followed, and the OIG closed its investigation.
The OIG reviewed the department's response to an in-cell death of an inmate.	The OIG conducted a preliminary investigation that included a review the inmate's central file to determine if there was a history of suicidal attempts, and to determine if medical staff responded appropriately in providing medical services.	We concluded that medical staff responded timely and provided adequate medical treatment. The autopsy report ruled the cause of death to be suicide. The OIG closed its investigation.
The OIG received a complaint, alleging CDCR staff members placed an elderly inmate's life in danger by housing him with a younger inmate, who allegedly assaulted him.	The OIG conducted a preliminary investigation into this case that included contact with CDCR institution staff, a review of both inmates' central files and various additional documentation.	As a result of the inquiry, it was determined neither inmate had a history of in-cell violence and, therefore, institution staff acted within CDCR policies and procedures. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee for his involvement in a murder. He was positively identified by an eyewitness as the primary murder suspect. OIG conducted the review to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation into this case that included contact with the CDCR parole staff, and 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 OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee for his involvement in the accidental drive-by murder of a 4-year-old boy to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation that included contact with the CDCR parole staff, a review of numerous documents, parole agent case records and the parolee's case history.	The OIG determined the parolee was supervised according to CDCR policy. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee for his involvement in the murder of two auto parts store employees to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation that included contact with the CDCR parole staff, a review of numerous documents, parole agent case records and the parolee's case history.	The OIG determined the parolee was supervised according to CDCR policy. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee for his involvement in the shooting death of a deputy sheriff to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation that included contact with the CDCR parole staff, a review of numerous documents, parole agent case records, and the parolee's case history.	The OIG determined the parolee was supervised according to CDCR policy. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee for his involvement in a murder to determine whether the parolee was properly supervised on parole.	The OIG conducted a preliminary investigation that included reviews of Parole and CDCR policies and to determine whether CDCR Headquarters properly provided policy and direction to the Division of Adult Parole Operations.	The inquiry found sufficient evidence to support that DAPO should take steps to ensure policy is distributed to all divisions and contractors in a timely manner. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the death of an inmate by his cellmate.	The OIG conducted a preliminary investigation into a possible violation of department policy regarding the double-celling of inmates. One of the two inmates had a history of in-cell violence, refused other cellmates and made threats toward potential cellmates.	The OIG has referred its findings to the CDCR's Office of Internal Affairs for consideration of possible administrative action.