QUARTERLY REPORT

APRIL – JUNE 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 April 1, 2010 through June 30, 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 second 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 second quarter of 2010, the Governor submitted three warden candidates to the OIG for evaluation. Also in this quarter, the OIG completed its evaluation of three wardens, two of which 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. 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 Federal 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 components 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 second quarter of 2010, the Medical Inspection Unit issued medical inspection reports for four institutions: California State Prison, Solano; California Substance Abuse Treatment Facility and State Prison, Corcoran; Valley State Prison for Women; and Ironwood State Prison.

The following schedule summarizes the weighted scores for the four institutions for which public reports were issued during the quarter.

	California State Prison, Solano	California Substance Abuse Treatment Facility and State Prison, Corcoran	Valley State Prison for Women	Ironwood State Prison
	Report issued April 2010	Report issued May 2010	Report issued May 2010	Report issued June 2010
Chronic Care	42.3%	57.8%	70.5%	38.7%
Clinical Services	59.9%	56.1%	65.7%	60.8%
Health Screening	76.9%	72.7%	85.8%	82.3%
Specialty Services	65.6%	61.5%	71.5%	82.4%
Urgent Services	70.4%	75.2%	66.9%	70.2%
Emergency Services	82.4%	69.6%	88.2%	73.2%
Prenatal Care/Childbirth/Post-Delivery	N/A	N/A	80.8%	N/A
Diagnostic Services	59.8%	56.0%	81.3%	57.5%
Access to Healthcare Information	57.8%	56.9%	75.5%	49.0%
Outpatient Housing Unit	N/A	N/A	88.5%	89.8%
Internal Reviews	75.0%	72.5%	85.5%	87.5%
Inmate Transfers	78.9%	100.0%	100.0%	95.3%
Clinic Operations	83.9%	98.5%	100.0%	97.0%
Preventive Services	58.0%	36.0%	81.4%	33.7%
Pharmacy Services	89.0%	90.0%	86.2%	82.8%
Other Services *	75.0%	100.0%	100.0%	85.0%
Inmate Hunger Strikes	87.9%	78.9%	N/A	N/A
Chemical Agent Contraindications	100.0%	100.0%	100.0%	100.0%
Staffing Levels and Training	100.0%	100.0%	100.0%	100.0%
Nursing Policy	71.4%	71.4%	100.0%	50.0%
Overall Score	**67.1%**	**68.1%**	**80.0%**	**68.3%**

*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.

We also performed medical inspections at seven institutions for which results were not yet published by the end of the second quarter. Medical inspection results are pending for the following institutions: Calipatria State Prison; Correctional Training Facility; Mule Creek State Prison; California Institution for Men; Salinas Valley State Prison; Pelican Bay State Prison; and Wasco State Prison.

Audits

One-Year Review

In the second quarter of 2010, the Bureau of Audits and Investigation (BAI) issued a one-year review on the performance of the warden at California State Prison, Los Angeles County. The purpose of this review was 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 toured the institution.

California State Prison, Los Angeles County (LAC)

In April 2010, we issued a one-year review of Warden Brian Haws. Our review found that under Warden Haws' leadership, the prison functioned satisfactorily in three areas reviewed, but the warden had several challenges in the areas of employee-management relations. Specifically, Warden Haws was unable to establish a productive working relationship with the California Correctional Peace Officer's Association (CCPOA) local chapter, had a significant number of correctional officers who expressed low morale, and had a fragmented senior management team. Several factors contributed to and compounded Warden Haws' challenges, including the unsettling nature of frequent leadership and mission changes at LAC since 2002. The difficulty of LAC's problems is underscored by the fact that Haws had two and one-half years as either the warden or acting warden to resolve the institution's significant personnel issues and was unable to do so.

Based on our interviews with prison employees, the warden's average performance rating was satisfactory; however, there was a noteworthy variance in employees' opinions. Many employees rated the warden as doing a very good or outstanding job, while many others rated him as doing an unacceptable job or needing improvement.

Warden Haws has retired from state service.

California Prison Health Care Receivership Corporation's Use of State Funds for Fiscal Year 2008-09

In June 2010, we issued our third annual report concerning how the California Prison Health Care Receivership Corporation spent state funds

to carry out its federal court mandate to oversee California's prison medical system during fiscal 2008-09. The review highlights how the receivership spent $91.2 million in state funds for its operating costs and long-term capital assets. It is important to note that the OIG reviews do not, and are not intended to, include a review of expenditures for direct medical care delivery.

By category, the receivership spent $72.1 million on capital assets, $12.4 million on professional fees, $4.5 million on employee compensation and benefits, and $2.2 million on other expenses.

With regard to the number of employees and employee compensation under the receiver's employment, we noted that the receivership reduced its total number of employees from 24 to 4 as of September 30, 2009. We also highlighted the amount of compensation the receivership paid to its employees and the contractual amounts spent for planning and designing new medical and mental health beds along with a new pharmacy system.

Although the report disclosed that the receivership implemented audit recommendations in the OIG's previous report regarding cash management and office space consolidations, the report highlights the receiver's large and growing capital asset expenditures that are outside the State's fiscal and legislative review process.

Special Reports

August 2009 Riot at the California Institution for Men

On April 22, 2010, the BAI released a special report concerning the August 2009 riot at the California Institution for Men in Chino (CIM). The purpose of the special report was to identify the conditions and circumstances leading up to the riot and to evaluate the institution's and the department's actions in addressing the riot and re-establishing normal operations in the riot's aftermath.

The report concluded that despite being warned of the inherent risks of housing reception center inmates in CIM's Reception Center West's open dormitory setting, where fights among inmates could quickly escalate and spread and where it was difficult for officers to gain control of inmates who assault staff members or other inmates, the department took no substantive action to alleviate the security risks in that facility's design. Such risks included wooden construction, numerous blind spots, glass windows, porcelain bathroom fixtures that could be broken and used for weapons, and an absence of fire suppression systems and gun coverage. Additionally, the report concludes that although CIM heeded warnings from past reviews and audits by enhancing its emergency medical preparedness, there are still areas in which CIM and the department could

have improved their performance, particularly with respect to ensuring sufficient armed escorts for inmates needing medical care. This issue delayed the transport of injured inmates to outside hospitals for treatment.

We made nine recommendations to correct the problems and deficiencies found during the review.

Parole Supervision of John Gardner

In June of 2010, the Bureau of Criminal Investigations (BCI) released a special report on CDCR's supervision of parolee John Gardner. On May 14, 2010, John Gardner was sentenced to state prison for life without the possibility of parole for the rapes and murders of 14-year-old Amber Dubois and 17-year-old Chelsea King, and for the assault on 23-year-old Candice Moncayo, with the intent to commit rape. Each of these heinous crimes occurred subsequent to CDCR's September 2008 discharge of Gardner after he completed a three year parole term for sexually assaulting a 13-year-old girl in 2000. This special report identified systemic problems that transcended the John Gardner case and jeopardized public safety. The investigation resulted in seven recommendations to help CDCR address the deficiencies we identified in parolee supervision. Among other findings, the special report revealed that during Gardner's parole supervision, CDCR did not use GPS information to identify the felony that Gardner committed which could have returned him to prison. CDCR also did not identify Gardner's other repeated parole violations, including being within 100 yards of places where children congregate, residing within a half-mile of a school, leaving his residence during curfew and having access to a storage facility.

The investigation also found that CDCR could enhance public safety by reviewing GPS data in batches rather than point by point. CDCR could also use trained specialists, not parole agents, to review GPS data and receive most system alerts and increase its use of GPS zones.

Intake and Investigations

The OIG received 749 complaints this quarter concerning the state correctional system, an average of 250 complaints a month. Most complaints arrive by mail or through the OIG'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's Office or the California State Legislature.

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 second quarter of 2010, the BAI and the BCI had 142 ongoing inquiries and investigations and completed one criminal investigation, two administrative investigations and ten 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 information from a confidential informant alleging a CDCR staff member was abusing overtime.	The OIG conducted a preliminary investigation that included a review of time cards and management reports, as well as staff interviews.	The OIG determined there was insufficient evidence to sustain the allegations. The OIG closed this investigation.
The OIG received an allegation that a contractor billed the Prison Industry Authority for consultative services he did not provide.	The OIG conducted a criminal investigation that included interviews of staff and vendors and a review of evidence collected during the investigation.	The OIG determined there was insufficient evidence to warrant further investigation into this matter and closed this investigation.
The OIG received an allegation that a CDCR employee was stealing construction materials and using State resources for personal gain.	The OIG conducted a criminal investigation that included staff interviews, site visits to a CDCR facility and the subject's personal residence, and a review of the evidence collected. The OIG determined there was insufficient evidence to support a criminal filing and closed the criminal investigation. However, the OIG opened an administrative investigation to review potential administrative violations identified in its criminal investigation. The administrative investigation also included staff interviews, site visits to the CDCR facility and subject's personal residence, a review of evidence collected during the investigation, and a subject interview.	The OIG identified potential administrative violations and forwarded the results to the hiring authority for appropriate action. The OIG closed this investigation.
The OIG received an anonymous complaint alleging a supervising registered nurse was billing the State for hundreds of hours of overtime per month for an extended period of time.	The OIG conducted a preliminary investigation that included interviews, a review of personnel records, and a review of CDCR and medical registry time sheets.	The OIG found no evidence to support the allegation. The OIG closed this investigation.
The OIG received an allegation that a warden approved several inmate rules violation reports, which inappropriately identified a confidential source.	The OIG conducted an administrative investigation that included a review of the rules violation reports in question, a review of staff training records, and conducted staff interviews.	The OIG found evidence to support the allegation and forwarded the information to the hiring authority for appropriate action. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding a parolee suspected of murdering four police officers to determine whether the parolee was properly supervised while on parole.	The OIG conducted a preliminary investigation that included a review of parole documents and classification data.	The OIG found that parole agents acted according to policy. The OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG previously found billing improprieties by a medical registry contracting with CDCR. Accordingly, the OIG conducted a follow-up review of the registry contractor to identify any fraud, waste, or abuse in the current billing practices.	The OIG conducted a preliminary investigation that included obtaining CDCR accounting data and California Prison Health Care Services payment data. In addition, the OIG visited three prisons to review time sheets and gate logs and to conduct interviews of budget analysts regarding the oversight of registry employees, as well as the approval process for registry employee payment.	The OIG found no evidence of improprieties by the registry. The OIG closed this investigation.
The OIG reviewed several serious crimes committed by parolees who absconded from parole supervision and were classified as parolees-at-large.	The OIG conducted a preliminary investigation into whether the Division of Adult Parole Operations (DAPO) properly supervised the parolees and followed department policy once the parolees absconded from parole supervision. The review included obtaining and analyzing data from the department's Cal Parole system and reviewing parole field files at various DAPO field parole units.	The OIG found that DAPO staff do not generally complete all activities required by policy to locate parolees who have absconded from parole supervision. However, DAPO is currently creating regional Parolee Apprehension Teams whose sole focus will be to apprehend parolees who have absconded from parole supervision. This should allow DAPO to provide more focused attention on these parolees.
The OIG conducted a routine review of the circumstances surrounding the arrest of a sexually violent predator parolee who absconded from parole to determine whether the parolee was properly supervised while on parole.	The OIG conducted a preliminary investigation that included the collection and review of parole records, crime reports, investigative reports, departmental policy, and state regulations.	The OIG found no violations of departmental policies, procedures, or state regulations. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee suspected of burglary, assault, and vehicular manslaughter to determine whether the parolee was properly supervised while on parole.	The OIG conducted a preliminary investigation that included reviews of parole documents and classification data.	The inquiry found sufficient evidence to support that parole staff members acted according to policy. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding an alleged sexual assault of an inmate to determine whether CDCR prison staff followed proper PREA protocols after the alleged incident was reported.	The OIG conducted a preliminary investigation that included a review of all documents related to the incident and an interview with prison staff.	The OIG determined that the CDCR prison staff followed proper PREA protocols. 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 a hit-and-run accident that killed a Southern California woman, to determine whether the parolee was properly supervised.	The OIG conducted a preliminary investigation that included the collection and review of parole records, crime reports, and investigative reports.	The OIG found no violations of departmental policies, procedures, or state regulation. The OIG closed this investigation.
The OIG received a complaint that alleged an acting warden had improperly suspended security housing unit terms for violent inmates in order for the inmates to participate in mental health group activities.	The OIG conducted a preliminary investigation that included reviewing pertinent hiring documents and interviewing witnesses who may have had information related to the alleged improper suspensions.	The OIG found no evidence to support the allegations. The OIG closed this investigation.