QUARTERLY REPORT

JULY – SEPTEMBER 2010

OFFICE OF THE INSPECTOR GENERAL

BUREAU OF AUDITS

AND

BUREAU OF 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 July 1, 2010 through September 30, 2010. These functions are performed primarily by the Bureau of Audits (BOA) and the Bureau of Investigations (BOI).

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 third 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 third quarter of 2010, the Governor submitted two warden candidates to the OIG for evaluation. Also in this quarter, the OIG completed its evaluation of four wardens, three of which were submitted to our office in the previous quarter and one that was submitted to our office in the first quarter. We presented our recommendations 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 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 third quarter of 2010, the Medical Inspection Unit issued medical inspection reports for five institutions: Chuckawalla Valley State Prison; California State Prison, Corcoran; Calipatria State Prison; Correctional Training Facility; and Mule Creek State Prison. The

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

	Chuckawalla Valley State Prison	California State Prison, Corcoran	Calipatria State Prison	Correctional Training Facility	Mule Creek State Prison
	Report issued July 2010	Report issued July 2010	Report issued July 2010	Report issued August 2010	Report issued September 2010
Chronic Care	51.5%	57.5%	75.0%	56.2%	69.8%
Clinical Services	60.6%	68.0%	60.1%	59.2%	68.7%
Health Screening	75.9%	72.7%	80.0%	64.2%	81.0%
Specialty Services	86.1%	55.1%	74.5%	69.0%	75.8%
Urgent Services	77.9%	75.7%	88.3%	74.8%	74.6%
Emergency Services	73.1%	88.2%	85.2%	81.0%	64.0%
Prenatal Care/Childbirth/Post-Delivery	N/A	N/A	N/A	N/A	N/A
Diagnostic Services	56.2%	67.7%	57.5%	71.5%	68.1%
Access to Healthcare Information	49.0%	72.5%	37.3%	77.5%	72.5%
Outpatient Housing Unit	99.0%	61.7%	92.5%	87.1%	N/A
Internal Reviews	67.5%	65.8%	75.0%	93.0%	82.5%
Inmate Transfers	73.3%	86.7%	100.0%	67.9%	68.4%
Clinic Operations	90.9%	90.3%	100.0%	90.9%	100.0%
Preventive Services	48.3%	30.3%	48.3%	51.0%	40.0%
Pharmacy Services	82.8%	86.2%	96.6%	88.6%	93.1%
Other Services *	100.0%	92.7%	100.0%	66.7%	85.0%
Inmate Hunger Strikes	N/A	30.0%	100.0%	N/A	81.6%
Chemical Agent Contraindications	N/A	100.0%	100.0%	100.0%	100.0%
Staffing Levels and Training	100.0%	100.0%	100.0%	100.0%	100.0%
Nursing Policy	71.4%	85.7%	100.0%	100.0%	88.6%
Overall Score	**69.4%**	**68.9%**	**76.6%**	**72.0%**	**74.5%**

*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.

During the third quarter, we also performed medical inspections at two institutions for which results were not yet published by the end of the quarter. Results are pending for inspections performed at the following institutions during the quarter: California State Prison, Sacramento and California Medical Facility.

Audits

One-Year Reviews

In the third quarter of 2010, the BOA issued three one-year reviews on the performance of the wardens at three California state prisons. These reviews were titled: Warden Mary Lattimore One-Year Audit at the Central California Women's Facility; Warden Ron Barnes One-Year Audit at the California Correctional Center; and Warden Tina Hornbeak One-Year Audit at Valley State Prison for Women. These reviews are mandated by statute, and their purpose of the reviews is to assess the warden's performance one year after his or her appointment to the position. During these reviews, the OIG surveyed employees, key stakeholders, and department executives; analyzed operational data compiled and maintained by the department; interviewed employees, including the wardens; and toured the institutions.

Warden Mary Lattimore at the Central California Women's Facility (CCWF)

In July 2010, we issued a one-year review of Warden Mary Lattimore at the Central California Women's Facility. Our review found that although Warden Lattimore was performing satisfactorily, certain problems existed that the California Department of Corrections and Rehabilitation (CDCR) and warden should address.

The OIG recommended that the CDCR and the warden at CCWF take the following actions:

- Improve communication among management employees by providing clear, written direction whenever possible. Also, seek input from relevant management employees before filling vacancies.
- Improve safety and security by reevaluating the practice that allows inmates from different yards to commingle on weekends and holidays.
- Examine whether use-of-force incidents can be reduced by training staff who work with mentally disordered inmates.
- Repair defects in critical areas of the prison's physical plant.

Our review also noted that although CCWF employees rated the prison's safety and security overall as average, CCWF has had riots in the main yard and more use-of-force incidents than in many male institutions.

Overall, the warden's managers and employees rated her slightly above satisfactory. After the OIG's audit fieldwork was completed, Warden Lattimore retired from state service at the end of April 2010.

Warden Ron Barnes at the California Correctional Center (CCC)

In September 2010, we issued a one-year review of Warden Ron Barnes at the California Correctional Center. Our review found that under Warden Barnes the prison functioned well in the areas of safety and security, inmate programming, and business operations. However, OIG inspectors heard several complaints from employees concerning errors by the institution's personnel department that negatively affected employee pay and benefits. Specifically, the employees identified problems with:

- Pay issues, such as the correct calculation of salary calculations, merit salary adjustments, overtime payments and child support deductions.
- Timekeeping issues, including timely receipt of leave balances and employee attendance records.
- Benefit determinations, such as dental plan eligibility.
- Emergency notifications and concealed-weapon permits for retired correctional officers.

The OIG recommended that the warden continue to monitor the personnel department's performance and take corrective action where appropriate. Despite the above-listed complaints, most CCC employees we interviewed told us the institution's employee-management relations have improved since Warden Barnes became warden in 2008. On average, the warden's managers and employees rated him between very good and outstanding.

Warden Tina Hornbeak at Valley State Prison for Women (VSPW)

In September 2010, we issued a one-year review of Warden Tina Hornbeak at Valley State Prison for Women. Our review found that while many employees spoke positively about Warden Hornbeak's leadership, security awareness, and the cohesiveness of her executive team, we determined that her performance in employee-management relations needed improvement. The report identified several employee-management relations issues that affect VSPW's employee morale that CDCR should consider. Specifically, some employees at VSPW expressed concerns about the warden's lack of communication, her low visibility on the facilities, and their perception of the warden favoring certain staff.

Analysis from employee survey results revealed that custody employees generally expressed negative opinions about the warden's overall performance, but that VSPW management staff, key stakeholders, and CDCR executives expressed mostly positive opinions. Also, many VSPW employees told us in interviews that the prison's overall operations have improved since the warden's appointment in 2007.

Critical comments the OIG received focused more on the warden's employee-management relations. For example, custody employees criticized her for not facilitating effective communication between management and custody employees, for actions perceived as favoritism, and for failing to satisfy employee expectations that the warden tour the prison regularly and talk personally with employees.

In April 2010, subsequent to our fieldwork, CDCR assigned Warden Hornbeak as the acting associate director for CDCR's Division of Adult Institutions, general population levels II and III. On May 26, 2010, Warden Hornbeak returned to VSPW as the chief deputy warden, and in June 2010, she became the associate warden of Healthcare Services at Mule Creek State Prison. In response to Hornbeak's departure from VSPW, CDCR assigned Walter Miller, effective September 7, 2010, as the acting warden of VSPW.

2010 Accountability Audit of the California Department of Corrections and Rehabilitation, 2000-2008

In July 2010, the OIG issued the 2010 Accountability Audit of CDCR. This two-chapter audit analyzed 87 open recommendations from nine prior reports and special reviews. Chapter 1 presented the results from our first follow-up audit of 49 recommendations that we identified in three audit reports issued in 2008. Chapter 2 presented the results from our follow-up review of 38 recommendations that we identified in six audit and special review reports issued from 2000 through 2007.

The purpose of the accountability audit is to bring transparency to the state's correctional system. The accountability audit provides periodic follow-up results on previous audits and special reviews, and it assesses whether CDCR and the California Prison Health Care Services (CPHCS) have implemented each of our recommendations. This unified audit allows us to efficiently track CDCR's and CPHCS' progress and keep important issues in the public eye.

Overall, we found that the CDCR has fully or substantially implemented 62 percent of the recommendations we made that were still applicable. However, work remains for many recommendations, including eight

unimplemented recommendations related to on-going safety and security issues that continue to concern the OIG. Specifically, CDCR continues to allow custody officers to work armed posts without having completed quarterly weapons proficiency requirements.

The OIG issued or reissued 21 recommendations regarding the unresolved findings.

Special Reports

Special Report – The Board of Parole Hearings: Psychological Evaluations and Mandatory Training Requirements

In July 2010, the OIG released a special report concerning the Board of Parole Hearings' (parole board) process for preparing psychological evaluations used for parole suitability hearings and the parole board's commissioner training program. The purpose of the special report was to review concerns expressed by the Senate Rules Committee for two particular issues: (1) that factual errors may exist in psychological evaluations and (2) that certain psychologists may give elevated risk assessment conclusions when compared to conclusions made in prior psychological evaluations. In addition, the report addressed the parole board's executive officer's request to examine its new commissioner training program.

The OIG found that the parole board lacks reliable data to determine the number of factual errors contained in psychological evaluations and lacks reliable data to determine the number of low, medium, and high risk assessment conclusions—data that would allow it to perform certain analytical procedures to measure performance. In addition, we found weaknesses in the parole board's oversight of the methods it uses to review psychological evaluations. Specifically, it does not require senior psychologists to use source documentation when conducting their reviews, limiting the effectiveness of the reviewers' ability to detect certain mistakes. The parole board also does not actively monitor senior psychologists' activities by requiring them to account for their time by case or by activity. Finally, the parole board failed to provide commissioners, deputy commissioners, and senior psychologists with the sufficient number of mandatory training hours.

The OIG issued eight recommendations to the parole board to address the issues.

Management Letter – CDCR Statewide Electronic Law Library

As requested by the Governor's Office, we performed a review as to whether potential savings could be realized if CDCR implemented a statewide electronic law library system. In August 2010, we issued the results of our special review to CDCR. The 1972 *Gilmore v. Lynch* decision required the CDCR to provide incarcerated adults with specific titles referred to as the Gilmore Law Collection. To comply with the court mandate, the CDCR purchases and maintains at least one complete, up-to-date print collection of the legal law library at each institution.

In 2004, the California Performance Review recommended that CDCR implement touch screen legal information resource kiosks at each prison by July 1, 2005, based on its estimate that CDCR could save $1.9 million annually. In 2005, CDCR implemented the Law Library Electronic Delivery System (LLEDS) statewide, which according to the CDCR, provides the court mandated Gilmore Collection in a stand-alone electronic format. However, the CDCR continues to maintain the hard copy format of the law library as well.

Our research from the review indicated potential savings of approximately $2.8 million per year (after the first year) by replacing the print collection law libraries with touch screen kiosks department wide. However, CDCR will need to perform a more detailed cost analysis that considers factors, which could reduce any potential savings.

We recommended that CDCR conduct further research on the cost effectiveness of switching to an electronic law library system and develop solutions that will reduce its costs in this area. Further, we asked CDCR to develop an action plan and report to us the status of its plan within 90 days.

Intake and Investigations

The OIG received 731 complaints this quarter concerning the state correctional system, an average of 244 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 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 third quarter of 2010, the BOI had 132 ongoing inquiries and investigations and completed four criminal investigations, four administrative investigations and 14 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 a hospital was billing the CPHCS for medical materials they did not provide to inmates treated at the hospital.	The OIG conducted a criminal investigation that included interviews with staff from the CPHCS and California Department of Health Care Services and current and former hospital staff members. Further, the OIG reviewed the evidence collected during the investigation.	The OIG determined there was insufficient evidence to warrant further investigation into this matter. The OIG closed this investigation.
The OIG received an allegation that staff at a Department of Juvenile Justice facility was taking wards off grounds to restaurants and an amusement park.	The OIG conducted a preliminary investigation that included interviews and a review of departmental policy.	The OIG found no violations of departmental policies. The OIG closed this investigation.
The OIG reopened an investigation into potential fraud by state vendors who contract with the CDCR.	The OIG conducted a criminal investigation in conjunction with the U.S. Attorney's Office. The investigation included grand jury subpoenas of various records pertaining to the state vendors.	The OIG determined that no further investigation was warranted based on a review of the subpoenaed documents and the U.S. Attorney's closure of its case. The OIG has closed this investigation.
During the first quarter, the OIG reported on two investigations into allegations that contract psychiatrists were billing for more hours than they actually provided at the institution. During this quarter, the OIG closed three additional investigations against three more psychiatrists on the same allegations.	The OIG opened a separate criminal investigation for each contract psychiatrist. The investigations included collection of volunteer/contractor logs, secured perimeter gate entry video tapes, medical invoices, witness interviews, and subject interviews.	The cases were submitted to the Monterey County District Attorney's Office for criminal filings against the contract psychiatrists. The OIG closed the cases as they are being adjudicated in the Monterey County Superior Court.
The OIG conducted a routine review to determine whether CDCR medical contractors and physicians are receiving compensation by both CDCR and other funding sources (i.e., California Medi-Cal or Blue Shield) for medical services provided to inmates.	The OIG conducted a preliminary investigation that included obtaining listings of medical staff employed by and contracted with by CDCR. The OIG then compared payment information for Medi-Cal, Blue Shield, and CDCR.	The OIG's comparison did not disclose that medical contractors or physicians employed by CDCR have been receiving compensation for medical services provided to inmates from both CDCR and other funding sources. The OIG closed this investigation.
The OIG received an allegation that a correctional officer was over familiar with members of an outlaw motorcycle gang.	The OIG conducted a preliminary investigation that included contact with an outside law enforcement agency and a review of data from CDCR.	The OIG forwarded the case to the OIA for review and disposition. The OIG closed this investigation.
The OIG received an allegation that a CDCR contract medical doctor may have been submitting fraudulent bills to CDCR.	The OIG conducted a preliminary investigation that included interviews with CDCR and CPHCS staff, the review of inmate medical records, and a review of the prison's entry and exit logs.	The OIG found no evidence to substantiate the allegation. The OIG closed this investigation.
The OIG received an allegation that a warden observed an employee assault another employee and failed to take corrective action against the alleged	The OIG conducted an administrative investigation that included interviews, photographs, and the review of departmental policy relative to workplace	The OIG found insufficient evidence to substantiate the allegations. The OIG has closed this investigation.

Allegation/Incident	Investigation	Result
aggressor. It was further alleged that the institution's internal affairs staff failed to take appropriate action after learning of the incident.	violence.	
The OIG conducted a routine review to determine if CDCR was allowing employees to earn overtime, when their classifications are exempt from earning overtime.	The OIG conducted a preliminary investigation that included interviews with staff from the Federal Receivers' Office and CDCR's Office of Personnel Services, and a review of policies and union contracts.	The OIG determined no violations of State administrative regulations or departmental guidelines were violated. The OIG closed this investigation.
The OIG conducted a routine review to determine whether the compensation benefits provided to parolees, who were injured while working during incarceration, cease upon a parolee's return to prison, as required by law.	The OIG conducted a preliminary investigation that included interviews with CDCR and State Compensation Insurance Fund (SCIF) staff, and a review of applicable laws and department policy.	The OIG found that parolees are not continuing to receive workers' compensation benefits after they are returned to prison. Moreover, SCIF has a Specialized Adjuster Unit that monitors parolees, should they be returned to prison, in order to stop their benefits. The OIG closed this investigation.
The OIG received an allegation that a parole agent was placing multiple parolees, who are required to register as sex offenders, in the same single-family dwellings, which is against the law.	The OIG conducted a preliminary investigation into the allegation by reviewing applicable law and department policy.	The OIG determined there was no evidence to support criminal or administrative wrongdoing. The OIG closed this investigation.
The OIG received an allegation that a warden gave preferential treatment to an employee during a promotional interview, which resulted in the employee being promoted.	The OIG conducted an administrative investigation that included staff interviews and the collection and review of hiring packages.	The OIG determined there was no evidence to substantiate the allegations. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the death of an inmate.	The OIG conducted a preliminary investigation that included interviews with prison staff and a review of all documents related to the incident. The death was determined to be a suicide.	The OIG found no evidence to indicate prison staff failed to follow appropriate policies and procedures. The OIG closed this investigation.
The OIG received an allegation that money was missing from a petty cash fund at a parole office.	The OIG conducted a preliminary investigation that included interviews with parole staff from the involved parole office, as well as a review of documents pertaining to the petty cash fund.	The OIG referred this matter to the OIA for review and appropriate action. The OIG closed this investigation.
The OIG conducted a routine review into the circumstances surrounding a parolee's involvement in a major vehicle collision that resulted in multiple fatalities, to determine whether the parolee was properly supervised while on parole.	The OIG conducted an administrative investigation that included interviews with parole staff and a review of parole documents and classification data.	The OIG found that parole staff properly followed CDCR policy in the supervision of the parolee. The OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received an allegation that a prison manager did not follow CDCR policy following an institutional riot.	The OIG conducted an administrative investigation that included interviews with prison staff, site visits to the prison, and a review of all documentation related to the riot.	The OIG determined there was insufficient evidence to sustain the allegation. The OIG closed this investigation.
The OIG received an allegation concerning the issuance of Asmanex inhalers to inmates after the inhalers had expired.	The OIG conducted a preliminary investigation that included interviews with medical staff and a review of inmate medical records and other relevant documentation.	The OIG referred this matter to the California Board of Pharmacy for review and appropriate action. The OIG closed this investigation.
The OIG conducted a routine review of the department's response to an in-cell death of an inmate.	The OIG conducted a preliminary investigation that included a review of the inmate's central file and medical records. The death was determined to be a suicide.	The OIG found no evidence to indicate staff failed to follow appropriate policies and procedures. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding an inmate riot that resulted in a death of an inmate.	The OIG conducted a preliminary investigation to determine if the riot was preventable and if staff responded timely.	The investigation has been referred to the OIA for review and appropriate action, and the BIR is monitoring the investigation. The OIG closed this investigation.
The OIG conducted a routine review of the department's response to an in-cell death of an inmate.	The OIG conducted a preliminary investigation into a possible violation of department policy regarding double-celling of inmates. The inmate aggressor had no history of in-cell violence.	The OIG determined that prison staff acted within CDCR policies and procedures. The OIG closed this investigation.
The OIG received an allegation that an inmate was extracted from the exercise yard and taken to the shower for decontamination where she was ordered to remove all of her clothing while being video recorded.	The OIG conducted a preliminary investigation into a possible violation of department policy regarding the use of force when extracting the inmate from the yard and video recording the inmate decontamination.	The matter was referred to the hiring authority for appropriate action. The OIG closed this investigation.
The OIG reviewed the department's response to an in-cell death of an inmate to determine if medical staff responded appropriately in providing medical services.	The OIG conducted a preliminary investigation that included a review of the inmate's central file and medical records. The death was determined to be a suicide.	The OIG concluded that medical staff responded timely and provided adequate medical treatment. The OIG closed its investigation.