QUARTERLY REPORT

JANUARY – MARCH 2011

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 January 1, 2011 through March 31, 2011. 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 first quarter of 2011. 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 2011, the Governor submitted four warden candidates to the OIG for evaluation. Also in this quarter, the OIG completed its evaluation of four 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. Two candidate evaluations are still suspended from the previous quarter. The CDCR via the Governor's Office withdrew one candidate's name for evaluation during the vetting process.

Medical Inspections

Background

In 2001, California faced a class action lawsuit (*Plata v. Brown,* previously *Plata v. Schwarzenegger*) 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. Toward that end, the Inspector General agreed to inspect each state prison on a cycle basis. In designing the medical inspection program, we reviewed 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' 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 first quarter of 2011, the medical inspection unit issued medical inspection reports for three institutions: California State Prison, Sacramento; California Institution for Women; and California Medical

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

	California State Prison, Sacramento	California Institution for Women	California Medical Facility
	Report issued February 2011	Report issued March 2011	Report issued March 2011
Chronic Care	72.9%	72.6%	68.3%
Clinical Services	67.1%	66.4%	67.1%
Health Screening	83.4%	75.9%	74.8%
Specialty Services	62.8%	88.0%	75.7%
Urgent Services	61.5%	85.8%	85.4%
Emergency Services	82.2%	67.6%	79.5%
Prenatal Care/Childbirth/Post-Delivery	N/A	80.9%	N/A
Diagnostic Services	82.5%	81.5%	73.5%
Access to Healthcare Information	75.5%	58.8%	72.5%
Outpatient Housing Unit	98.2%	60.2%	92.3%
Internal Reviews	70.0%	85.7%	85.0%
Inmate Transfers	94.7%	100.0%	N/A
Clinic Operations	93.9%	100.0%	100.0%
Preventive Services	76.0%	71.3%	85.0%
Pharmacy Services	90.3%	97.6%	97.6%
Other Services *	85.0%	70.0%	100.0%
Inmate Hunger Strikes	60.0%	N/A	92.6%
Chemical Agent Contraindications	84.7%	100.0%	100.0%
Staffing Levels and Training	100.0%	100.0%	100.0%
Nursing Policy	50.0%	77.1%	60.0%
Overall Score	**76.3%**	**77.5%**	**79.0%**

*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.

By the end of the first quarter we had performed medical inspections at eleven institutions for which results were not yet published. Those inspections include: Richard J. Donovan Correctional Facility; Central California Women's Facility; Centinela State Prison; California Men's Colony; California Rehabilitation Center; Pleasant Valley State Prison; Sierra Conservation Center; North Kern State Prison; California State Prison, Los Angeles County; San Quentin State Prison; and Valley State Prison for Women.

Audits

Special Reports

The California Department of Corrections and Rehabilitation's Monitoring of Employee Discipline

In March 2011, the OIG issued at special report concerning the California Department of Corrections and Rehabilitation's (CDCR) imposition of disciplinary actions against employees who violate CDCR policies, state laws, or regulations governing employee conduct. Our review of CDCR's disciplinary process examined the department's compliance with its own policies concerning tracking and reporting of employee discipline cases, and tested a sample of cases to determine whether prescribed penalties were actually imposed on employees found to have committed misconduct.

The report concludes that the department does not adhere to its policies for tracking and reporting employee discipline cases, and does not prepare required quarterly reports of disciplinary statistics or required annual reports on the effectiveness of CDCR's disciplinary process. Further, in following up on past disciplinary cases, our sample disclosed cases in which the prescribed monetary discipline was misapplied, causing employees to be either over-or-under-penalized. In some cases, the prescribed discipline was not imposed at all. Finally, our report found cases in which financial penalties imposed upon disciplined employees were never collected.

We made nine recommendations to CDCR in the report.

Intake and Investigations

The OIG received 641 complaints this quarter concerning the state correctional system, an average of 214 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 first quarter of 2011, the BOI had 87 ongoing inquiries and investigations and completed one administrative investigation, two retaliation investigations and six 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 a complaint from CDCR institutional staff regarding allegations of waste caused by missed inmate off-site medical appointments.	The OIG conducted an investigation which included interviews with medical staff, as well as a review of transportation documents and medical records.	The OIG found that the number of outside medical appointment referrals declined recently due to stricter oversight by staff. Furthermore, the new medical facilities recently approved for construction are predicted to further reduce the need for transporting inmates outside the institutions for medical care. The OIG closed this investigation.
The OIG received an allegation that a CDCR employee was dishonest during an investigation.	The OIG conducted an administrative investigation that included interviews with CDCR staff, a site visit to the institution and a subject interview. During the course of the investigation, additional information was presented to the OIG that the CDCR employee may have provided false information during the OIG subject interview.	The OIG found sufficient information to support the allegations and referred the matter to the hiring authority for appropriate action. The OIG closed this investigation.
The OIG received a fraud referral from a prison employee alleging some medical staff members were leaving the prison early but being paid for the entire day.	The OIG conducted an investigation, which included a review of the bargaining unit contract and an interview with the appropriate manager.	The OIG determined the employees in question were salaried employees and not subject to normal hours. Furthermore, management took appropriate steps to ensure employees were on site as required and performing within the requirements of the bargaining unit contract. The OIG closed this investigation.
The OIG received an anonymous complaint alleging a state employee was committing time card fraud. The complaint alleged that the state employee on several occasions was not working full eight hour days and was claiming overtime pay for the same eight hour periods. The OIG opened an investigation to review the allegation that the state employee was committing time card fraud.	The OIG contacted the institution and arranged to monitor the state employee. The OIG also interviewed California Prison Health Care Services (CPHCS) staff to identify that controls were implemented to ensure state employees were signing in and out on their timesheets (CDCR 998 form). The OIG obtained copies of documents from the Division of Correctional Health Care Services (DCHCS) that documented the state employee's hours.	The OIG found that sufficient controls were implemented internally by CPHCS staff to minimize time card abuse by state employees. The OIG closed its investigation.
The OIG conducted a routine review of an alleged rape by a parolee to determine whether the parolee was properly supervised while on parole.	The OIG conducted a preliminary investigation that included a review of the parole field file and interviews with parole staff.	The OIG found no violations of departmental policies or procedures. The OIG closed this investigation.
The OIG received an allegation that a CDCR manager was retaliating against a staff member.	The OIG conducted a retaliation investigation that included a review of documents and interviews with parole staff.	The OIG was unable to substantiate the allegations. The OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received an allegation that a Prison Industry Authority (PIA) employee was committing fraud by sending good milking cows to be auctioned and a relative of the employee was purchasing the cows for his own dairy at a reduced value. During the course of the investigation, it was further alleged the employee was participating in improper bidding practices.	The OIG researched the complaint by contacting the PIA Administration to identify regulations regarding the cow auctioning process and the bidding process. The OIG interviewed current and former PIA employees who had knowledge of the alleged misconduct. During the interview process, it was determined the allegations regarding the fraud dated back to 1998. The information regarding improper bidding practices dated back to 2001.	The OIG was unable to determine that the alleged subject is currently committing fraud by sending good milking cows to be auctioned. Furthermore, the OIG determined there was insufficient evidence to show the alleged subject is currently involved in improper bidding practices. The OIG closed this investigation.
The OIG received allegations that prison investigative staff was falsifying dates on Department of Justice drug testing results in order to avoid established timeframes in processing inmate Rules Violation Reports.	The OIG conducted a preliminary investigation into the allegations and found that although misconduct may have occurred in the past, the prison investigative staff resolved the backlog of cases that gave rise to the alleged misconduct. The OIG reviewed 12 cases processed during 2010 and found that the respective drug testing dates in all the cases were accurate.	The OIG notified the warden of the potential past staff misconduct recommending he take appropriate action. The OIG closed this investigation.
The OIG received allegations of possible retaliation against a CDCR staff member by CDCR management.	The OIG conducted an administrative investigation that included an evaluation of information related to the alleged retaliatory treatment.	The investigation found there were no retaliatory acts and no evidence to support the allegations. The OIG closed this investigation.