QUARTERLY REPORT

APRIL – JUNE 2011

OFFICE OF THE INSPECTOR GENERAL

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, 2011 through June 30, 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 second 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.

(Note: As of July 1, 2011, the OIG's mission has now changed. The OIG's new mission is conducting reviews of policies, practices and procedures of the California Department of Corrections (CDCR) when requested by the Governor, the Senate Committee on Rules or the Speaker of the Assembly. The OIG is also responsible for contemporaneous oversight of internal affairs investigations and the disciplinary process of CDCR, conducting reviews of the delivery of medical care at each state institution, as well as determining the qualifications of candidates submitted by the Governor for the position of warden.)

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 2011, the Governor submitted two warden candidates to the OIG for evaluation. Also in this quarter, the OIG completed its evaluations of two wardens 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 a 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 second quarter of 2011, the medical inspection unit issued medical inspection reports for seven institutions: Richard J. Donovan Correctional Facility; California Rehabilitation Center; Centinela State Prison; Pleasant Valley State Prison; Central California Women's Facility; California Men's Colony; and Sierra Conservation Center. The following schedule summarizes the weighted scores for the seven institutions for which public reports were issued during the quarter. [1]

By the end of the second quarter, we had performed medical inspections at twelve institutions for which results were not yet published. Those inspections include: North Kern State Prison; California State Prison, Los Angeles County; San Quentin State Prison; Valley State Prison for Women; California Correctional Institution; Kern Valley State Prison; California Substance Abuse Treatment Facility and State Prison, Corcoran; High Desert State Prison; Deuel Vocational Institution; Folsom State Prison; California State Prison, Corcoran; and California Correctional Center.

Summary and Analysis of the First Cycle of Medical Inspections of California's 33 Adult Prisons

In May 2011, the OIG issued a summary and analysis of the first 33 medical inspections of adult prisons operated by CDCR. These first 33 medical inspections denoted OIG's first cycle of medical inspections. The report analyzes and summarizes the prisons' overall scores and their scores in up to 20 components of prison medical care. The report also includes analysis of the scores in five general medical categories: medication management, access to medical providers and services, primary care provider responsibilities, continuity of care, and nurse responsibilities.

Unlike the individual inspection reports, this 33-prison report put the prisons' scores into a qualitative context. We did so by comparing the prisons' average and individual scores to the Receiver's scoring criteria for three levels of adherence to policies and procedures. Thus, scores below 75 percent denote low adherence, scores ranging from 75 to 85 percent denote moderate adherence, and those above 85 percent reflect high adherence.

[1] Please refer to Appendix A.

Only nine of the 33 prisons met or exceeded the 75 percent minimum score for moderate adherence, and no prison achieved high adherence. Twenty-four of the 33 prisons performed below the minimum score for moderate adherence, but 12 were close, with scores of 70 percent to 74 percent; the average overall weighted score was 72 percent. Prisons' scores ranged from 83 to 62 percent.

When analyzing the 20 components of medical care, we found prisons scored low adherence in eight components, scoring particularly poorly in two of those component areas. The average score for preventive services was only 44 percent and the average score for inmate hunger strikes was 57 percent. However, the prisons' achieved moderate adherence in seven of the 20 components and high adherence in the remaining five component areas.

We also reviewed the 33 prisons' performance in these five general medical categories: medication management, access to medical providers and services, primary care provider responsibilities, continuity of care, and nurse responsibilities. In doing so, we noted two significant recurring problems. First, nearly all prisons were ineffective at ensuring that inmates receive their medications. The 33 prisons' average score of 59 percent in medication management was significantly below the minimum score for moderate adherence.

The second recurring problem among the 33 prisons was poor access to medical providers and services. Prisons were generally ineffective at ensuring that inmates were seen or provided services for routine, urgent, and emergency medical needs according to timelines set by CDCR policy. Effective prison medical care depends on inmates' timely access to providers and services. Only six prisons met the 75 percent minimum score for moderate adherence on access to providers and services, while ten prisons scored 60 percent or less. The average score, at 66 percent, was substantially less than the minimum score for moderate adherence.

More encouragingly, the 80 percent score in nurse responsibilities and the 76 percent score in continuity of care enabled both categories to exceed the minimum score for moderate adherence. However, by averaging 72 percent, primary care provider responsibilities fell below the minimum score for moderate adherence.

We found that the wide variation among component scores within prisons, and the wide variation among prisons' average component scores, suggest that the Receiver has not yet implemented a system that ensures that CDCR medical policies and procedures and medical community standards are followed across the prison system. The higher scores in some component areas and medical categories; however, demonstrate that system-wide improvement can be achieved.

In providing a qualitative context to the percentage scores by using the Receiver's scoring criteria for the three levels of adherence to policies and procedures, it was not our intention to determine or imply the percentage score that meets a constitutional standard of medical care. That determination remains with the Court.

Audits

One-Year Warden Audits

In the second quarter of 2011, the OIG issued four one-year warden audits on the performance of the wardens at four California state prisons. These audits were titled: Warden Michael Martel One Year Audit at Mule Creek State Prison; Warden Anthony Hedgpeth One Year Audit at Salinas Valley State Prison; Warden Socorro Salinas One Year Audit at Deuel Vocational Institution; and Warden Fernando Gonzalez One Year Audit at the California Correctional Institution.

The purpose of these audits is to satisfy our statutory requirement to assess the wardens' performance one year after appointment to their position. During these audits, 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 institution. [2]

Warden Michael Martel One Year Audit at Mule Creek State Prison

In April 2011, we issued a one-year audit of Warden Michael Martel at Mule Creek State Prison (MCSP). Our audit found that Warden Martel is an experienced correctional leader who has the skills necessary to meet the challenges of managing MCSP and has successfully performed his job as warden. MCSP employees we interviewed cited improvements to the institution's safety and security and a management style that has improved overall communication and teamwork as among his major accomplishments. Additionally, Warden Martel was commended by various employees for his leadership outside the prison, and his involvement in community projects and events. When we asked institutional employees to rate the warden's overall performance, 90 percent of the custody employees, institutional management, stakeholders, and non-custody personnel rated the warden as doing an "outstanding" or "very good" job. Many positive comments from employee interviews focused on three areas of safety and security: the staff accountability

[2] As of July 1, 2011, the OIG is no longer required to conduct one-year follow-ups on the performance of wardens.

system using the employee ID card swipe reader to track employees entering and leaving the premises, the take-home key process, and the enhanced security for the central corridor. Warden Martel became acting warden at San Quentin State Prison on February 22, 2011.

Warden Anthony Hedgpeth One Year Audit at Salinas Valley State Prison

Also in April 2011, we issued a one-year audit of Warden Anthony Hedgpeth at Salinas Valley State Prison (SVSP). Our audit found that Warden Hedgpeth has successfully performed his job and many institution employees we interviewed told us the institution's operations have improved since he became warden in October 2009. Several employees said he is the best warden they have ever worked for. The Inmate Advisory Council representatives we interviewed had no concerns with the warden or inmate relations. Overall, survey and interview respondents indicated that Warden Hedgpeth was doing a "very good" to "outstanding" job.

Warden Socorro Salinas One Year Audit at Deuel Vocational Institution

In May 2011, we issued a one-year audit of Warden Socorro Salinas at Deuel Vocational Institution (DVI). Our audit found that Warden Salinas has satisfactorily performed her job as warden of DVI. Employees we interviewed who work closest with Warden Salinas almost unanimously indicated she is a good leader. In addition, employees told us that the warden has recruited a management team that works well together.

Based on our survey results, a majority of responding employees expressed negative opinions about the warden's overall performance. Also, many respondents gave her low ratings in specific warden-related performance questions, and also voiced complaints about low employee morale or excessive employee investigations. However, when we conducted follow-up interviews, we heard little direct evidence to support the low scores.

Warden Fernando Gonzalez One Year Audit at California Correctional Institution

In June 2011, we issued a one-year audit of Warden Fernando Gonzalez at California Correctional Institution (CCI). Our audit found that Warden Gonzalez successfully performed his job as warden until his retirement in December 2010. CCI employees we interviewed cited physical improvements to the institution's safety and security and staff accountability as hallmarks of his tenure.

After conducting over 60 interviews, we found that interviewees commended the warden for his high level of professionalism, knowledge

of departmental policies and procedures, proactive management style, and commitment to the prison's safety and security. However, many interviewees and survey respondents voiced concerns about the warden's perceived lack of approachability and about employee disciplinary sanctions as reasons for CCI's low employee morale. Also, we found that opinions varied between custody employees and non-custody employees. Specifically, when we asked employees if safety and security, inmate programming, business operations, or employee-management relations had improved since the warden's appointment, the custody staff members responding to our survey gave the warden lower ratings than either of the non-custody groups.

California Prison Health Care Receivership Corporation

Pursuant to the federal court's order in Plata v. Brown, establishing the California Prison Health Care Receivership Corporation, the OIG entered into an agreement with the Receiver to perform periodic reviews of the Receivership's use of state funds for its administrative operations.

In April 2011, we issued our fourth annual report of the California Prison Health Care Receivership Corporation's (corporation) expenditures for fiscal year 2009-2010. The review highlights how the receivership spent state funds for its administrative operations and capital assets. The report does not include a review of expenditures for direct medical care delivery. During the year, the corporation spent $12.4 million for its operating costs and long-term capital assets. This amount represents less than 1 percent of the $1.5 billion spent in fiscal year 2009-2010 to provide medical care to the California Department of corrections and Rehabilitation's adult inmate population. We noted in the report that the total corporation expenditures decreased by $78.8 million, from $91.2 million in fiscal year 2008-2009 to $12.4 million in fiscal year 2009-2010. The decrease was attributable to a significant decline in capital asset and operational expenditures.

Of the $12.4 million the corporation spent, $9.3 million was for capital asset final construction costs to improve medical facilities at the Avenal and San Quentin State Prisons. Finally, our review disclosed that the corporation implemented corrective action to address recommendations we made in our prior report.

Accountability Audit

In May 2011, the OIG issued the 2011 Accountability Audit of the CDCR. This audit analyzes 90 open recommendations from nine prior reports and special reviews directed to CDCR and the California Prison Health Care Services (CPHCS). We performed an initial review of 69 recommendations that we identified in seven audit and special review reports completed in 2009 and performed a subsequent review of 21 recommendations that we

identified in two audit reports issued in 2008. 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 CPHCS have implemented each of our recommendations.

Overall, we found the CDCR has satisfactorily implemented 82 percent of the recommendations we made that are still relevant. Also, the CPHCS implemented two of three recommendations, or 67 percent. This represents a significant improvement from our 2010 Accountability Audit, which resulted in an overall implementation rate of only 62 percent.

Special Reports

Mule Creek State Prison Must Improve Its Oversight of Some Employees' Work Hours and Timekeeping

In April 2011, we issued a special report regarding the oversight of employees' work hours and timekeeping at Mule Creek State Prison (MCSP). The purpose of this special report was to evaluate a concern regarding employee timekeeping and workload at MCSP. The report concludes that many of the prison's mental health and educational employees were fully paid, but did not average working full days inside the prison over a three-month period, ending August 2010. For example, 46 of 51 mental health clinicians averaged working 8.4 hours of their scheduled ten-hour days, the equivalent of 33.6 hours per week. Similarly, 20 of the prison's educators also averaged working less than full days, ranging between 33 to 39 hours per week. In total, theses employees' unaccounted-for hours—time for which they were paid, but which they did not spend inside the prison, in training, or in time off—amounted to $272,900 over the three-month period, or, at this rate, nearly $1.1 million in a year. Moreover, the report concludes that timekeeping mistakes made by employees and the prison's personnel office on a sample of timesheets over a four-month period resulted in some employees being overcharged more than $6,500 and other employees being undercharged nearly $102,000 in leave hours. The report includes 15 recommendations.

Intake and Investigations

The OIG received 574 complaints this quarter concerning the state correctional system, an average of 191 complaints a month. Most complaints arrive by mail or through the OIG's 24-hour toll-free telephone line. Others were brought to our attention during audits or related investigations. Prior to July 1, 2011, the OIG was also statutorily authorized to conduct investigations at the request of CDCR officials in cases that involve potential conflicts of interest or misconduct by high-

level administrators, and 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 as part of its disciplinary monitoring process, if they meet applicable criteria. These monitoring activities are publicly reported 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 2011, the OIG had 81 ongoing inquiries and investigations and completed two administrative investigations, one retaliation investigation and nine preliminary investigations. Those completed investigations are summarized in the table that follows.[3]

[3] Please refer to Appendix B.

	R.J. Donovan Correctional Facility	California Rehabilitation Center	Centinela State Prison	Pleasant Valley State Prison	Central California Women's Facility	California Men's Colony	Sierra Conservation Center
	Report issued April 2011	Report issued April 2011	Report issued May 2011	Report issued May 2011	Report issued May 2011	Report issued June 2011	Report issued June 2011
Chronic Care	66.9%	66.4%	71.7%	61.7%	64.4%	71.1%	77.4%
Clinical Services	60.7%	63.9%	74.5%	72.6%	76.7%	70.9%	84.3%
Health Screening	76.6%	78.7%	80.0%	73.0%	86.3%	94.2%	87.9%
Specialty Services	81.8%	78.9%	83.2%	76.2%	73.3%	76.1%	84.2%
Urgent Services	79.5%	75.8%	72.4%	59.0%	69.3%	74.1%	89.3%
Emergency Services	77.6%	90.2%	78.3%	96.9%	66.9%	85.2%	100.0%
Prenatal Care/Child-birth/Post-Delivery	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Diagnostic Services	79.4%	60.4%	68.3%	89.8%	65.2%	84.0%	99.0%
Access to Healthcare Information	43.1%	72.5%	49.0%	49.0%	82.4%	77.5%	95.1%
Outpatient Housing Unit	N/A	86.1%	N/A	N/A	N/A	N/A	98.5%
Internal Reviews	62.2%	65.5%	70.0%	67.5%	85.5%	75.0%	79.3%
Inmate Transfers	74.5%	100.0%	84.1%	81.3%	95.3%	100.0%	87.3%
Clinic Operations	81.2%	87.9%	91.5%	93.3%	100.0%	86.4%	95.5%
Preventive Services	70.0%	81.0%	58.7%	66.0%	81.0%	76.0%	96.0%
Pharmacy Services	93.1%	89.7%	86.2%	93.1%	100.0%	65.5%	86.2%
Other Services *	100.0%	100.0%	77.8%	100.0%	100.0%	100.0%	100.0%
Inmate Hunger Strikes	93.7%	N/A	N/A	66.8%	N/A	100.0%	N/A
Chemical Agent Contraindications	100.0%	N/A	100.0%	75.0%	N/A	100.0%	76.5%
Staffing Levels and Training	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	95.0%
Nursing Policy	50.0%	87.1%	80.0%	50.0%	80.0%	90.0%	50.0%
Overall Score	**73.0%**	**75.9%**	**74.7%**	**73.3%**	**77.5%**	**80.0%**	**87.5%**

*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.

Allegation/Incident	Investigation	Result
The OIG received an allegation that a contracted employee was supervising staff employed from his own registry, which is a conflict of interest.	The OIG conducted a preliminary investigation that included interviews with staff from the institution and reviewed the documentation 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 a State employee possessed narcotics and was diverting narcotics for distribution.	The OIG conducted a preliminary investigation that included contact with prison staff to arrange to monitor the State employee. The OIG also interviewed California Prison Health Care Services (CPHCS) staff that witnessed statements made by the State employee. In addition, staff was also interviewed in regard to how management handled the potential narcotic diversion issue. The OIG also obtained copies of documentation from the Division of Correctional Health Care Services (DCHCS) that contained the distribution of narcotics to inmates and actions taken by CPHCS management.	The OIG found that sufficient controls were implemented internally by CPHCS staff to minimize the diversion of narcotics. In addition, internal measures were being taken to investigate the potential diversion of narcotics. The OIG closed this investigation.
The OIG received a complaint from an attorney representing a correctional officer. The attorney alleged that a CDCR special agent violated the Health Insurance Portability and Accountability Act (HIPAA) when he issued two administrative subpoenas to the officer's medical provider in order to access the officer's medical records.	The OIG conducted a preliminary investigation by reviewing the administrative subpoenas.	The OIG determined that CDCR violated HIPAA on one of the subpoenas. The OIG referred the case to the hiring authority for review and appropriate action. The OIG closed this investigation.
The OIG received a complaint regarding a private healthcare company who was contracted with CPHCS to provide healthcare consulting services. The complaint alleged that CPHCS was being billed for time not provided by the contracted healthcare consultants. The OIG opened an investigation to review the allegation that CPHCS was overbilled for services not provided.	The OIG conducted a preliminary investigation that included obtaining and reviewing a copy of the contract the private healthcare company had with CPHCS, as well as the billing invoices submitted by the private healthcare company for their consulting services. The OIG also obtained copies of billing invoices for two private healthcare providers that were billed by the private healthcare company during the same period CPHCS was billed.	The investigation revealed no evidence to support the allegation of overbilling by the private healthcare company. The OIG closed this investigation.
The OIG received an allegation from a CDCR employee that she was being exposed to various illegal drugs in her classroom; furthermore, she was concerned for the effects the drug exposure may be having on her body.	The OIG conducted a preliminary investigation that included an interview of the complainant. OIG staff also conducted a site visit and met with key personnel.	The investigation found sufficient evidence to support the allegation; however, the OIG determined CDCR administration is currently taking proactive measures to eliminate the drug and contraband problem at that facility. The OIG also determined further investigation into this matter was not warranted. The OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received an allegation that an inmate was being extorted by other inmates and that a correctional officer threatened him.	The OIG conducted a preliminary investigation that included an interview with prison staff.	The OIG determined there was insufficient evidence to warrant further investigation into this matter and closed the investigation.
The OIG initiated a routine review of the gang assault on a correctional officer at a prison.	The OIG conducted a preliminary investigation that included the collection and review of numerous documents, the department's Office of Correctional Safety gang validation process, and interviews of prison staff.	The OIG found that the department acted in accordance with policy. The OIG closed this investigation.
The OIG received an allegation that special agents from the CDCR executed an illegal search warrant at the home of a CDCR employee.	The OIG conducted an administrative investigation that included interviews of staff and appropriate witnesses, and a review of pertinent CDCR documents and evidence.	The OIG found no evidence that CDCR violated any state laws or policies in its execution of the search warrant. The OIG closed this investigation.
The OIG received an allegation that a CDCR employee allegedly was being retaliated against for reporting employee misconduct to prison managers.	The OIG conducted an administrative investigation that included an interview with the alleged victim and key personnel and a review of documentary evidence.	The OIG determined there was no nexus between the protected activity and the perceived retaliatory treatment to the alleged victim. The OIG closed this investigation.
The OIG initiated a routine review to monitor prison staff's response and follow-up on their requirements regarding the development and implementation of a Quality Improvement Plan (QIP) after the suicide death of an inmate.	The OIG conducted a preliminary investigation that included the collection and review of a suicide report prepared by DCHCS and the Suicide Case Review Focused Improvement Team, Case Management System notes, and a report on the implementation of prison's QIP.	The OIG found that prison staff was over five months late on implementing the QIP as required by DCHCS; however, CDCR's Office of Internal Affairs was responsible for most of this delay. The OIG closed this investigation.
The OIG received an allegation that a CDCR manager retaliated against an employee for reporting misconduct.	The OIG conducted a retaliation investigation that included interviews with the complainant, the alleged subject, and other CDCR employees, and a review of personnel records and other documentation.	The OIG found evidence to substantiate the allegation of retaliation and forwarded the results of the investigation to the hiring authority for appropriate action. The OIG closed this investigation.
The OIG received allegations that a CDCR supervisor was creating a hostile work environment and discriminating against certain employees. It was further alleged that the supervisor retaliated against one employee for filing a formal complaint.	The OIG conducted a preliminary investigation that included interviews with key personnel and a review of documentary evidence.	The OIG determined that there was insufficient evidence to indicate that the supervisor engaged in the alleged acts. The OIG closed its investigation.