Office of the Inspector General

Matthew L. Cate, Inspector General

Accountability Audit

Review of Audits of the California Department of Corrections and Rehabilitation

2000–2005

July 2007

State of California

Matthew L. Cate, Inspector General

Office of the Inspector General

July 30, 2007

James E. Tilton, Secretary
California Department of Corrections and Rehabilitation
1515 S Street, Room 502 South
Sacramento, California 95814

Dear Mr. Tilton:

Enclosed is the Office of the Inspector General's 2007 accountability audit of the California Department of Corrections and Rehabilitation. The audit analyzed the department's success in implementing 182 recommendations that remained unimplemented in 2005 from 15 prior audits. Together, the 15 audits included 349 original recommendations—330 directed to the Division of Juvenile Justice and the other 19 directed to the Board of Parole Hearings. Overall, the department has addressed 79 percent of the 349 recommendations, including 83 percent of the 330 recommendations directed to the Division of Juvenile Justice and 11 percent of the 19 recommendations directed to the Board of Parole Hearings.

Nonetheless, the department's implementation efforts since 2005 raise some concerns. The Division of Juvenile Justice has only partially implemented or not implemented 33 percent of the 160 recommendations that remained unimplemented as of 2005, including recommendations concerning important areas such as restricted programs, facility security, and education services. Worse yet, the Board of Parole Hearings has only partially implemented or not implemented 93 percent of the 15 recommendations that remained unimplemented as of 2005. For example, the board continues to conduct unnecessary placement hearings, and it has made little progress in implementing procedures to govern foreign language interpreter services. This potential waste of state funds continues despite the department having ample time to correct the problem.

This report presents 74 follow-up recommendations to address deficiencies identified in the course of the audit. The department's response appears as an attachment to the report.

Thank you for the courtesy and cooperation extended to my staff during the accountability audit.

Sincerely,

Matthew L. Cate

MATTHEW L. CATE
Inspector General

cc: Bernard Warner, Chief Deputy Secretary, Division of Juvenile Justice
John Monday, Executive Officer, Board of Parole Hearings
Kim Holt, External Audits Coordinator

Enclosure

OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

ACCOUNTABILITY AUDIT

REVIEW OF AUDITS OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

2000–2005

JULY 2007

STATE OF CALIFORNIA

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EXECUTIVE SUMMARY

This report presents the Office of the Inspector General's annual effort to perform a comprehensive follow-up review on previous recommendations issued to the California Department of Corrections and Rehabilitation. In this effort, the Office of the Inspector General assesses the department's progress in implementing past recommendations affecting the Division of Juvenile Justice (formerly the California Youth Authority) and the Board of Parole Hearings (formerly the Board of Prison Terms).

The Office of the Inspector General analyzed the department's efforts to take corrective action on 182 recommendations included in two 2005 Accountability Audits—comprising 12 audits the Inspector General originally issued from 2000 to 2003—as well three audits completed in 2005. Together, the 15 audits included 349 original recommendations—330 directed to the Division of Juvenile Justice and the other 19 directed to the Board of Parole Hearings. The Office of the Inspector General found that the department has successfully addressed about 79 percent of the 349 recommendations reported in the original audits included in this review. To its credit, the Division of Juvenile Justice successfully addressed 83 percent of its 330 recommendations. However, the Board of Parole Hearings successfully addressed only 11 percent of its 19 recommendations.

Additionally, the department's implementation efforts since 2005 raise some concerns. In its 2005 audits, the Office of the Inspector General issued 182 recommendations to the department. Most of these recommendations related to problems identified in previous audits. The Office of the Inspector General determined that of the 182 recommendations, seven were no longer applicable, leaving 175 to review—160 related to the Division of Juvenile Justice and 15 related to the Board of Parole Hearings. Of these recommendations, the department has fully or substantially implemented 108 (62 percent) and has only partially implemented or not implemented the remaining 67 (38 percent) even though it has had ample time to do so—in some cases up to seven years.

The Office of the Inspector General determined that the Division of Juvenile Justice has fully or substantially implemented 67 percent of the 160 recommendations that remained unimplemented as of 2005. However, the division failed to make adequate progress in several important areas such as restricted programs, security, and education. Of greatest concern is the division's inability to provide all wards in "restricted programs" with basic services and at least three hours outside their rooms every day. These ongoing weaknesses could pose added threats to wards with mental illnesses and may increase the risk of suicide. On a positive note, the Division of Juvenile Justice has made good progress responding to recommendations related to most mental health programs and the provision of counseling services. Also, similar to its findings in its 2006 Accountability Audit,[1] the Office of the Inspector General found that staff members and management of individual juvenile facilities have been more responsive than the department to recommendations from past audits and reviews.

[1] *Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation Adult Operations and Adult Programs 2000–2004.* April 2006. http://www.oig.ca.gov/reports/pdf/Accountability-Audit-CORR-Volume%20I.pdf.

The Office of the Inspector General determined that the Board of Parole Hearings' response to recommendations made in 2005 was far worse. The board failed to make adequate progress on 93 percent (14 of 15) of the recommendations that were still applicable in 2005 and covered in this follow-up review. For example, because of the board's continued failure to adequately respond to prior recommendations, the same conditions exist that allowed the board to pay numerous false claims for interpretation services and conduct many unnecessary hearings.

In addition, the Office of the Inspector General found that the California Department of Corrections and Rehabilitation overstated the extent of its corrective action to many recommendations. These overstatements indicate that the department either did not fully understand the intent of the Office of the Inspector General's original recommendation or it was not fully aware of the extent of the actions it had taken in response to the recommendations.

THE DIVISION HAS FAILED TO ADEQUATELY ADDRESS MANY CRITICAL ISSUES

Although the Division of Juvenile Justice has implemented 83 percent of the prior Office of the Inspector General recommendations, it still struggles to adequately address problems in several key areas. Specifically, the division has failed to adequately implement recommendations related to restricted programs, security, education, and medical services. These long-standing problems identify systemic deficiencies that the division must address in order to rehabilitate youthful offenders and prepare them for release.

Restricted programs. The Office of the Inspector General determined that the division's efforts to implement restricted program recommendations were not fully successful. In its restricted programs, the division limits the movements of certain wards—and thus the time that these wards spend outside their rooms—as a result of wards exhibiting ongoing violent and disruptive behavior, or if they pose a danger to themselves or others. Of the 11 recommendations made to the division in past reports, it had failed to take appropriate action on seven of these recommendations (64 percent). For example, during its December 2006 visits to five youth correctional facilities, the Office of the Inspector General reviewed 50 wards who spent a total of 526 days in restricted programs during a 14-day period. The Office of the Inspector General found that the facilities could not show that they provided the required minimum of three hours out-of-room time for 178 of the 526 days (34 percent). In sum, the facilities' failure affected 41 of the 50 wards (82 percent). The most egregious example is the Heman G. Stark Youth Correctional Facility, where none of the wards in restricted programming had received the mandated three hours outside their rooms for any of the days examined. This is of concern because extended confinement combined with lack of exercise or recreation may aggravate existing mental health problems and increase the risk of suicide.

Facility security. In addition, the Office of the Inspector General followed up on 32 recommendations it had made in previous reports that related to security at the division's facilities and determined that the division failed to implement 44 percent (14). Most of these recommendations were made to the N.A. Chaderjian Youth Correctional Facility and are

related to concerns about either the facility's physical plant, such as placing concrete at the base of the perimeter fences, or the facility's policies and procedures, such as making needed updates to its hostage procedures and hostage negotiation training.

Education services. The division has also made inadequate progress in its response to recommendations related to education services provided to wards in division custody. The division has either failed to implement or only partially implemented 32 percent (10 of 31) of the recommendations the Office of the Inspector General made in past reports. Most of these recommendations address personnel issues—such as the need to attract and retain education staff members—at the schools the division operates at the N.A. Chaderjian, Heman G. Stark, and Ventura youth correctional facilities.

Medical care. Moreover, the division has not taken adequate action on many of the medical recommendations the Office of the Inspector General made in past reports. Of the seven medical-related recommendations made to the division in the reports covered in this follow-up review, the division either failed to implement or only partially implemented four of these (57 percent). Two of these recommendations related to the division's administration of psychotropic medications at the N.A. Chaderjian Youth Correctional Facility, while the others related to medical staffing issues at the N.A. Chaderjian Youth Correctional Facility and policies and procedures of medical peer reviews at reception centers and clinics.

THE DIVISION HAS IMPROVED ITS MENTAL HEALTH AND COUNSELING SERVICES

On a positive note, the California Department of Corrections and Rehabilitation has improved in some important areas. For example, the Office of the Inspector General found that the department has made progress in implementing recommendations related to Division of Juvenile Justice mental health programs. The Office of the Inspector General determined that the division has fully or substantially implemented 77 percent (17 of 22) of the mental health recommendations included in past audit reports. Most notably, the division has made progress in its suicide prevention, assessment, and response efforts at the N.A. Chaderjian Youth Correctional Facility and the Southern Youth Correctional Reception Center and Clinic. However, the Office of the Inspector General found that the division still has not made adequate progress in other mental health areas, such as the timely completion of ward treatment needs assessments.

The Office of the Inspector General also discovered that the division has made substantial progress in implementing recommendations related to counseling the wards in its custody. The Office of the Inspector General noted that the division has fully or substantially implemented 82 percent (14 of 17) of the recommendations the Office of the Inspector General made in past audit reports that relate to counseling services. The division reported that it had taken action to improve staffing, scheduling, and monitoring of the counseling services it provides to wards at the N.A. Chaderjian and Heman G. Stark youth correctional facilities and the Southern Youth Correctional Reception Center and Clinic.

FACILITIES HAVE BEEN MORE RESPONSIVE THAN THE DEPARTMENT ITSELF

In carrying out its work on the 2007 Accountability Audit, the Office of the Inspector General identified themes that were also prevalent in its 2006 Accountability Audit of the California Department of Corrections and Rehabilitation's adult operations and programs. In its 2006 report, the Office of the Inspector General noted that the department was much less responsive to recommendations than staff members and management at individual adult institutions.[2] Similarly, in this 2007 follow-up review, the Office of the Inspector General determined that the department has been less effective than individual facilities in implementing recommendations related to Division of Juvenile Justice operations and programs. Of 93 recommendations directed to superintendents or principals at juvenile facilities, 82 percent (76) have been fully or substantially implemented. In contrast, only 48 percent (30) of the 62 recommendations made to administrators in the department have been fully or substantially implemented. The following table illustrates these results.

TABLE 1
IMPLEMENTATION STATISTICS
BY RESPONSIBLE PARTY

Responsible Party	Totals	Fully Implemented		Substantially Implemented		Partially Implemented		Not Implemented		Not Applicable
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Division of Juvenile Justice Recommendations										
Headquarters	62	23	37%	7	11%	24	39%	8	13%	2
Superintendent	93	59	64%	17	18%	13	14%	4	4%	3
Chief Medical Officer	5	0	0%	1	20%	3	60%	1	20%	0
Total for Division	**160**	**82**	**51%**	**25**	**16%**	**40**	**25%**	**13**	**8%**	**5**
Board of Parole Hearings	15	0	0%	1	7%	12	80%	2	13%	2
Grand Totals	**175**	**82**	**47%**	**26**	**15%**	**52**	**30%**	**15**	**8%**	**7**

THE BOARD OF PAROLE HEARINGS HAS BEEN INATTENTIVE TO CHANGE

The Office of the Inspector General determined that the Board of Parole Hearings had failed to adequately respond to 93 percent (14 of 15) of the recommendations contained in five previously issued audits despite having up to seven years to take action. The Office of the Inspector General found that the board had made little progress in responding to recommendations contained in a March 2005 report on the board's procedures governing services provided by foreign language interpreters, noting that two years later, the same conditions exist that allowed numerous false claims to be paid. Further, the Office of the Inspector General found that even though it has repeatedly recommended since March 2000

[2] *Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation Adult Operations and Adult Programs 2000–2004.* April 2006, p. ES-1. http://www.oig.ca.gov/reports/pdf/Accountability-Audit-CORR-Volume%20I.pdf.

that the board establish a centralized system to track indeterminate sentence hearing cases, the board has only recently taken action—seven years later—and the board does not expect this system to be operational until November 2007. Finally, the Office of the Inspector General found that the board continues to automatically conduct placement hearings for mentally disordered offenders 60 days after placing them in Department of Mental Health custody, even though the Office of the Inspector General reported in January 2003 that this practice did not allow enough time for the medical treatment team to assess the patient's suitability for outpatient treatment. In fact, 99 percent of the 60-day placement hearings resulted in an order that the patient remain in a Department of Mental Health hospital for continued inpatient treatment. Although the board has drafted revised hearing procedures that should correct this inefficiency, the board has not yet implemented them. As a result, the board has conducted many unnecessary hearings since 2003 when the Office of the Inspector General first raised the issue.

THE DEPARTMENT OVERSTATED THE EXTENT OF ITS CORRECTIVE ACTIONS

The Office of the Inspector General is concerned with the number of instances in which the California Department of Corrections and Rehabilitation overstated the extent of its actions to implement the recommendations from prior reports. Of the 175 prior recommendations included in this follow-up review, the Office of the Inspector General performed work to verify the department's assertions for 108 recommendations (see the scope and methodology section of this report for discussion of how recommendations were selected for review). After it completed its verification work, the Office of the Inspector General determined that the department had overstated the extent of its actions for 28 percent of the recommendations (30 of the 108). For 12 of these recommendations (11 percent), the department substantially overstated the extent of its actions—meaning that the Office of the Inspector General determined, based on its review, that the department had not implemented or only partially implemented the recommendation when the department had reported full implementation. Of particular concern is that six of these 30 recommendations relate to the department's confinement of wards in restricted programs. The department's overstatement of its actions indicates that either the department did not fully understand the intent of the Office of the Inspector General's original recommendation, or the department was not fully aware of the extent of the actions it had taken in response to the recommendations.

As a result of its 2007 Accountability Audit, the Office of the Inspector General has issued 74 follow-up recommendations, detailed in the body of this report, to address remaining deficiencies. The following table summarizes the results of the Office of the Inspector General's review for each report included in this follow-up review.

TABLE 2
SUMMARY OF RESULTS OF THE 2007 ACCOUNTABILITY AUDIT BY REPORT

Report (Year Issued)	Total Applicable Recommendations		Fully Implemented		Substantially Implemented		Partially Implemented		Not Implemented		Not Applicable
			Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Division of Juvenile Justice Reports	**Original Reports**	**As of 2005**									
23-and-1 Confinement (2000)	4	7	1	14%	1	14%	5	72%	0	0%	0
Intensive Treatment Program (2002)	10	4	2	50%	0	0%	2	50%	0	0%	0
Death of a Ward at the N.A. Chaderjian Youth Correctional Facility (2005)	16	16	5	31%	3	19%	6	38%	2	12%	0
N.A. Chaderjian Youth Correctional Facility (2005)	56	52	27	52%	6	12%	14	26%	5	10%	4
Heman G. Stark Youth Correctional Facility (2000)	44	16	6	38%	4	25%	4	25%	2	12%	0
Southern Youth Correctional Reception Center and Clinic (2003)	77	26	18	69%	5	19%	2	8%	1	4%	1
Ventura Youth Correctional Facility (2002)	101	30	19	63%	5	17%	5	17%	1	3%	0
Office of Audits and Compliance (2003)	9	6	2	33%	1	17%	1	17%	2	33%	0
Juvenile Parole Board (2002)	7	1	0	0%	0	0%	1	100%	0	0%	0
Welfare and Institutions Code Section 1732.8 (2003)	6	2	2	100%	0	0%	0	0%	0	0%	0
Total for Division	**330**	**160**	**82**	**51%**	**25**	**16%**	**40**	**25%**	**13**	**8%**	**5**
Board of Parole Hearings Reports											
Interpretation Services Procedures (2005)	5	5	0	0%	0	0%	4	80%	1	20%	0
Indeterminate Sentence Hearings (2000)	4	6	0	0%	1	17%	4	66%	1	17%	1
Supervision of Deputy Commissioners (2003)	6	2	0	0%	0	0%	2	100%	0	0%	1
Hearings for Mentally Disordered Offenders (2003)	2	1	0	0%	0	0%	1	100%	0	0%	0
Review of Board of Parole Hearings Decisions (2003)	2	1	0	0%	0	0%	1	100%	0	0%	0
Total for Board	**19**	**15**	**0**	**0%**	**1**	**7%**	**12**	**80%**	**2**	**13%**	**2**
Grand Totals	**349**	**175**	**82**	**47%**	**26**	**15%**	**52**	**30%**	**15**	**8%**	**7**

INTRODUCTION

This report presents the results of a comprehensive follow-up audit of 15 previous audits and reviews conducted by the Office of the Inspector General of the Division of Juvenile Justice and the Board of Parole Hearings from 2000 through 2005. The purpose of the follow-up audit was to assess the California Department of Corrections and Rehabilitation's progress in implementing the Office of the Inspector General's previous recommendations. The audit was performed pursuant to California Penal Code section 6126, which assigns the Office of the Inspector General responsibility for oversight of the California Department of Corrections and Rehabilitation and its subordinate entities, which include the Division of Juvenile Justice and the Board of Parole Hearings.

BACKGROUND

Effective July 1, 2005, the Youth and Adult Correctional Agency was dissolved and its former entities were reorganized as the California Department of Corrections and Rehabilitation. As a result of the reorganization, the California Youth Authority became the Division of Juvenile Justice and the Board of Prison Terms became the Board of Parole Hearings.

THE DIVISION OF JUVENILE JUSTICE

The Division of Juvenile Justice operates eight youth correctional facilities and two conservation camps throughout the state. As of April 2007, 2,824 youthful offenders were in Division of Juvenile Justice custody, and another 2,845 youths were on parole under the division's jurisdiction. Ninety-five percent of youthful offenders in Division of Juvenile Justice custody are male. The division has approximately 3,776 employees and an operating budget in fiscal year 2006-07 of $530,491,000.

The division defines its mission as follows:

> *[T]o protect the public from criminal activity by providing education, training, and treatment services for youthful offenders committed by the courts; assisting local justice agencies with their efforts to control crime and delinquency; and encouraging the development of state and local programs to prevent crime and delinquency.*

The Division of Juvenile Justice carries out its responsibilities through the Division of Juvenile Facilities, the Division of Juvenile Programs, and the Division of Juvenile Parole Services.

The Division of Juvenile Justice provides youths committed to its custody—who are called wards—with education services, medical care, counseling, and mental health treatment and is mandated to provide wards with constitutionally adequate conditions of confinement. California Welfare and Institutions Code section 1120 requires the division to operate a statewide school district, and each of the division's eight facilities provides academic and vocational classes to enable wards to attain a high school diploma or equivalent (GED) before they are released.

Over the past decade, the number of youthful offenders committed to the Division of Juvenile Justice has declined from 10,114 in June 1996 to 2,824 in April 2007. The Governor's proposed 2007-08 budget estimates that the ward population will decline to about 2,500 wards by the end of the budget year. This dramatic decline is primarily the result of fewer juvenile court commitments to state facilities. The May Revision to the Governor's proposed 2007-08 budget reflects a further

reduction in the ward population by an estimated 931 wards. Specifically, beginning July 1, 2007, the Division of Juvenile Justice would stop accepting all female juvenile offenders and specified non-violent male juvenile offenders. In addition, female wards in Division of Juvenile Justice custody on July 1, 2007, and male wards not committed for California Welfare and Institutions Code section 707(b) crimes (specified violent crimes committed by a juvenile over 16 years old) would have their sentences recalled for placement at the county level.

The Division of Juvenile Justice has come under public criticism because of violence in its facilities, ward suicides, and failure to provide mandated education and treatment. In January 2003, the Prison Law Office filed the lawsuit now known as *Farrell v. Tilton*, which condemned conditions in the juvenile justice system. In fiscal year 2005-06, the Division of Juvenile Justice began implementing reforms stipulated by the *Farrell v. Tilton* consent decree in the form of remedial plans for ward safety and welfare, sex offender treatment, education services, wards with disabilities, health care services, and mental health treatment.

The state has allocated about $166 million over the past two budget years to comply with the *Farrell v. Tilton* lawsuit. The Division of Juvenile Justice per capita cost for 2007-08 is projected to be $188,000 annually—nearly four times the per capita cost of $49,200 for fiscal year 2002-03.

THE BOARD OF PAROLE HEARINGS

The Board of Parole Hearings conducts hearings to grant, deny, revoke, or suspend the parole of inmates, and the board makes decisions on parole consideration hearings for inmates sentenced under indeterminate sentencing laws. Indeterminate sentencing applies to a prison term that, instead of being fixed in advance by the court, is set by the court for an "indeterminate period" such as 25 years to life. Offenders are eligible for parole consideration after they serve the minimum prison term specified by state law for the particular crime they committed. The board also conducts parole revocation hearings for parolees who have violated their parole conditions. In addition, the board advises the Governor on clemency applications and helps screen inmates scheduled for parole to determine whether they should be classified as mentally disordered offenders to be confined to state hospitals for treatment, or classified as sexually violent predators subject to civil confinement.

Pursuant to California Penal Code section 5075, et seq., the Governor is authorized to appoint 12 commissioners to the Board of Parole Hearings for four-year staggered terms, subject to Senate confirmation.

In addition to the commissioners, the Board of Parole Hearings has 90 approved deputy commissioner positions. The deputy commissioners conduct parole revocation hearings, serve as panelists in parole consideration hearings, and conduct other hearings and functions under the board's jurisdiction. For fiscal year 2007-08, the board has a proposed operating budget of $108 million.

The passage of Senate Bill 737 (Chapter 10, Statutes of 2005) in May 2005 made permanent the board's ability to convene two-person parole consideration hearing panels for so-called "lifer" inmates (inmates sentenced to indeterminate prison terms) with only one commissioner and a deputy commissioner when a backlog of hearings exists. This resulted in a significant increase in the

number of lifer parole consideration hearings scheduled—from about 4,000 in 2004 to about 7,000 hearings in 2006. The board's records indicate that this and other measures decreased the hearing backlog from 2,273 in October 2005 to 1,153 in September 2006, a significant improvement.

In November 2003, the California Department of Corrections and Rehabilitation and the Board of Parole Hearings agreed to a stipulated permanent injunction in the *Valdivia v. Schwarzenegger* lawsuit after the court found that California's parole revocation system violated plaintiffs' due process rights under the 14th Amendment by "allowing a delay of up to forty-five days or more before providing the parolee an opportunity to be heard regarding the reliability of the probable cause determination." The remedial plan adopted under the injunction was intended to improve the timeliness of parole revocation proceedings and included provisions for using alternative sanctions for minor parole violations. These provisions include a probable cause hearing no more than 10 business days after a parolee is notified of charges, a revocation hearing no later than 35 days after a parole hold is placed, and appointment of attorneys to represent all parolees facing revocation proceedings.

In November 2004, the lawsuit commonly known as *Rutherford v. Schwarzenegger* (now known as *Lugo v. Schwarzenegger* with the death of inmate Rutherford) was granted class action status. This lawsuit was filed on behalf of lifer prisoners who had reached their minimum eligible parole dates without receiving a parole suitability hearing within the time frames required by law. In March 2006, the department entered into a stipulated agreement requiring, among other things, that the department develop and implement a statewide networked scheduling and tracking system for lifer prisoner parole hearings.

OBJECTIVES, SCOPE, AND METHODOLOGY

This audit's purpose was to assess the department's progress in implementing the recommendations from all audit reports issued in 2005. Because some reports issued in 2005 were follow-up audits on previously issued reports, this review covers original audits issued from 2000 through 2005. There were 15 of these audits and a total of 349 recommendations. As of 2005, the department had yet to implement 182 recommendations. Ten audits were of Division of Juvenile Justice facilities and programs, and there were a total of 330 recommendations. As of 2005, the division had yet to implement 165 recommendations. The remaining five audits were of various Board of Parole Hearings functions, and there were a total of 19 recommendations. As of 2005, the board had yet to implement 17 recommendations. This follow-up audit focuses on the 182 recommendations the department had not implemented as of 2005.

To conduct the follow-up review, the Office of the Inspector General performed the following procedures:

- Reviewed all audits and special reviews completed by the Office of the Inspector General's Bureau of Audits and Investigations in 2005. These included the 2005 Accountability Audit of the Division of Juvenile Justice and the 2005 Accountability Audit of the Board of Parole Hearings. Two audits issued in 2005 are excluded from this review because the Office of the Inspector General had previously issued follow-up reports on them in 2006. These reports are *Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr.* and *Special Review: Commission on Correctional Peace Officer Standards and Training.*

- Reviewed statutes, regulations, lawsuits, and other documents pertinent to the California Department of Corrections and Rehabilitation's current operating environment.

- Contacted the California Department of Corrections and Rehabilitation and requested the status and supporting documentation on the department's progress in implementing the Office of the Inspector General's recommendations. The department's unedited responses are included, verbatim, in the matrix section of each chapter of this report.

- Conducted interviews, made observations, reviewed records, performed tests, or relied on the statements the department provided based on a risk assessment of the recommendations and the department's responses. The extent of audit procedures performed for each recommendation is described in the comments section of each matrix contained in the chapters of this report.

- Evaluated the information developed from the audit procedures and classified the department's progress in implementing each recommendation into one of the following five categories:
  - ***Fully implemented:*** The recommendation has been implemented, and no further corrective action is necessary.
  - ***Substantially implemented:*** More than half of the corrective actions necessary to fulfill the recommendation have been implemented.
  - ***Partially implemented:*** Half or less than half of the corrective actions necessary to fulfill the recommendation have been implemented.
  - ***Not implemented:*** The recommendation has not been implemented.
  - ***Not applicable:*** The recommendation is no longer applicable.

In some instances, the department successfully addressed the problems by implementing alternative solutions; wherever that has occurred, those achievements are acknowledged in the report. The original 15 audits covered in this follow-up accountability audit had issue dates ranging from March 2000 through December 2005. The California Department of Corrections and Rehabilitation, therefore, had significant time to implement the Office of the Inspector General's recommendations before this follow-up audit was conducted. The large number of audits and recommendations that required follow-up caused the fieldwork completion dates for this follow-up accountability audit to range from January 2007 through April 2007. (The specific completion date for fieldwork is indicated in each chapter.) It is therefore possible that in a few cases the department took action to address some of the Office of the Inspector General's recommendations after completion of the follow-up audit fieldwork. In such cases, the corrective action would not be reflected in this report.

During the course of any Office of the Inspector General follow-up audit, a small number of recommendations may be added, modified, or deemed no longer applicable as a result of changes in the operating environment. The 182 recommendations that were yet to be acted upon at the onset of this audit include the effects of these adjustments.

23-AND-1 CONFINEMENT

IMPLEMENTATION REPORT CARD
2005 Follow-up recommendations: 7
Fully implemented: 1 (14%)
Substantially implemented: 1 (14%)
Partially implemented: 5 (72%)
Not implemented: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has failed to ensure that wards isolated in restricted programs receive certain basic services, such as education and counseling, and are provided at least three hours outside their rooms daily—which may aggravate existing mental health problems and increase the risk of suicide. In addition, the Office of the Inspector General found conditions that presented a threat to the safety and security of wards and staff members in four of the five restricted programs at Division of Juvenile Justice facilities it visited in December 2006. One likely explanation for why the division continues to fail in its administration of restricted programs is the division's failure to provide adequate guidance to its staff.

In December 2000, the Office of the Inspector General examined the Division of Juvenile Justice's (formerly the California Youth Authority's) practice of confining wards with psychological and behavioral problems to rooms 23 hours a day. The 2000 review determined that 16.4 percent of wards at six facilities—one in six wards—were on so-called "23-and-1" schedules at that time. The Office of the Inspector General also found that the reasons wards were confined for all but one hour a day were not clearly documented, that the wards did not appear to be receiving mandated services, and that the rooms had inadequate lighting and heating and were generally in disrepair. The Office of the Inspector General made four recommendations to address these issues.

In his August 2004 confirmation hearing before the Senate Rules Committee, the director of the former California Youth Authority announced that the 23-and-1 confinement practice had ended. Nonetheless, the Office of the Inspector General determined in its 2005 follow-up review that a significant number of wards—about 9 percent of the wards in the five facilities visited—were still under 23-and-1 confinement. The Inspector General reported that restriction to rooms 23 hours a day over long periods deprives wards of programming opportunities, thereby detracting from the ultimate goal of rehabilitation and lengthening the wards' stay in division facilities. Long periods of isolation and the consequent lack of sensory stimuli, the Inspector General stated, may also increase the wards' need for mental health services. The Inspector General concluded that the long-term confinement of wards on a 23-and-1 schedule is both ineffective and dehumanizing and should cease as soon as possible.

In its 2005 follow-up review, the Office of the Inspector General determined that 27 wards at the Heman G. Stark Youth Correctional Facility were only allowed out of their rooms for five-minute daily showers. Among the five facilities visited, only the Southern Youth Correctional Reception Center and Clinic had ended the 23-and-1 practice. In addition, the Office of the Inspector General reported that 39 wards at the N.A. Chaderjian Youth Correctional Facility had been on administrative lockdown for more than 30 days, while

another three wards had been on administrative lockdown for more than 200 days. This lockdown continued even though administrative lockdown—in which all wards in a living unit or a facility are confined to their rooms because of an operational emergency—is supposed to continue only as long as necessary to restore safe operation of the facility. As a result of the 2005 follow-up review, the Office of the Inspector General made seven follow-up recommendations.

BACKGROUND

Under normal circumstances, wards in the general population or in specialized programs have relatively few restrictions and are allowed to leave their rooms for several hours daily to receive various services such as academic or vocational instruction, individual or group counseling, and exercise or leisure activities. In addition, such wards may also be allowed to leave their rooms to participate in work assignments, to eat meals, to obtain medical and dental care, and to engage in telephone calls, visitations, and religious services.

In contrast, the division limits the movement of certain wards, thus limiting the time that these wards spend outside their rooms, under what the division calls "restricted programs." The division has three types of restricted programs. The special management program—normally a separate living unit—is for wards who have exhibited ongoing violent and disruptive behavior. Consequently, the program segregates these wards into a structured environment to provide them education, counseling, medical care, and mental health services. Wards in the special management program generally spend most of their time in their rooms except for time allowed for showers and exercise. The other types of restricted programs temporarily confine wards to their assigned rooms. Specifically, wards assigned to any living unit can be placed in temporary detention whereby they are isolated in their rooms for short periods, generally a day or two, if they pose a danger to themselves or others or are themselves endangered. Alternatively, an entire living unit or facility may be placed on administrative lockdown because of an operational emergency when it becomes necessary to restrict a large number of wards. Each of these conditions results in a "restricted program" for a ward.

Youth correctional facilities are required to provide wards in restricted programs—including the special management programs—with access to certain "mandated services" unless delivery of these services would compromise the safety and security of the facility. These services include exercise, education, counseling, and treatment. However, because of the potentially violent or disruptive behavior exhibited by wards in special management programs, the facilities provide educational and counseling services in secure program areas—typically wards' rooms because of a lack of other available space.

The Department of Corrections and Rehabilitation's general policy governing restricted programs is that such programs be temporary. The *Division of Juvenile Justice Institutions and Camps Branch Manual* states in section 7200 that "a ward should be programmed in a general population setting. When it becomes necessary to restrict a ward's program, staff shall take every step necessary to reintegrate the ward back into the general population as soon as it is safe to do so." Department policy also stipulates that the average length of assignment to the

special management program be 60 to 90 days. A facility's superintendent must approve a ward's stay in the special management program that exceeds 90 days.

Historically, the division's practices confined wards in restricted programs to their rooms for 23 hours a day, allowing wards out of their rooms for one hour of exercise. This was referred to as 23-and-1 confinement. In July 2004, however, the division expanded this out-of-room period to a minimum of three hours.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

In its January 2005 follow-up review, the Office of the Inspector General determined that the Division of Juvenile Justice had not adequately acted on any of the four recommendations made in the December 2000 review. The Office of the Inspector General found that a significant number of wards at four of the five facilities reviewed were still on 23-and-1 confinement schedules as of September 23, 2004. Among the five facilities, only the Southern Youth Correctional Reception Center and Clinic had ended the 23-and-1 practice. The Office of the Inspector General identified 140 wards at the remaining four facilities who were assigned to 23-and-1 confinement. In addition, the audit team estimated that another 103 wards at the Heman G. Stark Youth Correctional Facility not in restricted programs were on de facto 23-and-1 schedules because the facility lacked enough teachers to provide educational services, with the result that wards simply remained in their rooms 23 hours a day instead of attending classes. The Office of the Inspector General found that out of a total population of 2,658 wards at the five facilities, an estimated 243 wards—9 percent—were on 23-and-1 confinement as of September 23, 2004.

The review determined that division headquarters failed to provide clear direction, resources, policies, and procedures to end 23-and-1 confinement practices. Formal direction from headquarters pertaining to 23-and-1 status appeared to have been limited to one memorandum to facility superintendents, issued in July 2004, advising that 23-and-1 confinement was no longer an acceptable practice for wards in special management programs. The memorandum did not address 23-and-1 confinement for wards in other restricted programs and did not spell out implementation procedures for ending 23-and-1 status. Instead, the memorandum directed superintendents to develop their own solutions to implementing the directive. As a result, implementation was inconsistent. The superintendent of the Southern Youth Correctional Reception Center and Clinic told the Office of the Inspector General that she relied on the director's Senate testimony to end 23-and-1 confinement for all wards, while the other four superintendents said they relied strictly on the director's memorandum, which mentioned only wards in special management programs.

The Office of the Inspector General found that lack of clear direction and additional resources from department headquarters to implement the directive may have had several unintended consequences. For example, ending 23-and-1 confinement for special management program wards, who tend to be the most disruptive and violent, may have served as a disincentive to positive behavior for wards in other restricted programs who remained on 23-and-1. Superintendents also expressed concern about the increased risk to

staff members and wards from allowing potentially violent wards to spend more time out of their rooms without additional resources to address the associated risks.

In addition to determining that 23-and-1 confinement had not ended at the facilities, the follow-up review revealed a number of other findings. Most significantly, the review found that 27 wards who were on administrative lockdown at the Heman G. Stark Youth Correctional Facility as of October 7, 2004, were not being allowed out of their rooms at all, except for five-minute daily showers. Moreover, the review found that of the 46 wards on administrative lockdown at the N.A. Chaderjian Youth Correctional Facility, 39 had been on administrative lockdown status for more than 30 days, and three had been on administrative lockdown for more than 200 days.

The review also found numerous unsafe conditions in the rooms of wards at the Heman G. Stark Youth Correctional Facility. Paper and towels blocked windows, preventing the staff from monitoring activity inside the rooms, and in one case, a rope made from a twisted bed sheet was draped over a ceiling light fixture.

The Office of the Inspector General reported the unsafe conditions to the director of the former California Youth Authority on October 5, 2004, yet found that the conditions still had not been corrected eight days later, on October 13, 2004. When the audit team discussed the issue with the superintendent on October 13, 2004, he reported that he had not been notified of the problem by division headquarters and had been unaware of the unsafe conditions. On November 16, 2004, the Office of the Inspector General again visited the facility and found that the conditions had been corrected.

The Office of the Inspector General made seven follow-up recommendations to the Division of Juvenile Justice to address the report's findings.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The California Department of Corrections and Rehabilitation reported that it had fully or substantially implemented all of the Office of the Inspector General's recommendations from the 2005 follow-up review. However, the Office of the Inspector General found that the Division of Juvenile Justice still fails to ensure that it provides wards in restricted programs basic services, such as education and counseling, and at least three hours outside their rooms every day. The division's failure is of concern because long periods of isolation and the consequent lack of sensory stimuli may increase the wards' needs for mental health services and increase the risk of suicide. Furthermore, the division still has not finalized key policies intended to guide its staff members who work in the restricted programs. These draft policies do not discuss the critical issue of the minimum time that the department requires wards to be out of their rooms. The Office of the Inspector General also identified conditions at four of the five facilities it visited in December 2006 that presented safety and security concerns to staff members and wards. As a result, the Office of the Inspector General disagrees that the department has fully or substantially implemented five of the seven recommendations from the 2005 follow-up review.

Mandated services are not always provided or properly documented. In response to an Office of the Inspector General recommendation to review its tracking of mandated services provided to wards in restricted programs, the Division of Juvenile Justice stated that it had implemented a daily reporting and review process to ensure mandated services are provided to wards and properly documented. Moreover, the division stated that it had instituted audits of facilities to determine whether they are providing mandated services to these wards. Although these monitoring processes appear to provide an adequate method for documenting the provision of mandated services to wards, the Office of the Inspector General found that the division still falls short of delivering mandated services to all wards in restricted programs. In its visits to five Division of Juvenile Justice facilities in December 2006, the Office of the Inspector General found that many wards in restricted programs still are not receiving all mandated services, particularly educational and counseling services. The Office of the Inspector General reviewed 50 wards who spent a total of 526 days in restricted programs during a 14-day period. The Office of the Inspector General found that for 174 of the 526 days (33 percent) the facilities failed to provide or properly document their provision of mandated services—predominantly education and counseling. Overall, 39 of the 50 wards (78 percent) were affected by the division's failure to deliver or track mandated services.

For example, at the Heman G. Stark Youth Correctional Facility, the Office of the Inspector General found that none of the three wards it reviewed who were housed in the facility's special management program had received educational services during the two-week period reviewed. This is consistent with the findings reported in the Office of the Inspector General's recently released report *Special Review of the High-Risk Issues at the Heman G. Stark Youth Correctional Facility*. In this report, the Office of the Inspector General found that few of the wards in the facility's special management program receive educational services, noting that the principal of the facility's school attributed the facility's inability to provide adequate educational services to excessive teacher vacancies and inadequate classroom space. The facility also struggles to provide educational services to wards assigned to its temporary detention program. Although each of the six wards reviewed stayed in the program three days or fewer, none of them received educational services during their stay in the temporary detention program.

In addition, the Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility did not always properly document its provision of mandated services to wards in restricted programs. The *Division of Juvenile Justice Institutions and Camps Branch Manual* requires the facility to provide wards in restricted programs at least 10 minutes of behavioral counseling every school day in which the ward is unable to attend school in the facility's school area and to document a ward's counseling participation or refusal to participate in the restricted program mandated services log. Nonetheless, the Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility did not always document why some wards failed to receive counseling services every school day. On each of the school days reviewed by the Office of the Inspector General, the facility reported in its mandated services log that a significant number of its wards—ranging from 29 to 52 percent of the wards in restricted programs—did not receive counseling services. However, the facility did not include in its mandated service log an explanation of why the wards had not received counseling services.

Facilities are failing to provide wards at least three hours outside their rooms daily. The department also reported that it had taken actions to ensure that wards who are in special management programs are provided at least three hours outside their rooms daily. However, the Office of the Inspector General found that the Division of Juvenile Justice still struggles to meet this goal for special management and temporary detention programs. During its December 2006 visits to five youth correctional facilities, the Office of the Inspector General reviewed 50 wards who spent a total of 526 days in restricted programs during a 14-day period. The Office of the Inspector General found that the facilities had not provided or properly documented their provision or the wards' refusal of the minimum of three hours out-of-room time for a total of 178 of the 526 days (34 percent). In sum, the facilities' failure affected 41 of the 50 wards (82 percent). This failure to provide out-of-room time is of concern because extended confinement restricts programming opportunities and, when combined with lack of exercise or recreation, may aggravate existing mental health problems and increase the risk of suicide. Some of the facilities appeared to do a better job than others did in providing restricted program wards at least three hours outside their rooms daily. For example, the Office of the Inspector General found that the El Paso de Robles Youth Correctional Facility had provided all seven of the wards reviewed who were housed in its special management program at least three hours outside their rooms daily during the period reviewed.

However, other facilities reviewed did not fare as well. The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility had not provided any of the wards reviewed in restricted programs at least three hours outside their rooms for any of the days examined. For one ward, the facility had failed to keep any record of time the ward spent outside his room; therefore, the Office of the Inspector General was unable to make a determination. These and other findings are included in the Office of the Inspector General's report issued on February 26, 2007, titled *Special Review of High-Risk Issues at Heman G. Stark Youth Correctional Facility*.

The Office of the Inspector General also found that wards in temporary detention at the Southern Youth Correctional Reception Center and Clinic and the El Paso de Robles Youth Correctional Facility routinely had not received at least three hours outside their rooms. All 10 of the wards reviewed in the temporary detention program at the Southern Youth Correctional Reception Center and Clinic had not received three hours outside their rooms during their time in the program, which ranged from one to eight days. Two of the three wards reviewed in temporary detention at the El Paso de Robles Youth Correctional Facility—where wards typically serve longer temporary detention terms than wards at other facilities—had not received three hours outside their rooms for 13 of the 14 days reviewed. One other ward at the facility had not received three hours on any of the 14 days reviewed.

One likely explanation for why the Division of Juvenile Justice continues to struggle in providing wards sufficient time outside their rooms is the division's continuing failure to provide adequate guidance to its staff members working in the restricted programs. In response to the 2005 follow-up review, the division reported that it had developed revisions to its restricted program policy. The Office of the Inspector General reviewed the division's policy, which is still only in draft form, and found that it is incomplete regarding the

department's expectation of the amount of time wards should be confined to their rooms. In its 2005 follow-up review, the Office of the Inspector General reported that the division had failed to provide clear direction, resources, policies, and procedures to end 23-and-1 confinement. The Office of the Inspector General noted that the division's guidance was limited to a memorandum issued in July 2004 to all facility superintendents advising that 23-and-1 confinement was no longer an acceptable practice.

Nonetheless, the division still has not included in its *Division of Juvenile Justice Institutions and Camps Branch Manual*—including its draft revisions—its policy of allowing wards in restricted programs outside their rooms for at least three hours daily. Since the 2005 follow-up review, the division has continued to communicate the policy to facilities through memorandums only. Further, the department's memorandum to facility superintendents discussing its three-hour policy identifies only wards in special management programs and does not include wards in temporary detention. Although temporary detention is designed to be a short-term program—generally a day or two—the division sometimes keeps wards in the program for longer periods. Therefore, to ensure that wards housed in temporary detention receive appropriate time out of their rooms, the division needs to address these programs in its policy.

The risk of a misunderstanding of the division's current policy was demonstrated during a recent Office of the Inspector General audit at the Heman G. Stark Youth Correctional Facility. During this audit, the Office of the Inspector General and the Heman G. Stark administration and staff members believed that division policy required the facility to provide wards in a restricted program at least three hours outside their rooms daily. However, in later discussions with division headquarters staff, the Office of the Inspector General learned that division policy—as described in a memorandum to the facilities—provided an exception to the Heman G. Stark Youth Correctional Facility, only requiring it to allow wards in restricted programs at least two hours outside their rooms daily. The memorandum explained that the Heman G. Stark Youth Correctional Facility was provided an exception to the three-hour requirement because of its "unique population and physical plant challenges."

Not only were the Heman G. Stark administration and staff members unaware of the division's policy, but the Office of the Inspector General learned that the division's chief deputy secretary also was unaware of—and did not approve of—the division policy that provided the exception to the three-hour policy. This example underscores the importance of the division clearly communicating its policy of providing wards in restricted programs at least three hours outside their rooms daily. The division continues to fail to provide clear direction, resources, policies, and procedures to ensure that wards in restricted programs receive at least three hours outside their rooms daily because it has failed to formalize the policy in its *Division of Juvenile Justice Institutions and Camps Branch Manual.*

Ward room conditions threaten safety and security. The department also reported that it had implemented quarterly reviews to address substandard living conditions in wards' rooms identified by the Office of the Inspector General in its 2005 follow-up review. However, these efforts are insufficient to ensure that all facilities with wards on restricted status are complying with department policies. The Office of the Inspector General found

conditions that presented a threat to the safety and security of wards or staff members at four of the five youth correctional facilities it visited in December 2006. For example, the Office of the Inspector General found contraband in 53 of the 77 special management program rooms it inspected at the Heman G. Stark Youth Correctional Facility, including 22 rooms that had a window partially or fully covered, obstructing the staff members' view into the rooms. Each of these facilities was included in the department's quarterly reviews, which were completed before the Office of the Inspector General's 2005 follow-up review. Even so, the department did not identify and report the conditions described above in its quarterly review of findings.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Division of Juvenile Justice take the following actions:

- **Review its methods for tracking mandated services to wards and implement procedures to ensure that weekly and monthly, as well as daily, services are provided and accurately documented.**

- **Finalize and implement policies and procedures that provide clear justification for isolating wards in restricted programs.**

- **As part of the department's efforts to finalize the above policy, include its policy of allowing wards in restricted programs—including wards assigned to temporary detention—at least three hours outside their rooms every day in its *Division of Juvenile Justice Institutions and Camps Branch Manual*.**

- **Hold staff accountable for failing to follow policies related to wards' living conditions, particularly conditions that threaten safety and security.**

The Office of the Inspector General conducted its work on 23-and-1 confinement from November 15, 2006, through April 2, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of findings that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 1

A significant portion of the wards interviewed said they were deprived of their rights while housed in temporary detention units. (December 2000)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Review methods for tracking mandated services to wards and implement procedures to ensure that weekly and monthly, as well as daily, services are accurately documented. (December 2000)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. On September 3, 2004, the Division of Juvenile Justice implemented a daily institutional review and reporting process to report mandated services to executive management. Revisions have been implemented to allow accurate documentation.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed a description of the department's monitoring process and concurs that it provides an adequate means of documenting the provision of mandated services to wards. Under the department's process, facilities input the services provided daily to wards on restricted status into the Ward Information Network system. In addition, as reported in Finding 3 below, the department has instituted audits of facilities to determine whether they are providing mandated services to wards in restricted programs. However, the Office of the Inspector General found that the department has not fully implemented this process, and as a result still falls short of properly documenting and delivering mandated services to all wards in restricted programs. The Office of the Inspector General visited five of the six juvenile facilities originally included in the December 2000 review. During these visits, conducted in December 2006, the Office of the Inspector General reviewed the records of at least 10 wards at each facility in restricted programming. The 10 wards were selected from a combination of temporary detention and special management programs, depending on the programs operated at the particular facility. The Office of the Inspector General then

RECOMMENDATION	STATUS	COMMENTS
		reviewed mandated services logs for these wards to determine, among other things, whether the wards were receiving mandated services. During the visits—which were subsequent to the department's audits of facilities to determine whether they are providing mandated services to wards in restricted programs—the Office of the Inspector General found that many wards are still not receiving all mandated services, particularly educational and counseling services. The Office of the Inspector General also found that the department still is not properly documenting its provision of mandated services to wards placed in restricted programs. The 50 wards the Office of the Inspector General reviewed spent a total of 526 days in restricted programs during a 14-day period. The Office of the Inspector General found that for 174 of the 526 days (33 percent) the facilities failed to provide, or properly document, as described below, their provision of mandated services—predominantly education and counseling. Overall, 39 of the 50 wards—78 percent—were affected by the department's failure to deliver or track mandated services. Therefore, the Office of the Inspector General disagrees with the department's assertion that it has fully implemented the recommendation. Following is a discussion of the conditions found at each of the youth correctional facilities reviewed by the Office of the Inspector General. ***Heman G. Stark Youth Correctional Facility*** At the Heman G. Stark Youth Correctional Facility, the Office of the Inspector General found that none of the three wards it reviewed who were housed in the facility's special management program had received educational services during the two-week period reviewed. One additional ward in the special management program was a high school graduate, and therefore was not required to receive educational services. This finding is consistent with the findings reported in the Office of the Inspector General's recently released report *Special Review of the High-Risk Issues at the Heman G. Stark Youth Correctional Facility*. In this report, the Office of the Inspector General found that few of the wards in the facility's restricted programs receive educational

RECOMMENDATION	STATUS	COMMENTS
		services, noting that the principal of the facility's school attributed the facility's inability to provide adequate educational services to excessive teacher vacancies and inadequate classroom space. The facility also failed to provide educational services to wards placed in temporary detention. The Office of the Inspector General reviewed six wards who were placed in temporary detention at the Heman G. Stark Youth Correctional Facility. None of them had received educational programs during their stay in the temporary detention program. The Office of the Inspector General notes that even though a ward's stay in temporary detention is generally short—three days or fewer for each of these six wards—department policy requires that these wards receive educational services by the second school day after placement in restricted programs. In addition, the facility did not always properly document its provision of mandated services to wards in restricted programs. The *Division of Juvenile Justice Institutions and Camps Branch Manual* requires the facility to provide wards in restricted programs at least 10 minutes of behavioral counseling every school day in which the ward is unable to attend school in the facility's school area. The manual also requires the facility to document a ward's counseling participation or refusal to participate in the restricted program mandated services log. Nonetheless, the Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility had not always documented why some wards failed to receive counseling services every school day. On each of the 10 school days reviewed by the Office of the Inspector General, the facility reported in its mandated services log that a significant number of its wards—ranging from 29 to 52 percent of the wards in restricted programs—had not received counseling services. And yet the facility did not include in its mandated services log an explanation of why the wards had not received counseling services. ***El Paso de Robles Youth Correctional Facility*** The Office of the Inspector General found that all three of the wards

RECOMMENDATION	STATUS	COMMENTS
		reviewed in the El Paso de Robles Youth Correctional Facility's temporary detention program had received little or no educational services during the 14-day period reviewed. Indeed, only one of the three wards had received a single day of educational services during the period reviewed. Moreover, the El Paso de Robles Youth Correctional Facility did not always properly document its provision of mandated services to wards in restricted programs—both temporary detention and the special management program. As discussed above, the *Division of Juvenile Justice Institutions and Camps Branch Manual* requires the facility to document a ward's counseling participation or refusal to participate in the restricted program mandated services log. However, the Office of the Inspector General found that all 10 of the wards it reviewed had not received required counseling services during their time in restricted programs, and the facility did not document in its mandated services log why these wards had failed to receive the services. ***Southern Youth Correctional Reception Center and Clinic*** The Office of the Inspector General found that wards in the temporary detention program at the Southern Youth Correctional Reception Center and Clinic had not received educational services during the period reviewed. According to facility records, six of the 10 wards in the temporary detention program at the Southern Youth Correctional Reception Center and Clinic had received no educational services during their stays in the program, which ranged from one to eight days. The facility failed to properly track services provided to the other four wards, so the Office of the Inspector General was unable to determine the services provided to them. Also, the Southern Youth Correctional Reception Center and Clinic had not always properly documented its provision of mandated services to wards in temporary detention. As discussed above, the *Division of Juvenile Justice Institutions and Camps Branch Manual* requires the facility to document a ward's counseling participation or refusal to participate in the restricted program mandated services log. However, the Office of the Inspector General found

RECOMMENDATION	STATUS	COMMENTS
		that for all of the 10 wards it reviewed, the facility had not provided, or properly documented its provision of, required counseling services, and the facility had not documented in its mandated services log why these wards failed to receive the services. ***N.A. Chaderjian Youth Correctional Facility*** Although the Office of the Inspector General found additional wards at the N.A. Chaderjian Youth Correctional Facility who had not received educational services on some of the days reviewed, their numbers were not as severe as in the above examples. At the N.A. Chaderjian Youth Correctional Facility, the Office of the Inspector General found that five of the 10 wards reviewed in restricted programs had been provided an opportunity to participate in educational services on all weekdays during the 14-day period reviewed. Four of the 10 wards reviewed had missed only one day of school during the 14-day period reviewed, and another ward had missed three days. ***Preston Youth Correctional Facility*** Similar to the N.A. Chaderjian Youth Correctional Facility, the Office of the Inspector General found wards in restricted programs at the Preston Youth Correctional Facility who had not received educational services on some of the days reviewed; however, their numbers were also not as severe as in the above examples. At the Preston Youth Correctional Facility, the Office of the Inspector General found that five of the 10 wards reviewed in restricted programs had been provided an opportunity to participate in educational services on all weekdays during the 14-day period reviewed. Two of the 10 wards reviewed had missed only one day of school, one ward had missed two days, and two other wards had missed three days.

FOLLOW-UP RECOMMENDATION

The Division of Juvenile Justice should review its methods for tracking mandated services to wards and implement procedures to ensure that weekly and monthly, as well as daily, services are provided and accurately documented. (December 2000)

FINDING NUMBER 2

The reasons for wards' detention were not clearly documented. (December 2000)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Direct the task force on conditions of confinement to develop and implement policies and procedures that provide clear justification for isolating wards in restricted programs. (December 2000)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. A drafted revision to the restricted program policy has been developed with input from Juvenile Justice experts. Proposed changes will further address staff authority and justification for placing wards in confinement. This is a further revision from the changes made from the original recommendation. The Division of Juvenile Justice has drafted procedures for placement in restricted programs with due process provisions.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the division's draft policy and confirmed that it addressed the criteria for isolating wards in restricted programs. However, the division has yet to finalize these policies and distribute them to facilities as formal division policy. Therefore, the Office of the Inspector General disagrees that this recommendation is substantially implemented. Furthermore, as discussed below, the policies and procedures are incomplete with regard to the department's expectation of the amount of time wards should be confined to their rooms.
Determine the conditions— if any—under which it is appropriate to confine wards to cells for 23 hours a day. If these conditions are found to exist, develop clear policies and procedures to identify these conditions and the time limits that will apply. If the conditions are not found to exist, develop an implementation plan for eliminating the 23-and-1	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Ongoing, Fully Implemented. With the exception of short term Temporary Detention (TD) based upon recent specific information of a ward's violence potential, there is no program designed for 23-1 confinement.* *From time to time, institutions experience difficulties with space and security issues to ensure 21 and 3 programs on a daily basis. The Division of Juvenile Facilities (DJF)*

RECOMMENDATION	STATUS	COMMENTS
schedule in favor of additional education, treatment, and programming services. (January 2005)		*receives weekly mandated services reports for each SMP program, which report the compliance of the 3-hours out mandate. (Copy provided to OIG Deputy Inspector [name omitted] on February 5, 2007). The DJF Director established a compliance report to the facilities on a weekly basis regarding time out their room in December 2005, and the facilities were provided a standard compliance reporting tool. On March 26, 2007, Heman G. Stark Youth Correctional Facility (HGS) exemption of 2-hours was removed and HGS was required to adhere to the 3-hour standard. Less than 100% compliance of these standards requires an intervention plan, identifying the issues impacting the lack of programming services and identifying ways to mitigate those issues. This is reported back to the DJF Director for review on a weekly basis.* **Office of the Inspector General's comments:** The Office of the Inspector General found that the division still has not included in the *Division of Juvenile Justice Institutions and Camps Branch Manual*—or in its draft revisions—its policy of allowing wards in restricted programs at least three hours daily outside their rooms. Because of the failure to provide clear direction, resources, and policies, the facilities still fail to get wards in restricted programs out of their rooms for at least three hours per day an estimated 34 percent of the time. In its 2005 follow-up review, the Office of the Inspector General reported that the Division of Juvenile Justice had failed to provide clear direction, resources, policies, and procedures to end 23-and-1 confinement. The Office of the Inspector General noted that the division's guidance was limited to a memorandum issued in July 2004 to all facility superintendents advising that 23-and-1 confinement was no longer an acceptable practice for wards in special management programs. Since the 2005 follow-up review, the division has continued to communicate the three-hour requirement to facilities through memorandums. In one memorandum to facility superintendents, the department explained its process for monitoring the facilities' provision of three hours out-of-room time for wards in special management programs. None of these

RECOMMENDATION	STATUS	COMMENTS
		memorandums addressed whether wards assigned to temporary detention should receive three hours out-of-room time daily. However, based on the department's comments above, it appears that wards placed on temporary detention continue to be on 23-and-1 confinement. Although temporary detention is designed to be a short-term program—generally a day or two—the division sometimes keeps wards in the program for longer periods, as at the El Paso de Robles Youth Correctional Facility discussed below. Therefore, to ensure that wards housed in temporary detention receive appropriate time out of their rooms, the division needs to also address the temporary detention program in its policy. The risk of misunderstanding the division's current policy was demonstrated during a recent Office of the Inspector General review at the Heman G. Stark Youth Correctional Facility. During this review, the Office of the Inspector General and the Heman G. Stark administration and staff members believed that division policy required the facility to provide wards in a restricted program at least three hours outside their rooms daily. However, in later discussions with division headquarters staff, the Office of the Inspector General learned that division policy—as described in a memorandum to the facilities—provided an exception to the Heman G. Stark Youth Correctional Facility, requiring it to allow wards in restricted programs a minimum of only two hours outside their rooms daily. The memorandum explained that the Heman G. Stark Youth Correctional Facility was provided an exception to the three-hour requirement because of its "unique population and physical plant challenges." Not only were the Heman G. Stark administration and staff members unaware of the division's policy, but the Office of the Inspector General learned that the division's chief deputy secretary also was unaware of—and did not approve of—the division policy that provided for the exception to the three-hour out-of-room policy. In a meeting between the Office of the Inspector General and the division to discuss the results of the Office of the Inspector General's recent report, *Special Review of the High-Risk Issues at the*

RECOMMENDATION	STATUS	COMMENTS
		Heman G. Stark Youth Correctional Facility, the Office of the Inspector General explained to the division's chief deputy secretary that division policy—as described in a memorandum to the facilities—allowed the Heman G. Stark Youth Correctional Facility to limit wards in restricted programs to only two hours outside their rooms daily. The chief deputy secretary told the Office of the Inspector General that he was unaware of the exception provided to the Heman G. Stark Youth Correctional Facility, that he has committed the division to providing wards three hours outside their rooms daily, and that he expected all facilities would meet the goal. Subsequently, the department has provided documentation that it has removed this exception. This example underscores for the division the importance of clearly communicating its policy of providing wards in restricted programs at least three hours outside their rooms daily. To determine whether the wards were receiving at least three hours outside their rooms every day, the Office of the Inspector General visited five of the six youth correctional facilities originally included in the December 2000 review and examined the records of 10 wards in restricted programming at each facility. The 10 wards were selected from a combination of temporary detention and special management programs, depending on the programs operated at the particular facility. During its December 2006 visits, the Office of the Inspector General reviewed 50 wards who spent a total of 526 days in restricted programs during a 14-day period. The Office of the Inspector General found that the facilities had not provided or properly documented their provision or the wards' refusal of the minimum of three hours out-of-room time for a total of 178 of the 526 days (34 percent). In sum, the facilities' failure affected 41 of the 50 wards (82 percent). Based on the results of this review, described in detail below, the Office of the Inspector General believes that the facilities' staff members still do not fully understand—or have not fully implemented—the division's expectations related to allowing wards in special management programs outside their rooms at least three hours every day. Specifically, the Office of the Inspector General found that,

RECOMMENDATION	STATUS	COMMENTS
		to varying degrees, each facility failed to provide all wards in restricted programs at least three hours outside their rooms every day. This failure is of concern because extended confinement combined with lack of exercise or recreation may aggravate existing mental health problems and increase the risk of suicide. The Office of the Inspector General reviewed supporting documentation of out-of-room time the facilities provided to wards in restricted programs over a two-week period and made the following findings: ***Heman G. Stark Youth Correctional Facility*** The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility had not provided nine of the 10 wards reviewed in restricted programs at least three hours outside their rooms for any of the days reviewed. The facility had failed to keep any record of time the remaining ward spent outside his room; therefore, the Office of the Inspector General was unable to make a determination. These and other findings are included in the Office of the Inspector General's report issued on February 26, 2007, titled *Special Review of High-Risk Issues at Heman G. Stark Youth Correctional Facility*. ***El Paso de Robles Youth Correctional Facility*** The El Paso de Robles Youth Correctional Facility had provided all seven of the wards reviewed who were housed in its special management program at least three hours outside their rooms every day during the period reviewed. However, the Office of the Inspector General also found that wards in temporary detention at the facility routinely had not received at least three hours outside their rooms. Two of the three wards reviewed in temporary detention at the facility—where wards typically serve longer temporary detention terms than wards at other facilities—had not received three hours outside their rooms for 13 of the 14 days reviewed. A third ward in temporary detention at the facility had not received three hours on any of the 14 days reviewed. Although temporary detention is designed to be short-

RECOMMENDATION	STATUS	COMMENTS
		term—generally a day or two—the Office of the Inspector General found that the El Paso de Robles Youth Correctional Facility kept wards in the program for longer periods. At the time of the Office of the Inspector General's visit to the facility, eight of the 23 wards in temporary detention had been there for more than two weeks. ***Southern Youth Correctional Reception Center and Clinic*** The Office of the Inspector General found that wards in temporary detention at the Southern Youth Correctional Reception Center and Clinic routinely had not received at least three hours outside their rooms. All 10 of the wards reviewed in the temporary detention program at the Southern Youth Correctional Reception Center and Clinic had not received three hours outside their rooms every day during their time in the program, which ranged from one to eight days. ***Preston Youth Correctional Facility*** At the Preston Youth Correctional Facility, the Office of the Inspector General found that the facility normally does not provide wards in restricted programs three hours outside their rooms on weekends. In its review, the Office of the Inspector General found that all 10 wards it reviewed at the Preston Youth Facility had received fewer than three hours outside their rooms for at least one of the days reviewed. ***N.A. Chaderjian Youth Correctional Facility*** The Office of the Inspector General found that the N.A. Chaderjian Youth Correctional Facility had provided wards housed in restricted programs at least three hours outside their rooms on most of the 14 days reviewed. Five of the 10 wards reviewed had been provided an opportunity to receive at least three hours outside their rooms daily. A sixth ward had received three hours outside his room on 12 of the 14 days reviewed. Three other wards reviewed had been provided at least three hours outside their rooms on all days reviewed except for one day during which the facility had restricted the wards to their rooms for disciplinary reasons. The final ward had been

RECOMMENDATION	STATUS	COMMENTS
		similarly restricted for three days reviewed. The *Division of Juvenile Justice Institutions and Camps Branch Manual* provides that the facility may withhold mandated services from wards in a restricted program if the delivery of such services would compromise the safety and security of the facility. Although, as discussed above, the division does not include in its *Division of Juvenile Justice Institutions and Camps Branch Manual* the three-hour requirement as a mandated service, the Office of the Inspector General believes it is reasonable for the facility to restrict a ward's time outside his room if staff members determine that not doing so would pose a threat to the safety and security of the facility. Based on the findings described above, the Office of the Inspector General believes that the division continues to fail to provide clear direction, resources, policies, and procedures to ensure that wards in restricted programs receive at least three hours outside their rooms daily. Finally, the department also reported that in response to concerns raised by the courts in the *Farrell v. Tilton* litigation, it intends to replace its special management program with a Behavioral Treatment Program that provides enriched staffing and program content, as well as defined program entrance and exit criteria. The department stated that it has committed to the court to initiate the Behavioral Treatment Program by June 30, 2007, with full implementation projected to begin September 30, 2008.
Define confinement schedules for wards in restricted programs and promulgate and enforce uniform policies and procedures, including those governing the size of outdoor exercise enclosures and the provision of water, toilet facilities, and recreation items, to ensure consistency throughout the department. (January 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Department has provisions that mandate consistent and verifiable services including but not limited to basic services such as water, toilet facilities, education, counseling and recreation. Each facility develops operation procedures to ensure this basic mandated services be provided to each youth daily.* *Headquarters staff conducts reviews. Documentation of these reviews was provided to the Deputy Inspector General, [name omitted] OIG on February 5, 2007. These reviews included but are not been limited to:*

RECOMMENDATION	STATUS	COMMENTS
		• *Overall room cleanliness* • *Delivery and documentation of mandated services* • *Program changes and modifications* *A condition of confinement group met and developed SMP stage (level) program enhancements and standardization. These enhancements are in the final review stages of internal review by the field.* *Additional modifications of these areas to provide uniform program service delivery are addressed as part of the remedial plan focused on the Behavior Treatment Programs.* **Office of the Inspector General's comments:** The Office of the Inspector General notes that ward confinement schedules are discussed in the previous recommendation and therefore will not be repeated for this recommendation. As part of its December 2006 fieldwork, the Office of the Inspector General tested the division's compliance with other elements included in this recommendation and found only one exception. At the Preston Youth Correctional Facility, staff members told the Office of the Inspector General that when wards request to use the bathroom during their exercise period in a special programming area, they are allowed to go, but their exercise period is terminated. As a result, these wards still may not be receiving the minimum required amount of time outside their rooms every day for exercise.
Address the inconsistency that allows wards in special management programs to receive more time out of their cells than many wards who are not in special management programs. (January 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The two facilities where this was a potential problem are Heman G. Stark and N.A. Chaderjian (NAC). The other two facilities with SMPs, El Paso de Robles and Preston have open dorm settings for the general population youth. Dorms do not have the "out of cell" time issue single rooms present.* *Youth not in SMP have many opportunities to participate in core program such as regular school, pre-parole activities, vocational training, communal dining, increased recreational*

RECOMMENDATION	STATUS	COMMENTS
		activity, multicultural events, and participation in the youth incentive program. Youth assigned to SMP are limited in the privileges they can earn based on the high custody level of the SMP. **Office of the Inspector General's comments:** The Office of the Inspector General disagrees with the department's statement that "youth not in SMP have many opportunities to participate in core program such as regular school, pre-parole activities, vocational training, communal dining, increased recreational activity, multicultural events, and participation in the youth incentive program." In its 2005 follow-up review, the Office of the Inspector General found that an estimated 103 wards at the Heman G. Stark Youth Correctional Facility were being confined to their rooms 23 hours a day even though they were not assigned to restricted programs. The Office of the Inspector General reported on this issue again in its February 2007 report *Special Review of the High-Risk Issues at the Heman G. Stark Youth Correctional Facility*. The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility operated a "step-down" program intended to help violence-prone wards transition from its special management programs to less-restrictive programs. Although well-intentioned, the step-down program resembled a restrictive special management program in that wards typically ate meals in their rooms and were not allowed to attend school in a classroom environment away from the unit. The Office of the Inspector General reported that logs maintained in the housing unit of the step-down program showed that wards in the program were allowed outside their rooms for recreational activity daily for a period averaging just over two hours. However, the frequency and duration of additional time out of rooms could not be independently verified because these events were not required to be officially recorded for wards in the transitional program. As a result of its February 2007 review, the Office of the Inspector General

RECOMMENDATION	STATUS	COMMENTS
		made four recommendations to address these conditions. Therefore, the Office of the Inspector General will not make additional recommendations in this report.

FOLLOW-UP RECOMMENDATIONS

The Division of Juvenile Justice should take the following actions:

- **Finalize and implement policies and procedures that provide clear justification for isolating wards in restricted programs. (December 2000)**

- **As part of the department's efforts to finalize the above policy, include its policy of allowing wards in restricted programs—including wards assigned to temporary detention—at least three hours outside their rooms every day in its *Division of Juvenile Justice Institutions and Camps Branch Manual*. (2007)**

FINDING NUMBER 3

Living conditions in the wards' rooms and cells were substandard. (December 2000)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Implement the previous recommendation [*from December 2000 report*] to hold staff accountable for failing to follow policies related to wards' living conditions, particularly conditions that threaten safety and security. (December 2000)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Division of Juvenile Justice has instituted quarterly departmental audits of these programs. The audits focus on specific components of the restricted program and are provided to executive management for corrective action. Individual incidents of staff misconduct are examined in management reviews. These audits ensure completion of the daily inspections which are required by policy.*

RECOMMENDATION	STATUS	COMMENTS
		Office of the Inspector General's comments: According to documents the department provided to the Office of the Inspector General, the department has completed two "quarterly reviews" of restricted programs at Division of Juvenile Justice facilities. These reviews represent the department's efforts to hold staff members accountable for following the policies related to wards' living conditions. However, the Office of the Inspector General found that these efforts are not sufficient to ensure that all facilities that have wards on restricted status are complying with department policies. The Office of the Inspector General found the following conditions that presented a threat to the safety and security of either wards or staff members at four of the five juvenile facilities it visited in December 2006: ***Heman G. Stark Youth Correctional Facility*** At the Heman G. Stark Youth Correctional Facility, the Office of the Inspector General found contraband in 53 of the 77 occupied rooms it inspected in the special management program. The Office of the Inspector General found that 22 of the rooms had a window partially or fully covered, obstructing the staff members' view into the rooms. One room had 17 Styrofoam cups containing ingredients for making pruno, an alcoholic drink, and one room had a knotted-towel rope suspended from the light fixture that was used for pull-ups. The Office of the Inspector General reported these and other findings in its February 2007 report *Special Review of the High-Risk Issues at the Heman G. Stark Youth Correctional Facility*. During this review, the Office of the Inspector General visited the facility on three occasions; each time it found unsafe conditions and potentially dangerous materials in the rooms of wards whose violent or disruptive behavior elevate the risk that they will exploit these unsafe conditions or use the dangerous materials to attack staff members or injure themselves. The Office of the Inspector General found fabric used to

RECOMMENDATION	STATUS	COMMENTS
		cover windows and make clotheslines that could be used for suicide attempts in over half the rooms inspected at the facility. The Office of the Inspector General reported that it continued to observe these conditions despite reporting to the department its findings of similar conditions after two visits in 2005. ***Southern Youth Correctional Reception Center and Clinic*** At the Southern Youth Correctional Reception Center and Clinic, the Office of the Inspector General found ropes fashioned from linens or clothing and found holes in the walls between rooms that allowed wards to communicate with each other and to exchange contraband items. The Office of the Inspector General also found that wards had partially or fully covered windows, obstructing the staff members' view into the rooms. ***El Paso de Robles Youth Correctional Facility*** The Office of the Inspector General found clotheslines in 19 of the 40 rooms it inspected at the El Paso de Robles Youth Correctional Facility. ***Preston Youth Correctional Facility*** The Office of the Inspector General found five rooms with rear windows obstructed out of the 50 rooms reviewed at the Preston Youth Correctional Facility. Each of these facilities was included in the department's quarterly reviews, which were completed before the Office of the Inspector General's review. Nonetheless, the department did not identify and report the conditions described above in its reports of findings. Therefore, the Office of the Inspector General does not concur with the department that it has substantially implemented the recommendation.

FOLLOW-UP RECOMMENDATION

The Division of Juvenile Justice should hold staff accountable for failing to follow policies related to wards' living conditions, particularly conditions that threaten safety and security. (December 2000)

FINDING NUMBER 4

The Division of Juvenile Justice headquarters did not have the timely and reliable information necessary to effectively monitor management of 23-and-1 programs at its facilities. (December 2000)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Evaluate the reason for the extended administrative lockdown at the N.A. Chaderjian Youth Correctional Facility and take steps to place the wards in appropriate programs. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. On October 30, 2004, N.A. Chaderjian Youth Correctional Facility wards were released to full program. Intake to N.A. Chaderjian Youth Correctional Facility was stopped in August of 2005 and all wards have been evaluated and placed in the appropriate programs.* **Office of the Inspector General's comments:** The Office of the Inspector General confirmed that as of October 2005, all N.A. Chaderjian wards had been released from administrative lockdown and returned to programming.

FOLLOW-UP RECOMMENDATIONS

None

INTENSIVE TREATMENT PROGRAM

The Office of the Inspector General found that although the department has made progress in admitting wards to the intensive treatment program and providing follow-up care to wards leaving the program, it still struggles to complete timely treatment needs assessments for newly arriving wards. In addition, the department does not always score and review in a timely manner the assessments it does complete, and it is still developing needed training in mental health treatment principles and methods for its staff.

IMPLEMENTATION REPORT CARD

2005 Follow-up recommendations: 4

Fully implemented: 2 (50%)

Substantially implemented: 0 (0%)

Partially implemented: 2 (50%)

Not implemented: 0 (0%)

In November 2002, the Office of the Inspector General conducted a review of the intensive treatment program administered by the California Youth Authority—now the Division of Juvenile Justice within the California Department of Corrections and Rehabilitation. One of the three principal components of the department's mental health treatment system, the intensive treatment program provides care to wards who are acutely suicidal or who are suffering from moderate to severe mental illness, including schizophrenia, psychosis, depression, and bipolar disorder. The November 2002 review determined that the intensive treatment program was serving only a small percentage of wards suffering from severe mental illness and that the treatment provided was generally substandard. The Office of the Inspector General made 10 recommendations to address the deficiencies.

In its January 2005 follow-up review, the Office of the Inspector General found that the Division of Juvenile Justice had made improvements to its intensive treatment program, such as establishing procedures for parental consent of medications for minors, as well as standardizing the treatment modalities of the intensive treatment programs at the various facilities. The division was still failing, however, to ensure that newly committed wards and parole violators received the required treatment needs assessment. The Office of the Inspector General made four follow-up recommendations to address the remaining deficiencies.

BACKGROUND

Providing mental health services to wards is one of the department's core responsibilities. Studies have found that mental illness is pervasive among incarcerated youths at the Division of Juvenile Justice. A 2001 study of division wards found that 97 percent suffered from at least one mental health disorder and that most exhibited numerous mental health problems.[1] The percentage of division wards with serious mental health problems and treatment needs has steadily increased since the introduction in 1997 of a sliding fee scale intended to encourage counties to find alternatives to state commitment for non-violent offenders.

[1] "The Assessment of the Mental Health System of the California Youth Authority: Report to Governor Gray Davis," prepared by Principal Investigator: Hans Steiner, M.D., Co-Principal Investigator: Keith Humphreys, Ph.D., and Project Manager: Allison Redlich, Ph.D., Department of Psychiatry, Stanford University School of Medicine, December 31, 2001.

The Division of Juvenile Justice operates intensive treatment programs at five facilities: the Southern Youth Correctional Reception Center and Clinic, Preston Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, Ventura Youth Correctional Facility, and Heman G. Stark Youth Correctional Facility. At the time of the November 2002 review, the division was operating 273 intensive treatment program beds, but it was planning to decrease the number of beds to 210 to improve treatment by increasing staff-to-ward ratios.

The intensive treatment program is part of a larger approach the division uses to deliver mental health services. In addition to the intensive treatment program, the division operates the following programs for wards with mental health problems: a specialized counseling program at five facilities for wards who generally do not need the full array of medical services required by the intensive treatment program; a Correctional Treatment Center at the Heman G. Stark Youth Correctional Facility, an inpatient psychiatric program for youth in need of acute care; the intermediate care program at the Southern Youth Correctional Reception Center and Clinic, a short-term inpatient psychiatric program operated jointly with the Department of Mental Health for wards who have severe and persistent mental illness; and a specialized behavioral treatment program at the Preston Youth Correctional Facility for wards who are both violent and mentally ill. The division also operates treatment programs for substance abusers and sex offenders, and it is mandated to provide individual, small-group, and large-group counseling to wards in the general population.

Among the methods the Division of Juvenile Justice uses to assess wards' mental health is a treatment needs assessment process, which identifies at-risk wards needing specific treatment services at the time of their admission to a facility. Indicators of thought disorder, suicide risk, distress and restraint, depression and anxiety, and anger have been defined by the division as potential red flags for mental health problems needing treatment. Section 6260 of the *Institutions and Camps Branch Manual* requires that "all incoming wards, including commitments, diagnostic and contract cases, recommitments, and parole violators" be scheduled for mental health assessment "no later than the third week following admission" to the facility. Accordingly, the Office of the Inspector General used a standard of 21 days in this review to determine whether the division performed the tests in a timely manner. Next, the assessments must be mechanically scored within one day of their completion, and if the scoring indicates elevated levels of certain suicide, anger, or thought disorders, the assessments are to be forwarded to a psychologist for evaluation by the end of that workday.

If the treatment needs assessment does not identify issues needing further assessment, a ward will likely be placed in the general population. Alternatively, if the results of the treatment needs assessment identify a need for subsequent psychological evaluations or psychiatric assessments, a ward may receive a "special program assessment of needs" evaluation. The special program assessment of needs evaluation determines whether a ward needs to be placed in a specialized program or placed in the facility's general population.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the January 2005 follow-up review, the Office of the Inspector General determined that seven of the 10 recommendations from the November 2002 review still had not been adequately addressed. The Office of the Inspector General found that the division had

made progress in some areas, such as establishing procedures for obtaining parental consent for minors to receive medication, but made the following specific findings:

- A mental health level-of-care designation had been added to the Ward Information Network system to track the delivery of mental health services to wards in specialized programs. The Office of the Inspector General found, however, that the mental health section of the Ward Information Network system did not capture all the mental health services provided to wards.

- The division reported that a tracking system at the reception centers ensured that wards received treatment needs assessments within 21 days of arrival. The Office of the Inspector General found, however, that between January and November 2004, 627 parole violators had not received treatment needs assessments as required by the division's *Institutions and Camps Branch Manual*, section 6260. In addition, 114 newly committed wards had not received the treatment needs assessment within the 21 days required by the manual. Some newly committed wards had gone as long as 10 months without treatment needs assessments—delaying needed mental health treatment and putting wards at increased risk for suicide.

- Youth correctional counselors received training in mental health treatment during fiscal year 2003-04. However, the amount of training described by the division was minimal and did not meet the intent of the Office of the Inspector General's recommendation.

- Mental health assessment and treatment protocols implemented as part of the *Farrell v. Tilton* remedial plan would standardize the intensive treatment program at the various facilities and provide comprehensive treatment plans for intensive treatment program wards.

The Office of the Inspector General made four recommendations to the Division of Juvenile Justice as a result of the 2005 review. The specific recommendations are listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The California Department of Corrections and Rehabilitation reported that it had fully addressed recommendations previously made by the Office of the Inspector General related to admitting wards to the intensive treatment program at any time during their confinement and to developing policies and procedures for providing care to wards leaving the program. The Office of the Inspector General reviewed changes the department made to its Special Program Assessment Needs process and the related guidance it provided to staff members and determined that, if operated as described, the revised program would provide an opportunity to admit a ward to the intensive treatment program—or other level of care—at any time during the ward's incarceration. In addition, the Office of the Inspector General noted that the department's description of its Special Program Assessment Needs process provides that a ward is not transferred from the intensive treatment program—or other levels of care—to the facility's general population without the review and approval of a senior psychologist.

The department also reported that it had substantially implemented an Office of the Inspector General recommendation to ensure that all wards—parole violators, as well as newly committed wards—each receive a treatment needs assessment within the time limit required by division policy. However, the Office of the Inspector General found in its visits to seven juvenile justice facilities in December 2006 that the division still struggles to complete treatment needs assessments for wards who return after violating the terms of their parole. Although the Office of the Inspector General determined that the division had completed treatment needs assessments for nearly 90 percent (39 out of 44) of the wards reviewed who were committed to the division on a new offense, it failed to complete assessments for half (13 out of 26) of the wards reviewed who had returned to the division after violating their parole. Therefore, because the division still struggles to complete assessments on parole violators, the Office of the Inspector General does not agree that the division has substantially implemented the recommendation.

The Office of the Inspector General recently communicated this same concern to the department in a February 2007 report, *Special Review of High-Risk Issues at the Heman G. Stark Youth Correctional Facility*. In this report, the Office of the Inspector General noted that the facility failed to complete treatment needs assessments on some wards returned to the facility after violating their parole. A psychologist at the facility told the Office of the Inspector General that the failure to administer the treatment needs assessment to each ward was caused by staffing problems. Specifically, the youth correctional counselor position responsible for administering the assessments had been filled intermittently because of transfers, promotions, or other issues. As a result, the needs assessments were not administered consistently.

The February 2007 special review also noted that the facility did not always score and review in a timely manner the treatment needs assessments it did complete. A psychologist at the facility told the Office of the Inspector General that its scoring of assessments is delayed because the facility does not have a Scantron scoring machine and instead must send the assessments to Sacramento to be scored. These findings are consistent with conditions the Office of the Inspector General found when it visited seven youth correctional facilities—including the Heman G. Stark Youth Correctional Facility—as part of its 2007 Accountability Audit. Specifically, the Office of the Inspector General found that 41 percent of the time (21 of 51 wards reviewed), the facilities did not score within one workday the treatment needs assessments completed for wards as required by division policy. The Ventura Youth Correctional Facility also reported that it was not able to score its assessments within one workday because its Scantron scoring machine was inoperable and consequently had to send the assessments to Sacramento to be scored. The Heman G. Stark and N.A. Chaderjian youth correctional facilities also were late in scoring completed assessments because they did not have Scantron scoring machines and instead had to send the assessments to Sacramento for scoring.

The Office of the Inspector General further found that the division does not always forward to mental health staff for timely review scored assessments that indicate a red flag for key areas assessed. Nine of the 70 assessments the Office of the Inspector General reviewed identified a red flag in either the anger, thought disturbance, or suicidal ideation attributes of the assessment. According to division policy, the division must notify the senior psychologist or designated assessment psychologist before the end of the workday the assessment is scored if the scoring report shows a red flag on the suicide, anger, or thought disorder scales. Nonetheless, the Office

of the Inspector General found that psychologists at the facilities did not review in a timely manner the scored assessments in six (67 percent) of the nine cases.

Finally, the department reported that it partially implemented an Office of the Inspector General recommendation to continue to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education to psychiatrists, psychologists, and other members of the mental health staff. The department added that the Safety and Welfare Remedial Plan and the Mental Health Remedial Plan being developed will both address the training issues included in this recommendation. The Office of the Inspector General reviewed the department's remedial plans and confirmed that both plans include an element for providing training to division staff.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the department:

- **Ensure that all wards—parole violators, as well as newly committed wards—receive a treatment needs assessment within the time limit required by division policy.**

- **Provide each youth correctional facility the appropriate equipment to allow immediate scoring and reviewing of wards' treatment needs assessments at the facilities.**

- **Ensure that scored assessments that identify a red flag on the suicide, anger, or thought disorder scales are reviewed by a psychologist the same workday the assessment is scored.**

- **Continue to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education to psychiatrists, psychologists, and other members of the mental health staff.**

The Office of the Inspector General conducted its work on the intensive treatment program from November 15, 2006, through February 28, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after each recommendation.

FINDING NUMBER 2

The division's process to screen wards for placement in the intensive treatment program failed to ensure that all wards needing intensive treatment were identified and received the necessary treatment. (November 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing. (November 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A Special Program Assessment Needs program is utilized at all facilities and allows staff the ability to refer a youth for evaluation at any time. Procedures have been implemented to move wards to a higher level of care when warranted.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed changes the department has made to its Special Program Assessment Needs process and the related guidance it provided to staff members and determined that, if operated as described, the revised program would provide an opportunity to admit a ward to the intensive treatment program—or other level of care—at any time during the ward's incarceration.
Ensure that all wards—parole violators, as well as newly committed wards—receive a treatment needs assessment within the 21 days required by division policy. (November 2002)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Currently, youth (including parole violators) receive a treatment needs assessment within 21 days of entry/intake into the facilities. The assessments are administered and reviewed for indications which may require mental health services.* *The Treatment Need Assessments will be modified to include other screening instruments as recommended by Court-appointed experts as the various remedial plans are implemented.* **Office of the Inspector General's comments:** Although the division may have improved its ability to provide treatment needs assessments to parole violators and newly committed wards, further improvement is still needed. The Office of the Inspector General found in its

RECOMMENDATIONS	STATUS	COMMENTS
		visits to juvenile facilities during December 2006 that the division did not complete treatment needs assessments for more than 25 percent of the wards reviewed (18 of 70). Of particular concern, the Office of the Inspector General found that the division still struggles to complete treatment needs assessments for wards who are parole violators. Of the 26 parole violators reviewed by the Office of the Inspector General, the division had not completed treatment needs assessments on half (13). The Office of the Inspector General also found that 41 percent of the time (21 of 51 wards reviewed) the facilities did not score within one workday the treatment needs assessments they did complete, as required by division policy. The Ventura, N.A. Chaderjian, and Heman G. Stark youth correctional facilities reported that they are not able to score assessments within one workday because they do not have the equipment to do so and consequently have to send assessments to Sacramento to be scored. The Office of the Inspector General further found that the division does not always forward to mental health staff for timely review scored assessments that indicate a red flag for key areas being assessed. Nine of the 70 assessments the Office of the Inspector General reviewed identified a red flag in either the anger, thought disturbance, or suicidal ideation attributes of the assessment. According to division policy, the division must notify the senior psychologist or designated assessment psychologist before the end of the workday the assessment is scored if the scoring report shows a red flag on the suicide, anger, or thought disorder scales. Nonetheless, the Office of the Inspector General found that psychologists at the facilities did not review in a timely manner the scored assessment in six (67 percent) of the nine cases.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the department:

- **Ensure that all wards—parole violators, as well as newly committed wards—receive a treatment needs assessment within the time limit required by division policy. (November 2002)**

- **Provide each youth correctional facility the appropriate equipment to allow immediate scoring and reviewing of wards' treatment needs assessments at the facilities. (2007)**

- **Ensure that scored assessments that identify a red flag on the suicide, anger, or thought disorder scales are reviewed by a psychologist the same workday the assessment is scored. (2007)**

FINDING NUMBER 3

Treatment services provided to wards in the intensive treatment program were limited in scope, lacking in planning, poorly documented, and generally deficient in quality. (November 2002)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Continue to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education to psychiatrists, psychologists, and other members of the mental health staff. (November 2002)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Safety & Welfare and Mental Health Remedial Plans will address the development of the Integrated Behavioral Treatment Model and the training of treatment and mental health staff in the treatment modalities. Time frames for implementation of these are contained in the cited plans. The Division of Juvenile Justice has been working with California State University, Chico to assist in the development of curricula. Division of Juvenile Justice staff is reviewing/ attending training programs in January 2007 and will be selecting specific training programs to be delivered to institutional and mental health staff (approximately April 2007).* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the Safety and Welfare Remedial Plan and the Mental Health Remedial Plan and confirmed that both plans provide for training to division staff members. According to the department, however, the training will not be conducted until April 2007.

FOLLOW-UP RECOMMENDATION

The Division of Juvenile Justice should continue to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education to psychiatrists, psychologists, and other members of the mental health staff. (November 2002)

FINDING NUMBER 5

Wards leaving the intensive treatment program lacked necessary follow-up care. (November 2002)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Develop policies and procedures for providing follow-up care to wards leaving the intensive treatment program. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Internal directives have been issued so that no youth being treated in an intensive treatment program will be moved directly to general population programs without review and direction from the chief psychiatrist. Youth are stepped-down from the intensive treatment program to the specialized counseling program, and then to general population/core treatment programs while ensuring that youth receive the necessary follow-up treatment.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed a description of the department's Special Program Assessment Needs process and determined that it provides that a ward will not be transferred from the intensive treatment program—or other levels of care—to the institution's general population without the review and approval of a senior psychologist.

FOLLOW-UP RECOMMENDATIONS

None

DEATH OF A WARD ON AUGUST 31, 2005, AT THE N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

IMPLEMENTATION REPORT CARD

2005 Recommendations: 16

Fully implemented: 5 (31%)

Substantially implemented: 3 (19%)

Partially implemented: 6 (38%)

Not implemented: 2 (12%)

While the department reports that the statewide average length of time wards are in limited programs or administative lockdowns has decreased from 12.2 days in 2005 to 7.7 days in 2006, the Office of the Inspector General found that some wards are still isolated in their rooms and receive too few mandated services as described in this report's chapter on 23-and-1 confinement. In addition, the Division of Juvenile Justice's efforts to stop wards from covering their windows has been inadequate. Also, the division has yet to develop and implement a custody classification system to assist in identifying the best placement for wards. On a positive note, the N.A. Chaderjian Youth Correctional Facility is providing suicide prevention training to all its staff members and has improved its sick call procedures for wards who request to be seen by mental health staff. The facility also has revised staff duty statements to ensure better communication between living unit staff and the communications center.

In December 2005, the Office of the Inspector General issued a special review into the circumstances surrounding the August 31, 2005, suicide of a ward at the N.A. Chaderjian Youth Correctional Facility (N.A. Chaderjian) in Stockton. The purpose of the special review was to determine whether the Division of Juvenile Justice and N.A. Chaderjian followed essential policies and procedures for screening, treating, and confining the ward before his suicide and whether the facility staff followed policies and procedures from the time they discovered that the ward had covered the windows of his room through the time the department announced his death.

The review found that the eight-week isolation and the denial of mental health and other services might have contributed to the ward's suicide. The Division of Juvenile Justice also failed several times to properly assess and act on the ward's mental health needs. The review further determined that staff members failed to follow key policies and procedures, resulting in a period of 38 minutes from the time the living unit staff discovered that the ward had covered his windows and was unresponsive until the time his door was finally opened.

BACKGROUND

The ward was an 18-year-old Northern Hispanic gang member committed to the Division of Juvenile Justice for vehicle theft. He was a resident of Pajaro Hall at N.A. Chaderjian when he was found at approximately 6:53 p.m. on August 31, 2005, hanging from the upper bunk of his single occupancy room with a bed sheet tightly fastened around his neck. He had covered the windows of his room to keep the staff from observing his actions. The ward was found not breathing and without a pulse. He was taken to San Joaquin General Hospital,

where he was pronounced dead at 7:55 p.m. The coroner's report listed the cause of death as suicide.

At the time of his death, the ward had been confined to his room for nearly 24 hours a day for eight weeks because members of his gang had violently attacked three staff members, even though the ward did not participate in the attack. While the ward had a history of involvement in numerous ward fights, he had no history of attacking staff members. The attack prompted a lockdown of the entire facility. Although other living units gradually moved toward normal operation, the ward and the other Northern Hispanics in Pajaro Hall remained locked in their rooms while the staff tried to persuade them to renounce gang behavior in exchange for increased privileges. This resulted in a deadlock between administrators and the gang members, who were led by a powerful Northern Hispanic gang member who also resided in Pajaro Hall—a ward described as a "shot caller" in the Northern gang structure who had previously been identified as the "number two man" at Pleasant Valley State Prison, an adult institution. Aside from brief showers about three times a week, the ward and the other Northern Hispanics in Pajaro Hall received virtually no exercise, education, mental health treatment, or other mandated services during the lockdown.

N.A. Chaderjian is one of eight youth correctional facilities operated by the Division of Juvenile Justice within the California Department of Corrections and Rehabilitation. At the time of the ward suicide, many of the wards at N.A. Chaderjian were among the most dangerous in the division's custody and were serving lengthy sentences for crimes such as murder, rape, armed robbery, and assault. Although their crimes were committed while they were juveniles, nearly all wards at N.A. Chaderjian were between 18 and 25 years of age. Most had transferred from other facilities, while others were parole violators. Still others had come from California Department of Corrections and Rehabilitation adult prisons to complete confinement and programming that was suspended when they were convicted of felonies as adults while either in the Division of Juvenile Justice or on parole.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the December 2005 review:

- The extent to which the Division of Juvenile Justice deprived the ward and other Northern Hispanic wards in Pajaro Hall of services during the lockdown is inconsistent with the Division of Juvenile Justice's mission. The extended lockdown placed the ward in the position of either renouncing his gang and facing violent retribution, or continuing to live in what for him appeared to be increasingly intolerable conditions.

- The Division of Juvenile Justice failed to assess or act on the ward's mental health needs, missing several signals that should have prompted it to provide the ward with mental health services. For example, the ward requested four times to be seen by mental health staff, but he was never seen. In addition, when the ward first entered the juvenile justice system at the Preston Youth Correctional Facility, the facility neglected to refer him for

an in-depth mental health assessment as required. Finally, the division did not have a custody classification system to ensure that criminally sophisticated wards are not placed in the same living units as unsophisticated wards.

- The staff failed to follow key policies and procedures, resulting in a period of 38 minutes before staff members opened the ward's door. Despite a policy requiring the immediate reporting of covered windows, Pajaro Hall staff did not report the situation to the control sergeant for approximately 15 minutes. The control sergeant then delayed in communicating with the watch commander and in dispatching the search and escort team. This 38-minute period resulted in a response so prolonged it could not be expected to successfully prevent the suicide of the ward. However, because death by hanging can occur within six minutes, it is not possible to determine whether a quicker response would have saved the ward's life.

In its January 2005 Accountability Audit, the Office of the Inspector General recommended that the former California Youth Authority end the practice of confining wards 23 hours a day. Nonetheless, the department's successor agency, the Division of Juvenile Justice, continued to use this practice to maintain order. The December 2005 special review demonstrated once more the dangers of the practice. The Office of the Inspector General again recommended that the California Department of Corrections and Rehabilitation immediately end the practice of isolating wards in their rooms over extended periods.

The Office of the Inspector General recommended that the Division of Juvenile Justice develop policies and procedures to provide a minimum level of mental health intervention during lockdowns or modified programs exceeding 14 days. The Office of the Inspector General also recommended that the secretary of the California Department of Corrections and Rehabilitation be required to approve in writing lockdowns or modified programs extending beyond 14 days. In total, the Office of the Inspector General presented 16 recommendations, six directed to the N.A. Chaderjian Youth Correctional Facility, nine to the California Department of Corrections and Rehabilitation, and one to the Preston Youth Correctional Facility.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The Office of the Inspector General found that beginning in August 2005 the Division of Juvenile Justice placed a moratorium on the intake of new wards into the N.A. Chaderjian Youth Correctional Facility. The resultant substantial reduction in the ward population, coupled with the transfer of gang leaders out of the facility, played a major role in significantly reducing the incidents of violence at the facility and directly helped to resolve several of the issues identified in the December 2005 special review. The department's data shows that as of December 18, 2006, there were 252 wards assigned to the facility, compared to 449 wards on August 31, 2005, a 44 percent decrease. Pajaro Hall, where the ward resided, had 32 wards assigned to it on the date of the ward's suicide, but on December 18, 2006, there were only nine wards assigned to Pajaro Hall. According to facility records, along with the decrease in population of 44 percent, ward assaults on staff members decreased by 67 percent in 2006, falling from 42 incidents in 2005 to 14 incidents in 2006.

The department reported that the N.A. Chaderjian Youth Correctional Facility had no program changes (limited programs or administrative lockdowns) in 2006 and that the average duration of program changes at all Division of Juvenile Justice facilities had decreased from 12.2 days in 2005 to 7.7 days in 2006. The Office of the Inspector General, however, was unable to verify this assertion because the data provided by the department lacked sufficient detail. Even if the department's assertions are accurate, the Office of the Inspector General found evidence that wards are still isolated in their rooms. During visits to five juvenile justice facilities in December 2006, the Office of the Inspector General found that some wards on restricted programs receive little time outside their rooms and insufficient mandated services. This finding is discussed in detail in the 23-and-1 Confinement chapter in this accountability audit.

The follow-up review also noted that wards continue to cover their windows despite a memorandum issued to superintendents on March 29, 2006, that states "for safety and security purposes, it is imperative staff have a clear unobstructed view of all wards while they are in their rooms. When wards cover their windows and obstruct the view of staff, it is a security issue requiring immediate intervention." As reported in the Office of the Inspector General's February 2007 *Special Review of High-Risk Issues at the Heman G. Stark Youth Correctional Facility*, during a site visit on April 17, 2006, 15 percent of the occupied rooms inspected had covered windows. Also, on a subsequent site visit to the facility on December 12, 2006, 29 percent of the occupied rooms inspected had covered windows.

The Office of the Inspector General found that N.A. Chaderjian provided suicide prevention training to all staff members and has included the training in its annual block training to the staff. However, the facility does not track whether contractors and volunteers who have contact with wards also attend the annual suicide prevention training as required by section 6263 of the *Division of Juvenile Justice Institutions and Camps Branch Manual*. Perhaps because of the staff training, the Office of the Inspector General found that N.A. Chaderjian staff administered the Suicide Risk Screening Questionnaires to wards in restricted programs. Specifically, the Office of the Inspector General found that the facility computer system indicated that the staff administered 12 of the 13 questionnaires within the timelines specified by division policy. The Office of the Inspector General was unable, however, to find the questionnaires in the wards' unified health records as required by policy.

The follow-up review also found that the Division of Juvenile Justice has sick call procedures that specify the process for wards to request mental health care. The youth correctional counselors interviewed by the Office of the Inspector General at N.A. Chaderjian noted that wards' mental health requests are fulfilled either by wards using the same form they use to request medical attention or by the youth correctional counselors entering the wards' requests into the facility's computer system. The youth correctional counselors also noted that mental health staff members are usually prompt in their response to wards' requests.

The Division of Juvenile Justice did not implement the Office of the Inspector General's recommendation that the department work with the Legislature and the courts to end the practice of returning adult inmates to juvenile justice facilities. Instead, the division reported it will develop a research-based classification system to ensure that dual-commitment wards

are appropriately placed upon their return to a youth facility. The system will include a review of the wards' prior Division of Juvenile Justice programs and adult commitment information to ensure returnees are placed in appropriate programs based on risk factors. In the interim, all wards assigned to the Division of Juvenile Justice have been reclassified based on their institutional behavior. Given the significant safety and security concerns associated with returning criminally sophisticated wards to juvenile facilities, the Office of the Inspector General continues to recommend that the department research alternatives to this practice.

Lastly, the Preston Youth Correctional Facility, where the ward first entered the juvenile justice system, reported it has not had a late treatment needs assessment in over 1½ years and that any assessments requiring a psychologist review (i.e., "red flags") are immediately forwarded to the senior psychologist. During a site visit to the facility on December 14, 2006, the Office of the Inspector General randomly selected 10 treatment needs assessments for compliance with existing policy and found that all 10 treatment needs assessments were administered within the 21-day requirement. However, the two treatment needs assessments requiring immediate review by a psychologist were not reviewed in the mandated timeframes. This finding is discussed in detail in the Intensive Treatment Program chapter in this accountability audit.

FOLLOW-UP RECOMMENDATIONS

As a result of the 2007 follow-up review, the Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation take the following actions:

- **End immediately the practice of isolating wards in their rooms over extended periods of time.**

- **Ensure that wards receive assessments and counseling as needed by monitoring the Division of Juvenile Justice's provision of mental health services during lockdowns and modified programming that exceed 14 days as required in the policies and procedures that became operational in 2006.**

- **Work with the Legislature and the courts to end the practice of returning adult inmates to Division of Juvenile Justice facilities.**

The Office of the Inspector General also recommends that the Division of Juvenile Justice take the following actions:

- **Develop and implement a custody classification system. Included in this system should be an instrument designed to assist in identifying the most appropriate placement for wards. The instrument should consider whether the ward has the sophistication and maturity level for the recommended placement.**

- **Ensure that the revised policies and procedures for addressing all aspects of wards' covering their room windows are incorporated into the *Division of***

Juvenile Justice Institutions and Camps Branch Manual **and adhered to by all facilities.**

The Office of the Inspector General further recommends that the N.A. Chaderjian Youth Correctional Facility take the following actions:

- **Ensure that staff members file the suicide risk screening questionnaires in the wards' unified health records as required by policy.**

- **Modify the existing video surveillance system so that it will accurately date and time stamp all video recordings.**

Lastly, the Office of the Inspector General recommends that the Preston Youth Correctional Facility should ensure that it complies with existing treatment needs assessment policies and procedures. The facility should require specific mental health problems identified during the assessments—suicide, anger, or thought disorder—be given "red flags" and forwarded promptly to the senior psychologist or treatment needs assessment psychologist.

The Office of the Inspector General conducted its work the N.A. Chaderjian Youth Correctional Facility from November 15, 2006, through March 16, 2007.

The following tables summarize the results of the 2007 follow-up review. Each finding is numbered in accordance with the original report, and the date a finding and recommendation was first made is listed in parentheses.

FINDING NUMBER 1

Although the lockdown was justified at its inception, the extent to which the Division of Juvenile Justice deprived the ward and other Northern Hispanic wards in Pajaro Hall of services during the lockdown is inconsistent with the Division of Juvenile Justice's mission. (December 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The California Department of Corrections and Rehabilitation should:		
End immediately the practice of isolating wards in their rooms over extended periods of time. (December 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. There have been no extended lockdowns since September 2005.* **Office of the Inspector General's comments:** The department still has not ended its practice of isolating wards in their rooms over extended periods of time. Although staff members from both N.A. Chaderjian and the Division of Juvenile Justice told the Office of the Inspector General that there had been no extended lockdowns since 2005, the Office of the Inspector General was unable to verify this assertion. The data provided to the Office of the Inspector General by the Division of Juvenile Justice lacked sufficient detail and only stated that the average length of program change (such as administrative lockdowns or limited programs) had declined from 12.2 days in 2005 to 7.7 days in 2006. The Office of the Inspector General also found contrary evidence during site visits to five juvenile justice facilities in December 2006. During those visits, the Office of the Inspector General found that some wards on restricted programs are still isolated in their rooms, receive insufficient time outside their rooms, and do not receive sufficient mandated services. This finding is discussed in detail in the 23-and-1 Confinement chapter in this accountability audit. The lack of time outside their rooms and non-receipt of mandated services is significant because wards can spend months in restricted programs. The Office of the Inspector General does not agree with the department that it

RECOMMENDATIONS	STATUS	COMMENTS
		has fully implemented this recommendation.
Require written approval by the secretary of the California Department of Corrections and Rehabilitation for the placement of wards on lockdown or modified programs beyond 14 days. In addition, the department should require the Division of Juvenile Justice to develop policies and procedures specifying that the restricted program review committee shall approve or deny the continuation of wards' placement on lockdown or modified programs beyond 30 days, and then every 15 days thereafter, subject to the approval of the secretary. (December 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Division of Juvenile Justice, with expert and Plaintiff input, has developed a new policy with standards related to notification, approvals, and mental health considerations for limited programs. The essential elements of the new policy were made operational in 2006. The formal policy is being vetted through all of the appropriate stakeholders and will be sent to the Chief Deputy Secretary for final approval by early 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the new policy that became effective March 9, 2007. The policy requires that within 48 hours of implementing an administrative lockdown or modified program the facility submits a plan of operation to the director of juvenile facilities for review and approval. The new policy further requires the chief deputy secretary, division of juvenile justice to approve administrative lockdowns exceeding 14 days. While the policy does not address who is responsible for approving modified programs extending beyond 14 days, it appears the director of juvenile justice retains that approval authority. The Office of the Inspector General accepts the department's decision to place the approval with the chief deputy secretary rather than with the department's secretary as the Office of the Inspector General recommended.
Require the Division of Juvenile Justice to develop policies and procedures that provide a minimum level of mental health intervention by mental health professionals during lockdowns or modified programs that exceed 14 days. (December 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Division of Juvenile Justice, with expert and Plaintiff input, has developed a new policy with standards related to notification, approvals, and mental health considerations for limited programs. The essential elements of the new policy were made operational in 2006. The formal policy is being vetted through all of the appropriate stakeholders and will be sent to the Chief Deputy Secretary for final approval by early 2007.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General reviewed the revised policy and found that when an administrative lockdown continues beyond 24 hours, the policy requires a psychologist or other mental health professional to make rounds at least once every 24 hours to all youthful offenders subject to the administrative lockdown.
Ensure that wards receive assessments and counseling as needed by monitoring the Division of Juvenile Justice's provision of mental health services during lockdowns and modified programming that exceed 14 days as required in the policies and procedures that became operational in 2006. (December 2005)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Division of Juvenile Justice, with expert and Plaintiff input, has developed a new policy with standards related to notification, approvals, and mental health considerations for limited programs. The essential elements of the new policy were made operational in 2006. The formal policy is being vetted through all of the appropriate stakeholders and will be sent to the Chief Deputy Secretary for final approval by early 2007.* **Office of the Inspector General's comments:** The California Department of Corrections and Rehabilitation did not provide documentation to show it is monitoring the Division of Juvenile Justice's provision of mental health services during lockdowns and modified programming that exceed 14 days. As noted above, the revised policy requires 24-hour intervention but does not note any monitoring functions.
Work with the Legislature and the courts to end the practice of returning adult inmates to Division of Juvenile Justice facilities. (December 2005)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. A Legislative solution has not been feasible. The protocol will institute a review of the wards prior Division of Juvenile Justice programs, and adult commitment information to ensure returnees are placed in appropriate programs based on risk factors. The Division of Juvenile Justice is integrating dual commitment returnees into our new classification system for appropriate placement upon return.* **Office of the Inspector General's comments:** Department staff told the Office of the Inspector General that it is unconstitutional to involuntarily require juveniles to serve their sentences in an adult prison because the juvenile court process is very different from the

RECOMMENDATIONS	STATUS	COMMENTS
		adult court process. Adult criminal prosecutions require that defendants be provided a trial by jury, and if convicted, the defendants are sentenced to prison to be punished for their crimes. In contrast, juveniles do not have the right to a jury trial and are not convicted of crimes. Instead, the juvenile court finds that because of the juvenile's delinquency, he or she must be incapacitated and provided with treatment, training, and education. Once placed into a juvenile facility, if a ward commits a felony and is convicted, the current department policy is to transfer the ward to an adult institution. This is called dual commitment. At the end of the felony sentence, the ward is given the option of staying at the adult institution to finish out his juvenile term or returning to the juvenile facility to serve the remainder of his juvenile sentence. The Office of the Inspector General's concern with this practice is the safety and security issues associated with placing a criminally sophisticated ward who has served time at an adult institution in the same living unit with unsophisticated wards. The Office of the Inspector General contacted other states to learn what their practices are when a ward commits a felony while in a juvenile facility. Although there were many scenarios, none placed the ward in an adult prison and then back into a juvenile facility to finish out the ward's juvenile term. Other states' practices included the following scenarios: • The ward initially receives a blended sentence whereby if he misbehaves in the juvenile facility, he is transferred to an adult institution where he will serve the remainder of his sentence; • The felony sentence is added to his juvenile sentence; • The ward serves the felony sentence in the county jail and then transfers back to the juvenile facility to finish out his juvenile sentence; and • The youth authority submits an early closure for the youth authority time (i.e., his juvenile term is terminated) if the felony term is longer than the remaining juvenile term, and he is then sentenced to an adult institution where he will remain until the end of his sentence.

RECOMMENDATIONS	STATUS	COMMENTS
		The department did not provide documentation to support its statement that it is unconstitutional to require a ward to serve his time in an adult institution, nor did it provide any information to show if it had researched any alternatives that could address this recommendation within the confines of existing law. Also, because of the significant safety and security concerns associated with the department's practice of returning adult inmates to juvenile facilities, the Office of the Inspector General continues to recommend that the department research alternatives to this practice. The ultimate alternative chosen may require the department to work with the Legislature and the courts to address any legal or constitutional issues.

FOLLOW-UP RECOMMENDATIONS:

The California Department of Corrections and Rehabilitation should take the following actions:

- **End immediately the practice of isolating wards in their rooms over extended periods of time. (December 2005)**
- **Ensure that wards receive assessments and counseling as needed by monitoring the Division of Juvenile Justice's provision of mental health services during lockdowns and modified programming that exceed 14 days as required in the policies and procedures that became operational in 2006. (December 2005)**
- **Work with the Legislature and the courts to end the practice of returning adult inmates to Division of Juvenile Justice facilities. (December 2005)**

FINDING NUMBER 2

The Division of Juvenile Justice failed to assess or act on the ward's mental health needs. (December 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The N.A. Chaderjian Youth Correctional Facility should:		
Ensure that all staff members, contractors, and volunteers who have contact with wards receive the annual suicide prevention training required by section 6263 of the *Division of Juvenile Justice Institutions and Camps Branch Manual*, as recommended in the Office of the Inspector General's May 2005 management review audit. (December 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Suicide prevention training is completed in the months of November and December.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed documentation provided by the facility and found that the staff at N.A. Chaderjian received the required suicide prevention training. The facility has also included the training requirement in its annual block training. The Office of the Inspector General does not consider this recommendation fully implemented because N.A. Chaderjian does not track whether contractors and volunteers who have contact with the wards receive the required training.
Ensure that staff members administer suicide risk assessment questionnaires as required by existing policy. (December 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. N.A. Chaderjian has designated a manager to review and monitor suicide prevention assessment response results at the institution on a monthly basis.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the facility's electronic ward information system and found that the system indicates that the staff administered 12 of 13 suicide risk screening questionnaires within the timelines specified by division policy. The Office of the Inspector General was unable, however, to find the questionnaires in the wards' unified health records, as required by policy.
The Preston Youth Correctional Facility should:		
Ensure that it complies with existing treatment needs assessment policies and procedures, including those that require specific mental health problems identified during the assessments—suicide, anger, or thought disorder—be given "red flags" and forwarded	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A memorandum was issued that ensures "red flag" cases are reported and reviewed by the Senior Psychologist. Additionally, this was part of the monthly Superintendent's report.*

RECOMMENDATIONS	STATUS	COMMENTS
promptly to the senior psychologist or treatment needs assessment psychologist. (December 2005)		**Office of the Inspector General's comments:** The program administrator told the Office of the Inspector General that the facility has not had a late treatment needs assessment in over 1½ years. The program administrator receives a monthly report that shows when the ward arrived and when the ward received the treatment needs assessment. The program administrator also told the Office of the Inspector General that any mental health referrals (i.e., "red flags") resulting from the assessment are immediately forwarded to the senior psychologist. During a site visit to the Preston Youth Correctional Facility on December 14, 2006, the Office of the Inspector General randomly selected 10 treatment needs assessments to test for compliance with existing policy. Although the Office of the Inspector General found that all 10 treatment needs assessments were administered within the 21-day requirement, the two treatment needs assessments requiring immediate review by a psychologist were not reviewed in the mandated timeframes. This finding is discussed in detail in the Intensive Treatment Program chapter in this accountability audit. Based on evidence that the psychologist is not reviewing the assessments on time, the Office of the Inspector General does not agree that the department has fully implemented this recommendation.
The Division of Juvenile Justice should:		
Develop procedures, similar to medical sick call procedures, that require mental health staff to respond to ward interview requests in a timely and appropriate manner and ensure that treatment occurs. To ensure compliance, the facilities should track the ward requests and document the interviews. (December 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Sick call procedures require mental health staff to respond to ward requests for mental health intervention. The Division of Juvenile Justice has requested the Office of Audits and Compliance include a program compliance audit on this requirement in the 2007 audit plan.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the Division of Juvenile Justice's access to care policy and found that it addresses the recommendation. The policy also states the ward should be seen by the next

RECOMMENDATIONS	STATUS	COMMENTS
		business day of the request and requires the health care staff to monitor and track the request and delivery of services. The Office of the Inspector General interviewed four youth correctional counselors who indicated that wards' requests for mental health services were fulfilled either by the wards' use of the medical request form or by the youth correctional counselors entering the wards' requests into the facility's computer system. The youth correctional counselors also said that mental health staff members are usually prompt in their response to wards' requests.
Develop and implement a custody classification system. Included in this system should be an instrument designed to assist in identifying the most appropriate placement for wards. The instrument should consider whether the ward has the sophistication and maturity level for the recommended placement. (December 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. A research based classification system based on institutional behavior will be developed through a Request for Proposal by late 2007. In the interim, all wards assigned to the Division of Juvenile Justice have been reclassified utilizing a pro tem classification system predicated on institutional behavior.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed documentation on the interim classification system. The documentation provided indicates a policy is not yet in place and that a formal process to classify the risk level of youth offenders as high, medium, moderate, and low will be developed in the future.

FOLLOW-UP RECOMMENDATIONS

The N.A. Chaderjian Youth Correctional Facility should ensure that staff members file the suicide risk screening questionnaires in the wards' unified health records as required by policy. (2007)

The Preston Youth Correctional Facility should ensure that it complies with existing treatment needs assessment policies and procedures, including those that require specific mental health problems identified during the assessments—suicide, anger, or thought disorder—be given "red flags" and forwarded promptly to the senior psychologist or treatment needs assessment psychologist. (December 2005)

The Division of Juvenile Justice should develop and implement a custody classification system. Included in this system should be an instrument designed to assist in identifying the most appropriate placement for wards. The instrument should consider whether the ward has the sophistication and maturity level for the recommended placement. (December 2005)

FINDING NUMBER 3

Living unit staff and communication center staff failed to follow key policies and procedures, resulting in a period of 38 minutes before staff opened the ward's door. However, it is not possible to determine whether a faster response would have saved the ward's life. (December 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The N.A. Chaderjian Youth Correctional Facility should:		
Ensure that all incidents requiring a search and escort response be communicated to the control sergeant and the watch commander in a timely manner as required by the *Division of Juvenile Justice Institutions and Camps Branch Manual.* (December 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. N.A. Chaderjian has established standards consistent with this recommendation.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the revised Duties and Performance Standards for a Youth Correctional Officer and found the updated standard addresses this recommendation. According to the facility's program administrator, security supervisors monitor this standard to ensure compliance and have used progressive discipline, up to adverse action, for non-compliance.
Ensure that the watch commander communicates back to the control sergeant when a threat or other security situation is resolved. (December 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. N.A. Chaderjian has established standards consistent with this recommendation.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the revised Duties and

RECOMMENDATIONS	STATUS	COMMENTS
		Performance Standards for a Lieutenant and found the updated standard addresses this recommendation. According to the facility's program administrator, security supervisors monitor this standard to ensure compliance and have used progressive discipline, up to adverse action, for non-compliance.
Develop and implement policies and procedures for ensuring that all facility clocks are synchronized. (December 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. All N.A. Chaderjian clocks have been synchronized.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Modify the existing video system so that it will accurately date and time stamp all video recordings. Also, place a synchronized living unit clock in plain sight of the camera view to facilitate living unit log entries. (December 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. A departmental expert has evaluated the N.A. Chaderjian camera systems for the time/date stamp. The current camera system will be modified to incorporate a date and time stamp process on the video recordings. All the living unit clocks have been synchronized and placed in sight of the camera view.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Division of Juvenile Justice should:		
Review the policies and procedures in the *Division of Juvenile Justice Institutions and Camps Branch Manual* and consider adding detailed policies and procedures for addressing all aspects of wards' covering their room windows, including communication, removing visual obstructions, entering rooms, and disciplining wards. (December 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. A memorandum outlining expectations of staff when wards covered their windows has been distributed on a statewide basis. The memorandum has been circulated to staff statewide, and discussed in training sessions. The expectations will be incorporated into the Division of Juvenile Justice Institutions and Camps Manual section, but there are currently over 100 policies being written or proposed related to reform efforts.* **Office of the Inspector General's comments:**

RECOMMENDATIONS	STATUS	COMMENTS
		This recommendation was directed to the Division of Juvenile Justice as a statewide matter because, in addition to the dangerous conditions found at N.A. Chaderjian in December 2005, the Office of the Inspector General also reported covered windows at the Heman G. Stark Youth Correctional Facility as part of its 2005 Accountability Audit. The Office of the Inspector General reviewed the department's March 29, 2006, memorandum referred to above, and it appears to address the recommendation by stating "for safety and security purposes, it is imperative staff have a clear unobstructed view of all wards while they are in their rooms. When wards cover their windows and obstruct the view of staff, it is a security issue requiring immediate intervention." Also, the Office of the Inspector General toured the Special Management Program housing unit at N.A. Chaderjian on December 13, 2006, and observed that all windows were clear of obstructions. On visits to another facility, however, the Office of the Inspector General observed obstructed windows and therefore disagrees that the issuance of the March 29, 2006, memorandum substantially implemented this statewide recommendation. The Office of the Inspector General reported the dangerous conditions of obstructed windows in its report issued in February 2007, *Special Review of High-Risk Issues at the Heman G. Stark Youth Correctional Facility*. As part of that review, the Office of the Inspector General visited the Heman G. Stark Youth Correctional Facility on April 17, 2006, and found that 11 of the 72 occupied rooms (15 percent) inspected had covered windows. During another site visit to the facility on December 12, 2006, the Office of the Inspector General observed that 22 out of 77 occupied rooms (29 percent) had one or both of their windows covered. As a result of these observations, the Office of the Inspector General concludes that the March 29, 2006, memorandum was not adequate for communicating the need, on a statewide basis, to keep all wards' windows clear of obstructions.
The California Department of Corrections and Rehabilitation Office of Internal Affairs should:		

RECOMMENDATIONS	STATUS	COMMENTS
Consider the information presented in this report in conducting its investigation into the culpability of specific individuals associated with the delay in responding to the death of the ward. (December 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Appropriate investigations and actions have been completed in this matter.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS:

The N.A. Chaderjian Youth Correctional Facility should modify the existing video surveillance system so that it will accurately date and time stamp all video recordings. (December 2005)

The Division of Juvenile Justice should ensure that the revised policies and procedures for addressing all aspects of wards' covering their room windows are incorporated into the *Division of Juvenile Justice Institutions and Camps Branch Manual* and adhered to by all facilities. (2007)

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

IMPLEMENTATION REPORT CARD	
2005 recommendations:	56
Less: Recommendations no longer applicable:	4
Recommendations still applicable:	52
Fully implemented: 27 (52%)	
Substantially implemented: 6 (11%)	
Partially implemented: 14 (27%)	
Not implemented: 5 (10%)	

The Office of the Inspector General found that beginning in August 2005, the Division of Juvenile Justice placed a moratorium on the intake of new wards into the N.A. Chaderjian Youth Correctional Facility. The ensuing reduction in the ward population was substantial and, coupled with the transfer of gang leaders out of the facility, played a major role in significantly reducing the incidence of violence at the facility. The reduction in population also contributed to the progress in implementing recommendations related to counseling and education services. However, the Division of Juvenile Justice has made little progress in addressing structural deficiencies and maintenance problems at the facility, with the exception of commissioning a visual assessment of the facility. In addition, the Office of the Inspector General's recommendations related to the administration of psychotropic medications have remained unaddressed, due in part to the Division of Juvenile Justice's delay in fully implementing the *Farrell v. Tilton* Mental Health Remedial Plan.

The Office of the Inspector General released a management review audit of the N.A. Chaderjian Youth Correctional Facility (N.A. Chaderjian) in May 2005. The audit found N.A. Chaderjian to be a troubled facility that failed to provide a safe environment for wards and staff members. The facility also failed to provide wards with the education and programs that would give them the opportunity to lead a crime-free life once they were released.

The May 2005 audit determined that the facility was not providing wards with the counseling and mental health care they are required to receive under state law and was endangering wards by failing to consistently monitor those receiving psychotropic medications. In addition, despite two suicides the previous year at facilities within the California Department of Corrections and Rehabilitation's Division of Juvenile Justice (formerly known as the California Youth Authority), N.A. Chaderjian was not complying with all department-mandated suicide prevention procedures.

Education services were similarly lacking. The audit found that special education wards at the facility were not receiving all the special education service time they were mandated to receive; moreover, the auditors found that the special education service providers at the facility had consistently over-reported the amount of services provided. At the same time, more than one-third of the academic classes scheduled at the high school ended up being canceled, mainly because teachers routinely failed to show up for class. Teachers at the

facility took so much time off that the high school could not provide enough substitutes to cover the absences.

The facility was also a dangerous place. The Office of the Inspector General found that the facility was not complying with numerous department-mandated security requirements and that the facility was riddled with structural and design defects that jeopardized the safety of wards and employees alike. The Division of Juvenile Justice had sought special repair funding for some of the problems identified in the audit report, but the Department of Finance had denied the requests.

Many of the employees at the facility feared for their safety, and with good reason—the facility recorded 12 physical, non-gassing[1] assaults on staff members in 2003 and 23 in 2004. Employee morale was reported to be low, and the staff vacancy rate was high, with almost one-third of the youth correctional counselor positions unfilled at the time of the audit.

As a result of the audit, the Office of the Inspector General made 56 recommendations to address the deficiencies.

BACKGROUND

The N.A. Chaderjian Youth Correctional Facility is one of eight youth correctional facilities operated by the Division of Juvenile Justice. Along with O.H. Close and DeWitt Nelson, it is one of three youth correctional facilities comprising the Northern California Youth Correctional Center complex in Stockton. Constructed in 1991 with a design capacity of 600 beds, N.A. Chaderjian assists the Division of Juvenile Justice in pursuing its mission of providing educational, training, and treatment services for youthful offenders (wards) committed for confinement by the courts.

At the time of the May 2005 review, the ward population at N.A. Chaderjian was 590, more than double the current population. Many of the wards were in Phase I, the most restrictive phase of the three-phase system of privileges that was in place at the time. Accordingly, they had few privileges to lose by disrupting daily operations. Ward programming at the facility had diminished in the wake of large-scale fights and assaults on staff members, resulting in lockdowns of living units. In this environment, the facility had been attempting to implement an "open programming" model in response to the *Farrell v. Tilton* settlement agreement between the Division of Juvenile Justice and the Prison Law Office. Under this agreement, the facility was responsible for restoring safe general population programming and ensuring that wards were out of their rooms daily for educational, vocational, and treatment programming, as well as meals and recreation, by June 1, 2005.

The profile of the N.A. Chaderjian Youth Correctional Facility has changed dramatically since the Office of the Inspector General's May 2005 review. Shortly after the release of the

[1] "Gassing" is the practice of throwing human excrement or bodily fluids.

review, N.A. Chaderjian transferred gang leaders out of the facility and the Division of Juvenile Justice implemented a moratorium on the intake of wards into the facility, resulting in a reduction in ward population from 590 wards on April 7, 2005, to 232 wards as of March 1, 2007. N.A. Chaderjian is no longer a general population facility, and the *Farrell v. Tilton* Safety and Welfare Remedial Plan calls for N.A. Chaderjian to be completely converted into a special treatment facility by April 2007. While the Division of Juvenile Justice concedes that it will most likely miss this target date, N.A. Chaderjian currently has a number of specialized programs, including intensive medical and psychiatric treatment, special counseling programs for wards who exhibit symptoms of mild to moderate mental illness, sex offender programs, and a special management program for violent and disruptive wards.

For fiscal year 2006-07, N.A. Chaderjian has a budgeted staff of 446 and an operating budget of $38 million. Staff positions include administrators, administrative support personnel, youth correctional officers, and youth correctional counselors. In addition, the staff includes academic and vocational education instructors, administrators, and support staff, all of whom report to the Division of Juvenile Justice Education Services Branch, rather than to the N.A. Chaderjian superintendent. Staff members performing medical, dental, mental health, and facility maintenance services report to the Northern California Youth Correctional Center.

There are six buildings on the facility grounds (Units I through VI), each housing two living units of 50 rooms. A common wall separates the living units, and there is an elevated control tower at the top of the common wall. The control tower monitors ward activity in the central areas of the living units, which are known as day rooms, and controls the movement of wards into and out of the living units. In addition, the control tower maintains video surveillance of the outdoor recreation areas. Wards generally receive counseling services in their living units, but they leave the living units to participate in other programs at various locations on the facility grounds. The programs include attending the facility's N.A. Chaderjian High School and obtaining vocational training. Wards also leave their living units to obtain medical and dental services at the facility's clinic and to attend religious services.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the May 2005 management review audit, the Office of the Inspector General developed four findings encompassing a wide array of the facility's operations. In addition to serious structural and design defects, the findings included observations of deficiencies in ward counseling, education, and mental health care. The management review audit made the following specific findings:

- ***Wards at N.A. Chaderjian were not receiving the counseling and other treatment services they were required to receive under state law.*** Further, the treatment services they did receive were of questionable quality, largely because the youth correctional counselors, who provide the bulk of the counseling, not only lacked training but spent only about 10 percent of their time counseling wards. The rest of their time

was consumed by custody and security tasks, such as supervising meals and showers and working in the control tower. The failure of the facility to provide treatment services deprived the wards of the tools they need for successful reintegration into society and put them at greater risk of committing future crimes.

- ***Education services provided to wards at N.A. Chaderjian were deficient.*** The N.A. Chaderjian High School was not adequately fulfilling its responsibility to provide wards with education services. Special education wards, who made up 38 percent of the high school's enrolled students, did not receive all of their mandated special education service time. Moreover, special education providers consistently over-reported the amount of service provided. At the same time, more than one-third of the academic classes scheduled at the high school were routinely canceled, mainly because teachers did not show up for class. Class cancellations contributed significantly to the school's low effectiveness rating, which measures actual—versus potential—attendance and classes held. The effectiveness rating of the high school was 40 percent, meaning that wards were receiving only 40 percent of their assigned education programming. Poor oversight by school administrators contributed to the problems. The school had had four principals since 2002, and the acting principal spent only about half his time at the facility.

- ***Structural defects, maintenance problems, and deficient management practices at N.A. Chaderjian jeopardized the safety of employees, wards, and visitors.*** N.A. Chaderjian had significant structural deficiencies and was not complying with numerous security policies and procedures required by the *Division of Juvenile Justice Institutions and Camps Branch Manual*. These deficiencies, combined with maintenance problems and inadequate management practices, jeopardized the safety of the staff, wards, and visitors to a degree that exceeded even the normal risks inherent in a correctional setting.

- ***Staff at N.A. Chaderjian were not consistently complying with department policies and procedures governing the use of psychotropic medications and suicide prevention, assessment, and response.*** Wards at the facility received psychotropic medications without proper testing and monitoring. As a result, the facility jeopardized the health of wards receiving psychotropic medications and did not take adequate measures to protect wards from suicide. The failure of the facility to comply with required policies and procedures also exposed the department to potential lawsuits resulting from death or injury to wards.

As a result of the May 2005 management review audit, the Office of the Inspector General made 56 recommendations to the California Department of Corrections and Rehabilitation's Division of Juvenile Justice and the N.A. Chaderjian Youth Correctional Facility to address these findings.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

N.A. Chaderjian and the Division of Juvenile Justice have made significant progress toward implementing recommendations related to the finding that wards were not receiving the counseling and other treatment services they were required to receive under state law.

- Shortly after the release of the 2005 review, the Division of Juvenile Justice halted the intake of new wards into the facility, and the ward population at N.A. Chaderjian dropped from 590 on April 7, 2005, to 232 on March 1, 2007. With the decrease in the ward population came a corresponding decrease in violence. The Division of Juvenile Justice reported that in comparing the five months before the population reduction to the five months after the start of the reduction, serious incidents of youth-on-youth violence went down 17 percent; group disturbances went down more than 80 percent; assaults on staff decreased 76 percent; incidents involving the use of force decreased 24 percent; and use of restraints went down nearly 45 percent.

- The facility reports that it no longer has high vacancies in its youth correctional counselor positions, although it has had some difficulty keeping its senior youth correctional counselor positions filled. With no significant youth correctional counselor vacancies and an average of 24 wards in each living unit, the facility reports that it has increased the number of hours of formal counseling provided to each ward weekly.

- The Division of Juvenile Justice reports that it contracted with California State University, Chico, to conduct a training needs assessment, which included the scope of work for youth correctional counselors. Once approved by the Division of Juvenile Justice, the training identified in the assessment will be developed and implemented. The Division of Juvenile Justice also reports that it is still developing a statewide training program to supplement the *Farrell v. Tilton* Remedial Plans.

N.A. Chaderjian and the Division of Juvenile Justice have made some progress toward implementing recommendations related to the finding that education services provided to wards at N.A. Chaderjian were deficient.

- The N.A. Chaderjian High School was granted interim accreditation from the Western Association of Schools and Colleges through June 30, 2009. In addition, N.A. Chaderjian now has a number of teachers who are credentialed in special education services, and teachers' attendance at case conferences has improved. The school schedule has been adjusted to provide five class periods per day, and class cancellations have been reduced.

- The Division of Juvenile Justice reports that it has yet to appoint a superintendent of education, and the N.A. Chaderjian High School has had an acting principal since May 2006.

The Division of Juvenile Justice has made limited progress toward implementing recommendations related to the finding that structural defects, maintenance problems, and deficient management practices at N.A. Chaderjian jeopardized the safety of employees, wards, and visitors.

- The Division of Juvenile Justice commissioned a visual assessment of N.A. Chaderjian that addresses many of the deficiencies identified in the May 2005 report and contains comprehensive recommendations and cost estimates. The Division of Juvenile Justice reports, however, that any plans for moving forward with repairs at N.A. Chaderjian have been temporarily put on hold pending the outcome of the Governor's 2007-08 budget proposal to place certain juvenile offenders in county facilities rather than state facilities.

- N.A. Chaderjian has fully implemented the Personal Alarm Locator System that tracks staff members and visitors at various locations throughout the facility. In addition, N.A. Chaderjian implemented an hourly ward count process that includes logging the movement of wards to and from the living units in the unit log books. Wards are also required to carry a movement pass whenever they move to and from a living unit unescorted, and the sending and receiving parties must be notified upon each ward's departure and arrival.

- N.A. Chaderjian reports that it now has more radios and a better battery replacement process; however, as noted in the May 2005 report, the radio system itself is antiquated and needs upgrading. The Division of Juvenile Justice has upgraded the radio systems of all the youth facilities, with the exception of those that make up the Northern California Youth Correctional Center complex (N.A. Chaderjian, O.H. Close, and DeWitt Nelson). The Division of Juvenile Justice reports that it anticipates upgrading the radio systems of the complex in the next budget year.

- A ward incentive program has been implemented statewide. The program contains disciplinary measures and positive reinforcement options that can be used with wards as disincentives to poor behavior and incentives for good behavior.

- The N.A. Chaderjian superintendent conducted an evaluation of the facility's compliance with the safety and security standards found in sections 1800 through 1848 of the *Division of Juvenile Justice Institutions and Camps Branch Manual*. As required in section 1800, the superintendent forwarded the results to the Division of Juvenile Facilities (formerly known as the Institution and Camps Branch). However, the Division of Juvenile Facilities was unable to assemble a review team to visit the facility and complete the annual security audit.

N.A. Chaderjian and the Division of Juvenile Justice have made some progress toward implementing recommendations related to the finding that facility staff were not consistently complying with department policies and procedures governing suicide prevention, assessment, and response.

- The Office of the Inspector General verified that N.A. Chaderjian assigned a higher priority to the suicide prevention, assessment, and response program by appointing the assistant superintendent as chairperson of the Suicide Prevention Assessment and Response Committee. In addition, the superintendent issued two memorandums to all staff members emphasizing the importance of suicide prevention, assessment, and response.

- The Office of the Inspector General reviewed the Suicide Prevention Assessment and Response Committee quarterly reports for 2005 and 2006 and verified that the committee conducted annual room inspections in 2005 and 2006. The Office of the Inspector General also reviewed N.A. Chaderjian's suicide prevention and response training records and verified that facility staff received training in 2005 and again in 2006.

- The Office of the Inspector General reviewed the unified health records of 10 N.A. Chaderjian parole violators who arrived at the facility in 2006. Of these 10, only four unified health records contained completed treatment needs assessments. Since then, the facility reported that it has identified and remedied deficiencies in its treatment needs assessment scheduling and tracking process. However, the assessments cannot be scored within one day as required by section 6260 of the *Division of Juvenile Justice Institutions and Camps Branch Manual* because the facility does not have a Scantron scoring machine. Instead, the assessments must be sent to Division of Juvenile Justice headquarters in Sacramento for scoring.

N.A. Chaderjian and the Division of Juvenile Justice have made little progress toward implementing recommendations related to staff compliance with department policies and procedures governing the use of psychotropic medications.

- The Office of the Inspector General noted in its May 2005 report that N.A. Chaderjian had only two part-time psychiatrists who provided a combined total of about 18 hours per week of psychiatric services. N.A. Chaderjian reports that there are now three psychiatrists under contract for the Northern California Youth Correctional Center complex, and each psychiatrist typically spends one day per week at N.A. Chaderjian. In light of the substantial decrease in the ward population at the facility, this is an improvement from the previous review; however, if the facility is to be converted to a special treatment facility as called for in the *Farrell v. Tilton* Safety and Welfare Remedial Plan, the ongoing issue of psychiatrist vacancies will need to be addressed.

- In response to the Office of the Inspector General's recommendation that the N.A. Chaderjian chief medical officer develop a psychotropic medication protocol and forward a copy to the director of the department's Division of Correctional Health Care Services for review and approval, the Division of Juvenile Justice reported that the *Department of Mental Health Psychotropic Medication Guidelines* were issued in May 2005. Moreover, the *Farrell v. Tilton* Mental Health Remedial Plan addresses the development of policies and procedures specific to psychotropic medication protocol. This

recommendation was intended to address the finding that wards at the facility received psychotropic medications without proper testing and monitoring. The use of the *Department of Mental Health Psychotropic Medication Guidelines* does not remedy these findings. The mental health policies, procedures, and guidelines required by the *Farrell v. Tilton* Mental Health Remedial Plan should adequately address the Office of the Inspector General's findings; however, the Division of Juvenile Justice reports that the mental health policies, procedures, and guidelines are still in the development and approval stage and have yet to be implemented.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the management of N.A. Chaderjian take the following actions:

- **Assess the training needs of the facility's counseling staff, particularly those of the youth correctional counselors, and make available the funding and time necessary to upgrade their knowledge, skills, and ability through formal training. In addition, use in-house staff, such as psychologists, staff experienced in using the Ward Information Network, and the best and most experienced treatment staff to provide structured on-the-job training on counseling techniques, living unit file documentation methods, and other relevant topics.**

- **Develop and implement a comprehensive plan in conjunction with the plant operations staff of the Northern California Youth Correctional Center to identify, prioritize, and correct all building deficiencies that create security and safety risks. The plan should specifically address the deficiencies identified in the May 2005 report and should have cost estimates and a schedule with target dates for completion. The Division of Juvenile Justice headquarters should assist the facility with the plan.**

- **Take steps to secure the recreation yard fences. In so doing, consider "climb-resistant" fences and using wire of the appropriate gauge to lessen the possibility of wards ripping or breaking through the fence.**

- **Update and formalize hostage procedures and provide hostage training as necessary.**

- **Set the bottom of the perimeter fence in concrete (as required in section 1813 of the *Division of Juvenile Justice Institutions and Camps Branch Manual)* and, if necessary, replace fence poles with poles of a larger diameter.**

- **Develop and implement a radio replacement schedule in conjunction with Division of Juvenile Justice headquarters and dedicate funding for that function in order to supply facility personnel with adequate communication devices.**

- **Improve security related to the ward visiting area by providing uninterrupted visual coverage. The facility's management should also consider adding another staff person to the visiting tower so that one person can continually monitor the visiting area while the other can operate the doors for wards entering and leaving.**

- **Augment electronic mail and the read-and-initial system by conducting quarterly meetings involving line staff and management to enhance communication and provide a forum to discuss issues affecting the work environment. The facility's management should also ensure that meeting times are rotated so that staff from different shifts can attend.**

The Office of the Inspector General recommends that the Division of Juvenile Justice take the following actions:

- **Expedite the appointment of a superintendent of education.**

- **Bargain during the next Bargaining Unit 3 negotiations for removal of the exempt status of teachers, as it relates to the manner in which leave credits are charged for partial day absences.**

- **Bargain during the next Bargaining Unit 6 negotiations to eliminate the authority of counselors to keep wards from attending high school classes.**

- **Use the results of the Kitchell Engineering visual assessment of N.A. Chaderjian to recommend to the administration and the Legislature whether to make the repairs and keep the facility open or close it and find a suitable alternative for housing the wards.**

- **Require the Division of Juvenile Facilities (formerly known as the Institutions and Camps Branch) to perform the annual security audit of the N.A. Chaderjian Youth Correctional Facility and other facilities as required by section 1800 of the *Division of Juvenile Justice Institutions and Camps Branch Manual*.**

- **Expedite the development and implementation of the general mental health and pharmacy services/medication administration policies and procedures, as called for in the *Farrell v. Tilton* Mental Health Remedial Plan.**

The Office of the Inspector General recommends that the management of the Education Services Branch of the Division of Juvenile Justice and the facility's education administrators take the following actions:

- **Expedite the appointment of a permanent principal for N.A. Chaderjian High School.**

- **Use performance appraisals and progressive discipline to hold teachers and administrators accountable for their performance, including attending case conferences, meeting performance objectives, and accurately reporting special education services and attendance.**

The Office of the Inspector General recommends that the chief medical officer at N.A. Chaderjian take the following actions:

- **Continue to work with the department's Division of Correctional Health Care Services to fill vacancies in psychiatrist positions at the facility.**

- **Develop a checklist for the unified health record that itemizes all the requirements to be met by mental health staff before administering psychotropic medications. These requirements should include fulfilling requirements for mental health testing and psychiatric evaluations; written informed consent; developing treatment plans; and statements of duration of prescription time and desired clinical effect; and performing laboratory tests.**

- **Ensure that incoming parole violators receive treatment needs assessments.**

The Office of the Inspector General conducted its work on the N.A. Chaderjian Youth Correctional Facility from December 12, 2006, through March 16, 2007.

The following table summarizes the results of the 2007 follow-up review. Each finding is numbered in accordance with the original report, and the date a finding and recommendation was first made is listed in parentheses.

FINDING NUMBER 1

Wards at N.A. Chaderjian were not receiving the counseling and other treatment services they were required to receive under state law. (May 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice and N.A. Chaderjian administrators should:		
Provide adequate staffing to the facility's general population living units by evaluating the needs of the facility relative to the needs of other facilities and act accordingly. If necessary, the administrators should also redirect resources from other facilities. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A safety and welfare plan has been filed in addition to other remedial plans that outline the establishment and redirection of existing positions throughout the Division of Juvenile Justice. When the intake of wards ceased the population was reduced to the current population of 250 wards.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the *Farrell v. Tilton* Safety and Welfare Remedial Plan, which reports that in 2005 the Division of Juvenile Justice began to reduce the size of living units at N.A. Chaderjian by significantly reducing intake at that facility. By early 2006, all but two of the living units had only 24 wards in each. Staffing levels were not changed. Taking into account the lower population levels and comparing the five months before the population reduction to the five months after the start of the reduction, the Safety and Welfare Remedial Plan reports that serious incidents of youth-on-youth violence went down 17 percent; group disturbances went down more than 80 percent; assaults on staff decreased 76 percent; incidents involving the use of force decreased 24 percent; and use of restraints went down nearly 45 percent. N.A. Chaderjian reports that the ward population remains low, with 232 wards as of March 1, 2007.
Fill staff vacancies by aggressively recruiting senior youth correctional counselors and youth correctional counselors for the facility. In addition, the	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. All youth correctional counselor positions have been filled; however, there are currently four senior youth correctional counselor vacancies at N.A.*

RECOMMENDATIONS	STATUS	COMMENTS
administrators should hire more staff for the counselor relief pool. (May 2005)		*Chaderjian. In addition, N.A. Chaderjian currently has ten (10) filled permanent full time vacation relief positions for youth correctional counselors. The current level of youth correctional counselor relief is adequate based on the dramatic decrease in staff vacancies and extended leave. To assist in filling vacancies, the Division of Juvenile Facilities has established a joint recruitment program with the California Department of Corrections and Rehabilitation's Peace Officer Selection Unit.* **Office of the Inspector General's comments:** The Office of the Inspector General found that nearly all of N.A. Chaderjian's youth correctional counselor positions are filled. N.A. Chaderjian acknowledged that the facility has had ongoing difficulty retaining senior youth correctional counselors who have numerous transfer and promotional opportunities with other California Department of Corrections and Rehabilitation facilities in the area. This recommendation was intended to address the finding that at the time of the May 2005 audit the facility had a population of 590 wards and a 29 percent vacancy rate for both youth correctional counselors and senior youth correctional counselors. N.A. Chaderjian now has a ward population of 232 and a very low youth correctional counselor vacancy rate.
The management of N.A. Chaderjian should:		
Schedule more than one hour of formal counseling per week per general population ward as vacancies diminish and staffing levels increase and ensure that counseling for wards in all living units includes at least some formal, individual counseling of at least one hour duration. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Casework and counseling expectations, requirements for scheduling small group counseling sessions, and monthly monitoring of the completion of casework has been established. Managers submit monthly reports that document the monitoring of casework responsibilities. Youth correctional counselors are required to conduct a minimum of one hour of individual formal counseling, one hour of small group formal counseling, and a formal counseling resource group, per week, for each general population ward. The Division of Juvenile Justice's Remedial Plans will substantially increase counseling efforts.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General reviewed documentation provided by N.A. Chaderjian and found that youth correctional counselors appear to be providing wards with more than one hour of formal counseling per week. In addition, the Office of the Inspector General verified that the *Farrell v. Tilton* Safety and Welfare Remedial Plan includes a provision to increase the staff-to-youth ratios to, among other things, facilitate additional small groups and more individual counseling.
Assess the training needs of the facility's counseling staff, particularly those of the youth correctional counselors, and make available the funding and time necessary to upgrade their knowledge, skills, and ability through formal training. In addition, use in-house staff, such as psychologists, staff experienced in using the Ward Information Network, and the best and most experienced treatment staff to provide structured on-the-job training on counseling techniques, living unit file documentation methods, and other relevant topics. (May 2005)	**PARTIALLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Division of Juvenile Justice contracted with Cal State Chico's, Research Unit to conduct a training needs assessment which includes the scope of work for youth correctional counselors. The initial assessment is complete and is being evaluated by stakeholders. Once approved, the Division of Juvenile Justice will develop and implement the training identified in the assessment. The Division of Juvenile Justice is in the process of developing a statewide training program to supplement the Farrell Remediation Plans. N.A. Chaderjian is developing a training plan to assist in the proposed transition of the mental health programs in 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Improve the monitoring of casework by ensuring that living unit files are organized and use progressive discipline to emphasize the importance of maintaining current, accurate information in these files. (May 2005)	**FULLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Casework and counseling expectations, requirements for scheduling small group counseling sessions, and monthly monitoring of the completion of casework has been established. Managers documented the monitoring of casework responsibilities and deficiencies requiring progressive discipline. Monthly reports are submitted to evaluate the achievement of goals with recommended remediation efforts.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify

RECOMMENDATIONS	STATUS	COMMENTS
		the department's representation.
Sample ward files regularly for compliance with the treatment provisions of the *Division of Juvenile Justice Institutions and Camps Branch Manual.* (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Youth Correctional Counselors have been instructed in documentation and completion of casework requirements in ward files. Managers submit a monthly report that documents the monitoring of casework responsibilities.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Hold administrators, supervisors, parole agents, and counselors accountable for counseling wards through timely performance appraisals and progressive discipline. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. All peace officer performance appraisals were completed in 2006 and a procedure has been implemented to ensure all performance appraisals will be completed in a timely manner in 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Division of Juvenile Justice should:		
Hold the facility's high school administrators responsible for ensuring that a teacher attends every case conference and use performance appraisals and progressive discipline to enforce compliance. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A Case Conference Educational team for N. A. Chaderjian, was established in April 2005, and outlines the attendance mandates for Case Conferences. Yearly and monthly case conference schedules are distributed to Education administrators and teachers. Teachers not attending are reported and disciplinary action is taken. Monthly meetings are conducted between N. A. Chaderjian administrators and Education administrative staff, to resolve Case Conference scheduling issues; thereby maximizing teacher participation.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify

RECOMMENDATIONS	STATUS	COMMENTS
		the department's representation.
Consider reducing or eliminating the "70-30" split for filling youth correctional counselor positions in future labor negotiations on behalf of the entire Division of Juvenile Justice. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A memorandum has been sent to the Office of Labor Relations requesting that this be a priority item for the negotiations with Bargaining Unit 6, and is currently under consideration in on-going negotiations.* **Office of the Inspector General's comments:** The Office of the Inspector General verified that reducing or eliminating the "70-30" split for filling youth correctional counselor positions is a labor issue that has been introduced for negotiation with Bargaining Unit 6 (California Correctional Peace Officers Association).
Provide funding for interactive journals and similar items critical to the department's core functions of treatment and training. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A Budget Change Proposal was approved in fiscal year 2005/2006 to fund the development of intensive treatment journals and annual purchasing of core journals. Facility staff has access to reproduce journals as needed.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Evaluate the additional workload placed on treatment staff due to the passage and implementation of Senate Bill 459 and provide budget support for the facilities as necessary. (May 2005)	NOT APPLICABLE	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. The request to conduct a study to ascertain the impact of SB459 was denied.* **Office of the Inspector General's comments:** This recommendation was intended to address the finding that the passage of Senate Bill 459 (Chapter 4, Statutes of 2003) caused an increased workload for parole agents. Prior to the passage of Senate Bill 459, wards appeared before the Juvenile Parole Board, and if the board denied parole, the board decided on the additional confinement period. Senate Bill 459 created a

RECOMMENDATIONS	STATUS	COMMENTS
		Youth Authority Administrative Committee at each facility and shifted the decision on additional confinement time to the committee. This committee added more paperwork and casework time to the parole agents' workload and added more responsibilities and work for the parole agent III who chairs the committee. While the Office of the Inspector General performed no audit procedures to verify the department's representation, three years have passed since Senate Bill 459 went into effect on January 1, 2004, and N.A. Chaderjian reports that the workload for this function has been absorbed. N.A. Chaderjian also reports that because the ward population has been significantly reduced at the facility, the additional workload created by Senate Bill 459 is more manageable; therefore, this recommendation is considered no longer applicable.

FOLLOW-UP RECOMMENDATION

The management of N.A. Chaderjian should assess the training needs of the facility's counseling staff, particularly those of the youth correctional counselors, and make available the funding and time necessary to upgrade their knowledge, skills, and ability through formal training. In addition, use in-house staff, such as psychologists, staff experienced in using the Ward Information Network, and the best and most experienced treatment staff to provide structured on-the-job training on counseling techniques, living unit file documentation methods, and other relevant topics. (May 2005)

FINDING NUMBER 2

Education services provided to wards at N.A. Chaderjian were deficient. (May 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Expedite the appointment of a superintendent of education. (May 2005)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. On December 1, 2005, the CEA III, Superintendent of Education examination was utilized for executive recruitment, selection and hiring process. A permanent Superintendent of Education appointment is pending.* **Office of the Inspector General's comments:** This recommendation was intended to address the finding that the Division of Juvenile Justice's Education Services Branch had four different superintendents in 2004 alone, resulting in a lack of direction to N.A. Chaderjian High School staff. Because a permanent superintendent of education has not been appointed since the recommendation was made, the Office of the Inspector General disagrees with the department's assertion that it has partially implemented this recommendation, and the status of the recommendation has been changed to not implemented.
Bargain during the next Bargaining Unit 3 negotiations for removal of the exempt status of teachers. (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Applicable. The designation of teachers as exempt employees falls under the Fair Labor Standards Act. The state has no discretion with regard to this recommendation.* **Office of the Inspector General's comments:** The recommendation to remove the exempt status of teachers was intended to address the finding that some N.A. Chaderjian teachers took advantage of their exempt status by abusing leave time. The exempt status allows teachers to take partial days off without charging any leave credits. The Office of the Inspector General does not agree with the department's response that the state has no discretion with regard to this recommendation. According to the Department of Personnel Administration (the state department responsible for negotiating labor contracts with each bargaining unit), charging leave for partial day absences does not violate the Fair Labor Standards Act and is allowed by U.S. Department of Labor regulations and opinion letters.

RECOMMENDATIONS	STATUS	COMMENTS
		Therefore, the Office of the Inspector General disagrees with the department's assertion that this recommendation is not applicable, and because the Department of Personnel Administration reports that this topic is currently under discussion with Bargaining Unit 3 (California State Employees Association), the status of the recommendation has been changed to partially implemented.
Bargain during the next Bargaining Unit 6 negotiations to eliminate the authority of counselors to keep wards from attending high school classes. (May 2005)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Applicable. As part of the overall reform efforts, the Division of Juvenile Justice is developing a Program Service Day concept, which will address this concern by expanding the number of hours staff can provide services to wards through modifying hours of work.* **Office of the Inspector General's comments:** The Office of the Inspector General disagrees with the department's assertion that this recommendation is not applicable. The intent of this recommendation was to reduce the number of instances in which wards were pulled out of school for casework purposes. N.A. Chaderjian acknowledged that the program service day concept mentioned above has yet to be fully implemented and some wards, particularly those in the mental health intensive treatment program and the sexual behavior treatment program, are still being pulled out of school for counseling services. In addition, the provision of the California Correctional Peace Officers Association Bargaining Unit 6 contract authorizing youth correctional counselors to hold back wards from high school classes is still in effect; therefore, the status of the recommendation has been changed to not implemented.
The management of the Education Services Branch of the Division of Juvenile Justice and the facility's education administrators should:		
Expedite the appointment of a permanent principal for N.A. Chaderjian High School. (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A Principal was appointed effective May 1, 2005; however, the*

RECOMMENDATIONS	STATUS	COMMENTS
		Principal has been on special assignment since May 2006. An Acting Principal has been fulfilling the duties of this position. **Office of the Inspector General's comments:** The Office of the Inspector General disagrees with the department's assertion that this recommendation has been fully implemented. Appointing a permanent principal in May 2005 partially implemented the recommendation; however, the intent of this recommendation was to address the finding that from 2002 to 2005 N.A. Chaderjian High School had four principals in either acting or permanent positions, and the acting principal at the time of the review was working concurrently at department headquarters in Sacramento and spending only about half his time at the facility. As the department reports above, the principal that was appointed in May 2005 has been gone from the facility since May 2006, and N.A. Chaderjian High School has had an acting principal since that time. The Office of the Inspector General reported in its original review that this lack of continuity in leadership lead to low morale among members of the teaching staff and allowed teachers to abuse leave time resulting in, among other things, class cancellations.
Use performance appraisals and progressive discipline to hold teachers and administrators accountable for their performance, including attending case conferences, meeting performance objectives, and accurately reporting special education services and attendance. (May 2005)	**PARTIALLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Classroom observations are mandated on a yearly basis according to Education policy. In May and June of 2005, site administrators conducted classroom observations of two-thirds of the teaching staff. N. A. Chaderjian is making every effort to complete the quarterly observations, and weekly observations. Walk-through observation forms have been designed, distributed and their use implemented. Quarterly and annual evaluation formats have been adopted for more accurate evaluations of performance. Special Education services and Case Conference attendance is being monitored.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

RECOMMENDATIONS	STATUS	COMMENTS
Reduce class cancellations by working with the facility superintendent to improve scheduling and coordination between the facility staff and the high school administration and eliminate the scheduling conflict between small group counseling and wards' attendance in school. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. In May 2005, a memorandum was issued to Superintendents and school Principals outlining their responsibilities to improve ward/student attendance. Monthly meetings are conducted between N. A. Chaderjian administrators and Education administrative staff to resolve Case Conference scheduling issues; thereby maximizing teacher participation.* *The N. A. Chaderjian Principal, Vice Principal, Superintendent and Middle Managers meet monthly to discuss the Student Ward Absentee Tracking analysis. The Education Review Committee comprised of the Program Administrator, Treatment Team Supervisor, Senior Youth Correctional Counselor, Gang Coordinator and Education Administration meet monthly to discuss any issues that may interfere with ward attendance. As of August 2005, teachers are required to submit Student Consultation Team referrals prior to removing students from assigned classes for lack of school attendance. In July 2006, the new school schedule was implemented.* **Office of the Inspector General's comments:** The Office of the Inspector General's review of a three-month period in 2006 found an average of 164 classes canceled per month—8.3 percent of the total classes offered. This is an improvement from the 34 percent class cancellation rate reported in the previous review.
Consider developing alternatives to obtaining a high school diploma as a criterion for parole consideration for wards 18 years of age and older. While obtaining a high school diploma should remain the primary goal for the majority of wards, alternatives such as adult basic education and vocational programs should be considered as appropriate options for educating wards and earning parole consideration. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Education program offers more than one curricular path and alternative for students to complete their education including, High School Diploma, General Education Diploma, California High School Proficiency Exam and Certificate of Completion. All of these alternatives are in the Education Services Branch Policy and Procedures Manual. When a student enters the clinic intake process, a High School Graduation Plan is developed and is revised/updated every six months. This Plan determines the curricular path and alternative for each student and is based upon the student's individual transcripts and course completions. This procedure is also in the Education Services Branch Policy and Procedures Manual.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: This recommendation was intended to address the finding that many wards at N.A. Chaderjian believed that earning a high school diploma was beyond their ability and only enrolled in classes because the policy at the time required wards to make "satisfactory progress" toward high school graduation to be considered for parole. In addition, wards who might have been more interested in learning a trade were denied that opportunity because the number of vocational education programs at the facility had shrunk to six. Since 2000, California law (Welfare and Institutions Code section 1120.1) has required the Division of Juvenile Justice to develop a high school graduation plan for every ward who has not achieved a high school diploma or equivalent. In January 2003, the lawsuit now known as *Farrell v. Tilton* was filed in the Alameda County Superior Court condemning conditions in the juvenile justice system, including education services. The Division of Juvenile Justice was ordered to develop, among other things, an education remedial plan to address deficiencies in a variety of areas, such as student access to academic education, vocational education, and life survival skills. The resulting *Farrell v. Tilton* Education Remedial Plan retains the Division of Juvenile Justice's policy requiring a high school graduation plan for each ward, citing (1) state law; (2) a 1996 Rand Corporation study reporting that "education is the most cost-effective" crime prevention method; and (3) California juvenile parole statistics since 1985 showing that parolees who have earned a high school diploma or equivalent are three to five times more likely to succeed on parole. The high school education program detailed in the Education Remedial Plan consists of three core components: academic preparation, vocational preparation, and life survival skills. In addition, one of the key principles of the *Farrell v. Tilton* Safety and Welfare Remedial Plan is to prepare wards for

RECOMMENDATIONS	STATUS	COMMENTS
		re-entry into the community by addressing vocational needs. The Safety and Welfare Remedial Plan also states that vocational programs will train young people in marketable skills and provide the support necessary to obtain and maintain employment. In compliance with the Safety and Welfare Remedial Plan, N.A. Chaderjian has added a vocational specialist (transition coordinator) to provide vocational and career counseling and coordination with parole and re-entry specialists in transition planning for future employment in the community. N.A. Chaderjian has also added three additional vocational courses since the May 2005 review (for a total of nine).
Eliminate the half-day reserved for case conferences if teachers' attendance at case conferences does not improve and require teachers to provide timely progress reports to the wards' youth correctional counselors. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. With the implementation of the newly negotiated school schedule, Case Conferences have been scheduled once a week. In the new schedule wards are held back for Case Conference for only one period during the scheduled weekly Case Conference day. Teachers' attendance at Case Conference is tracked and they are held accountable for their attendance.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed data for case conferences held in January and February 2007 and determined that teachers' attendance at case conferences improved by 52 percent from the May 2005 review.
Adjust the school schedule to provide for at least four class periods per day. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The new school schedule, which provides for five (5) class periods per day, was implemented in July 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General confirmed that the 2006-07 daily school schedule contains five class periods per day.
Study ways to lessen the negative effects of gang segregation within the high school in order to provide	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. This issue is discussed monthly in the Education Review Committee.*

RECOMMENDATIONS	STATUS	COMMENTS
all wards with equal educational opportunities. (May 2005)		*The Superintendent has met with N. A. Chaderjian Managers, Institutional Gang Coordinator and the Departmental Gang Coordinator in an effort to reduce gang incidents within the institution. Full-day education services are provided for all wards in general population, with the exception of wards that affiliate with the Fresno Bulldog gang. Those affiliated wards receive full-day education services in their living units.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Comply with all recommendations of the Western Association of Schools and Colleges in order to obtain full accreditation for N.A. Chaderjian High School. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Interim Western Association of Schools and Colleges accreditation has been granted through June 30, 2009.* **Office of the Inspector General's comments:** The Office of the Inspector General verified that N.A. Chaderjian High School has received accreditation from the Western Association of Schools and Colleges through June 30, 2009.
Use existing special education staff to provide special education services and ensure that only properly credentialed special education staff are providing the services. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. As of December 1, 2006, all necessary staff have been hired, appropriately placed and are properly credentialed. N. A. Chaderjian hired two teachers credentialed in special education services, i.e.: Emotionally/Learning Handicapped.* **Office of the Inspector General's comments:** The Office of the Inspector General confirmed that the special education staff members at N.A. Chaderjian are properly credentialed.

FOLLOW-UP RECOMMENDATIONS

The Division of Juvenile Justice should take the following actions:

- **Expedite the appointment of a superintendent of education. (May 2005)**

- **Bargain during the next Bargaining Unit 3 negotiations for removal of the exempt status of teachers, as it relates to the manner in which leave credits are charged for partial day absences. (May 2005)**

- **Bargain during the next Bargaining Unit 6 negotiations to eliminate the authority of counselors to keep wards from attending high school classes. (May 2005)**

The management of the Education Services Branch of the Division of Juvenile Justice and the facility's education administrators should take the following actions:

- **Expedite the appointment of a permanent principal for N.A. Chaderjian High School. (May 2005)**

- **Use performance appraisals and progressive discipline to hold teachers and administrators accountable for their performance, including attending case conferences, meeting performance objectives, and accurately reporting special education services and attendance. (May 2005)**

FINDING NUMBER 3

Structural defects, maintenance problems, and deficient management practices at N.A. Chaderjian jeopardized the safety of employees, wards, and visitors. (May 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The facility's management should:		
Develop and implement a comprehensive plan in conjunction with the plant operations staff of the Northern California Youth Correctional Center to identify, prioritize, and correct all building deficiencies that create security and safety risks. The plan should specifically address the deficiencies identified in this	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Office of Facilities Management commissioned the services of Kitchell Engineering to complete a structural and infrastructure assessment of the facility. The report was completed in July 2006. It is anticipated that a Statewide Facilities Master Plan will be completed in June 2007, to include a project plan based on the Kitchell report, complete with estimated costs and project timeline.*

RECOMMENDATIONS	STATUS	COMMENTS
report and should have cost estimates and a schedule with target dates for completion. The Division of Juvenile Justice headquarters should assist the facility with the plan. (May 2005)		**Office of the Inspector General's comments:** The Office of the Inspector General reviewed the facility assessment final report that was completed by Kitchell Engineering. The plan does address many of the deficiencies identified in this report and contains comprehensive recommendations and cost estimates. However, the Division of Juvenile Justice reports that any plans for moving forward with repairs have been temporarily put on hold pending the outcome of the Governor's 2007-08 budget proposal to place certain juvenile offenders in county facilities rather than state facilities.
Take steps to secure the recreation yard fences. In so doing, consider "climb-resistant" fences and using wire of the appropriate gauge to lessen the possibility of wards ripping or breaking through the fence. (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. There are two fencing projects currently being considered at N. A. Chaderjian. The first fencing project involves enhancing recreation yard fences on all recreation yards. A Minor Capital Outlay Project was approved, but not funded. A Budget Change Proposal project request was submitted in June 2005, to improve the Unit 1 recreation yard and to provide more recreational access. This is included in the Kitchell Engineering structural assessment. See above response.* *The second recreation yard fence project involves the individual recreation areas on Unit 1 Kern Hall. This project has been approved and funded. In November 2006, a start-up meeting was conducted with the contractor. It was discovered that the contractor had modified the project without review or approval by Plant Operations and the N. A. Chaderjian Management Team. It was noted that the project no longer met the required standards. The project was returned to the contractor for re-design.* **Office of the Inspector General's comments:** The Office of the Inspector General verified that initial steps have been taken toward securing the recreation yard fences; however, as noted above, no actual work has begun on the fence replacement project.

RECOMMENDATIONS	STATUS	COMMENTS
Have security staff at the main entrance track visitors and staff on an electronic spreadsheet until a properly functioning electronic entry/exit system is installed. The spreadsheet should be structured so that it can easily be sorted by estimated exit time to track the names of individuals whose anticipated exit time has passed. (May 2005)	NOT APPLICABLE	**California Department of Corrections and Rehabilitation's response:** *Not Applicable. Everyone entering the facility is logged in on the N. A. Chaderjian Accountability Form. This accountability form indicates that a person has entered the institution, estimated time out of the institution, and the actual time they leave the institution. This sheet is reviewed by a Youth Correctional Officer at the Check-in/Check-out gate to ensure that staff entered the institution, leave at their estimated time of departure.* *Staff have been trained in Entrance Gate/Accountability responsibilities and duties and a Post Order has been developed specifically for this post. N. A. Chaderjian is the first facility in the complex to go on-line with the Personal Alarm Locator System implemented in July 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General observed the Personal Alarm Locator System in use at N.A. Chaderjian. Because the facility now has a properly functioning electronic entry/exit system, this recommendation is no longer applicable.
Hold the security major accountable for improving the thoroughness and overall quality of the facility's annual section 1800 security audits. The facility should ensure that unresolved deficiencies are resolved promptly. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Section 1800 matrix is completed on an annual basis. The Security Major is held responsible for completion of assignments. The latest 1800 Security Audit was completed in October, 2006. Resulting projects are reviewed and prioritized.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Improve ward accountability and movement by requiring that movement of wards to and from the living units be recorded in the unit log books. Recorded information should include the time of	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Applicable. The recommendation to log wards' names and numbers in the living unit log book upon departure or arrival is a duplication of the existing policy and procedures. N. A. Chaderjian implemented a count system that indicates the location of each ward at*

RECOMMENDATIONS	STATUS	COMMENTS
arrival and departure for each ward and his name and identification number. Staff from each sending area should be required to provide prior notification to staff at the receiving area that ward movement is about to occur, and the receiving area should be required to confirm receipt of the wards by notifying the sending area when ward movement is completed. Staff should ensure that all wards carry a pass during movement. (May 2005)		*the time of hourly counts. Staff and wards have been informed of the expectation that wards are not to communicate with other wards that are secured in their rooms, without staff permission and supervision. Out-of-bound areas were also addressed. Staff will be held accountable through the Progressive Discipline System and wards through the Disciplinary Decision Making System.* **Office of the Inspector General's comments:** The Office of the Inspector General verified that N.A. Chaderjian implemented an hourly count process that includes logging the movement of wards to and from the living units in the unit log books. In addition, the superintendent issued a directive to all staff requiring that wards carry a movement pass whenever they move to and from the living unit unescorted. The directive also requires that the sending and receiving parties be notified upon each ward's departure and arrival. Although the department reported that the recommendation was not applicable, the Office of the Inspector General considers the actions of N.A. Chaderjian staff members to have substantially implemented the recommendation.
Develop procedures for handling erroneous ward counts, including recording each occurrence and identifying the responsible staff member to determine whether additional training, discipline, or procedural changes are needed. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Sergeants and lieutenants are required to document staff calling in erroneous counts. Documentation shall include staff name, date, time, and work location recorded on the count form. The form will be routed to the employee's manager/supervisor for appropriate action (training, discipline, and/or procedural changes) with a copy to the Chief of Security.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

RECOMMENDATIONS	STATUS	COMMENTS
Update the multi-hazard emergency plan and provide training and notification of changes to appropriate staff as necessary. (May 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The N. A. Chaderjian Multi-Hazard Emergency Plan has been revised and updated to reflect the July 1, 2005, organizational change to the California Department of Corrections and Rehabilitation. N. A. Chaderjian will be completing National Incident Management System response training during calendar year 2007 which is directly related to the institutional Multi-Hazard Emergency Plan.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Update and formalize hostage procedures and provide hostage training as necessary. (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Office of Correctional Safety oversees hostage response and negotiations through the Regional Crisis Response Team, in conjunction with the Law Enforcement Investigation Unit. Training and coordination efforts will be provided by the Office of Correctional Safety in 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General determined that N.A. Chaderjian updated and formalized its hostage procedures and has included them in its Multi-Hazard Emergency Plan. However, the plan mentioned above for the Office of Correctional Safety to oversee hostage response and negotiations through the Regional Crisis Response Team has yet to be implemented; therefore, training and coordination efforts have not been provided.
Require all staff entering the living units to notify the living unit control tower so that security personnel are aware of their presence. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Upon arrival, staff is to notify the Unit Control Tower staff of their presence on the unit and must sign in on the Living Unit Visitor Log. The log must be obtained from living unit staff to ensure a peace officer is aware of their presence. The new Personal Alarm Locator System allows the Control Sergeant to identify staff presence if an alarm is activated.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General observed staff members signing in and out of living unit visitor logs and notifying living unit control towers as they entered and exited the living units.
Set the bottom of the perimeter fence in concrete and, if necessary, replace fence poles with poles of a larger diameter. (May 2005)	**NOT IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Not Applicable. N. A. Chaderjian will not pursue this recommendation as it is an unsound construction practice and will lead to deterioration of fence fabric and ineffectiveness of the fence alarm system. This issue was discussed with Southwest Microwave Systems, a national provider of fence alarm systems, in 1999.* **Office of the Inspector General's comments:** The Office of the Inspector General disagrees with the department's assertion that this recommendation is not applicable. Although the department states that it will not pursue this recommendation because it has known since 1999 that setting the bottom of the perimeter fence in concrete is an unsound construction practice, section 1813 (revised December 2003) of the *Division of Juvenile Justice Institutions and Camps Branch Manual* specifically requires that the bottom portion of perimeter security fences be set in concrete. In addition, the department did not dispute this recommendation in its August 10, 2005, response to the management review audit. Instead, the department stated that there was a budget change proposal in the current five-year plan to correct the deficiencies to all the perimeter fences. Therefore, the status of this recommendation has been changed to not implemented.
Develop and implement a radio replacement schedule in conjunction with Division of Juvenile Justice headquarters and dedicate funding for that function in order to supply facility personnel with adequate communication devices. (May 2005)	**PARTIALLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Radio systems will be upgraded at Herman G. Stark, Southern Youth Correctional Reception Center and Clinic, Paso De Robles, and Pine Grove during fiscal year 2006/2007. N. A. Chaderjian received fifteen (15) new radios with an additional ten (10) radios currently on order. The replacement of radios is scheduled to occur at in July 2007. In the meantime, batteries for the existing radio system*

RECOMMENDATIONS	STATUS	COMMENTS
		will be replenished according to the Radio Battery Replacement Schedule. **Office of the Inspector General's comments:** The Office of the Inspector General found that N.A. Chaderjian partially implemented this recommendation by ensuring that there are now more radios and a better battery replacement process. However, the Division of Juvenile Justice acknowledged that the radio system itself is antiquated, and they have upgraded the radio systems of all the youth facilities, with the exception of those that make up the Northern California Youth Correctional Center complex (N.A. Chaderjian, O.H. Close, and DeWitt Nelson). The Division of Juvenile Justice reports that it anticipates upgrading the radio systems of the Northern California Youth Correctional Center complex in the next budget year.
Update the facility's operations manual and post orders. The facility's management should also provide post orders for every post on every watch, provide training on procedures requiring major changes, and use the read-and-initial system to ensure that staff personnel receive copies of important procedural changes and confirm receipt within a reasonable time. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Post Orders for Bargaining Unit 6 rank and file were revised and signed by staff at the time of their annual performance appraisal, including post supervisory peace officer staff. Staff was also reminded of their responsibility to read and initial all memorandums from the Read and Initial Board on their assigned living units. Deficiencies are reported in the monthly report. N. A. Chaderjian's Operations Manual was updated in September 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General verified that N.A. Chaderjian updated the facility's post orders and operations manual.
Update escape procedures and provide training annually. (May 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Multi-Hazard Emergency Plan has been revised and updated to reflect the July 1, 2005 organizational change to California Department of Corrections and Rehabilitation, and is currently under review. Upon approval, training needs will be assessed and provided to staff as necessary.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General performed no audit procedures to verify the department's representation.
Improve security related to the ward visiting area by providing uninterrupted visual coverage. Consider adding another staff person to the visiting tower so that one person can continually monitor the visiting area while the other can operate the doors for wards entering and leaving. (May 2005)	**NOT IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. N. A. Chaderjian has three security staff assigned inside the visiting hall during visiting hours to provide uninterrupted visual supervision of wards and visitors.* **Office of the Inspector General's comments:** The Office of the Inspector General accepts the department's assertion that this recommendation has not been implemented. Although no audit procedures were performed to verify the department's representation, the number of staff assigned to the ward visiting area remains the same as it did at the time of the May 2005 review and the department's response does not describe any actions taken to improve security in the visiting area.
Augment electronic mail and the read-and-initial system by conducting quarterly meetings involving line staff and management to enhance communication and provide a forum to discuss issues affecting the work environment. The facility's management should also ensure that meeting times are rotated so that staff from different shifts can attend. (May 2005)	**PARTIALLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. N. A. Chaderjian has multiple avenues of sharing concerns such as e-mailing, telephone contact, speaking with managers/administrators during their daily visits to the living units and supervisory logbook contacts are effective ways to discuss work related issues.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Conduct more random searches of both employees and visitors and record searches by identifying the names of those searched, the time and date of the search, and the results of the search. The facility's management should also ensure that searches occur on a random and unpredictable schedule. (May 2005)	**FULLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Employees and visitors are informed that they can be subject to random search, prior to entering the facility. The name of the person searched, date, time and results of the search are recorded on the Employee Search Log.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General reviewed search logs for 2005 and 2006 and noted that the facility has consistently conducted searches of employees and visitors.
Refer inquiries involving a management employee as a subject, complainant, or primary witness to a neighboring institution to improve the integrity of the inquiry and its findings. (May 2005)	NOT APPLICABLE	**California Department of Corrections and Rehabilitation's response:** *Not Applicable. This recommendation will not be pursued as presented. All inquiries and investigation reports are reviewed by the Juvenile Facilities Division for content and quality prior to submittal to the Internal Affairs Unit.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation; however, changes to the internal affairs investigation process departmentwide have made this recommendation no longer applicable.
Develop policies and procedures to implement a workplace violence prevention program, train or orient staff on the program as necessary, and ensure that the policies and procedures comply with the required time limits. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Mandatory workplace violence training was conducted in November and December 2005. Employees will continue to receive this training as part of their annual block training.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Division of Juvenile Justice should:		
Contract for a thorough, independent study that tests the structural integrity of the buildings in the facility before committing resources to implement the facility's comprehensive plan cited above. If the contractor finds that structural deficiencies exist, the	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Office of Facilities Management commissioned the services of Kitchell Engineering to complete a structural and infrastructure assessment of the facility. The Kitchell report was completed in July 2006, and a Statewide Facilities Master Plan will be completed in June 2007. The Office of Facilities Management will implement a*

RECOMMENDATIONS	STATUS	COMMENTS
contractor should include in the study the estimated costs to fix them. The director should use the test results to recommend to the administration and the Legislature whether to make the repairs and keep the facility open or close it and find a suitable alternative for housing the wards. (May 2005)		*project plan based on the Kitchell report, to include estimated costs and a timeline for the project.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the N.A. Chaderjian facility assessment prepared by Kitchell Engineering. The assessment includes estimated costs to fix structural deficiencies. As noted above, a statewide facilities master plan has not been completed.
Require the Division of Juvenile Facilities to perform the annual security audit of N.A. Chaderjian Youth Correctional Facility and other facilities as required by section 1800 of the *Division of Juvenile Justice Institutions and Camps Branch Manual.* (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Correctional Standards Authority completed a Staff Safety Evaluation of N. A. Chaderjian in August 2005 and provided a series of recommendations. N. A. Chaderjian developed and has implemented its Corrective Action Plan. N. A. Chaderjian conducted a self-audit which was completed and submitted to the Director of the Division of Juvenile Facilities in October, 2006. The Juvenile Facilities Branch will resume security audits of all facilities in accordance with Section 1800 of the Institutions and Camps Branch Manual.* **Office of the Inspector General's comments:** The Office of the Inspector General disagrees with the department's assertion that this recommendation has been fully implemented. As the department reported above, in October 2006 the N.A. Chaderjian superintendent conducted an evaluation of the facility's compliance with the safety and security standards found in sections 1800 through 1848 of the *Division of Juvenile Justice Institutions and Camps Branch Manual.* As required in section 1800, the superintendent forwarded the results to the director of the Division of Juvenile Facilities. These actions by N.A. Chaderjian partially implemented the Office of the Inspector General's recommendation. However, the recommendation was directed at the Division of Juvenile Facilities, who is required by section 1800 to assemble a review team to visit the facility and conduct an audit of compliance. The Division of Juvenile Facilities reported that they have been unable to do so.

RECOMMENDATIONS	STATUS	COMMENTS
Evaluate staffing ratios and work requirements for each living unit to determine whether the current staffing ratios are appropriate given the types of resident wards, the physical design of the units, and the job requirements of staff. Based on the results, the division should propose to the California Correctional Peace Officers Association realignment of the staffing ratios of the living units. (This recommendation is partially addressed in Finding 1, which discusses staffing in the general population living units.) (May 2005)	NOT APPLICABLE	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Staffing ratios are dictated by Bargaining Unit 6 Memorandum of Understandings and are subject to the Ralph Dills Act. The contract expired July 2, 2006. Staff/ward ratios and work requirements of each living unit have been enhanced by the reduction in the count on general population halls.* *The Division of Juvenile Justice has filed a Safety and Welfare Plan in addition to other remedial plans that outline the establishment and redirection of existing positions. The Office of Labor Relations is aware of the possible impact of these issues. The population at N. A. Chaderjian has been reduced from four hundred eighty-one (481) on August 12, 2005 (when the intake of wards ceased) to the current population of two hundred fifty (250) wards, as of November 28, 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General found that because of the significant reduction in the number of general population wards now housed at N.A. Chaderjian, this recommendation is no longer applicable. This recommendation was originally intended to address the finding that at the time of the May 2005 review, N.A. Chaderjian primarily housed wards over age 18 who had committed violent offenses and consistently displayed poor in-custody behavior, yet the living units had a lower staffing ratio than other facilities. N.A. Chaderjian no longer receives general population wards, and the *Farrell v. Tilton* Safety and Welfare Remedial Plan calls for the facility to be converted to a special treatment facility.
Explore and evaluate disciplinary measures and positive reinforcement options that can be used with wards as disincentives to poor behavior and incentives for good behavior, giving consideration to the fact that many wards cannot have time added to their commitments. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Ward Incentive Program training was provided to managers, supervisors and line staff in September, October and November 2005, and has been fully integrated department-wide. The program includes various privileges, such as MP3 players and incentives to increase available ward program credits. A User Manual was made available to institutions and camps in February 2006 with comprehensive instructions for use of the Ward Incentive Program in the Ward Information Network 2005 database.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General verified that an incentive system has been implemented throughout the Division of Juvenile Justice, as called for in the *Farrell v. Tilton* Safety and Welfare Remedial Plan.
Provide department staff with the status of the revised use-of-force policy and advise staff on what policy to follow until the new policy is final. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. During the months of April and May 2006, mandatory Use of Force training was provided to all N. A. Chaderjian staff.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

N.A. Chaderjian management should take the following actions:

- **Develop and implement a comprehensive plan in conjunction with the plant operations staff of the Northern California Youth Correctional Center to identify, prioritize, and correct all building deficiencies that create security and safety risks. The plan should specifically address the deficiencies identified in the May 2005 report and should have cost estimates and a schedule with target dates for completion. The Division of Juvenile Justice headquarters should assist the facility with the plan. (May 2005)**

- **Take steps to secure the recreation yard fences. In so doing, consider "climb-resistant" fences and using wire of the appropriate gauge to lessen the possibility of wards ripping or breaking through the fence. (May 2005)**

- **Update and formalize hostage procedures and provide hostage training as necessary. (May 2005)**

- **Set the bottom of the perimeter fence in concrete (as required in section 1813 of the *Division of Juvenile Justice Institutions and Camps Branch Manual)* and, if necessary, replace fence poles with poles of a larger diameter. (May 2005)**

- **Develop and implement a radio replacement schedule in conjunction with Division of Juvenile Justice headquarters and dedicate funding for that function in order to supply facility personnel with adequate communication devices. (May 2005)**

- **Improve security related to the ward visiting area by providing uninterrupted visual coverage. The facility's management should also consider adding another staff person to the visiting tower so that one person can continually monitor the visiting area while the other can operate the doors for wards entering and leaving. (May 2005)**

- **Augment electronic mail and the read-and-initial system by conducting quarterly meetings involving line staff and management to enhance communication and provide a forum to discuss issues affecting the work environment. The facility's management should also ensure that meeting times are rotated so that staff from different shifts can attend. (May 2005)**

The Division of Juvenile Justice should take the following actions:

- **Use the results of the Kitchell Engineering visual assessment of N.A. Chaderjian to recommend to the administration and the Legislature whether to make the repairs and keep the facility open or close it and find a suitable alternative for housing the wards. (May 2005)**

- **Require the Division of Juvenile Facilities (formerly known as the Institutions and Camps Branch) to perform the annual security audit of the N.A. Chaderjian Youth Correctional Facility and other facilities as required by section 1800 of the *Division of Juvenile Justice Institutions and Camps Branch Manual*. (May 2005)**

FINDING NUMBER 4

Staff at N.A. Chaderjian were not consistently complying with department policies and procedures governing the use of psychotropic medications and suicide prevention, assessment, and response. (May 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The chief medical officer at N.A. Chaderjian should:		

RECOMMENDATIONS	STATUS	COMMENTS
Continue to work with the department's Division of Correctional Health Care Services to fill vacancies in psychiatrist positions at the facility. (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. In June 2005, the former Department of Youth Authority Health Care Services (now Division of Juvenile Justice) Medical Remedial Plan Transition Team met and discussed primary recruitment contacts, policy review and the Remedial Plan. A retention and recruitment plan was established effective July 1, 2005. N. A. Chaderjian has a contract with two separate agencies for psychiatrists; however, there have been no psychiatrists available through either agency to date. N.A. Chaderjian is currently using two part-time psychiatrists and continues the efforts to collaborate with local schools of psychiatry in attempts to develop resident positions and to recruit graduates.* **Office of the Inspector General's comments:** The Office of the Inspector General noted in its May 2005 report that N.A. Chaderjian was staffed with only two part-time psychiatrists who provided a combined total of about 18 hours per week of psychiatric services. N.A. Chaderjian reports that there are now three psychiatrists under contract for the Northern California Youth Correctional Center complex, and each psychiatrist typically spends one day per week at N.A. Chaderjian. In light of the substantial decrease in the ward population at the facility, this is an improvement from the previous review. However, if the facility is to be converted to a special treatment facility as called for in the *Farrell v. Tilton* Safety and Welfare Remedial Plan, the ongoing issue of psychiatrist vacancies will need to be addressed.
Develop a psychotropic medication protocol and forward a copy to the director of the department's Division of Correctional Health Care Services for review and approval. (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Revised Psychotropic Medication Guidelines were issued May, 2005, instructing Chief Medical Officers in the use of the revised guidelines in their institution's Medical Staff Standards. It also instructs all psychiatrists and general physicians of their responsibility to read, initial and follow the new standards. The Mental Health Remedial Plan was filed in August 2006. The plan addresses the development of policies and procedures specific to psychotropic medication protocol that align with community standards of care.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General disagrees with the department's assertion that this recommendation has been substantially implemented. Although the N.A. Chaderjian chief medical officer received a copy of the *Department of Mental Health Psychotropic Medication Guidelines*, these guidelines were developed to improve the efficacy, cost-effectiveness, and efficiency of antipsychotic prescribing practices in various state departments and contain only minimum laboratory monitoring guidelines. In contrast, this recommendation was intended to address the finding that wards at the facility received psychotropic medications without proper testing and monitoring. The chief medical officer's use of the *Department of Mental Health Psychotropic Medication Guidelines* does not remedy these findings. The mental health policies, procedures, and guidelines required by the *Farrell v. Tilton* Mental Health Remedial Plan should adequately address the Office of the Inspector General's findings. However, because the Division of Juvenile Justice reports that the mental health policies, procedures, and guidelines are still in the development and approval stage, the status of this recommendation has been changed to partially implemented.
Monitor more closely the work of employees to ensure that they comply with Division of Juvenile Justice policies and procedures and best professional practices. When employees are not doing work correctly, the chief medical officer should provide on-the-job training and formal training as necessary. The chief medical officer should provide timely feedback to employees through accurate performance appraisals and hold staff accountable for their work through progressive discipline. (May 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Division of Juvenile Justice's Medical Director receives monthly reports from all Chief Medical Officers, documenting training and disciplinary action taken. Statewide meetings are held quarterly to address policy, procedure and training issues.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Develop a checklist for the unified health record that itemizes all the requirements to be met by mental	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. A flow-sheet checklist has been developed for monitoring the*

RECOMMENDATIONS	STATUS	COMMENTS
health staff before administering psychotropic medications. These requirements should include fulfilling requirements for mental health testing and psychiatric evaluations; written informed consent; developing treatment plans; and statements of duration of prescription time and desired clinical effect; and performing laboratory tests. (May 2005)		*distribution of psychotropic medications as part of the quality management program. Thirty-two (32) health care policies are currently being vetted through the regulation process, including ones related to psychotropic medication and quality management. The Mental Health Remedial Plan addresses the issue of protocols for the administration of psychotropic medication.* **Office of the Inspector General's comments:** The Office of the Inspector General disagrees with the department's assertion that this recommendation has been partially implemented. The Division of Juvenile Justice uses the checklist as part of its process of biannually auditing the unified health records of 30 percent of wards receiving psychotropic medications. The Division of Juvenile Justice, however, has not implemented a unified health record checklist that itemizes all the requirements to be met by mental health staff before administering psychotropic medications, as the Office of the Inspector General recommended.
Ensure that incoming parole violators receive treatment needs assessments. (May 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A memorandum was issued in January, 2005, identifying the current Treatment Needs Assessment process for Institutions & Camps Manual Section 6260. All wards defined in this section must have the Treatment Needs Assessment testing process completed within twenty-one (21) days of arrival. The completion of the Treatment Needs Assessment testing is monitored through the monthly report submitted by the Superintendent to the Director of the Division of Juvenile Facilities.* **Office of the Inspector General's comments:** The Office of the Inspector General disagrees with the department's assertion that this recommendation has been fully implemented. In December 2006, the Office of the Inspector General reviewed the unified health records of 10 N.A. Chaderjian parole violators who arrived at the facility in 2006. Of these 10, only four unified health records contained completed treatment needs assessments. Since then, the facility reports that it

RECOMMENDATIONS	STATUS	COMMENTS
		has partially implemented this recommendation by identifying and remedying deficiencies in their treatment needs assessment scheduling and tracking process that were causing some parole violators to not receive treatment needs assessments. However, the facility reports that the treatment needs assessments still cannot be scored within one day as required in section 6260 of the *Division of Juvenile Justice Institutions and Camps Branch Manual* because the facility does not have a Scantron scoring machine. Instead, the assessments must be sent to Division of Juvenile Justice headquarters in Sacramento for scoring.
N.A. Chaderjian's superintendent should:		
Assign a higher priority to the suicide prevention, assessment, and response program by emphasizing to all staff the program's importance. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A memorandum was issued in April, 2006 to all staff outlining their responsibilities in the Suicide Prevention Assessment and Response Policy. In November, 2006, a memorandum was issued to all staff stressing the need for increased diligence for the Holiday Season with regard to suicide prevention.* **Office of the Inspector General's comments:** The Office of the Inspector General verified that N.A. Chaderjian assigned a higher priority to the suicide prevention, assessment, and response program by appointing the assistant superintendent as chairperson of the Suicide Prevention Assessment and Response Committee. In addition, the Office of the Inspector General reviewed the memorandums mentioned above and verified that the superintendent issued them to all staff members to emphasize the importance of suicide prevention, assessment, and response.
Monitor attendance at the suicide prevention, assessment, and response committee meetings and review the committee's quarterly reports. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Suicide Prevention Assessment and Response meetings are held quarterly; minutes have been completed, as well as quarterly reports. Suicide Prevention Assessment and Response Committee members unable to attend are to contact the Assistant Superintendent's Office.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General performed no audit procedures to verify the department's representation.
Appoint a suicide prevention, assessment, and response committee chairman and a risk management officer at the program administrator level or above and hold those individuals accountable for the positions' duties, including ensuring that suicide risk lists are properly posted and reviewed by the living unit staff. (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A Program Administrator has been appointed Chairperson of the N. A. Chaderjian Suicide Prevention Assessment and Response Committee. All Suicide Risk Levels are reviewed daily and filed by the Risk Management Officer.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Ensure that the suicide prevention, assessment, and response committee conducts annual room inspections and reports on conclusions and recommendations as required by section 6263 of the *Division of Juvenile Justice Institutions and Camps Branch Manual.* (May 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Suicide Prevention Assessment and Response Committee completed an inspection of Suicide Watch, Step-down and Standard Risk rooms in May, 2006. The Suicide Prevention Assessment and Response Committee Chair, Chief of Plant Operations, Safety Committee Chair, completed a thorough assessment of all safe rooms and several living units as part of the implementation of the Mental Health Remedial Plan; physical plant issues continue to be evaluated.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the Suicide Prevention Assessment and Response Committee quarterly reports for 2005 and 2006 and verified that the committee conducted annual room inspections in 2005 and 2006.
Ensure that all staff members who have routine contact with wards receive the training required by section 6263 of the *Division of Juvenile Justice Institutions and Camps Branch Manual.* (May 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. In November and December 2005, mandatory Suicide Prevention Assessment and Response training was provided for all peace officer staff who have routine contact with wards. In November 2006, mandatory Suicide Prevention Assessment and Response training was provided to all staff. Attendance was better than*

RECOMMENDATIONS	STATUS	COMMENTS
		95 percent with discipline utilized for non-attendance. **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the N.A. Chaderjian suicide prevention and response training records and verified that facility staff members received training in 2005 and again in 2006, but it does not appear that the three contract psychiatrists received the training.

FOLLOW-UP RECOMMENDATIONS

The chief medical officer at N.A. Chaderjian should:

- **Continue to work with the department's Division of Correctional Health Care Services to fill vacancies in psychiatrist positions at the facility. (May 2005)**
- **Develop a checklist for the unified health record that itemizes all the requirements to be met by mental health staff before administering psychotropic medications. These requirements should include fulfilling requirements for mental health testing and psychiatric evaluations; written informed consent; developing treatment plans; and statements of duration of prescription time and desired clinical effect; and performing laboratory tests. (May 2005)**
- **Ensure that incoming parole violators receive treatment needs assessments. (May 2005)**

The Division of Juvenile Justice should expedite the development and implementation of the general mental health and pharmacy services/medication administration policies and procedures, as called for in the *Farrell v. Tilton* Mental Health Remedial Plan. (2007)

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

IMPLEMENTATION REPORT CARD
2005 Follow-up recommendations: 16
Fully implemented: 6 (38%)
Substantially implemented: 4 (25%)
Partially implemented: 4 (25%)
Not implemented: 2 (12%)

The Heman G. Stark Youth Correctional Facility has made progress in some operations since a January 2005 follow-up audit. The Office of the Inspector General found that most wards now eat in group settings where socialization can take place. The facility has also improved its process for monitoring weekly and small group counseling. However, the facility is not effectively using its inquiry database to track complaints against its employees, and it continues to struggle with teacher vacancies, limiting the number of ward class assignments.

The Office of the Inspector General issued a management review audit report on the Heman G. Stark Youth Correctional Facility in October 2000. The management review audit identified numerous problems with the facility's operation, including failure to consistently fulfill two of the department's core functions: providing wards with education and providing them with treatment services, including individual and small group counseling. The Office of the Inspector General made 44 recommendations to resolve the deficiencies.

In light of the seriousness of the findings, in July 2002 the Office of the Inspector General conducted a follow-up review of the facility's progress in implementing the recommendations from the October 2000 audit report. The 2002 follow-up review found that the Heman G. Stark Youth Correctional Facility had implemented just 18 of the 44 earlier recommendations. In fact, the facility regressed in providing individual and small group counseling to wards, as evidenced by compliance rates significantly lower than the unsatisfactory rates revealed in the October 2000 audit report. Nevertheless, some areas that had been found unsatisfactory in the October 2000 management review audit showed marginal improvement. In particular, the facility's high school had become accredited, class cancellations had declined, and special education instruction time had improved. As a result of the 2002 follow-up review, the Office of the Inspector General made 25 recommendations.

In a second follow-up review released in January 2005, the Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility continued to fail at providing mandated education and treatment services to wards. Class cancellations had increased, instruction time had declined, and standardized test scores had dropped. Similarly, the follow-up review determined that only 33 percent of a sample of wards at the facility had received mandated counseling. Among the wards in the facility's general population, the compliance rate was zero—meaning that not a single general population ward in the sample had received the minimum individual and small group counseling required by California Department of Corrections and Rehabilitation policy. The Office of the Inspector General made 16 follow-up recommendations.

BACKGROUND

The Heman G. Stark Youth Correctional Facility is one of eight youth correctional facilities within the Division of Juvenile Justice (formerly the California Youth Authority). The facility assists the Division of Juvenile Justice in fulfilling its mission of protecting the public from criminal activity by providing education, training, and treatment services for youthful offenders committed by the courts. Located on 101 acres outside Chino in Southern California, the Heman G. Stark Youth Correctional Facility houses youthful offenders aged 18 to 25, many of whom have committed serious offenses, including murder, rape, armed robbery, and assault. At present, the facility houses about 800 youthful offenders, a number significantly lower than the nearly 1,300 wards housed at the facility during the Office of the Inspector General's October 2000 management review audit.

For fiscal year 2006-07, the Heman G. Stark Youth Correctional Facility has a budgeted staff of 877.5 positions and an operating budget of $77,040,000. Staff positions include administrators, medical and dental professionals, psychologists, administrative support personnel, youth correctional officers, and youth correctional counselors. In addition, the staff includes academic and vocational education instructors, administrators, and support staff, all of whom report to the Division of Juvenile Justice Education Services Branch rather than to the superintendent.

Wards at Heman G. Stark Youth Correctional Facility participate in counseling programs, which include individual and small group counseling based on individual needs. Some living units house general population wards, while others specialize in orienting newly transferred wards, treating sex offenders and drug abusers, and providing intensive treatment and special counseling to wards with recognized needs.

Most wards leave the living units to participate in other programs and services at various locations on the facility grounds. These include attending the facility's Lyle Egan High School, obtaining vocational training, receiving medical and dental care, and attending religious services.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the 2005 follow-up review, the Office of the Inspector General made the following findings:

- The effectiveness rating of the institution's high school for fiscal year 2003-04 was only 30 percent, meaning that wards received an average of only 30 percent of available instruction time during the year. This is a drop of seven percentage points from the 37 percent effectiveness rating for fiscal year 2002-03.

- Class cancellations averaged 540 per month for fiscal year 2003-04, compared to 460 per month the previous fiscal year. More classes were canceled in fiscal year 2003-04 than

were canceled during the Office of the Inspector General's management review audit in 2000.

- The Office of the Inspector General's review of standardized test scores showed that scores had continually declined in all subject areas since 1998. For example, in 2004, 88 percent of Lyle Egan wards had cumulative subject scores below the 25th national percentile rate compared to 68 percent of the school's wards in 1998.

- For fiscal years 2002-03 and 2003-04, the Lyle Egan High School had reported absenteeism rates of 36 percent and 45 percent, respectively. Those absenteeism rates were significantly higher than the 24 percent absenteeism rate found in the Office of the Inspector General's October 2000 management review audit.

- As a result of teacher vacancies, combined with ward absences, wards enrolled for at least 90 days during fiscal year 2003-04 earned an average of only 9.45 high school credits.

- Only 30 percent of the special education wards assigned to special day classes received the services prescribed in their individual education plans. That figure represented a decrease of eight percentage points from the 38 percent rate found by the Office of the Inspector General in the October 2000 management review audit.

- None of the 14 general population wards sampled by the Office of the Inspector General had received the minimum amount of weekly individual and small group counseling. Conversely, all seven of the wards sampled from specialized programs had received such counseling. General population wards, however, comprised most of the facility's population. In the 2000 management review audit and the 2002 follow-up to that audit, the Office of the Inspector General found compliance rates of 56 percent and 31 percent, respectively. Thus, the facility not only continued to fail, but it had also regressed in providing required counseling to wards.

- Many treatment team supervisors had not routinely performed the required monthly audits of 10 ward files. Of seven treatment team supervisors reviewed, an average of only one supervisor a month audited 10 ward files during the 10-month period reviewed by the audit team. One treatment team supervisor acknowledged that he performed no file reviews. Some treatment team supervisors attempted to delegate their responsibilities to subordinates, in violation of facility policy.

- The Division of Juvenile Justice had relieved the institutions of responsibility for conducting *Division of Juvenile Justice Institutions and Camps Branch Manual* section 4000 annual self-audit reports because of the need to implement parole hearing changes in the wake of Senate Bill 459. Thus, a proven monitoring tool had not been used for more than a year.

- To their credit, the superintendent and deputy superintendent at the time had attempted to monitor casework. The Office of the Inspector General obtained memorandums and

other documents showing that these officials had found discrepancies in monthly small group reports and had ordered remedial action and, in some cases, employee discipline. However, since 2000, the persistent failure of the facility to provide individual and small group counseling indicated the facility needed to intensify its efforts.

- Of the 21 randomly selected wards reviewed, only one ward had had a teacher attend his initial case conference, and no teachers attended any of the wards' progress case conferences. In addition, only three (14 percent) of the 21 ward files showed that the ward had been assigned to an education or work program within four days of arrival at his permanent living unit.

- A grievance filed and won by the local chapter of the California Correctional Peace Officers Association made it difficult for supervisory staff to efficiently monitor the casework of youth correctional counselors. The grievance relieved youth correctional counselors of documenting all casework in ward living unit files where it can be easily checked by supervisors. Instead, counselors documented small group counseling in records separate from ward living unit files. The grievance was granted by the labor relations unit in the Division of Juvenile Justice because casework documentation requirements imposed by the facility allegedly increased the counselors' workload beyond that agreed to in a 1995 agreement.

The Office of the Inspector General found improvement in some areas of facility operations. The most noteworthy improvements included the following:

- According to the institution, as of August 1, 2004, it had filled all youth correctional counselor vacancies. In addition, the Ward Information Network had been updated to assist staff members with tracking disciplinary decision-making actions, and administrators and treatment team supervisors reportedly monitored the living units daily to ensure that disciplinary actions were processed in a timely manner.

- The Office of the Inspector General conducted an on-site review at the facility to verify that each living unit had an up-to-date suicide risk list. The audit team also asked the staff to locate the Hoffman tool, a safety knife for quickly cutting down wards who attempt to hang themselves. The audit team found that all units had an up-to-date suicide risk list and were able to present the Hoffman tool within 8 to 21 seconds.

The Office of the Inspector General made 16 recommendations to the Heman G. Stark Youth Correctional Facility and the California Department of Corrections and Rehabilitation as a result of the 2005 follow-up review. The specific recommendations are listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The California Department of Corrections and Rehabilitation reported that it has made some progress implementing the 2005 follow-up recommendations made by the Office of

the Inspector General in the areas of ward education and delivery of treatment services. Specifically, the Heman G. Stark Youth Correctional Facility has filled 12 of 40 vacant teaching positions at the Lyle Egan High School, but the continuing shortage of teachers limits the number of classes available to wards. The facility audits its Student Ward Accountability Tracking System to identify the causes of ward absenteeism from school, and efforts are underway to re-establish a trade advisory committee to help the facility improve its vocational education program and enhance wards' job opportunities. The department also reported that the facility is holding treatment team supervisors accountable for monitoring counselors' work, but it is not requiring teachers to participate in case conferences because of problems with scheduling, which the facility is working to resolve.

The Office of the Inspector General also found the following:

- Since 2005, the department's internal affairs office has maintained a case management system database of all the department's internal affairs investigations and is responsible for monitoring the progress of investigations to ensure their timely completion. However, this database is not accessible by the Heman G. Stark Youth Correctional Facility. Instead, the facility uses its inquiry database to track complaints against its employees as they are processed, including complaints referred to the internal affairs office. The Office of the Inspector General found that the facility does not effectively use the database. The database is missing information on at least 15 open complaints, which suggests to the Office of the Inspector General that the facility failed to process the complaints, and thus, it may not be using the database to ensure that all complaints are processed.

- Youth correctional counselors document individual and small group counseling sessions in their case notes in the Ward Information Network and are expected to place printed copies of the case notes in ward living unit files where the information is readily available for review by supervisors. Counselors who do not comply with documentation requirements are asked to correct the deficiencies and may be verbally counseled.

- The administrative assistant is trained to use the computerized inquiry tracking system and the grievance tracking system maintained in the Ward Information Network. The administrative assistant works with the ward grievance coordinator to regularly reconcile ward grievances against facility staff members in the Ward Information Network with inquiries into those grievances in the inquiry tracking system. Nevertheless, as discussed above, it appears that the administrative assistant has not entered and updated notes in the inquiry tracking system indicating the status of at least 15 complaints.

- Most wards eat cafeteria-style in dining halls or living unit dayrooms where ward socialization can take place. Only wards who are considered high-risk continue to eat in their rooms as a result of their poor behavior. Yet, a high vacancy rate in cook positions undermines the facility's effort to consistently allow wards to eat in group settings.

- The control booth staff requires visitors to sign a log book upon entering the facility and leave official picture identification cards at the control booth until they exit the facility.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Division of Juvenile Justice and the Heman G. Stark Youth Correctional Facility take the following actions:

- **The superintendent should require the administrative assistant to enter all tracking notes in the inquiry database in a timely manner and periodically review the inquiry database looking for open complaints for which it appears a sufficient amount of time has elapsed for the complaints to have been processed and closed.**

- **The Division of Juvenile Justice Education Services Branch and the Heman G. Stark Youth Correctional Facility should increase efforts to recruit and retain qualified education staff, including full-time teachers, special education instructors, and substitutes.**

- **The Division of Juvenile Justice Education Services Branch and the principal should continue their efforts to develop trade advisory committees at the facility. The committees should use meeting agendas and minutes to develop and organize effective committee goals.**

- **The superintendent and the principal should require teachers to participate in case conferences as facilitated by the alternative education schedule.**

- **The superintendent and the principal should continue to take steps to ensure that wards are assigned to education and work programs within four days of arrival at their permanent living units.**

- **The Division of Juvenile Justice should conduct periodic audits of the Ward Information Network to ensure that only properly authorized staff can make programming changes.**

The Office of the Inspector General also recommends the following additional actions be taken:

- **To ensure that the Heman G. Stark Youth Correctional Facility has a sufficient number of cook staff to continue to provide wards meals in cafeteria-style settings, the Division of Juvenile Justice should research the existence of and reasons for vacancies in cook positions at the facility and, if appropriate, work with the California Department of Corrections and Rehabilitation, the Department of Finance, and the Department of Personnel Administration to enhance the facility's ability to fill the vacant positions.**

The Office of the Inspector General conducted its work on the Heman G. Stark Youth Correctional Facility from December 11, 2006, through March 15, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of findings that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after each recommendation.

FINDING NUMBER 1

The Heman G. Stark Youth Correctional Facility did not have a system to ensure that allegations of staff misconduct were promptly and properly investigated. Moreover, management actions relative to such investigations appeared to be questionable. (October 2000)

RECOMMENDATION	STATUS	COMMENTS
The Heman G. Stark Youth Correctional Facility should:		
Use a computerized system for tracking all requests for internal affairs investigations. The facility should explore the possibility of using the existing adverse action database for this purpose, as internal affairs investigations are presently input into this system. The system should track the originating grievance and inquiry numbers related to each investigation to allow for efficient cross-referencing and tracking of cases. (January 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A computerized database is in place to determine the status of internal affairs cases.* *The Ward Information Network (WIN) System tracks regular and emergency grievances initiated by wards. An automated system has been developed and implemented to track inquiries related to staff action grievances.* **Office of the Inspector General's comments:** Since 2005, the department's internal affairs office has maintained a case management system database of all of the department's internal affairs investigations and is responsible for monitoring the progress of investigations to ensure their timely completion. However, this database is not accessible by the Heman G. Stark Youth Correctional Facility. Instead, the Heman G. Stark Youth Correctional Facility uses its inquiry database to track complaints against its employees as they are processed, including complaints referred to the internal affairs office. The Office of the Inspector General found that the facility does not effectively use the database. The database is missing information on at least 15 open complaints, which suggests to the Office of the Inspector General that the facility failed to process the complaints, and thus, it may not be using the database to ensure that all complaints are processed. To track complaints in the inquiry database, the superintendent's administrative

RECOMMENDATION	STATUS	COMMENTS
		assistant told the Office of the Inspector General that she enters chronological notes indicating when various processing tasks are complete. The Office of the Inspector General reviewed the complaints and related notes in the inquiry database for complaints filed in 2005 and 2006. The review found 15 open complaints that appear to have had enough time elapse from the dates they were filed for the complaints to have been completely processed and closed. Yet, the most recent tracking note entered for five of the complaints indicates that the administrative assistant had sent complaint documents to the Division of Juvenile Justice director for review and approval. However, because the database lacks other notes to indicate that processing occurred beyond that point, coupled with the open status of the complaints, it appears that the administrative assistant failed to follow up with the director when she did not receive a response and that no subsequent processing took place. The most recent tracking note for five other complaints indicates a need for the facility to take action, such as conduct a polygraph or complete an internal inquiry; yet again, there is nothing to indicate those tasks were completed. Five other complaints had no tracking notes, which suggests to the Office of the Inspector General that the administrative assistant had not even begun to process them. By not entering and updating tracking notes in a timely manner, the facility is not effectively using the inquiry database as a tool to ensure timely processing and closure of all complaints. At the time of the Office of the Inspector General's review, the administrative assistant had not completely researched the 15 complaints to determine whether any of them had actually been processed and closed.

FOLLOW-UP RECOMMENDATION

The Heman G. Stark Youth Correctional Facility's superintendent should require the administrative assistant to enter all tracking notes in the inquiry database in a timely manner and periodically review the inquiry database looking for open complaints for which it appears a sufficient amount of time has elapsed for the complaints to have been processed and closed. (October 2000)

FINDING NUMBER 2

The Heman G. Stark Youth Correctional Facility educational and vocational classes were poorly attended and wards' academic achievement was low in comparison to other Division of Juvenile Justice facilities. (October 2000)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice Education Services Branch and the Heman G. Stark Youth Correctional Facility should:		
Continue efforts to recruit and retain qualified education staff, including full-time teachers, special education instructors, and substitutes. Those efforts should include working with the California Department of Corrections and Rehabilitation and the Department of Personnel Administration to provide competitive compensation for teachers. (October 2000)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Heman G. Stark Youth Correctional Facility's Lyle Egan High School collaborated with the California Department of Corrections and Rehabilitation and the Department of Personnel on a recruitment day held in March 2006. This event was advertised extensively to fill vacant teaching positions. Applications were accepted, interviews conducted and hiring offers made for all areas of academic and vocational positions.* *Twelve individuals were hired, but 28 vacancies remain. The Division of Juvenile Justice, in cooperation with the departmental recruitment program, intends to hold additional recruitment workshops in on-going recruitment efforts for teachers.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation. However, the Office of the Inspector General notes that the department reported in the Ventura Youth Correctional Facility chapter that the Department of Personnel Administration has entered into an agreement with the State Employees International Union to remedy the compensation for teacher pay.
The principal at the Heman G. Stark Youth Correctional Facility should:		

RECOMMENDATIONS	STATUS	COMMENTS
Continue to monitor the causes of ward absenteeism and make efforts to improve ward attendance and accurately report ward average daily attendance. The monitoring should include audits of the Student Ward Attendance Tracking system to ensure absences are appropriately documented and justified. (January 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The principal receives a weekly report generated from the Student Ward Accountability Tracking system. Audits are conducted to identify reasons for absenteeism as well as making referrals to the School Guidance Supervisor for enrollment needs.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Division of Juvenile Justice Education Services Branch and the principal should:		
Continue efforts to develop trade advisory committees at the facility. The committees should use meeting agendas and minutes to develop and organize effective committee goals. (October 2000)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. A trade advisory council is being established and it is anticipated that an advisory committee will be operational in May 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Division of Juvenile Justice should:		
Continue efforts to integrate its computer systems to minimize education-related reporting errors and duplication of effort. (July 2002)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Division of Juvenile Justice continues to address the computer integration process with education. At this time, there are more than 100 WIN projects being developed as part of the* Farrell *remedial effort.* **Office of the Inspector General's comments:** Although the Office of the Inspector General performed no verification procedures on this recommendation, this office accepts the department's representation as to the status of the recommendation. The Office of the Inspector General, however, notes that the department's response does not clearly support its assertion that it has substantially implemented the

RECOMMENDATIONS	STATUS	COMMENTS
		recommendation. Specifically, the department does not indicate what remains to be completed, and in fact, its comment that more than one hundred Ward Information Network projects are being developed suggests that much work remains before full integration can occur.

FOLLOW-UP RECOMMENDATIONS

- **The Division of Juvenile Justice Education Services Branch and the Heman G. Stark Youth Correctional Facility should increase efforts to recruit and retain qualified education staff, including full-time teachers, special education instructors, and substitutes. (October 2000)**
- **The Division of Juvenile Justice Education Services Branch and the principal should continue their efforts to develop trade advisory committees at the facility. The committees should use meeting agendas and minutes to develop and organize effective committee goals. (October 2000)**

FINDING NUMBER 3

Wards at Heman G. Stark Youth Correctional Facility were not provided with required treatment services. (October 2000)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Immediately take whatever steps necessary, including contract re-negotiation, to ensure efficient monitoring of weekly small group and individual counseling. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Reports on the number of small groups completed by each correctional youth counselor are submitted to executive management monthly. Youth counselors not meeting standards are subjected to progressive discipline. Small group counseling is also measured in monthly reports to the Director of Juvenile Facilities and through the COMPSTAT process on a quarterly basis.* **Office of the Inspector General's comments:** This recommendation was specifically intended to address inefficiency in

RECOMMENDATIONS	STATUS	COMMENTS
		auditing ward living unit files that occurred as a result of youth correctional counselors documenting small group counseling in files separate from ward living unit files. To determine whether the facility has improved efficiency in this area, the Office of the Inspector General interviewed treatment team supervisors who are responsible for auditing ward living unit files. The supervisors explained that youth correctional counselors document individual and small group counseling sessions in their case notes in the Ward Information Network. However, they are expected to place printed copies of the case notes in ward living unit files where the information is readily available for review. The facility provided the Office of the Inspector General examples of file audit results and other documentation indicating that youth correctional counselors who do not comply with documentation requirements are asked to correct the deficiencies and may be verbally counseled.
The Heman G. Stark Youth Correctional Facility superintendent should:		
Use progressive discipline to hold treatment team supervisors accountable for performing the required 10 audits of ward files per month. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Treatment team supervisors are held accountable to complete five file audits monthly for each living unit they supervise. Treatment teams typically supervise two living units for a total of ten file audits per month.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Division of Juvenile Justice should:		
Immediately resume the annual *Division of Juvenile Justice Institutions and Camps Branch Manual* section 4000 self-audit reporting requirement for all facilities. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Annual Section 4000 Audit was reinstated in 2005 for the 2004 reporting period. Heman G. Stark Youth Correctional Facility completed the audit as required. The Section 4000 Audit for 2006 (covering the reporting period of 2005) was also completed.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Heman G. Stark Youth Correctional Facility management should:		
Intensify its efforts to provide the individual and small group counseling to wards. Those efforts should include reiterating to staff the importance of counseling to the mission of the department, providing ongoing training as necessary, and using progressive discipline up to and including termination for employees who fail to meet counseling requirements. (October 2000)	**FULLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Program administrators are assigned the responsibility to review monthly small group discrepancies and utilize progressive discipline when counselors fail to meet counseling requirements. Verification of progressive discipline is forwarded to the deputy superintendent.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
The Heman G. Stark Youth Correctional Facility superintendent and the principal should:		
Require teachers to participate in case conferences as facilitated by the alternative education schedule. (October 2000)	**NOT IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. Based on the new academic school schedule, teacher participation does not coincide with case conference schedules. This issue is being resolved and teacher participation in case conference will resume early 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Take steps to ensure that wards are assigned to education and work programs within four days of arrival at their permanent living units. (January 2005)	**PARTIALLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Upon entry to a facility, wards are generally assigned to an orientation class within four days. After transfer to their permanent living unit, wards are immediately assigned to at least one academic class. Recruitment and retention of educational staff is*

RECOMMENDATIONS	STATUS	COMMENTS
		impacting the number of class assignments. *An application process is utilized for those wards eligible for institutional work program employment.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

The Heman G. Stark Youth Correctional Facility superintendent and the principal should take the following actions:

- **Require teachers to participate in case conferences as facilitated by the alternative education schedule. (October 2000)**
- **Continue to take steps to ensure that wards are assigned to education and work programs within four days of arrival at their permanent living units. (January 2005)**

FINDING NUMBER 4

System deficiencies and inadequate effort resulted in ward grievances not being promptly and appropriately addressed. (October 2000)

RECOMMENDATION	STATUS	COMMENTS
The Heman G. Stark Youth Correctional Facility superintendent should:		
Ensure that the administrative assistant is trained in the use of the computerized inquiry tracking system and the grievance tracking system maintained on the Ward Information Network. The administrative assistant should perform a periodic reconciliation of	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The administrative assistant has been trained in the use of the computerized inquiry tracking system and the grievance tracking system maintained in the WIN 2000 system.*

RECOMMENDATION	STATUS	COMMENTS
the staff action grievances contained in those systems. (January 2005)		*The ward's rights coordinator and administrative assistant meet monthly to reconcile staff action grievances. The administrative assistant also performs periodic reconciliations of staff action grievances contained in those systems.* **Office of the Inspector General's comments:** The Office of the Inspector General verified through interviews that the administrative assistant is trained in the use of the inquiry tracking system and the grievance tracking system maintained on the Ward Information Network. The ward rights coordinator identifies new staff action grievances in the Ward Information Network and enters them into the inquiry tracking system. The administrative assistant updates the status of grievances in the inquiry tracking system and works closely with the ward rights coordinator to ensure staff action grievances in the Ward Information Network and the inquiry tracking system reconcile. The Office of the Inspector General compared information in those systems and verified that the 2006 open staff action grievances reconcile. Nevertheless, as discussed in Finding 1 above, it appears that the administrative assistant has not entered and updated notes in the inquiry tracking system indicating the status of at least 15 complaints.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 5

All wards, including those in Phase 2 and 3, have been confined to eating in their rooms since the 1996 staff murder, hampering socialization efforts. (October 2000)

RECOMMENDATION	STATUS	COMMENTS
The Heman G. Stark Youth Correctional Facility superintendent should:		

RECOMMENDATION	STATUS	COMMENTS
Continue to pursue implementing cafeteria-type feeding for wards. (October 2000)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The facility has ten treatment teams with eight providing cafeteria style feeding. The KL and X living unit treatment teams are high risk and continue to feed in rooms based on the behavior of the wards.* **Office of the Inspector General's comments:** Through observations of mealtime activity at the facility and interviews with food service staff members, the Office of the Inspector General verified that most wards now eat breakfast and dinner in group settings, rather than alone in their rooms. Wards who are considered high risk, including those assigned to the Special Management Program, or whose behavior requires that their movement be restricted eat meals in their individual rooms. During an interview by the Office of the Inspector General in mid-December 2006, the superintendent stated that the Heman G. Stark Youth Correctional Facility was experiencing a shortage of nine cook staff members, causing two of the facility's six kitchens to be closed. The superintendent explained that, as a result of this shortage, there are fewer cook staff members available to supervise ward food service workers and cover absences of other cook staff, making it difficult to maintain the current feeding arrangements. According to the superintendent, the problem filling and retaining cook positions is due primarily to the fact that the department's Division of Adult Programs and Operations offers a $200 retention salary to cook classifications that the Division of Juvenile Justice does not. The cook positions, the superintendent further stated, are the lowest paid positions within an institution, making the $200 enough incentive for cooks to transfer out of juvenile facilities into adult facilities.

FOLLOW-UP RECOMMENDATION

To ensure that the Heman G. Stark Youth Correctional Facility has a sufficient number of cook staff to continue to provide wards meals in cafeteria-style settings, the Division of Juvenile Justice should research the existence of and reasons for vacancies in cook positions at the facility and, if appropriate, work with the California Department of Corrections and

Rehabilitation, the Department of Finance, and the Department of Personnel Administration to enhance the facility's ability to fill the vacant positions. (2007)

FINDING NUMBER 10

Facility safety and security could be enhanced. (October 2000)

RECOMMENDATION	STATUS	COMMENTS
The Heman G. Stark Youth Correctional Facility superintendent should:		
Require control booth staff to have all visitors sign in and sign out of the facility. (January 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Procedures to have visitors sign in and out have been implemented and included in the post orders.* **Office of the Inspector General's comments:** During its visit to the facility in December 2006, the audit team from the Office of the Inspector General observed that control booth staff members required visitors to sign a log book before entering and exiting the facility. The Office of the Inspector General reviewed the facility's post orders and found that the facility's post orders require that all visitors sign a visitor's log before entering the facility. Although the post orders do not include a requirement that visitors sign out before leaving the facility, they require entering visitors to present official picture identification, which the control booth staff retains until the visitor exits, thus ensuring that all visitors are accounted for.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 11

The Ward Information Network had numerous weaknesses. (October 2000)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Thoroughly test the WIN 2000 system to ensure that access is controlled properly, that programming requests are assigned priority according to department policy, and that timely feedback on the status of service requests is provided to institutions and other users. (October 2000)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The WIN unit has been upgraded and priorities for projects have been established.* **Office of the Inspector General's comments:** Although the Office of the Inspector General performed no verification procedures on this recommendation, this office accepts the department's representation as to the status of the recommendation. The Office of the Inspector General, however, notes that the department's response does not fully address the recommendation. Specifically, the department does not indicate whether it has tested the Ward Information Network for proper access control, nor does it indicate whether it provides timely feedback on service requests.
Conduct periodic audits of the Ward Information Network. (October 2000)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. A review of the WIN process concluded errors were caused by data input and not of the system itself. These problems are being resolved on an ongoing basis.* **California Department of Corrections and Rehabilitation's response:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATION

The Division of Juvenile Justice should conduct periodic audits of the Ward Information Network to ensure that only properly authorized staff can make programming changes. (October 2000)

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

IMPLEMENTATION REPORT CARD	
2005 Follow-up recommendations:	27
Less: Recommendations no longer applicable:	1
Recommendations still applicable:	26
Fully implemented: 18 (69%)	
Substantially implemented: 5 (19%)	
Partially implemented: 2 (8%)	
Not implemented: 1 (4%)	

The Southern Youth Correctional Reception Center and Clinic has significantly improved operations since the January 2005 follow-up audit. The facility has improved the thoroughness of its safety and security audits and has also improved access to counseling for wards in the work experience program. In addition, the facility has promptly completed all ward diagnostic assessments since June 2006, provided refresher training in suicide prevention and response to most of the staff, and filled vacant teacher positions. Building security, however, is at risk because some ward rooms have holes in the walls that allow contraband or other potentially dangerous items to be passed between wards. Moreover, the facility has not provided evidence that it conducts periodic armory inventories, and it still has no staff members trained as hostage negotiators. Finally, the Division of Juvenile Justice has not completed its policies and procedures for periodic peer reviews of medical programs at reception centers and clinics.

The Office of the Inspector General issued a management review audit report on the Southern Youth Correctional Reception Center and Clinic in June 2003. The audit identified serious problems involving nearly every aspect of the facility's operation. The audit found deficiencies in facility security, the ward diagnostic assessment process, mental health services, suicide prevention, education, medical care, the ward disciplinary decision-making system, the ward grievance system, and employee evaluations. The Office of the Inspector General noted that the then-recently appointed superintendent had made significant improvements during his short tenure and that some of the deficiencies, such as those relating to ward education, fell outside the superintendent's authority and required attention from Division of Juvenile Justice headquarters (formerly the California Youth Authority). To address the deficiencies, the report presented 77 recommendations.

In a follow-up review released in January 2005, the Office of the Inspector General found that although the Southern Youth Correctional Reception Center and Clinic had improved some of its operations since the June 2003 review, numerous deficiencies remained. The review found that the facility had improved safety and security, the intensive treatment program, and screening for wards with communicable diseases. However, the review also found that wards still were not receiving mandated education services and had fallen further behind in achievement, diagnostic assessments still were not being completed on time, and not all wards were receiving mandated counseling services. Further, required mental health and suicide prevention procedures were not consistently followed. To address these issues, the follow-up review presented 27 recommendations.

BACKGROUND

The Southern Youth Correctional Reception Center and Clinic in Norwalk, together with the Preston Youth Correctional Facility in Ione, receives and processes youthful offenders sent by the county courts to the Division of Juvenile Justice by providing diagnostic services, education, training, and treatment. At the reception center, wards undergo academic and vocational testing, medical and dental examinations, and mental health assessments followed by more in-depth psychological and psychiatric evaluations and treatment if necessary. The mental health clinicians at the facility perform an evaluation consisting of interviews and diagnostic testing and prepare a recommended treatment plan for each ward. The evaluations are used in determining each ward's programming requirements, length of incarceration, and parole consideration date.

In addition to serving as a reception center for newly committed wards, the Southern Youth Correctional Reception Center and Clinic also receives wards for court evaluation, temporary detention, and parole violation disposition hearings. Among the facility's residential programs is the 25-bed Marshall intensive treatment program, which provides emotionally disturbed wards aged 13 to 24 with long-term residential treatment, crisis intervention, and transitional services. Another residential program is a 30-bed short-term work experience program for parole violators aged 18 to 24, who work as apprentices to the facility's maintenance staff.

To ensure the public is protected from criminal activity and that wards and staff members have a safe and secure living and working environment, section 1800 of the *Division of Juvenile Justice Institutions and Camps Branch Manual* requires that every Division of Juvenile Justice facility conduct an annual audit. The audit report serves as an "evaluation of the facility for compliance with established Institutions and Camps Branch Safety/Security Standards, enumerated in Section 1800-1848 of the Institutions and Camps Branch Manual." The Southern Youth Correctional Reception Center and Clinic adheres to this requirement by completing an audit report each year.

The Southern Youth Correctional Reception Center and Clinic has a design capacity of 350 wards within eight living units. Wards leave the living units to obtain diagnostic and counseling services and to participate in programs throughout the facility, including academic courses at Jack B. Clarke High School and vocational training in janitorial services. Wards can receive medical and dental services at the facility's hospital and clinic and may attend religious services. For fiscal year 2006-07, the facility has a budgeted staff of 387.3 positions and an operating budget of nearly $32 million.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following findings in the 2005 follow-up review:

- The facility had taken several measures to improve safety and security, including repairing the perimeter fence; instituting random searches of the staff, visitors, and vendors; implementing a personal alarm pilot program for employees; installing automatic locks on classroom doors; updating the multi-hazard emergency plan; and improving control over maintenance tools.

- Significant improvements had been made to ensure that wards in the Marshall intensive treatment program received required weekly individual and small group counseling and related services and were promptly enrolled in education classes.

- Improvements had been made to screen wards for communicable diseases and to ensure that only wards with proper medical clearance were assigned to food service or kitchen duties.

- Safety deficiencies in the building housing the intensive treatment program had been corrected.

- Improvements had been implemented in the facility's disciplinary decision-making process to help ensure due process for wards.

The Office of the Inspector General noted the following continuing deficiencies:

- Wards still were not receiving mandated education services. The effectiveness rating of the facility's Jack B. Clarke High School for fiscal year 2003-04 was only 40 percent, meaning that wards received an average of only 40 percent of available instruction time during the year. That figure represents a drop of one percentage point from the 41 percent effectiveness rating for fiscal year 2002-03.

- Wards had fallen further behind in academic achievement, with cumulative test scores steadily declining since 1998. About 78 percent of wards at the facility's high school had cumulative subject scores below the 25th national percentile rate in 2004, compared to 67 percent of the school's wards in 2002 and 69 percent of the school's wards in 1998.

- Ward absenteeism from school had increased from 9 percent to 13 percent between 2003 and 2005.

- Wards still were not being processed through the initial diagnostic assessment within required time limits. The review found that 237 (82 percent) of the 288 initial case reviews held between January and August 2004 were not conducted within the 45-day time limit. The auditors noted that in one instance, the 45-day time limit was exceeded by 93 days. Several recommendations relating to improving the timeliness of the diagnostic assessment process still had not been implemented.

- Not all wards were receiving the weekly individual and small group counseling required by Division of Juvenile Justice policy. Nine (25 percent) of 36 randomly selected wards

who had been at the facility 12 months or less had not received the required counseling. Although all 13 of the Marshall intensive treatment program wards sampled had received the required counseling services, none of the wards in the work experience program had received the counseling.

- Special program needs assessments were not consistently completed on time. The facility claimed that psychologists completed 97 percent of special program needs assessments within 10 days. However, the audit team's review of internal tracking records found 43 of 80 (54 percent) of special program needs assessments were late during the July through December 2003 reporting period, while 65 of 136 (48 percent) were late in the period April through August 2004. In addition, the audit team found that four of the 18 wards taking psychotropic medications had not received special program needs assessments before being administered the drugs, in violation of California Department of Corrections and Rehabilitation policy.

- The mental health staff did not consistently obtain parental or guardian consent to administer psychotropic medication to wards, in violation of department policy.

- Although the facility reported that a checklist had been in use since October 2002 to ensure that wards receive timely orientations, the review found that all of the checklists in the files of wards in the work experience program were prepared immediately before the arrival of the audit team.

- Recommendations to correct deficiencies in the suicide prevention assessment and response program had been only partially implemented. Some staff members did not attend mandatory refresher training, and attendance at monthly meetings had been poor among security and medical staff.

- The facility's academic record-keeping practices relied too heavily on manual calculation of critical statistical indicators, including average daily attendance.

The Office of the Inspector General made 27 recommendations to the Southern Youth Correctional Reception Center and Clinic as a result of the follow-up review. The specific recommendations are listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The Office of the Inspector General determined that one of the 27 recommendations from the 2005 review is no longer applicable, and of the remaining 26, the Southern Youth Correctional Reception Center and Clinic has fully implemented 18 recommendations, substantially implemented five recommendations, partially implemented two recommendations, and had yet to implement the one remaining recommendation.

The Office of the Inspector General made the following findings in the 2007 follow-up review:

- The facility has continued to improve safety and security, including improving the overall quality of its security audits, removing potential barriers to observing wards, and ensuring ward rooms are locked when they are unoccupied.

- Improvements have been made to ensure that wards assigned to the work experience program receive required individual and group counseling.

- To improve the accountability of the chief medical officer, the department has reorganized the medical staff so that the chief medical officer now reports directly to the medical director of the Division of Juvenile Justice.

- According to reports generated by the tracking system, the facility completed all of the 101 special program assessment needs evaluations it delivered between June 2006 and November 2006 within the required time limits.

- The facility significantly improved its process for ensuring wards under the age of 18 are not prescribed psychotropic drugs without parental or guardian consent.

- The facility has provided most of its staff members with annual refresher training in suicide prevention and response.

- The facility has implemented procedures to ensure that wards do not move from class to class without notifying school security.

- The facility has increased its teacher staff from 12 teachers to 22 full-time teachers and four substitute teachers.

- The facility hired an analyst to track and analyze school attendance areas that need improvement.

- Ninety-five percent of the wards attending school in the facility have been receiving at least 240 minutes of classroom time per day since August 2006.

The Office of the Inspector General noted the following continuing deficiencies:

- Many of the wards' rooms have holes in the walls that provide opportunities for wards to pass contraband and other potentially dangerous materials without being seen by staff members.

- The facility still has not provided evidence that it has conducted an adequate inventory of its armory and weapons storage, and it did not develop a schedule for staff members to conduct periodic inventories until March 2007.

- The facility still does not have any staff members trained as hostage negotiators.

- The Division of Juvenile of Justice has still not finalized its policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics.

- The facility has not developed a system to identify and address delinquent annual employee appraisals and probation reports, which would allow it to hold supervisors accountable for completing those reports.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic take the following actions:

- **Continue efforts to repair holes in ward room walls and inventory the condition of the rooms once repairs are complete so wards can be held accountable for any damage they cause.**

- **Identify available hostage negotiator training courses and ensure the facility has at least one qualified and trained hostage negotiator on staff.**

- **Ensure armory staff have time to accurately inventory weapons and other controlled materials.**

- **Develop a system to identify and address delinquent annual employee appraisals and probation reports and hold supervisors accountable for completing the reports and appraisals.**

The Office of the Inspector General recommends that the Division of Juvenile Justice and the Southern Youth Correctional Reception Center and Clinic develop policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics.

The Office of the Inspector General conducted its work on the Southern Youth Correctional Reception Center and Clinic from December 12, 2006, through February 22, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after each recommendation.

FINDING NUMBER 1

The 2003 audit revealed that the Southern Youth Correctional Reception Center and Clinic had failed to comply with established security requirements. (June 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Improve the thoroughness and overall quality of the annual *Division of Juvenile Justice Institutions and Camps Branch Manual* section 1800 audits. (June 2003)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. To ensure thoroughness and quality of the Southern Youth Correctional Reception Center and Clinic 1800 review, each section reviewed prior reports and initiated steps to correct deficiencies: The 1800 Audit for 2006 was completed on November 10, 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the facility's November 2006 section 1800 audit and found it to be more thorough than those reviewed in 2003. The Office of the Inspector General visited the facility in February 2007 and verified that a sample of selected security areas deemed by the section 1800 audit as compliant were in fact so. However, while the facility has improved the thoroughness of its audits, it has failed to fully address important deficiencies identified in its reports. One area the facility's 2006 section 1800 audit identified as non-compliant related to ward rooms being in disrepair due to years of wards kicking and banging on walls and doors. The facility's proposed corrective action for this deficiency was that "these repairs will be completed as budgetary and work force limitations permit." The Office of the Inspector General noted during its December 2006 visit to the facility that many ward rooms did in fact have holes in walls that would allow contraband to be passed from room to room, and it notified the superintendent of the situation. When the Office of the Inspector General returned to the facility in February 2007, it found that many of the

RECOMMENDATIONS	STATUS	COMMENTS
		holes had been patched. However, the facility failed to inventory the condition of the ward rooms when they were repaired so it could hold wards individually accountable for any further damage they caused. As a result, the Office of the Inspector General also found during its February 2007 visit that some of the patched holes had been reopened by the wards, yet there were no discipline reports prepared holding the responsible wards accountable. Another deficiency noted in the facility's section 1800 audit was that the facility does not have a trained hostage negotiator. The section 1800 audit report noted that this has been an ongoing problem with the department that needs to be addressed through the Division of Juvenile Justice. This issue was identified in the original June 2003 Office of the Inspector General report and still has not been corrected.
Improve control over access to the armory and ensure armory staff have time to accurately inventory weapons and other controlled materials. (June 2003)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Access to the armory is limited to Chief of Security, Watch Commanders, and the locksmith. All control materials are stored in the outside armory building. A Lieutenant has been assigned to conduct audits and monitor the armory inventory.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the armory access logs and an armory inventory list. These documents, however, provide no assurances that the items listed on the inventory list are in fact present in the armory. The Office of the Inspector General notes that the facility had not formally devised a schedule or assigned staff members to conduct periodic inventories until the Office of the Inspector General made numerous inquiries as part of this review. The Office of the Inspector General confirmed that the facility now has a formal inventory schedule and has designated staff members to conduct those inventories, but no inventories have been conducted. Therefore, the Office of the Inspector General considers this recommendation partially implemented.
Remove discarded furniture and other items that present potential barriers to observing wards from	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The property controller and maintenance section continue to discard items*

RECOMMENDATIONS	STATUS	COMMENTS
behind the gym, commissary, and maintenance areas. (June 2003)		*from the identified areas on an ongoing basis. Many of the items previously stored behind the gym, commissary, and maintenance areas have been removed. A Youth Correctional Officer is assigned to the maintenance area to ensure security for the area. The property stored in the area is not a barrier to observing wards in the identified areas.* **Office of the Inspector General's comments:** The Office of the Inspector General visited the facility in February 2007 and confirmed that the discarded furniture previously identified has been removed.
Keep ward rooms locked when they are unoccupied to prevent unauthorized entry. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. On December 27, 2004, the Assistant Superintendent instructed all staff that wards rooms were to remain locked at all times. Living unit supervisors conduct spot checks on ongoing basis. Any violations by staff to this directive are addressed through progressive discipline.* **Office of the Inspector General's comments:** The Office of the Inspector General visited the facility in February 2007, tested all the doors in five of the eight housing units, and found that all doors tested were locked.

FOLLOW-UP RECOMMENDATIONS

The Southern Youth Correctional Reception Center and Clinic should continue to improve its security procedures by taking the following actions:

- **Continue efforts to repair holes in ward room walls and inventory the condition of the rooms once repairs are complete so wards can be held accountable for any damage they cause. (2007)**
- **Identify available hostage negotiator training courses and ensure the facility has at least one qualified and trained hostage negotiator on staff. (June 2003)**
- **Ensure armory staff have time to accurately inventory weapons and other controlled materials. (June 2003)**

FINDING NUMBER 2

The Southern Youth Correctional Reception Center and Clinic was not processing wards through the diagnostic assessment process within the required time limits. (June 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Develop an automated process to track and monitor caseworker productivity and ensure that the diagnostic assessment process for each ward is completed within the required time limits. (June 2003)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. A manual system is being used to track and monitor casework productivity and to ensure that the diagnostic process for each ward is completed within the required time frames.* *The Ward Information Network Team indicated that the proposed casework tracking system project was delayed due to Farrell plan priorities. It is currently utilized at N. A. Chaderjian Youth Correctional Facility and Herman G. Stark Youth Correctional Facility. Its use at all youth facilities is anticipated by the end of 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the manually prepared documents that track caseworker productivity and found that the manual system seemed effective at identifying caseworkers who exceeded the required time limits for completing diagnostic assessments. In addition, the Office of the Inspector General found that the supervising casework specialist used the monitoring results to initiate work performance counseling documents for those who failed to promptly complete their work assignments.
Conduct timely annual performance appraisals for all casework specialists, including the supervising casework specialist II. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Performance appraisals for all Casework Specialists were completed in March 2006.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General performed no audit procedures to verify the department's representation.
Make appropriate revisions to the supervising casework specialist II's duty statement to better ensure the quality and timeliness of the diagnostic assessment process. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Supervising Casework Specialist II duty statement has been revised.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 3

Wards in the Marshall intensive treatment program and the work experience program had not been provided with required counseling and related services. (June 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Ensure that the work experience program provides weekly individual and small-group counseling to wards. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Public Service Program is compliant based on an audit of Ward Information Network case notes. Case notes indicate the wards assigned to the Public Service Program are receiving individual and small group counseling per policy.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General reviewed case notes for a sample of four of the 13 wards in the public service program. It found that all files in the sample contained notes that indicate that the wards were receiving weekly individual and small group counseling.
Monitor the casework of all living units, including the work experience program, to ensure the casework management system is being used to manage the counseling of wards. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Public Service Program, Marshall, Sutter, and Gibbs living units utilize the Ward Information Network casework management system. Unit supervisors complete monthly monitoring of casework requirements and file audits. Progressive discipline is utilized with those staff not in compliance with required casework expectations.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Use progressive discipline to hold counseling staff and their supervisors accountable for failing to counsel wards. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Southern Youth Correctional Reception Center and Clinic administration and living unit managers utilize progressive discipline measures in addressing issues with staff who are not meeting expectations relative to counseling wards.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Ensure that staff use ward orientation checklists as intended. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. All new wards are provided orientation upon their arrival at Southern Youth Correctional Reception Center and Clinic. Each Public Service Program ward meets with the Casework Specialist to sign a contract, which outlines program expectations and the orientation checklist. Wards in living units Sutter, Gibbs, and Marshall meet with a Casework Specialist and review the orientation checklist.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 4

The Office of the Inspector General found deficiencies in medical services at the Southern Youth Correctional Reception Center and Clinic. (June 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic and the Division of Juvenile Justice should:		
Hold the chief medical officer accountable for the continued planning and monitoring of the medical staff's activities. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Effective July 1, 2005, the chief medical officer came under the direct supervision of the Medical Director of the Division of Juvenile Justice Health Care Services Division and is held accountable for the planning and monitoring of medical section operations and activities.* **Office of the Inspector General's comments:** The Office of the Inspector General verified that the chief medical officer reports directly to the medical director of the Division of Juvenile Justice Health Care Services Division.

RECOMMENDATIONS	STATUS	COMMENTS
Develop policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics. (June 2003)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Medical Director has developed a proposed peer review policy as part of the health care services remedial plan. This policy has been reviewed by legal affairs and is now in final division review. The Chief Medical Officer has been auditing the unified health records and reviewing and evaluating treatment ordered by physicians.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATION

The Division of Juvenile Justice and the Southern Youth Correctional Reception Center and Clinic should develop policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics. (June 2003)

FINDING NUMBER 5

Wards at the Southern Youth Correctional Reception Center and Clinic did not consistently receive required mental health services, and the facility did not consistently comply with required mental health procedures. (June 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Ensure the timely completion of special program assessment needs evaluations. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Special program assessment needs evaluations have been completed in a timely manner since June 15, 2006. A special program assessment needs tracking system has been implemented to track completion.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: According to reports generated by the facility's tracking system, the facility completed all the 101 special program assessment needs evaluations it delivered between June 2006 and November 2006 within the required time limits.
Not administer psychotropic drugs to wards who have not received treatment needs assessments. (January 2005)	NOT APPLICABLE	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. Many wards received from Juvenile Halls have been prescribed by a psychologist and are already taking psychotropic medications. It is medically dangerous to stop prescribed medication upon intake. Wards are assessed immediately upon intake for any medical or mental health needs.* **Office of the Inspector General's comments:** The Office of the Inspector General agrees that this recommendation does not apply to those wards already taking prescribed medication upon intake.
Ensure that employees obtain consent forms to administer psychotropic medications to wards under the age of 18. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. For wards that are under the age of 18, a verbal consent is obtained from the guardian by telephone. A consent form is then sent to the home. If it is not returned in two weeks, a parole agent is sent to the ward's home to secure the approval. Psychotropic medications are never prescribed to minors under the age of 18 without parental consent.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed all 30 files of wards under the age of 18 who were receiving psychotropic medications as of December 14, 2006, and found that all the files contained consent forms.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 6

The staff in the living units were not adequately informed about suicide prevention measures, and the suicide prevention assessment and response committee meetings were poorly attended. (June 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Ensure that all staff receive annual refresher training in suicide prevention and response. (June 2003)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A two-hour refresher training course in suicide prevention is provided annually. All staff is mandated to attend. Training for 2006 began in November and was completed in December 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the annual refresher training documents and found that 66 percent of the facility staff had received the refresher training within the last year, and 88 percent of the staff had received the training within the last 15 months.
Remind staff of the importance of the suicide prevention and response committee and enforce attendance at committee meetings. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Attendance at the suicide prevention and response committee meetings is mandatory for each section. Emphasis is placed on the importance of attendance at suicide prevention and response committee meetings. Verbal advisements are given to Section Heads when absences occur. It has been determined that monthly meetings will be held because of the young population and new intake wards.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 7

Academic achievement at the Southern Youth Correctional Reception Center and Clinic was low compared to other Division of Juvenile Justice facilities, and the facility was not providing wards with special education services in a timely manner. The facility also over-stated average daily attendance and misrepresented provider service hours in reports to the Education Services Branch. (June 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Ensure that wards do not move from class to class without notification by the staff to school security. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Attendance procedures have been put in place to track students from class to class and to appointments and are noted on attendance sheets.* **Office of the Inspector General's comments:** Based on a visual inspection and interviews with staff members, the Office of the Inspector General found that security staff consistently tracked and monitored ward movements.
Continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include working with the Division of Juvenile Justice and the Department of Personnel Administration to provide competitive compensation for teachers. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Southern Youth Correctional Reception Center and Clinic has increased its teacher staffing from 12 teachers to 22 teachers plus four substitute teachers. A full time psychologist, two emotionally learning handicap teachers, and an additional resource specialist for the special education program have been added. A new compensation program went into effect April 1, 2006 for teachers. Southern Youth Correctional Reception Center and Clinic has no teacher vacancies.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General performed no audit procedures to verify the department's representation.
Institute the Education Services Branch's student ward attendance tracking (SWAT) system at the facility. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. An analyst has been hired to conduct school-wide attendance tracking. School-wide attendance tracking reports are utilized to analyze attendance areas that are both good and those areas that need assistance.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Improve the high school's effectiveness rating by striving to make more classroom time available to wards. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Ninety five percent of Southern Youth Correctional Reception Center and Clinic High School students have been receiving at least 240 minutes a day since August 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Require all teachers to use the electronic version of the average daily attendance report. (January 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Ward Information Network permits the average daily attendance/school wide attendance tracking analyst to enter average daily attendance. It is not necessary for teachers to utilize the electronic version of the average daily attendance report.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

RECOMMENDATIONS	STATUS	COMMENTS
Require supervisory review and written approval of teachers' average daily attendance forms. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Supervisors review the average daily attendance and sign the monthly attendance calculations.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Notify courts that refer wards to the Division of Juvenile Justice of their obligation to provide complete special education data under *Welfare and Institutions Code* section 1742. The facility should develop a plan with court representatives to accomplish that purpose, including a timetable for submitting special education information. If cooperation is not forthcoming, the facility should refuse to accept wards who do not have complete special education background packages. (June 2003)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. A quarterly meeting is held with Los Angeles County to discuss issues related to Welfare and Institutions Code Section 1742 compliance. Los Angeles County has indicated that the county may not know an individual's education plan status in some cases. Wards are not accepted for delivery until an individual education plan is received for those wards whose records indicate the existence of an individual education plan. The last meeting was held on December 6, 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 9

The Southern Youth Correctional Reception Center and Clinic's disciplinary decision-making system did not ensure due process for wards and failed to provide management with important tools for monitoring disciplinary actions and ward grievance activity. (June 2003)

RECOMMENDATION	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Monitor the ward disciplinary process by conducting quarterly audits of a random sample of Level A and Level B reports covering the work of staff in each living unit. The facility should use the audit results as part of the annual performance appraisal of each member of the living unit staff. (June 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A ward's rights coordinator was appointed in October of 2006. This position is responsible for conducting quarterly audits of disciplinary reports. The findings are reported to the superintendent's office. The results of the audits are incorporated as appropriate into individual performance evaluations.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 11

Staff performance appraisals and probationary reports at the Southern Youth Correctional Reception Center and Clinic were not completed on time. (June 2003)

RECOMMENDATION	STATUS	COMMENTS
The Southern Youth Correctional Reception Center and Clinic should:		
Develop a system to identify and address delinquent annual employee appraisals and probation reports and hold supervisors accountable for completing the	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. The distribution of a delinquent performance appraisal list by personnel has been intermittent. A process for the distribution and completion of timely performance*

RECOMMENDATION	STATUS	COMMENTS
reports and appraisals. (June 2003)		*evaluations is being established with approved anticipated in 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATION

The Southern Youth Correctional Reception Center and Clinic should develop a system to identify and address delinquent annual employee appraisals and probation reports and hold supervisors accountable for completing the reports and appraisals. (June 2003)

VENTURA YOUTH CORRECTIONAL FACILITY

IMPLEMENTATION REPORT CARD
2005 Follow-up recommendations: 30
Fully implemented: 19 (63%)
Substantially implemented: 5 (17%)
Partially implemented: 5 (17%)
Not implemented: 1 (3%)

The Office of the Inspector General found that the Ventura Youth Correctional Facility has significantly improved operations since the January 2005 review. The female wards are receiving the required mental health assessment services in a timely manner, comprehensive policies and procedures have been developed to address medical care and medical transportation, and systems have been developed to track investigations and monitor ward grievances. Education services, however, continue to suffer because of teacher vacancies and the lack of substitute teachers. In addition, three security deficiencies remain unresolved.

In June 2002, the Office of the Inspector General issued a "baseline" management review audit report on the Ventura Youth Correctional Facility, which at the time was the only coeducational youth correctional facility within the California Youth Authority, predecessor to the California Department of Corrections and Rehabilitation's Division of Juvenile Justice. The audit was conducted following the appointment of a new superintendent and identified a number of serious problems at the facility, many of which stemmed from the difficulty of providing education, treatment, and other services to male and female wards while keeping the genders separated. The audit determined that operating as a coeducational facility disrupted programs, caused services to be duplicated, and in some cases, prevented Ventura Youth Correctional Facility wards from receiving the services provided to wards at other facilities.

In the audit, the Office of the Inspector General found that only 47 percent of a sample of wards had received required weekly counseling sessions and that only 54 percent had received timely case conferences. Also, the Office of the Inspector General found that only 29 percent of a sample of female wards had received treatment needs assessments within the required three weeks of arrival at the facility. Pregnancy care for female wards was inadequate; wards with communicable diseases were not adequately screened from working in food services; and the segregation of male and female wards limited access to medical services for both genders. The academic achievement of wards at the facility also was low compared to that of wards at other Division of Juvenile Justice facilities. The Office of the Inspector General found that a number of the deficiencies identified in education and medical care resulted from a shortage of resources and inadequate policy direction from Division of Juvenile Justice management. To address the deficiencies, the audit presented 101 recommendations.

In a follow-up review released in January 2005, the Office of the Inspector General found that the Ventura Youth Correctional Facility had improved its operations since the June 2002 management review audit. Treatment services, mental health assessments, medical care, security, aspects of education, employee investigations, ward discipline, and the ward

grievance process all improved. Although a number of the problems were solved by converting to an all-female facility—making it easier to provide wards with services—education services continued to be hampered by not having enough teachers. The Office of the Inspector General made 30 follow-up recommendations.

BACKGROUND

Located in Camarillo, the Ventura Youth Correctional Facility is one of eight youth correctional facilities operated by the California Department of Corrections and Rehabilitation's Division of Juvenile Justice. In March 2004, the department removed all the male wards from the facility, with the exception of those at the Sylvester Carraway Public Service and Fire Center camp, and converted the Ventura Youth Correctional Facility to an all-female facility. At the time of the 2005 follow-up review, the facility housed 157 female wards and the fire camp had a separate population of 46 male wards. At the time of this review, the facility housed 136 female wards and 57 male wards at the fire camp. For fiscal year 2006-07, the facility has 402.7 authorized positions and an operating budget of $34.1 million, which includes the fire camp operations.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the January 2005 follow-up review, the Office of the Inspector General determined that the facility had made considerable progress in implementing the recommendations from the June 2002 management review audit. The superintendent implemented a number of successful programs involving community volunteers to benefit wards, and the facility no longer operated as a coeducational facility. The Office of the Inspector General made the following specific findings in the January 2005 follow-up review:

- The facility had either fully or substantially implemented most of the recommendations pertaining to mental health assessment services. The facility, however, failed to provide female wards with the required mental health assessment services in a timely manner.

- The facility had improved medical services for pregnant wards, improved procedures for handling wards with communicable diseases, and eliminated barriers to medical care caused by operating as a coeducational facility. Although improvements were made, comprehensive policies and procedures related to the medical care of female wards and the medical transportation of wards in general were still lacking.

- Although three of the seven recommendations pertaining to education had been fully implemented, problems resulting from teacher vacancies and the inadequacy of the substitute teacher pool remained. From April 2004 through August 2004, 30 percent of classes at the facility's Mary B. Perry High School were canceled because teachers were not available. Even though an average of 18 classes a day were canceled, primarily because of teacher absences, the facility had only one substitute teacher available to fill in. This problem was reflected in the decline in the high school's effectiveness rating between fiscal year 2002-03 and fiscal year 2003-04. The effectiveness rating, which

measures actual instruction time as a percentage of available instruction time, dropped from 70 percent to 65 percent during that period.

- Despite the problem with teacher vacancies and substitute teacher shortages, wards' cumulative standardized test scores had increased from 2003 to 2004. While 71 percent of wards had cumulative subject scores below the 25th national percentile rate in 2003, only 54 percent of the wards had cumulative subject scores below the 25th national percentile rate in 2004. Further, the 54 percent rate was the facility's best since 1998. The improvement from 2003 to 2004 may have been partly attributable to the facility's ceasing operation as a coeducational facility during that period. The ward absenteeism rate during the same period increased slightly from 13 percent to 14 percent.

- Fundraising activities formerly conducted for the sole benefit of the staff had ceased, but money that should have been returned to the ward benefit fund had not been returned, and the facility did not review the activities of employees who were engaged in fundraising for possible disciplinary action.

- Nearly all the recommendations relating to investigation practices and procedures had been fully or substantially implemented. The facility, however, did not have a system in place to effectively track investigations.

- Thirteen of the 17 recommendations pertaining to security deficiencies had been fully or substantially implemented. Two of the remaining recommendations were related to a mutual aid agreement between the local law enforcement agency and the facility; another was related to the installation of bulletproof glass at the reception desk within the facility. These recommendations were awaiting action by the department. One recommendation was no longer applicable.

- Most of the recommendations pertaining to the disciplinary decision-making system had been fully implemented. The facility, however, was not providing annual training on the disciplinary decision-making system to all staff members responsible for the custody and treatment of wards.

- All but two of the recommendations pertaining to the ward grievance system had been fully or substantially implemented, but some aspects of the grievance process prevented management from holding facility staff accountable.

- All of the recommendations pertaining to the facility warehouse had been fully or substantially implemented.

To address the issues identified during the 2005 follow-up review, the Office of the Inspector General made 30 recommendations. The specific recommendations are listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The Office of the Inspector General found that the Ventura Youth Correctional Facility has made significant improvements since the follow-up review in January 2005. Among the findings of the follow-up review are the following:

- Female wards are receiving the required mental health assessments in a timely manner.

- Comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general have been developed.

- There continues to be a shortage of teachers and qualified substitutes willing to work at the facility. Even with the recent agreement to increase the compensation for teachers, the facility's recruitment efforts continue to fall short, and educational classes are still being canceled. The facility states that the Mary B. Perry High School has a daily class closure rate of almost 30 percent, which is slightly lower than the rate during the April 2004 through August 2004 time frame.

- The facility states that existing manuals have been revised and memorandums have been developed to address the administration of fundraising activities within the facility.

- Systems are in place to provide the facility with pertinent and timely information to track investigations.

- The facility has developed draft mutual aid agreements with the local law enforcement agency, but the agreements have not yet been signed. In addition, the facility has not installed bulletproof glass at its reception desk.

- The facility states that employees are currently receiving annual training on the disciplinary decision-making system.

- Policies have been revised to ensure that ward grievances are being tracked and monitored properly by staff members. In addition, the facility created a grievance coordinator position that is solely responsible for handling all levels of grievances.

Overall, the facility either fully implemented or substantially implemented 24 (80 percent) of the 30 recommendations made in January 2005.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Ventura Youth Correctional Facility take the following actions:

- **Make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.**

- **Explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid reasons, and that all alternatives to cancellation have been explored.**

- **Continue to pursue a mutual aid agreement with a local law enforcement agency and develop procedures for handling hostage situations, rather than waiting for the department to develop a standardized mutual aid agreement.**

- **Consider relying on local law enforcement to handle potential hostage situations and either amend or follow section 1809 of the *Division of Juvenile Justice Institutions and Camps Branch Manual* accordingly.**

- **Continue efforts to obtain funds to install bulletproof glass to protect the youth correctional officer stationed at the reception desk.**

The Office of the Inspector General recommends that the Division of Juvenile Justice take the following action:

- **Provide training to administrators at the Division of Juvenile Facilities, formerly the Institutions and Camps Branch, in the proper use of ward benefit funds.**

The Office of the Inspector General conducted its work on the Ventura Youth Correctional Facility from November 15, 2006, through March 2, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after each recommendation.

FINDING NUMBER 3

Female wards at the Ventura Youth Correctional Facility were not receiving required mental health assessment services or did not receive these necessary services in a timely manner. (June 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The management of the Ventura Youth Correctional Facility should:		
Conduct treatment needs assessments for all wards within three weeks of admission to the facility. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The superintendent and senior psychologist conduct treatment needs assessment audits quarterly to make certain that tests are conducted within three weeks of ward admission.* **Office of the Inspector General's comments:** During a site visit on December 14, 2006, the Office of the Inspector General reviewed a sample of 10 unified health records for wards who were admitted to the facility within the past 12 months. Based on the review, the Office of the Inspector General found that a treatment needs assessment was conducted for each of the wards within three weeks of admission to the facility.
Ensure that treatment needs assessment test booklets are scanned and scored no later than the next workday. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. In May 2006 the testing printer began malfunctioning and tests were mailed to Research, scored, and returned to the facility. The equipment was replaced December 5, 2006, and Ventura Youth Correctional Facility is now in compliance with this recommendation.* **Office of the Inspector General's comments:** During a site visit on December 14, 2006, the Office of the Inspector General reviewed a sample of 10 unified health records for wards who were admitted to the facility within the past 12 months. The Office of the Inspector General found that only 44 percent of the treatment needs assessment test booklets were scanned and scored by the next workday. The delay was attributed to an inoperable scoring machine, which required the facility to send the test booklets to Sacramento for scoring. After the site

RECOMMENDATIONS	STATUS	COMMENTS
		visit, the facility installed a new machine, which is now operable. On February 6, 2007, the Ventura Youth Correctional Facility provided the Office of the Inspector General with a report that verifies that the test booklets are now being scanned and scored by the next workday.
Ensure that the senior psychologist is notified before the end of the next workday if a treatment needs assessment scoring report shows a "red flag." (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Ventura Youth Correctional Facility replaced the equipment to correct the problem December 5, 2006, and the institution is again in compliance with this recommendation.* **Office of the Inspector General's comments:** The Office of the Inspector General notes that the department's response does not address the recommendation. However, during a site visit on December 14, 2006, the Office of the Inspector General reviewed a sample of 10 unified health records for wards who were admitted to the facility within the past 12 months. Based on the review, the Office of the Inspector General found that if a treatment needs assessment scoring report identified a "red flag," a senior psychologist was notified before the end of the next workday.
Ensure that the treatment needs assessment profile and scoring report is filed in the mental health section of the unified health record. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Audits of the unified health record reflect that completed treatment needs assessments are filed in the proper location.* **Office of the Inspector General's comments:** During a site visit on December 14, 2006, the Office of the Inspector General reviewed a sample of 10 unified health records for wards who were admitted to the facility within the past 12 months and found that the treatment needs assessment profile and scoring report was filed in the appropriate section of the unified health record.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 4

Some facility practices jeopardized the health of female wards, the infants of female wards, and wards in general by failing to provide timely access to quality medical care and providing inadequate protection against communicable diseases. (June 2002)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice and the chief medical officer should:		
Develop comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Ventura Youth Correctional Facility transports wards requiring additional medical treatment to outside clinics and hospitals, and maintains a weekly log of all scheduled and nonscheduled medical trips. Health Care Services have developed policies and procedures regarding medical care for the female population.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed draft policies and found that the language appears to adequately address the recommendation. Although the policies are in draft form, all facilities have been given a temporary department order to follow these policies prior to their approval. These policies are a result of the Health Care Services Remedial Plan, which states that the California Department of Corrections and Rehabilitation will develop standardized policies and procedures to match the needs of youth and conforms to an acceptable national standard of medical and nursing care.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 5

The academic achievement of Ventura Youth Correctional Facility's wards was low compared to that of other Division of Juvenile Justice facilities. (June 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice and the Ventura Youth Correctional Facility should:		
Promptly fill teaching vacancies and work with the California Department of Corrections and Rehabilitation and the Department of Personnel Administration to provide competitive teacher compensation by upgrading pay scales using compensation exceptions provided for by law, and other suitable methods. (June 2002)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Mary B. Perry High School has 20 filled teacher positions and 7 vacancies. Six positions have been added due to the Farrell lawsuit. Ventura Youth Correctional Facility has targeted specific areas to recruit qualified teachers to fill the vacancies. The agency has entered into an agreement with the State Employees International Union to remedy the compensation for teacher pay. In April 2006 a 30 percent salary increase was initiated for teachers. The Division of Juvenile Justice, in continued cooperation with the departmental recruitment unit, will hold a recruitment workshop for Venture Youth Correctional Facility.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent. (June 2002)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Attempts to fill these vacancies continue to fall short of expectations. Ventura Youth Correctional Facility recruiter and educational personnel have continued networking with local school districts and colleges to recruit qualified personnel.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Mary B. Perry High School has less than a 30 percent daily closure*

RECOMMENDATIONS	STATUS	COMMENTS
reasons, and that all alternatives to cancellation have been explored. (June 2002)		*rate for classes. The classes have been closed due to teacher vacancies and lack of substitute teachers.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Develop policies and procedures to facilitate the attendance of teachers at ward case conferences without the need to cancel classes. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A new class schedule was implemented in June 2006. Education advisement is scheduled to be conducted on Thursday afternoons with teachers scheduled on specific living units to provide educational advisement and case conference input for their assigned student caseload.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Study the factors contributing to the frequent cancellation of classes and the need for substitute teachers. These factors should include the impact of alternative work schedules on class cancellations. (June 2002)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Mary B. Perry High School needs a pool of qualified substitute teachers, and attempts to recruit and hire these classifications have fallen short of expectations. A new class schedule was implemented in June 2006 with teachers working a traditional 5/40 work schedule.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Continue to seek an integrated attendance system that automates daily classroom attendance to minimize reporting errors and to better utilize staffing resources. (January 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Mary B. Perry High School has hired an analyst to monitor this recommendation. The attendance system is included in the WIN system with data reported weekly and corrective action plans discussed. Data indicates that reporting errors decreased in November 2006.* **Office of the Inspector General's comments:**

RECOMMENDATIONS	STATUS	COMMENTS
		The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

The Ventura Youth Correctional Facility should take the following actions:

- **Make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent. (June 2002)**

- **Explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid reasons, and that all alternatives to cancellation have been explored. (June 2002)**

FINDING NUMBER 6

Certain fundraising activities conducted by staff at the Ventura Youth Correctional Facility were not properly administered. (June 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice and the Ventura Youth Correctional Facility should:		
Update the Ventura Youth Correctional Facility operations manual to specify the type of fundraisers that are acceptable for participation by staff or wards. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Ventura Youth Correctional Facility Operations manual was updated in 2004, and all business services personnel trained on the fundraising portion of the temporary institution policy.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

RECOMMENDATIONS	STATUS	COMMENTS
Update the *Division of Juvenile Justice Institutions and Camps Branch Manual* to provide clear guidance to facilities on the types of fundraising and financial transactions allowed between staff and wards. (June 2002)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. A memorandum was issued on the relationship of fundraising activities for staff. This was also discussed on a statewide basis with the distribution of the Ventura Youth Correctional Facility audit report. The policy will be incorporated into the Division of Juvenile Justice policy manual [California Youth Authority Institutions and Camps Branch Manual] by the middle of 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Provide training to Division of Juvenile Facilities administrators in the proper use of ward benefit funds. (June 2002)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. A new ward incentive system provided background training on ward benefit funds. The Juvenile Facilities Branch is currently assessing the use/allocation of ward benefit funds. A new set of guidelines on ward benefit fund use will be issued by February 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATION

The Division of Juvenile Justice should provide training to administrators at the Division of Juvenile Facilities in the proper use of ward benefit funds. (June 2002)

FINDING NUMBER 7

Significant deficiencies exist in the facility's practices and procedures in conducting investigations. (June 2002)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Provide the Ventura Youth Correctional Facility with pertinent and timely information for tracking investigations regardless of whether the case management system is ready for use. The information should include the Internal Affairs or Education Services Branch case number, the subject name, the allegation, the incident date, the discovery date, the investigator name, the case closure date, and the conclusions. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The tracking system was installed at Ventura Youth Correctional Facility in October 2004. Staff training was completed in February 2005. The superintendent and administrative assistant both received training in February 2006.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed documents generated from the tracking system developed by the facility and verified that the information needed to track investigations can be found in the system.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 8

The Division of Juvenile Justice and the Ventura Youth Correctional Facility failed to comply with established security requirements. (June 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Ventura Youth Correctional Facility should:		
Continue to pursue a mutual aid agreement with a local law enforcement agency and develop procedures for handling hostage situations, rather than waiting for the department to develop a standardized mutual aid agreement. (June 2002)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Ventura Youth Correctional Facility has met with local law enforcement to develop a plan to handle hostage situations. A mutual aid agreement has been written, but not signed due to liability issues raised by responding agencies. The Office of Correctional Safety has developed a response protocol for all juvenile facilities. At this time, hostage negotiations would be obtained from a responding local agency.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General reviewed the draft agreement and found that the language appears to adequately address the recommendation. The facility, however, needs to complete the approval process and implement the agreement.
Consider the advisability of relying on local law enforcement to handle potential hostage situations and either amend or follow section 1809 of the *Division of Juvenile Justice Institutions and Camps Branch Manual* accordingly. (June 2002)	**PARTIALLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Ventura Youth Correctional Facility has met with local law enforcement to develop a plan to handle hostage situations. A mutual aid agreement has been written, but not signed due to liability issues with other agencies. The Office of Correctional Safety has developed a response protocol for all juvenile facilities. At this time, hostage negation services would be obtained from a responding agency. Section 1809 of the Institutions and Camps Branch Manual will be modified by the middle of 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the draft agreement and found that the language appears to adequately address the recommendation. The facility, however, needs to complete the approval process and implement the agreement.
Continue efforts to obtain funds to install bulletproof glass to protect the youth correctional officer stationed at the reception desk. (June 2002)	**NOT IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. The 2005 Budget Change Proposal was denied. The Division of Juvenile Justice decided not to pursue this matter.* **Office of the Inspector General's comments:** The Office of the Inspector General interviewed security staff during a site visit at the facility on December 14, 2006. The information provided during the interview is consistent with the California Department of Corrections and Rehabilitation's response.
Trim back the vegetation growing against the fence near the maintenance area and tarp the fence to provide both a visual barrier and security containment. (June 2002)	**FULLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Vegetation was trimmed and removed as of December 2006. A tarp has been put into place along the fence line.*

RECOMMENDATIONS	STATUS	COMMENTS
		Office of the Inspector General's comments: The Office of the Inspector General visited the facility on December 14, 2006, and verified that the vegetation against the fence was trimmed back and that a tarp was placed along the fence to provide a visual barrier.
Ensure that the resolution of video pictures on all security monitors is clear. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. All video monitors are functioning as designed. Work orders are received and a monthly report is submitted to the superintendent's office to ensure cameras are clear and functional.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Replace chemical agent canisters not having durable serial numbers. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. In March 2005 Ventura Youth Correctional Facility purchased bar code inventory tags for each canister of chemical agent.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

The Ventura Youth Correctional Facility should take the following actions:

- **Continue to pursue a mutual aid agreement with a local law enforcement agency and develop procedures for handling hostage situations, rather than waiting for the department to develop a standardized mutual aid agreement. (June 2002)**
- **Consider relying on local law enforcement to handle potential hostage situations and either amend or follow section 1809 of the *Division of Juvenile Justice Institutions and Camps Branch Manual* accordingly. (June 2002)**
- **Continue efforts to obtain funds to install bulletproof glass to protect the youth correctional officer stationed at the reception desk. (June 2002)**

FINDING NUMBER 9

The disciplinary decision-making system at the Ventura Youth Correctional Facility had serious defects. (June 2002)

RECOMMENDATION	STATUS	COMMENTS
The Ventura Youth Correctional Facility should:		
Provide annual disciplinary decision-making system refresher training to all staff members responsible for the custody and treatment of wards. (June 2002)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Two hours of Disciplinary Decision-Making System refresher training is provided to every employee annually to ensure department standards are being achieved.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 10

The Ventura Youth Correctional Facility had a good working system for ward grievance monitoring and tracking, but some aspects of the process prevented management from holding facility staff accountable. (June 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Ventura Youth Correctional Facility should:		
Immediately investigate the cause of "withdrawn" fast track staff action grievances and document the reason the ward withdrew the grievance in the Ward	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Wards that withdraw staff action grievances are asked to explain the reasons for withdrawal, and their statement is entered into the WIN 2000 grievance*

RECOMMENDATIONS	STATUS	COMMENTS
Information Network 2000 system as noted in the Office of the Inspector General's review. (June 2002 and January 2005)		*section. Grievances exceeding time limits are reviewed weekly. In March 2006 Ventura Youth Correctional Facility hired an analyst solely responsible for handling all levels of grievances, including staff action and overdue grievances. The grievance policy has been revised by a departmental workgroup, chaired by the Division of Juvenile Justice ward rights coordinator. Training for all staff has been provided.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed withdrawn grievances and found that information is included to explain why the grievance has been withdrawn. In addition, based on an interview with the grievance coordinator, if a grievance has been withdrawn but an explanation is not provided, the coordinator will contact the ward for additional information.
Research the overdue grievances in the Ward Information Network 2000 and close out those that have already been addressed. Staff members responsible for the remaining overdue ward grievances should be held accountable for completing the grievances within mandated time frames. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Wards that withdraw staff action grievances are asked to explain the reasons for withdrawal, and their statement is entered into the WIN 2000 grievance section. Grievances exceeding time limits are reviewed weekly. In March 2006 Ventura Youth Correctional Facility hired an analyst solely responsible for handling all levels of grievances, including staff action and overdue grievances. The grievance policy has been revised by a departmental workgroup, chaired by the Division of Juvenile Justice ward rights coordinator. Training for all staff has been provided.* **Office of the Inspector General's comments:** The Office of the Inspector General interviewed the facility's grievance coordinator and found that each month the coordinator meets with the grievance clerks from each living unit to discuss all grievances submitted and to follow-up on any unresolved issues. In addition, the Office of the Inspector General reviewed the draft grievance policy and found that the language appears to adequately address the recommendation. The facility, however, needs to complete the approval process and implement the policy.

RECOMMENDATIONS	STATUS	COMMENTS
Provide annual training to staff on ward grievance procedures, including hands-on training on how to input the required data into the Ward Information Network 2000. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Wards that withdraw staff action grievances are asked to explain the reasons for withdrawal, and their statement is entered into the WIN 2000 grievance section. Grievances exceeding time limits are reviewed weekly. In March 2006 Ventura Youth Correctional Facility hired an analyst solely responsible for handling all levels of grievances, including staff action and overdue grievances. The grievance policy has been revised by a departmental workgroup, chaired by the Division of Juvenile Justice ward rights coordinator. Training for all staff has been provided.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 11

A large portion of the facility's projected budget deficit of $2 million for fiscal year 2001-02 was attributable to high costs of overtime, external contracts, and increased utility expenditures. (June 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Ventura Youth Correctional Facility should:		
Continue to reduce expenditures wherever possible and to track costs and reasons for unforeseen or unbudgeted expenditures. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The superintendent and business manager meet regularly on budget issues. All red flags are reported and necessary action is taken.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Track unforeseen or unbudgeted expenditures to support additional funding requests. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The superintendent and business manager meet regularly on budget issues. All red flags are reported and necessary action is taken.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 12

Deficiencies exist in the operation of the Ventura Youth Correctional Facility warehouse. (June 2002)

RECOMMENDATION	STATUS	COMMENTS
The Ventura Youth Correctional Facility should:		
Require all staff to arrange for the retrieval of items from the warehouse with prior notification. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. A program has been established on the 4-D system to assist Ventura Youth Correctional Facility to maintain compliance with this recommendation. The warehouse supervisor and the business services manager have issued a memorandum outlining the procedures to be followed and provided training to staff.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 13

The Ventura Youth Correctional Facility assigned some wards to more than one paid job. (June 2002)

RECOMMENDATION	STATUS	COMMENTS
The Ventura Youth Correctional Facility should:		
Exert a stronger effort to ensure that wards are assigned to only one paid job to increase the number of wards capable of earning money that can be used for canteen purchases. The facility should also document instances in which potentially capable wards decline the offer to work in a paid position. The ward should be required to sign a form declining the offer. (January 2005)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. Due to Ventura Youth Correctional Facility's low population, wards are allowed to have more than one paying job. If a ward chooses not to work or declines a job offer, a declination form is signed.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation. The facility's response, however, appears to address the recommendation. Wards have more than one paying job simply because there are more jobs than there are wards. In addition, the facility states that if a ward chooses not to work, the ward is required to sign a form declining the job offer.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 14

Staff performance appraisals and probationary reports were not completed on time. (June 2002)

RECOMMENDATION	STATUS	COMMENTS
The Ventura Youth Correctional Facility management should:		
Determine why managers and supervisors continue not to complete timely performance appraisals despite the reported improvements. Facility management should hold staff accountable as appropriate. (June 2002)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Ninety five percent of the employee appraisals have been completed in a timely manner.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

None

OFFICE OF AUDITS AND COMPLIANCE

IMPLEMENTATION REPORT CARD

2005 Follow-up recommendations: 6

Fully implemented: 2 (33%)

Substantially implemented: 1 (17%)

Partially implemented: 1 (17%)

Not implemented: 2 (33%)

The California Department of Corrections and Rehabilitation reported that its newly created Office of Audits and Compliance has addressed, or will address, many of the concerns raised by the Office of the Inspector General. The department reported that although it has yet to fill the new office's assistant secretary position, this new position will report directly to a department undersecretary. The department noted that the new office combined the internal audit and program compliance functions and that the office is tracking audit activity to assure quality. Finally, the department stated that the office has begun comprehensive risk assessments to determine where best to direct its resources. The office estimates that these assessments will take 18 to 24 months to complete, and it will contract in fiscal year 2007-08 with an auditing firm to perform an external assessment of the office.

The Office of the Inspector General conducted an audit in July 2003 to assess the effectiveness of the Division of Juvenile Justice's (formerly the California Youth Authority's) Office of Internal Audits. The audit also sought to determine whether the management practices and administrative procedures of the Office of Internal Audits were being carried out in accordance with applicable laws, regulations, and policies and to measure the performance of the Office of Internal Audits in relation to professional internal auditing standards.

The management audit found that the Division of Juvenile Justice was not effectively using the Office of Internal Audits to identify the serious problems affecting the department because it had unnecessarily restricted the work of the office to fiscal matters. Even within that limited framework, the Office of the Inspector General found that the Office of Internal Audits was failing to review the department's internal accounting and administrative controls. The audit determined that in the most recent two-year reporting period, and despite a staffing increase, the office had completed less than 6 percent of the 301 audits for which it was responsible. The Office of the Inspector General concluded that, because of the deficiencies, the division could not properly certify that it was maintaining a system of internal accounting and administrative control as required under the Financial Integrity and State Managers Accountability Act of 1983. To address the deficiencies, the July 2003 report presented nine recommendations.

In 2005, the Office of the Inspector General performed a follow-up review and found that the division was still not effectively using internal audits to identify problems affecting the department and had adequately addressed only three of the nine recommendations from the July 2003 audit. The 2005 follow-up review presented six follow-up recommendations.

BACKGROUND

The Financial Integrity and State Managers Accountability Act of 1983, California Government Code section 13400, et seq., requires every state agency to maintain effective internal accounting and administrative control systems as an integral part of its management practices. The act also requires state agency directors on a biennial basis to conduct an internal review and prepare a report on the adequacy of the agency's system of internal accounting and administrative control. Consistent with the act, the Office of Internal Audits was established within the division to review the department's internal accounting and administrative controls. Section 8500 of the division's *Administrative Manual* provides as follows:

> *In accordance with the Financial Integrity and State Managers Accountability Act of 1983 (Sections 13405 (a) and (b) of the Government Code), the Director is required to certify to the Governor, the Legislature, the Auditor General, and the Director of Finance that an effective system of internal accounting and administrative control is in effect and functioning to safeguard the State's assets, provide reliable accounting data, promote operational efficiency, and ensure adherence to prescribed managerial policies. The Office of Internal Audits reviews the internal accounting and administrative controls throughout the Department and issues reports to the Director.*

During the 2003 audit, the Office of Internal Audits had a staff of seven, including one senior management auditor, one staff management auditor, and five associate management auditors. Although the department had proposed a reorganization that could change its reporting structure, at the time of the audit the Office of Internal Audits reported directly to the assistant director of the Office of Internal Affairs and Internal Audits, who reported to the chief deputy director within the office of the director of the California Youth Authority.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

In its 2005 follow-up review, the Office of the Inspector General found that the division still was not making effective use of the Office of Internal Audits, at that time renamed the Internal Audits Unit. The department reported that changes to the internal audit function were expected as a result of the *Farrell v. Allen* (now *Farrell v. Tilton*) remedial plans being developed. In the meantime, the department had not integrated the internal audit and program compliance functions into a single office and had not combined staff to perform comprehensive fiscal and operational reviews using a comprehensive risk assessment process. Instead, the Internal Audits Unit continued to perform the same piecemeal fiscal audits that were being conducted at the time of the Office of the Inspector General's July 2003 audit. The department also appeared to have taken no action to ensure compliance with the *Standards for the Professional Practice of Internal Auditing*, and the reporting structure continued to jeopardize the independence of the internal audit function.

Of the nine recommendations issued by the Office of the Inspector General in July 2003, five had not been implemented by 2005. Only one recommendation had been fully

implemented, one had been substantially implemented, and two had been partially implemented.

The Office of the Inspector General reiterated the importance of the division implementing the recommendations from the July 2003 audit by making six follow-up recommendations that addressed the 2005 report's findings.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The Office of the Inspector General determined that the California Department of Corrections and Rehabilitation has fully or substantially implemented three of the six recommendations from the 2005 Accountability Audit, has partially implemented one, and has not implemented the remaining two.

The department reported that its newly created Office of Audits and Compliance has addressed, or will address, many of the concerns raised by the Office of the Inspector General. It reported that during the reorganization of the California Youth Authority and the California Department of Corrections into the California Department of Corrections and Rehabilitation, the internal audit and program compliance functions of the two departments were merged, forming the Office of Audits and Compliance.

The department reports that the Office of Audits and Compliance's chief is an assistant secretary who reports to the undersecretary of the California Department of Corrections and Rehabilitation. It adds, however, that the assistant secretary position is currently vacant; indeed, the department has yet to make a permanent appointment to the position since its inception. Therefore, the department is recruiting for an incumbent who possesses the knowledge and skills to effectively carry out the assignment of chief audit executive.

The department states that the Office of Audits and Compliance has begun a comprehensive risk assessment of the department. It estimates that this task will take 18 to 24 months to complete and notes that work on this task began in earnest in September 2006. The Office of the Inspector General reviewed the department's efforts and found that the department has prepared a matrix of areas and issues within the department that are potential audit areas. The department told the Office of the Inspector General that the Office of Audits and Compliance, in coordination with department executive management, will assess the relative level of risk of the identified areas and will develop an audit work plan for fiscal year 2007-08.

The department reported that the Office of Audits and Compliance is tracking audit activity from beginning to end and logging audit hours worked by staff members on specific projects. The department states that this information will be used by management to identify performance issues as well as to create a baseline for future performance. The department also stated that the Office of Audits and Compliance will contract with a professional auditing firm in fiscal year 2007-08 to arrange for external assessments of the office.

FOLLOW-UP RECOMMENDATIONS

The California Department of Corrections and Rehabilitation should take the following actions:

- **Provide for the Office of Audits and Compliance to be managed by an assistant secretary who can ensure that the office adheres to the *Standards for the Professional Practice of Internal Auditing*.**

- **Require that the assistant secretary of the Office of Audits and Compliance ensure that the department's comprehensive risk assessment includes division institutions, camps, education services, treatment programs, parole operations, and headquarters to identify areas of high risk when assigning resources and developing work plans.**

- **Arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the department director, in accordance with the *Standards for the Professional Practice of Internal Auditing*.**

The Office of the Inspector General conducted its work on the California Department of Corrections and Rehabilitation from November 15, 2006, through February 28, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after each recommendation.

FINDING NUMBER 1

The Division of Juvenile Justice was not making effective use of the Office of Internal Audits as a tool for identifying problems needing corrective action. (July 2003)

FINDING NUMBER 2

The Office of Internal Audits was poorly managed and inadequately supervised and was not fulfilling its audit responsibilities. (July 2003)

FINDING NUMBER 3

The reporting structure of the Office of Internal Audits did not adequately protect the independence of the internal audit function and impeded communication between the Office of Internal Audits and the department director. (July 2003)

The Office of the Inspector General made the following recommendations as a result of the three findings:

RECOMMENDATIONS	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Integrate the internal audit function and the program compliance function into a single office and combine staff to perform comprehensive fiscal and operational reviews. (July 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. During the reorganization of the California Youth Authority and the California Department of Corrections into the California Department of Corrections and Rehabilitation, the internal audit and program compliance functions of the two departments were merged forming the Office of Audits and Compliance.* *The recommendation made by the Office of the Inspector General in relation to comprehensive fiscal and operational audits of the former California Youth Authority was made prior to the Ferrell v. Tilton litigation. The implementation of this recommendation and the use of resources to make attempts at auditing an organization in flux would not have been a productive use of resources.* **Office of the Inspector General's comments:**

RECOMMENDATIONS	STATUS	COMMENTS
		The Office of the Inspector General performed no audit procedures to verify the department's representation.
Provide for the internal audit/program compliance office to be managed by someone who can ensure that the office adheres to the *Standards for the Professional Practice of Internal Auditing.* (July 2003)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. The Office of Audits and Compliance's chief is an Assistant Secretary who reports to the Undersecretary of the California Department of Corrections and Rehabilitation. As the Assistant Secretary position is vacant, the California Department of Corrections and Rehabilitation is recruiting for an incumbent who possess the knowledge and skills to effectively carry out the assignment of chief audit executive.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Provide for the head of the internal audit/program compliance office to report directly to the chief deputy director in the office of the department director. (July 2003)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Within the reorganization of the California Department of Corrections and Rehabilitation, the Assistant Secretary of the Office of Audits and Compliance will report to the Undersecretary.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
Require that the head of the internal audit/program compliance office perform a comprehensive risk assessment of division institutions, camps, education services, treatment programs, parole operations, and headquarters to identify areas of high risk when assigning resources and developing work plans. (July 2003)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Office of Audits and Compliance has begun comprehensive risk assessments of the California Department of Corrections and Rehabilitation. It is estimated that this will take 18 to 24 months for completion. Work on this task began in earnest in September 2006.* **Office of the Inspector General's comments:**

RECOMMENDATIONS	STATUS	COMMENTS
		The Office of the Inspector General reviewed the department's efforts in completing a comprehensive risk assessment. The department had prepared a matrix of areas and issues within the department that were potential audit areas. The department told the Office of the Inspector General that the Office of Audits and Compliance, in coordination with department executive management, would determine the relative risks of the identified areas and would develop an audit work plan for fiscal year 2007-08.
Implement an internal quality assurance program that enables management to measure staff and office performance in the areas of fiscal and program compliance; evaluation of budgeted and expended hours; effectiveness of reports; and monitoring of findings and recommendations. (July 2003)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. The Office of Audits and Compliance is tracking audit activity from beginning to end. Audit hours worked by staff are logged and tracked against specific projects. This information is used by management to identify performance issues as well as create a baseline for future performance.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.
In accordance with the *Standards for the Professional Practice of Internal Auditing*, arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the department director. (July 2003)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. Office of Audits and Compliance will contract with a professional auditing firm in fiscal year 07/08.* **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation.

FOLLOW-UP RECOMMENDATIONS

The California Department of Corrections and Rehabilitation should take the following actions:

- **Provide for the Office of Audits and Compliance to be managed by an assistant secretary who can ensure that the office adheres to the *Standards for the Professional Practice of Internal Auditing*. (July 2003)**

- **Require that the assistant secretary of the Office of Audits and Compliance ensure that the department's comprehensive risk assessment includes division institutions, camps, education services, treatment programs, parole operations, and headquarters to identify areas of high risk when assigning resources and developing work plans. (July 2003)**

- **Arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the department director, in accordance with the *Standards for the Professional Practice of Internal Auditing*. (July 2003)**

JUVENILE PAROLE BOARD

The Office of the Inspector General found that the Division of Juvenile Justice has continued to improve its process for assessing the effectiveness of program curriculum and treatment provided to its wards. All but one of seven recommendations from a 2002 review have been fully implemented.

IMPLEMENTATION REPORT CARD

2005 Follow-up recommendations: 1

Fully implemented: 0 (0%)

Substantially implemented: 0 (0%)

Partially implemented: 1 (100%)

Not implemented: 0 (0%)

In a review released in December 2002, the Office of the Inspector General examined the procedures used by the California Youth Authority (now the Division of Juvenile Justice) and the Youthful Offender Parole Board (now the Juvenile Parole Board within the Division of Juvenile Justice) to establish ward program requirements. The review found that responsibility for specifying the treatment programs wards must complete before they are released from custody rested with the Juvenile Parole Board. The board lacked treatment expertise, however, while the Division of Juvenile Justice, which has the expertise and responsibility for assessing wards' treatment needs, had authority only to recommend generally what programs a ward should complete. The review also found that the Juvenile Parole Board often required wards to complete more treatment programs than could reasonably be completed before their scheduled release date, causing them to be retained. The Office of the Inspector General made seven recommendations to resolve the deficiencies.

In its follow-up review released in January 2005, the Office of the Inspector General determined that the Division of Juvenile Justice had taken over many responsibilities from the Juvenile Parole Board, changed several procedures, and significantly improved the overall process for establishing wards' programming requirements. As a result of the review, the Office of the Inspector General determined that all but one of its seven recommendations from the 2002 review had been fully implemented and made only one follow-up recommendation.

BACKGROUND

Since the Office of the Inspector General's December 2002 review, both the Youthful Offender Parole Board and the California Youth Authority have been abolished. In January 2004, state law (Senate Bill 459) abolished the Youthful Offender Parole Board and assigned the duties of that seven-member board jointly to the California Youth Authority and a newly developed five-member Youth Authority Board within the California Youth Authority. In July 2005, state law (Senate Bill 737) established the California Department of Corrections and Rehabilitation, which replaced the state's Youth and Adult Correctional Agency, including its departments and boards. Responsibilities of the former California Youth Authority were transferred to the Division of Juvenile Justice and, initially, the responsibilities of the former Youth Authority Board were transferred to a body of youth board commissioners within the Board of Parole Hearings. Effective January 2007, however, the body of youth board commissioners transferred to the jurisdiction of the Division of

Juvenile Justice, and the former Youth Authority Board was renamed the Juvenile Parole Board.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the 2005 follow-up review, the Office of the Inspector General found that the Division of Juvenile Justice had implemented significant changes to its process for setting programming requirements for wards. For example, responsibility for recommending specific treatment shifted from the Juvenile Parole Board to the Division of Juvenile Justice, and the Division of Juvenile Justice implemented new procedures to develop a treatment plan for each ward. The division also implemented a core treatment program to promote consistency in the treatment provided to its wards.

In addition, the Division of Juvenile Justice had initiated discussions about possible methods for assessing the effectiveness of its new treatment program. Consequently, the Office of the Inspector General made one recommendation to the Division of Juvenile Justice as a result of the 2005 review. The specific recommendation is presented in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The Division of Juvenile Justice has only partially implemented procedures for identifying and assessing its treatment program for wards. According to the department, the Division of Juvenile Justice plans to implement an integrated treatment model by which assessment methods are applied to evidence-based treatment modalities covering eight standard treatment areas.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Division of Juvenile Justice institute methods of assessing the effectiveness of curriculum and treatment provided to wards.

The Office of the Inspector General conducted its work on the Division of Juvenile Justice and the Juvenile Parole Board from November 15, 2006, through March 9, 2007.

The following table summarizes the results of the 2007 follow-up review. The finding is numbered and dated in accordance with the report in which it first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 3

Despite incurring significant expense in providing a broad array of treatment programs for wards, the state had not sought to measure the effectiveness of the programs. (December 2002)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Institute methods of assessing the effectiveness of curriculum and treatment provided to wards. (December 2002)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Substantially Implemented. Change Company Journals covering eight treatment areas are the standard treatment modality for core treatment units. These journals are predicated on evidence based treatment. As the Division of Juvenile Justice continues its reform efforts, an integrated treatment model will be implemented, based on evidence based treatment modalities. There will be assessment methods applied to the treatment modalities used in the integrated treatment model.* **Office of the Inspector General's comments:** Although the Office of the Inspector General performed no audit procedures to verify the department's representation, based on the division's response, it has not yet implemented the integrated treatment model. Therefore, it has not assessed the effectiveness of the new curriculum and treatment methods that will be provided to the division's wards.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Division of Juvenile Justice institute methods of assessing the effectiveness of curriculum and treatment provided to wards. (December 2002)

WELFARE AND INSTITUTIONS CODE SECTION 1732.8

IMPLEMENTATION REPORT CARD

2005 Follow-up recommendations: 2

Fully implemented: 2 (100%)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 0 (0%)

The Office of the Inspector General found that the Division of Juvenile Justice has further improved its handling of dual-commitment wards serving Division of Juvenile Justice confinement time in Division of Adult Operations institutions under Welfare and Institutions Code section 1732.8. The Division of Juvenile Justice acted on all remaining recommendations to ensure that wards' due process rights are met and that grievances are addressed properly.

In February 2003, the Office of the Inspector General reviewed the implementation of Welfare and Institutions Code section 1732.8, which allows California Youth Authority (now the Division of Juvenile Justice) wards who have served sentences in Department of Corrections (now the Division of Adult Operations) institutions to elect to also serve their remaining Division of Juvenile Justice confinement time in Division of Adult Operations institutions. Wards covered by the statute are termed "dual-commitment wards." At the time of the February 2003 review, there were 40 dual-commitment wards in Division of Adult Operations institutions throughout the state.

The February 2003 review identified a number of deficiencies in the implementation of Welfare and Institutions Code section 1732.8. The Office of the Inspector General found that the Division of Juvenile Justice and the Juvenile Parole Board, within the Division of Juvenile Justice, lacked standards and procedures for programming dual-commitment wards and that the expectations of the Juvenile Parole Board were not clearly explained to the wards. In addition, dual-commitment wards were not afforded the rights provided to other wards to attend their annual review and parole consideration date hearings, and there were deficiencies in coordinating ward appeal and grievance procedures. To address these deficiencies, the 2003 report presented six recommendations.

The Office of the Inspector General performed a follow-up review in 2004 to determine if the Division of Juvenile Justice had implemented corrective action to address previous recommendations. The results of the 2004 follow-up review were reported in September 2004 and again in the Office of the Inspector General's January 2005 Accountability Audit. The Office of the Inspector General found that the Division of Juvenile Justice had significantly improved the handling of dual-commitment wards serving Division of Juvenile Justice confinement time in Division of Adult Operations institutions under Welfare and Institutions Code section 1732.8. However, the Office of the Inspector General identified two unresolved issues and presented two recommendations to the Division of Juvenile Justice to address them.

BACKGROUND

Section 1732.8 of the California Welfare and Institutions Code, which became effective January 1, 2002, allows "dual-commitment" Division of Juvenile Justice wards to choose to be confined in a Division of Adult Operations institution until they are released from custody. These are wards over the age of 18 who have committed felonies while in custody of the Division of Juvenile Justice or while on Division of Juvenile Justice parole; who have served court-imposed time for those felonies in a Division of Adult Operations institution; and who have confinement time remaining with the Division of Juvenile Justice. Approximately 60 days before the end of their sentence, dual-commitment wards are given a consent form allowing them to choose to remain in Division of Adult Operations custody or return to Division of Juvenile Justice custody. The law also requires that a Division of Juvenile Justice representative meet with the ward and explain the provisions of the law before the ward chooses. The consent form states these provisions.

Wards choosing to remain in Division of Adult Operations custody may still be subject to Division of Juvenile Justice treatment requirements such as anger management, victim awareness, or gang awareness. Wards also may be required to earn a high school diploma or a general educational development (GED) certificate. The Division of Adult Operations, however, is neither required to provide dual-commitment wards with the programs necessary for them to fulfill their treatment requirements nor is it obligated to provide wards with academic or vocational education. Such education is to be provided only to the extent that the appropriate programs are available. The effect of not completing treatment requirements, in turn, may be to lengthen a ward's juvenile confinement time. If a ward's adult sentence exceeds his or her juvenile confinement time, the Division of Juvenile Justice may dishonorably discharge the ward.

In January 2004, state law (Senate Bill 459) abolished the Youthful Offender Parole Board and created the Youth Authority Board within the California Youth Authority. The law also reassigned certain board administrative responsibilities from the prior Youthful Offender Parole Board to the California Youth Authority. Further changes to the law, effective in July 2005 and January 2007 (Senate Bill 737), reorganized the department and abolished both the Youth Authority Board and the California Youth Authority. In their place, the Juvenile Parole Board and the Division of Juvenile Justice were created. As a result of these changes, the current Juvenile Parole Board functions only in an advisory and affirming capacity, and the Division of Juvenile Justice determines the parole consideration date for each ward and conducts related ward case file reviews. These changes are discussed in the Juvenile Parole Board section of this report.

To accomplish some of its administrative tasks, the Division of Juvenile Justice formed a Youth Authority Administrative Committee within each juvenile facility. Each committee is typically composed of three treatment team members from the facility. Before the ward's parole board date hearing, the committee conducts a case file review. If a ward has not completed the requirements of his or her initial juvenile confinement time, the committee may decide to add time to a ward's confinement. To make its decision, the committee reviews the ward's case file, including progress reports, program treatment progress, and information provided by staff members at the adult institution where the ward was confined.

Even if a ward has incurred no disciplinary actions, the absence of programming efforts may be grounds for added time.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the January 2005 follow-up review, the Office of the Inspector General found that the Division of Juvenile Justice and the Juvenile Parole Board had made several changes to their processes and procedures for handling dual-commitment wards to ensure that their due process rights were being met. Consequently, the Office of the Inspector General determined that the Division of Juvenile Justice and the Juvenile Parole Board had made significant progress in implementing the six recommendations from the original review conducted in February 2003. The Office of the Inspector General determined, however, that the Division of Juvenile Justice and the Juvenile Parole Board needed to take further action to fully implement recommendations related to the following findings:

- Dual-commitment wards were not being allowed to attend their annual reviews and parole consideration date reviews and had little contact with the Division of Juvenile Justice and the Juvenile Parole Board. New procedures were implemented to ensure that wards are provided options to appear at their Juvenile Parole Board hearings or submit a written statement to be read at their hearing. In addition, more than 200 facility staff members received training on the new procedures.

- In making parole decisions, the Juvenile Parole Board did not provide evidence that it had taken into account that some dual-commitment wards did not have access to the equivalent of board-ordered youth programs at adult institutions. The Division of Juvenile Justice revised its consent form to clearly state dual-commitment wards' programming expectations and the consequences for failing to meet those expectations. To ensure that due process rights had been met for seven dual-commitment wards whose parole consideration dates had previously been extended due to the wards' failure to meet programming expectations, the Division of Juvenile Justice and the Juvenile Parole Board jointly reviewed their case files. The Office of the Inspector General found, however, that the case file reviews were not documented.

- The Division of Juvenile Justice had not developed adequate appeal and grievance procedures to meet the needs of dual-commitment wards. The Division of Juvenile Justice provided the Division of Adult Operations' inmate appeals coordinators with copies of its ward appeal and grievance forms. In addition, the department had drafted a memorandum addressing the distribution, processing, and retention of appeal and grievance forms for dual-commitment wards.

The Office of the Inspector General made two recommendations to the Division of Juvenile Justice as a result of the 2005 review. The specific recommendations are listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The Office of the Inspector General found that the Division of Juvenile Justice has fully implemented the two recommendations on documenting pre-hearing case file reviews and processing appeal and grievance forms for its dual-commitment wards. The Office of the Inspector General concluded that the current processes used by the Division of Juvenile Justice provide adequate documentation of file reviews and assurance that dual-commitment wards' due process rights have been observed. The Office of the Inspector General came to this conclusion after discussing the processes with staff members from the Juvenile Parole Board and the Division of Juvenile Justice and upon reviewing related policy memorandums and forms that are currently used.

FOLLOW-UP RECOMMENDATIONS

None

The Office of the Inspector General conducted its work on the Division of Juvenile Justice's implementation of Welfare and Institutions Code Section 1732.8 from November 15, 2006, through March 13, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 2

In making parole decisions, the Division of Juvenile Justice did not adequately take into account that dual-commitment wards do not have access to the equivalent of board-ordered programs at Division of Adult Operations institutions and did not develop programming standards for these wards. (February 2003)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Document review of the case files of wards who have had time added to the parole consideration date to ensure that due process rights have been fully observed. (September 2004)	FULLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. Under Senate Bill 459, the California Youth Authority was given the responsibility for ward time adds. A policy created in response to this responsibility was developed establishing the Youth Authority Administrative Committee review. As required by policy, the Youth Authority Administrative Committee reviews all case files and any relevant information, prior to holding a hearing that may result in time being added to the ward's Projected Board Date. This review is captured on a standard Youth Authority Administrative Committee form wherein the committee documents their review and findings for all wards under the Division of Juvenile Justice Jurisdiction (formerly California Youth Authority).* *Wards are given the right to appeal the Youth Authority Administrative Committee decision. On the Youth Authority Administrative Committee form, wards are asked to sign whether they are appealing or not appealing the Youth Authority Administrative Committee decision and are given the opportunity to submit a written 1st level appeal to the Superintendent. If time is added, the inmate/ward is given an opportunity to a 2nd level of appeal to the Board of Parole Hearings.* *If a ward under the jurisdiction of the California Department of Corrections, Adult Division, being held on confinement time based upon a commitment of a felony while still under the jurisdiction of the Division of Juvenile Justice the Youth Authority Administrative Committee hearing reports are forwarded to the inmate prior to the hearing. Even if the ward's Division of Juvenile Justice time add is less than the time of his adult convictions Earliest Possible Release Date, the ward is given an opportunity to appeal the Youth Authority Administrative Committee decision in writing. Such an*

RECOMMENDATION	STATUS	COMMENTS
		appeal shall be documented by Division of Juvenile Justice and handled as a regular Youth Authority Administrative Committee appeal noted above. **Office of the Inspector General's comments:** The Office of the Inspector General discussed the processes for conducting ward case file reviews and board hearings with staff members from the Division of Juvenile Justice and the Juvenile Parole Board. In addition, the Office of the Inspector General reviewed documents provided by the Division of Juvenile Justice, including its Dual Commitment Consent Form and its memorandum regarding the Youth Authority Administrative Committee hearing appearance consent. The Office of the Inspector General also reviewed the Division of Juvenile Justice's McPherson Information Packet, which is provided to all wards who elect to serve Division of Juvenile Justice commitment time in a Division of Adult Operations institution. The packet includes the following documents: • July 1, 2005, memorandum from the wards rights coordinator for the Division of Juvenile Justice, summarizing the distribution, processing, and retention of appeals and grievance forms. • Various grievance and appeal forms, including instructions for first and second level appeals to the Youth Authority Administrative Committee stating that wards may file an appeal if wards can show that their failure to complete a specific program was not their fault. • Acknowledgement of the information packet being received, requiring the ward's signature. Finally, the Office of the Inspector General reviewed the Division of Adult Operations' memorandum identifying the retention policy for Division of Juvenile Justice grievance and appeal forms.

RECOMMENDATION	STATUS	COMMENTS
		According to the division and based on the Office of the Inspector General's review of supporting documentation, the new process adequately documents the review of ward case files, thus ensuring that due process rights are fully observed.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 4

Although there was no evidence that dual-commitment wards had been purposely denied a means of appealing actions or grieving department policies, the Division of Juvenile Justice had not developed appeal and grievance procedures to meet the needs of these wards. (February 2003)

RECOMMENDATION	STATUS	COMMENTS
The Division of Juvenile Justice should:		
Ensure that the Division of Adult Operations' memorandum concerning the distribution, processing, and retention of appeal and grievance forms for Welfare and Institutions Code section 1732.8 wards is submitted in final form to the inmate appeals coordinators. (September 2004)	**FULLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Division of Juvenile Justice appeal and grievance forms are available in the Litigation Office of each adult institution. At each McPherson Waiver Interview; wards are fully informed of their appeal option including the appeal process within the McPherson consent form. At the time of the ward's interview regarding a McPherson waiver, a ward electing to remain in the Division of Adult Institutions is given a copy of the Division of Juvenile Justice Grievance and Appeal Forms with instructions.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the division's policy memorandums and forms, including the McPherson Information Packet,

RECOMMENDATION	STATUS	COMMENTS
		and verified with staff members that the wards rights coordinator is using the documents.

FOLLOW-UP RECOMMENDATIONS

None

INTERPRETATION SERVICES PROCEDURES

The Office of the Inspector General found that the Board of Parole Hearings has made little progress in implementing recommendations presented in the March 2005 special review of the board's interpretation services procedures. Two years have passed since the board drafted a comprehensive policy that addressed the Office of the Inspector General's findings; however, the policy has not been implemented and the same conditions exist that allowed numerous false claims to be paid.

IMPLEMENTATION REPORT CARD
2005 Recommendations: 5
Fully implemented: 0 (0%)
Substantially implemented: 0 (0%)
Partially implemented: 4 (80%)
Not implemented: 1 (20%)

In March 2005, the Office of the Inspector General issued a special review of the procedures used by the Board of Parole Hearings (then known as the Board of Prison Terms) to govern services provided by foreign language interpreters. The review was prompted by the Office of the Inspector General's investigation of a foreign language interpreter who submitted a large number of fraudulent claims to the Board of Parole Hearings for interpretation services provided at parole revocation hearings. The investigation determined that between August 23, 2000, and June 13, 2003, a foreign language interpreter submitted 261 false claims to the Board of Parole Hearings, for which she was paid $11,862. The Office of the Inspector General found that the interpreter inflated hours worked and travel expenses and also resubmitted and received payment for several invoices for which she had been paid months earlier. The case was settled by the San Diego District Attorney in January 2005 with the defendant pleading guilty to a felony violation of California Penal Code section 487 (grand theft) and agreeing to pay full restitution. Because of the investigation, the Office of the Inspector General conducted a special review into the Board of Parole Hearings' procedures governing services provided by foreign language interpreters. The special review provided five recommendations to address the deficiencies.

BACKGROUND

The Board of Parole Hearings reported that it conducted more than 105,000 parole hearings in fiscal year 2005-06. This included about 6,000 parole consideration hearings for "lifer" inmates serving indeterminate sentences and more than 99,000 parole revocation hearings to determine whether parolees had violated parole conditions and should be returned to prison. The board also conducts certification, placement, and parole revocation hearings for mentally disordered offenders and screens inmates for possible civil confinement as sexually violent predators.

The adult parole board comprises 12 commissioners, appointed by the Governor, who travel to the state's prisons conducting parole consideration hearings for inmates sentenced to life in prison with the possibility of parole. Deputy commissioners, who are civil service employees, conduct lifer parole hearings alongside commissioners, but they mainly conduct

parole revocation hearings, which are quasi-judicial hearings that determine whether a parolee has violated parole conditions. Deputy commissioners also conduct certification, placement, discharge, and re-hospitalization hearings for mentally disordered offenders, and they conduct probable cause hearings for inmates who are considered to be sexually violent predators.

In carrying out the responsibilities associated with the parole hearing process, the Board of Parole Hearings frequently retains the services of foreign language and sign language interpreters, who work as private vendors. According to the board, in fiscal year 2005-06, the board provided interpreters for 1,535 parole hearing proceedings at a cost of $280,000. The services were provided by 56 interpreters employed as vendors through the Board of Parole Hearings headquarters and through parole revocation units of the California Department of Corrections and Rehabilitation.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the March 2005 review:

- ***The Board of Parole Hearings did not specify in writing the terms and conditions of interpretation services to be provided.*** In the northern part of the state (Parole Regions I and II), the Board of Parole Hearings scheduled parole revocation hearings and sent confirmation letters to interpreters, but the letters did not fully cover the terms and conditions of service. While the letters included the inmate's name and the date, time, and location of the hearing, they did not address the board's cancellation policy or the specifics of travel reimbursement.

  In the southern part of the state (Parole Regions III and IV), the Board of Parole Hearings had delegated responsibility for scheduling hearings to California Department of Corrections and Rehabilitation parole revocation units. The parole revocation unit visited during the March 2005 review did not provide interpreters with written terms and conditions of service when scheduling hearings; they simply contacted the interpreter by telephone. Because of the lack of clearly defined terms and conditions of service, the parole revocation unit and the Board of Parole Hearings provided the Office of the Inspector General with conflicting information about authorized reimbursements. The parole revocation unit staff said that travel reimbursement was not allowed for the Richard J. Donovan Correctional Facility in San Diego, while the Board of Parole Hearings scheduling unit said that such travel reimbursement was authorized.

- ***Invoices for interpretation services were paid without verification that the services were provided.*** Interpreters submitted invoices directly to the Board of Parole Hearings headquarters in Sacramento for payment, but the headquarters staff did not verify that the interpreter actually provided the services before they authorized the payment. The staff member responsible for approving the invoices told the Office of the Inspector General that she did not reconcile the invoices with Board of Parole Hearings records or other documents, such as the hearing confirmation letter. She also stated that

she rejected invoices only if the interpreter failed to sign the document or failed to include an address or social security number.

- ***The Board of Parole Hearings did not use invoice records to detect fraud.*** The board did not keep copies of approved invoices or other records that would have enabled it to detect fraudulent claims. Furthermore, although invoice data was collected in an electronic spreadsheet and the data fields in the spreadsheet were adequate for sorting invoices and detecting duplicate claims, the staff did not use the spreadsheet for that purpose. Because of this deficiency, the interpreter who was the subject of the Office of the Inspector General's investigation received payment for duplicate service invoices and duplicate travel time even though the improper claims could have been detected with the use of the spreadsheet.

- ***Interpreters were not required to submit invoices within a prescribed time limit.*** This enabled the interpreter to file duplicate invoices as long as eight months after the service date even though she had already received payment for the original invoices.

The Office of the Inspector General made five recommendations to the Board of Parole Hearings as a result of the March 2005 review.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

Of the five recommendations from the earlier review, four have been partially implemented and one has not been implemented. The board has had a draft interpreter payment policy since April 2005; however, two years later, the policy has not been implemented and the same conditions exist that allowed numerous false claims to be paid.

The Board of Parole Hearings has electronic methods to record, track, and monitor payments to interpreters. Nevertheless, the board does not use these methods to effectively detect duplicate claims as recommended by the Office of the Inspector General in the March 2005 special review. Also, at the time of this review, the board's invoice tracking system was not interacting with the board's lifer and parole revocation hearing databases as it was designed to do. Therefore, the staff had to manually search the databases to verify that a hearing did in fact take place and the interpreter service was rendered. The invoice tracking system is not programmed to automatically cross-check for duplicate payments, and while the staff can manually review payee data fields to detect duplicate claims, they do not. The Office of the Inspector General reviewed 250 invoices and found two duplicate payments. When these duplicate payments were brought to the board's attention, by simply sorting their invoice database by inmate and hearing date, board staff members were able to easily confirm that duplicate payments had been made.

Because the interpreter payment policy is in draft form, the other four recommendations from the March 2005 special review have yet to be implemented.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Board of Parole Hearings take the following actions:

- **Provide interpreters with confirmation letters specifying the terms and conditions of the services to be provided for all hearings. The letters should include at least the following information:**
  - **Inmate's name and California Department of Corrections and Rehabilitation identification number**
  - **Date, time, and location of the hearing**
  - **Type of hearing**
  - **Agreed-upon reimbursement rate**
  - **Travel reimbursement policy, including mileage rate allowed**
  - **Hearing cancellation policy**
  - **Invoice process and timeframes for invoice submittal and payment**
  - **Signature block and telephone number block to allow a Board of Parole Hearings representative to verify services at completion of the hearing**
- **Ensure that the confirmation letter includes the reimbursement rate for each hearing when hiring one interpreter for multiple hearings.**
- **Require interpreters to bring the confirmation letter to the hearing.**
- **Require a Board of Parole Hearings representative to sign and date the confirmation letter and return it to the interpreter at the completion of service.**
- **Require a Board of Parole Hearings representative to affix the representative's initials next to each inmate's name, verifying that each hearing was held, if one interpreter is hired for multiple hearings.**
- **Require interpreters to submit invoices within prescribed time limits specified in the hearing confirmation letter.**
- **Use electronic methods to systematically record, track, and monitor payments to interpreters so as to detect duplicate claims.**
- **Audit interpreter payments, beginning with fiscal year 2003-04, and recoup overpayments.**

The Office of the Inspector General conducted its work on the Board of Parole Hearings from July 21, 2006, through February 20, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 1

The Board of Parole Hearings did not specify in writing the terms and conditions of interpretation services to be provided. (March 2005)

RECOMMENDATIONS	STATUS	COMMENTS
The Board of Parole Hearings should:		
Provide interpreters with confirmation letters specifying the terms and conditions of the services to be provided for all hearings. The letters should include at least the following information: • Inmate's name and California Department of Corrections and Rehabilitation identification number • Date, time, and location of the hearing • Type of hearing • Agreed-upon reimbursement rate • Travel reimbursement policy, including mileage rate allowed • Hearing cancellation policy • Invoice process and timeframes for invoice submittal and payment • Signature block and telephone number block to allow a Board of Parole Hearings representative to verify services at completion of the hearing (March 2005)	**PARTIALLY IMPLEMENTED**	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Board drafted an Interpreter Payment Policy and Letter of Agreement for interpreters. This policy incorporates the Inspector General's recommendations. The Board has requested additional positions in fiscal year 06/07 among whose duties are to perform these functions. The Board is currently interviewing staff for these positions and will be tasking the new staff to ensure confirmation letters are provided to all interpreters. In addition, staff will be assigned to specifically manage the interpreter database by ensuring all interpreters' personal information data is appropriately maintained. The Board will train the new support staff, Commissioners, and Deputy Commissioners on the policy and their respective roles and responsibilities upon full implementation by March 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General found that in the southern part of the state, the board continues to delegate responsibility for scheduling interpreters for parole revocation hearings to California Department of Corrections and Rehabilitation parole revocation units. The parole revocation units continue to hire individual interpreters or interpreter organizations by telephone and still do not provide interpreters with confirmation letters that specify the terms and conditions of service. Because of the lack of clearly defined terms and conditions of service, board staff members tasked with approving interpreter invoices have no way of verifying the rate of payment actually negotiated, and the amount of reimbursement varies widely statewide. In the northern part of the state, Board of Parole Hearings staff members

RECOMMENDATIONS	STATUS	COMMENTS
		continue to schedule interpreters for parole revocation hearings. Board staff members also schedule interpreters for lifer parole hearings statewide. These interpreters sometimes receive confirmation letters, but the letters reviewed by the Office of the Inspector General varied widely and lacked information on the policies for hearing cancellation, travel reimbursement, and invoice processing. In addition, none of the letters contained a signature block for a board representative to sign at the completion of a hearing. The Office of the Inspector General also found that when the board schedules one interpreter for multiple lifer hearings, it sometimes negotiates one lump sum with the interpreter and does not include the reimbursement rate for each hearing. When the interpreter submits an invoice for payment, the board returns the invoice to the interpreter with instructions to divide the lump sum between the hearings and submit one invoice for each inmate. This causes a delay in payment and can result in the interpreter receiving less payment than originally negotiated. The Office of the Inspector General verified that in April 2005 the board drafted an interpreter payment policy. This draft policy incorporated the Office of the Inspector General's recommendation that confirmation letters specify the terms and conditions of the services to be provided, including policies for hearing cancellation, travel reimbursement, invoice processing, and board representative confirmation. However, two years later, the policy has yet to be implemented.
Require interpreters to bring the confirmation letter to the hearing. (March 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Incorporated in above policy.* **Office of the Inspector General's comments:** As reported above, interpreters scheduled for parole revocation hearings in the southern part of the state are not being sent confirmation letters. Interpreters scheduled for lifer hearings and parole revocation hearings in the northern part of the state sometimes receive confirmation letters; however,

RECOMMENDATIONS	STATUS	COMMENTS
		none of the letters reviewed by the Office of the Inspector General required interpreters to bring the confirmation letter to the hearing. The Office of the Inspector General verified that the interpreter payment policy does require interpreters to bring the confirmation letter to the hearing, but because the policy is still in draft form, this recommendation has yet to be implemented.

FOLLOW-UP RECOMMENDATIONS

The Board of Parole Hearings should:

- **Provide interpreters with confirmation letters specifying the terms and conditions of the services to be provided for all hearings. The letters should include at least the following information:**
  - **Inmate's name and California Department of Corrections and Rehabilitation identification number**
  - **Date, time, and location of the hearing**
  - **Type of hearing**
  - **Agreed-upon reimbursement rate**
  - **Travel reimbursement policy, including mileage rate allowed**
  - **Hearing cancellation policy**
  - **Invoice process and timeframes for invoice submittal and payment**
  - **Signature block and telephone number block to allow a Board of Parole Hearings representative to verify services at completion of the hearing (March 2005)**
- **Ensure that the confirmation letter includes the reimbursement rate for each hearing when hiring one interpreter for multiple hearings. (2007)**

- **Require interpreters to bring the confirmation letter to the hearing. (March 2005)**

FINDING NUMBER 2

Invoices for services were paid without verification that the services were provided. (March 2005)

RECOMMENDATION	STATUS	COMMENTS
The Board of Parole Hearings should:		
Require a Board of Parole Hearings representative to sign and date the confirmation letter and return it to the interpreter at the completion of service. (March 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Incorporated into above policy.* **Office of the Inspector General's comments:** As reported above, interpreters scheduled for parole revocation hearings in the southern part of the state are not being sent confirmation letters. Interpreters scheduled for lifer hearings and parole revocation hearings in the northern part of the state sometimes receive confirmation letters; however, none of the letters reviewed by the Office of the Inspector General required a Board of Parole Hearings representative to sign and date the confirmation letter and return it to the interpreter at the completion of service. The Office of the Inspector General verified that the interpreter payment policy does require a Board of Parole Hearings representative to sign and date the confirmation letter and return it to the interpreter at the completion of service, but because the policy is still in draft form, this recommendation has yet to be implemented. In addition, the Office of the Inspector General found that when the board schedules one interpreter for multiple lifer hearings, it does not always send an individual confirmation letter for each hearing and will instead list multiple hearings in one confirmation letter. There may be times when one or more of the scheduled hearings is canceled, and there is no policy requiring a board representative to certify that interpretation services were provided at each hearing.

FOLLOW-UP RECOMMENDATIONS

The Board of Parole Hearings should:

- **Require a Board of Parole Hearings representative to sign and date the confirmation letter and return it to the interpreter at the completion of service. (March 2005)**

- **Require a Board of Parole Hearings representative to affix the representative's initials next to each inmate's name, verifying that each hearing was held, if one interpreter is hired for multiple hearings. (2007)**

FINDING NUMBER 3

The Board of Parole Hearings did not use invoice records to detect fraud. (March 2005)

RECOMMENDATION	STATUS	COMMENTS
The Board of Parole Hearings should:		
Use electronic methods to systematically record, track, and monitor payments to interpreters so as to detect duplicate claims. (March 2005)	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Board was successful in implementing the recommendation of the Office of the Inspector General to use electronic methods to systematically record, track, and monitor payments to interpreters and to detect duplicate claims. Upon review of the invoice, a staff member currently enters the billing information to the Invoice Tracking Database. The database interacts with two separate Board databases, which combine to provide verification that the hearing did in fact take place and the interpreter service was rendered.* **Office of the Inspector General's comments:** The Office of the Inspector General found that the Board of Parole Hearings uses an Oracle database to record payments to interpreters. At the time of this review, however, the database was not interacting with the board's lifer and revocation hearing databases as it was designed to do. Therefore, the staff had to manually verify that a hearing did in fact take place and the interpreter service was rendered. In addition, the database

RECOMMENDATION	STATUS	COMMENTS
		does not automatically check for duplicate payments and, although they could, staff members do not manually review payee data fields to detect duplicate claims. For example, the Office of the Inspector General reviewed 250 invoices and found two duplicate payments. When these duplicate payments were brought to the board's attention, by simply sorting their invoice database by inmate and hearing date, board staff members were able to easily confirm that duplicate payments had been made.

FOLLOW-UP RECOMMENDATIONS

The Board of Parole Hearings should:

- **Use electronic methods to systematically record, track, and monitor payments to interpreters so as to detect duplicate claims. (March 2005)**

- **Audit interpreter payments, beginning with fiscal year 2003-04, and recoup overpayments. (2007)**

FINDING NUMBER 4

Interpreters were not required to submit invoices within a prescribed time limit. (March 2005)

RECOMMENDATION	STATUS	COMMENTS
The Board of Parole Hearings should:		
Require interpreters to submit invoices within prescribed time limits specified in the hearing confirmation letter. (March 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. Incorporated into above policy.* **Office of the Inspector General's comments:** As reported above, interpreters scheduled for parole revocation hearings in

RECOMMENDATION	STATUS	COMMENTS
		the southern part of the state are not being sent confirmation letters. Interpreters scheduled for lifer hearings and parole revocation hearings in the northern part of the state sometimes receive confirmation letters; however, none of the letters reviewed by the Office of the Inspector General contained time limits for submitting invoices for reimbursement. The Office of the Inspector General verified that the interpreter payment policy does require interpreters to submit invoices within prescribed time limits, but because the policy is still in draft form, this recommendation has yet to be implemented.

FOLLOW-UP RECOMMENDATION

The Board of Parole Hearings should require interpreters to submit invoices within prescribed time limits specified in the hearing confirmation letter. (March 2005)

INDETERMINATE SENTENCE HEARINGS AND APPEALS

IMPLEMENTATION REPORT CARD	
2005 Follow-up recommendations:	7
Less: Recommendations no longer applicable:	1
Recommendations still applicable:	6
Fully implemented: 0 (0%)	
Substantially implemented: 1 (17%)	
Partially implemented: 4 (66%)	
Not implemented: 1 (17%)	

After seven years and repeated recommendations, the Board of Parole Hearings finally is developing a new system for tracking parole consideration hearings for inmates sentenced to indeterminate prison terms—so-called "lifer inmates." The system is to ensure that lifer hearings are held within mandated time limits, thereby reducing the board's hearing backlog. The board expects to begin using the system in November 2007. On a positive note, the board has taken action to reduce the number of lifer hearing postponements and decrease the hearing backlog. The board reported that it has not implemented one recommendation because of a class action lawsuit and court involvement.

In a review released in March 2000, the Office of the Inspector General examined the procedures used by the Board of Parole Hearings' predecessor, the Board of Prison Terms, to schedule parole consideration hearings and appeals for inmates sentenced to indeterminate prison terms. The review found that the board had a large backlog of parole consideration hearings, most of which were more than six months delinquent. The review also found that the board's process for identifying and scheduling the hearings failed to ensure that hearings were held within statutory time limits. The Office of the Inspector General made four recommendations to resolve the deficiencies.

The Office of the Inspector General conducted follow-up reviews of the Board of Parole Hearings in 2002 and 2005 to assess the board's progress in implementing previous recommendations. In the April 2002 follow-up review, the Office of the Inspector General also looked at the board's timeliness in delivering hearing decisions for indeterminate sentences and its procedures for reviewing, processing, and completing inmate and parolee appeals. The Office of the Inspector General reported that the board's system for identifying and scheduling parole consideration hearings continued to be incapable of ensuring that the hearings were held on time. That review determined that the Board of Parole Hearings had not taken effective measures to reduce the hearing backlog; that its projected schedule for eliminating the backlog was unrealistic; and that its process for responding to appeals challenging board decisions was inadequate to provide prompt disposition. As a result of the review, the Office of the Inspector General made 10 recommendations.

A July 2005 follow-up review of the 10 recommendations determined that even though the board had upgraded from a manual process to an automated system for tracking parole consideration hearings, the board continued to use manual methods to exchange information with the adult institutions. These manual methods minimize the value of the

automated system in identifying statutorily mandated hearing dates or in scheduling future hearings. Moreover, the parole consideration hearing backlog had increased. The review also revealed that the board had been reporting misleading statistics. In reporting the number of hearings "conducted," for example, the board had included hearings that were merely scheduled, whether or not the hearings actually took place—resulting in an overstatement of almost 4,000 hearings reported as conducted from 2002 through 2004. As a result of these findings, the Office of the Inspector General made seven follow-up recommendations.

BACKGROUND

Conducting parole consideration hearings for inmates sentenced to indeterminate prison terms—"lifer" inmates—is one of the core responsibilities of the Board of Parole Hearings. California Penal Code section 3041(a) requires the board to meet with a lifer inmate one year before the inmate's minimum eligible parole date to set a parole release date. Accordingly, *California Department of Corrections and Rehabilitation Operations Manual*, section 62090.5.1.2, requires the initial parole consideration hearing to be scheduled 13 months before the inmate's minimum eligible parole date.

The parole consideration hearing panel may set a parole date at the inmate's initial hearing unless it determines that public safety requires a longer period of incarceration, in which case the panel sets a subsequent hearing date. In practice, the board rarely grants a lifer inmate a parole date at the initial hearing. There is no maximum number of hearings available to a lifer inmate, and an inmate may undergo 10 to 15 subsequent hearings or may die in custody before the board grants a parole date. Initial parole consideration hearings make up 15 percent of hearings scheduled for indeterminate sentence inmates, while subsequent hearings make up 84 percent. The remaining 1 percent consists of miscellaneous proceedings such as rescission hearings.

The number of lifer inmates has steadily grown, tripling between 1990 and 2006 from 8,153 to 29,189. The increase presents an even greater challenge to the board's ability to handle its hearing workload. To address the hearing backlog, in 2001 the Legislature enacted Senate Bill 778 (Chapter 131, Statutes of 2001). This bill temporarily amended California Penal Code section 5076.1 to allow parole consideration hearings to be conducted by two-person panels that include only one commissioner, effectively doubling the number of panels available for hearings. In May 2005, the Legislature made that authority permanent with the passage of Senate Bill 737 (Chapter 10, Statutes of 2005). In addition, for purposes of calculating and reporting the "backlog" of lifer hearings, Senate Bill 737 defined which cases are to be considered part of the backlog. The bill also provided that when the backlog reached zero, the board must re-compose the hearing panels so that the majority of members are commissioners.

In May 2004, Jerry Rutherford, an inmate at California State Prison, San Quentin, filed a petition for a writ of habeas corpus in Marin County Superior Court alleging the state had failed to "hold a timely lifer parole hearing." His court-appointed attorney filed a motion for class certification, which the court granted in November 2004. The order defined the

affected class as "all prisoners serving indeterminate terms of life with the possibility of parole dates without receiving parole hearings within the time required" by California Penal Code section 3041(a). The resulting class action became the basis for the "Rutherford Task Force," which was established by the Youth and Adult Correctional Agency to address the backlog of hearings, commissioner vacancies, hearing postponements, and other issues affecting the parole consideration hearing process.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the July 2005 follow-up review, the Office of the Inspector General made the following specific findings regarding the unresolved issues:

- ***The reported backlog of parole consideration hearings had increased.*** In early December 2001, the board reported a backlog of 1,400 hearings; by March 31, 2005, the backlog had grown to a reported 1,607 hearings—a 15 percent increase. In the past, the board had attributed the backlog to commissioner vacancies, but since the passage of Senate Bill 778 in July 2001, the board had been allowed to conduct hearings using two-person panels that include only one commissioner instead of two. This bill's impact on the board's backlog was lessened because, at the time of the 2005 review, the Office of the Inspector General confirmed that the board had not had a full complement of commissioners since December 2002.

- ***The board could not identify inmates with approaching or overdue hearing dates.*** To schedule lifer hearings, the board used primarily manual methods involving a monthly exchange of faxes between board staff and a coordinator at each of the 31 Department of Corrections and Rehabilitations institutions housing lifer inmates. The board described improvements made to its database, but the Office of the Inspector General's review determined that, even though the board captured extensive detail for lifer hearings, it had not developed technology allowing it to obtain information from the institutions necessary to identify inmates needing hearings. For example, after evaluating the board's "initial hearing report" and its "subsequent hearing report," the Office of the Inspector General determined that these reports were of limited value in identifying statutorily mandated hearing dates or in scheduling future hearings. Therefore, although it used a database to help it manage its lifer hearings, the Board of Parole Hearings could not collectively identify all inmates with approaching or past-due mandated hearing dates so that hearings could be scheduled.

- ***The board reported misleading statistics on lifer hearings.*** The way the board reported the number of hearings it conducted each year inflated the total. For the three-year period from 2002 through 2004, the board overstated the number of hearings it held by nearly 4,000 because it counted hearings *scheduled* rather than actually *conducted*. For example, the board reported it conducted 4,826 hearings in 2002, but that number represented scheduled hearings; the board actually conducted only 3,926 hearings, with the reported number representing an overstatement of 900 hearings. Over the same three-year period, the board experienced a dramatic increase in hearing postponements,

which added to the difference between hearings scheduled and conducted. After the board adopted a regulation allowing inmates to request a hearing postponement "for any reason" no later than 10 working days before the scheduled hearing, the hearing postponement rates grew from 18 percent in 2002 to 37 percent in 2004 and from August 2004 through April 2005 to 44 percent.

The way the board determined the number of overdue hearings comprising the hearing backlog was similarly flawed. Instead of actually counting the number of overdue hearings, the board relied on a formula-driven calculation that excluded hearings that were postponed by the inmate but never actually held. For purposes of the board's official reports, the calculation counted inmate-initiated hearing postponements as "hearings conducted."

- ***Senate Bill 737 excluded hearings up to 30 days overdue from the backlog.*** In providing guidance to the board in reporting its hearing backlog, Senate Bill 737 defined "backlog" as hearings held "*more than 30 days past the statutory due dates"* [emphasis added]. The effect was to exclude from the backlog hearings overdue by up to 30 days, theoretically allowing the board to hold all of its hearings past the statutory due dates, yet still report a backlog of zero.

  Furthermore, according to Senate Bill 737, when the backlog reaches zero, the board's hearing panels are to consist of at least two commissioners. This has the effect of reducing by half the number of hearings that can be held even though hearings are as much as 30 days past due.

- ***Rutherford task force created to address indeterminate sentence hearing process.*** In February 2005, the Youth and Adult Correctional Agency formed a task force in response to a class action lawsuit, *Rutherford v. Perez, et al.*, which alleged that the state had failed to hold prompt lifer parole hearings. The purpose of the task force, which includes Board of Parole Hearings representatives, is to address issues affecting lifer inmates, including hearing postponements, vacancies in commissioner positions, and hearing workload.

The Office of the Inspector General made seven recommendations to the Board of Parole Hearings as a result of the 2005 review. The specific recommendations are listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

Since March 2000, the Office of the Inspector General has repeatedly recommended that the Board of Parole Hearings establish a centralized system for tracking hearing cases. After seven years, the board finally is taking action. The board reported that it is developing a new automated system for tracking and scheduling parole consideration hearings for inmates sentenced to indeterminate prison terms. The system is intended to ensure that hearings are held within statutory time limits, thereby reducing the hearing backlog. The new system—

the Lifer Scheduling and Tracking System, which is expected to be implemented in November 2007—is designed to do the following tasks:

- Provide regular monthly reports to help the board forecast, schedule, and manage the lifer hearing workload.

- Calculate the backlog of lifer hearings based on an actual count of hearings that have passed statutory due dates.

- Include a variety of features to ensure the quality of information entered, stored, and produced.

In addition, the board reported it has developed new policies and procedures and is working more closely with the institutions to reduce the number of lifer hearing postponements. The board's records indicate that these and other measures decreased the hearing backlog from 2,273 in October 2005 to 1,153 in September 2006. The board also reported that it has not implemented one of the recommendations because of a class action lawsuit and court involvement. As explained in the table that follows, one recommendation is no longer applicable: the recommendation that the board move its meetings to Mondays to allow for an increased hearing schedule during weeks that include a board meeting.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Board of Parole Hearings take the following actions:

- **Implement the Lifer Scheduling and Tracking System to enable the board to have access to the most current, accurate, and relevant information necessary to manage its lifer hearing responsibilities.**

- **Ensure that the Lifer Scheduling and Tracking System includes regular monthly reports for use in forecasting, scheduling, and managing the lifer hearing workload.**

- **Ensure that the Lifer Scheduling and Tracking System contains quality control features so that the information entered into, stored within, and produced by the system is accurate.**

- **Ensure that the Lifer Scheduling and Tracking System reports an actual count of hearings that have passed their statutory due dates.**

- **Ensure that the Lifer Scheduling and Tracking System counts the hearing backlog based on the hearing date required by California Penal Code section 3041(a) and request that the Legislature amend California Penal Code section 3041(d) accordingly. In addition, consider the impact of the requirement to**

have hearing panels consist of at least two commissioners when the backlog reaches zero.

The Office of the Inspector General conducted its work on the Board of Parole Hearings from November 15, 2006, through March 8, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 1

The Board of Parole Hearings' system for identifying and scheduling indeterminate sentence hearings was inadequate to ensure that the hearings were properly managed and conducted with reasonable promptness. (March 2000)

RECOMMENDATIONS	STATUS	COMMENTS
The Board of Parole Hearings should:		
Develop an information system that will result in the board having access to the most current, accurate, and relevant information necessary to manage its lifer hearing responsibilities. Such information should include, for example, minimum eligible parole dates and details of inmate status that may affect legally mandated subsequent hearing dates. (March 2000)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented.* *A. <u>Lifer Scheduling and Tracking System</u>* *The Board of Parole Hearings Lifer Scheduling and Tracking System is currently under development in the requirements phase and is scheduled to be released in November of 2007. The Feasibility Study Report was approved in May of 2006 and funding has been provided for fiscal year 2006/2007. This system will track life inmates throughout the life parole consideration hearing process and capture historical information on prior parole proceedings. The system will be able to report an individual case as it proceeds to a hearing, capturing important dates, the preparation of hearing documents, service of rights and the outcome and participants at hearings. Scheduling of parole hearings will be a major component of Lifer Scheduling and Tracking System allowing Board of Parole Hearings headquarter schedulers to calendar specific inmates at specific institutions according to their hearing due dates. The system will report the timeliness of parole hearings at each institution. The following system is also a necessary component of the lifer hearing process due to court mandates.* *B. <u>Disability Effective Communication System</u>* *The Board of Parole Hearings Disability Effective Communication System is in the beginning stages and currently the Feasibility Study Report is being finalized and funding has been identified. The Disability Effective Communication System has a planned release date of early 2007. The Disability Effective Communication System will provide the California Department of Corrections and Rehabilitation and the Board of Parole Hearings staff the ability to access a data base containing Americans with Disabilities Act and effective communication needs and accommodations provided to individual inmates and*

RECOMMENDATIONS	STATUS	COMMENTS
		parolees prior to, during, and after parole proceedings. It will contain historical information from the Board of Parole Hearings Americans with Disabilities Act Database, Distributed Data Processing System, and Cal parole. The data base will be accessed by a California Department of Corrections and Rehabilitations number and will provide the user with a comprehensive look at the inmate/parolee's historical Americans with Disabilities Act/Effective communication information gathered throughout his/her incarceration, during his/her parole period and at prior Board of Parole Hearings parole proceedings. *There are two phases to this project.* *<u>Phase One:</u> The California Department of Corrections and Rehabilitation and the Board of Parole Hearings staff contacting parolees involved in revocation and revocation extension hearings will be able to access this data base in the early part of 2007 in accordance with the Armstrong Court Order.* *<u>Phase Two:</u> Due to connectivity issues in the institutions, the California Department of Corrections and Rehabilitation and the Board of Parole Hearings staff contacting parolees involved in Life parole Consideration Hearings, Mentally Disordered Offender and Sexually Violent Predator Hearings will not be able to access the database until November 2007, when the Lifer Scheduling and Tracking System will be released providing connectivity to all users. Once connectivity has been established at institutions throughout the state, then the California Department of Corrections and Rehabilitation staff, including Correctional Counselor 1/Correctional Counselor 2s, mental health professionals, legal contractors and case records staff will be able to enter/update American with Disabilities Act/Effective Communication information into the database.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the California Department of Corrections and Rehabilitation's response, the Lifer Tracking and Scheduling System Project Management Schedule, and the December 2006 Independent Project Oversight Report. The Lifer Tracking and Scheduling System should allow the board access to information necessary to manage its lifer hearing

RECOMMENDATIONS	STATUS	COMMENTS
		responsibilities. The system, however, will not be available until November 2007, according to the board's reported schedule.
Further develop regular monthly reports for use by board management in forecasting, scheduling, and managing the lifer hearing workload. (July 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The above noted Lifer Scheduling and Tracking System will provide these types of reports.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the Lifer Tracking and Scheduling System Detailed Design Specification document. This document details a variety of reports that would provide the Board of Parole Hearings with data to help it forecast, schedule, and manage its lifer hearing workload as recommended. The system, however, will not be available until November 2007, according to the board's reported schedule.
Develop a system of quality control over data entry and compilation to ensure the quality of management reports. (April 2002)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The above-noted Lifer Scheduling and Tracking System will provide for the management reports.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the Lifer Tracking and Scheduling System Detailed Design Specification document and held discussions with Board of Parole Hearings staff. Board staff described a variety of quality control features, including mandatory fields of entry and system checks that will block alpha and numeric entries in certain instances. In addition, the Office of the Inspector General reviewed parts of the design document that detailed a secondary review requirement for certain reports before these reports can be submitted to the Lifer Tracking and Scheduling System. Secondary review will ensure the quality of information entered, stored, and produced. As stated previously, the board does not expect the system to be operational until November 2007.

FOLLOW-UP RECOMMENDATIONS

The Board of Parole Hearings should take the following actions:

- **Implement the Lifer Scheduling and Tracking System to enable the board to have access to the most current, accurate, and relevant information necessary to manage its lifer hearing responsibilities. (March 2000)**
- **Ensure that the Lifer Scheduling and Tracking System includes regular monthly reports for use in forecasting, scheduling, and managing the lifer hearing workload. (July 2005)**
- **Ensure that the Lifer Scheduling and Tracking System contains quality control features so that the information entered into, stored within, and produced by the system is accurate. (April 2002)**

FINDING NUMBER 2

The Board of Parole Hearings had not taken proactive measures to reduce the backlog of indeterminate sentence hearings, which continued to grow until the implementation of Senate Bill 778. Reductions in the backlog had resulted entirely from the enactment and implementation of Senate Bill 778 (Chapter 131, Statutes of 2001). (April 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Board of Parole Hearings should:		
Move its regular monthly meeting to Monday to increase the number of hearings held during that week. In the alternative, the board should conduct a half day of hearings at local prisons beginning at 1:30 p.m. on the Monday preceding the regular Tuesday meeting. (April 2002)	NOT APPLICABLE	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. This recommendation has been determined not viable. SB 737 (Chapter 10, Statutes of 2005) requires the Board to conduct 40 hours of training per year. The Board is therefore currently providing Commissioners en banc case review preparation time on Mondays and dependent on the extent of the en banc agenda providing them with training either Monday afternoon or Tuesday morning before the en banc public hearing. In addition, the Board is currently comprised of 11 filled hearing panels and due to increased case reviews by the number of hearing panels, the number of cases requiring an en banc higher review has increased dramatically. The Commissioners need sufficient time and opportunity to adequately prepare for both scheduled lifer hearings and for the*

RECOMMENDATIONS	STATUS	COMMENTS
		items/issues on the monthly regular board agenda. Travel and preparation time are necessary requirements for a Commissioner to properly fulfill their required duties. **Office of the Inspector General's comments:** The Office of the Inspector General performed no audit procedures to verify the department's representation. However, because the department states that it is ensuring its commissioners use the time leading up to its regular Tuesday meeting productively, this recommendation is considered no longer applicable.

FOLLOW-UP RECOMMENDATIONS

None

FINDING NUMBER 3

The Board of Parole Hearings' estimated schedule for eliminating the hearing backlog by May 2002 was unrealistic. (April 2002)

RECOMMENDATIONS	STATUS	COMMENTS
The Board of Parole Hearings should:		
Develop policies, procedures, and regulations to minimize the number of hearing postponements, both inmate-initiated and board-initiated. (July 2005)	SUBSTANTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Fully Implemented. The Board revised its policies and adopted emergency regulations, which became operative on June 28, 2004. Title 15, California Code of Regulations § 2253, Postponements, Continuances, and Stipulations of Unsuitability, expanded former regulations on postponements. The Board worked closely with the California Department of Corrections and Rehabilitation Case Records to ensure that timeframes were set which gave inmates incentives to resolve problems and request postponements sufficiently in advance so that other hearings could be substituted—thus reducing the backlog of overdue*

RECOMMENDATIONS	STATUS	COMMENTS
		life prisoner suitability hearings and reducing wasted workload by California Department of Corrections and Rehabilitation Records. Commissioners continue to receive periodic training on the new procedures. Prisoners and their attorneys for the suitability hearings are provided notice of this process when the hearings are first scheduled to optimize the orderly and efficient use of the Board and institutional resources and thus reduce the hearing backlog. *Further improvements have been developed, but their adoption has been delayed while plaintiffs in Lugo [Rutherford] class action review and comment. The parties have a "meet and confer" scheduled for December 2006, and hope to finalize the proposal during 2007. Then adoption of the regulation amendments would be placed on the Board Meeting Agenda for 2007.* **Office of the Inspector General's comments:** The Office of the Inspector disagrees that the board's adoption of *California Code of Regulations*, Title 15, section 2253 had a positive impact on the hearing backlog. In its 2005 accountability audit, the Office of the Inspector General reported that section 2253 exacerbated the dramatic increase in inmate postponements by allowing inmates to request a postponement for any reason no fewer than 10 working days prior to the scheduled hearing. Immediately after adoption of this change, the overall postpone rate for hearings scheduled for August 2004 through April 2005 rose to 44 percent. The Office of the Inspector General, however, accepts the board's representation that working closely with the department's case records staff has had a positive impact on its workload. Addressing inmate issues earlier has allowed the board to schedule substitute hearings when inmates request postponements. According to the board's statistics, the lifer parole consideration hearing backlog decreased from 2,273 in October 2005 to 1,153 in September 2006. The board reported that late or out-of-date psychological evaluations are a cause for many board initiated hearing postponements. To address this

RECOMMENDATIONS	STATUS	COMMENTS
		problem, the board is proposing to transfer responsibility for the psychological evaluations from the individual institutions to a new unit within the board. The sole function of the new unit will be to conduct psychological evaluations for lifer inmate parole hearings. The unit will consist of 17 full-time psychologists and two senior psychologists. According to the board, both senior psychologist positions have been filled as well as 13 of the psychologist positions. Four psychologists will be starting in March and April 2007. Because the board has taken corrective action to mitigate the impact of inmate postponements on the hearing workload but has not yet implemented the new process for conducting psychological evaluations, the Office of the Inspector General determined that the recommendation was substantially implemented rather than fully implemented.
For official reports, discontinue the current method of calculating the backlog of hearings and replace it with a method that reports an actual count of hearings that have passed their statutory due dates. (July 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The above noted Lifer Scheduling and Tracking System will provide for this.* **Office of the Inspector General's comments:** The Office of the Inspector General held discussions with Board of Parole Hearings staff and learned that the Lifer Scheduling and Tracking System will base the backlog calculation on whether the inmates' hearings are calendared for a date that is past their "no-later-than" date. These hearings will be considered late and will be included in the backlog calculation. The Board of Parole Hearings plans to begin using the Lifer Scheduling and Tracking System in November 2007.
Work with the Legislature to reconsider how the hearing "backlog" is defined in Penal Code section 3041(d), as revised by passage of Senate Bill 737. Additionally, consider the impact of the requirement to have hearing panels consist of at least two	NOT IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Not Implemented. This is being defined by the courts in the aforementioned class action lawsuit.* **Office of the Inspector General's comments:**

RECOMMENDATIONS	STATUS	COMMENTS
commissioners when the backlog reaches zero. (July 2005)		According to the executive director of the Board of Parole Hearings, the department has committed to the Superior Court of California in Marin County that the calculation for determining parole hearing backlogs will be based on the hearing date required by California Penal Code section 3041(a) and not 30 days after as defined in section 3041(d). Moreover, the new automated system being developed for tracking backlogs is being programmed accordingly. The Office of the Inspector General further notes that the department's comments do not address that portion of the recommendation regarding hearing panels consisting of at least two commissioners.

FOLLOW-UP RECOMMENDATIONS

The Board of Parole Hearings should take the following actions:

- **Ensure that the Lifer Scheduling and Tracking System reports an actual count of hearings that have passed their statutory due dates. (July 2005)**

- **Ensure that the Lifer Scheduling and Tracking System counts the hearing backlog based on the hearing date required by Penal Code section 3041(a) and request that the Legislature amend California Penal Code section 3041(d) accordingly. In addition, consider the impact of the requirement to have hearing panels consist of at least two commissioners when the backlog reaches zero. (July 2005)**

SUPERVISION OF DEPUTY COMMISSIONERS

IMPLEMENTATION REPORT CARD

2005 Follow-up recommendations: 3

Less: Recommendations no longer applicable: 1

Recommendations still applicable: 2

Fully implemented: 0 (0%)

Substantially implemented: 0 (0%)

Partially implemented: 2 (100%)

Not implemented: 0 (0%)

The Office of the Inspector General learned that the Board of Parole Hearings has contracted for a new workload study that will give the board information to properly estimate the number of deputy commissioner positions it requires. In addition, the board has implemented procedures to better supervise its deputy commissioners.

The Office of the Inspector General released a review in January 2003 concerning the legitimacy of a proposal by the Board of Prison Terms, the Board of Parole Hearings' predecessor, to fill 24 of its vacant deputy commissioner positions in light of the state budget crisis. The Office of the Inspector General reported that the board did not need additional deputy commissioners, and that, in fact, with more efficient use of its resources, the board could fulfill its responsibilities with slightly more than half its then-existing staff. The Office of the Inspector General also reported that the board's parole revocation process was deficient partly because the board failed to adequately supervise its deputy commissioners. The Office of the Inspector General made six recommendations to address these issues.

In its 2005 follow-up review, the Office of the Inspector General found that the board had not yet implemented a time-management system, thereby hindering its ability to project the number of deputy commissioners it needed to fulfill its responsibilities. The board, however, had increased its supervision and the productivity of its deputy commissioners. As a result of the review, the Office of the Inspector General made three follow-up recommendations.

BACKGROUND

Deputy commissioners are central to the Board of Parole Hearings' mission and functions; they conduct a variety of hearings including those for parole revocation and mentally disordered offenders, among other duties. The board reported that it had 90 authorized deputy commissioner positions for fiscal year 2006-07. To justify the positions, the board uses a "workload analysis," a calculation that incorporates the number of hearings and other functions it performs each year, the time required to complete each function, and each deputy commissioner's available work hours.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the July 2005 follow-up review, the Office of the Inspector General determined that three of the six recommendations from the original January 2003 review still had not been adequately addressed. Specifically, the Board of Parole Hearings had improved its supervision and the productivity of its deputy commissioners, as recommended, by

increasing both the number of supervisors relative to deputy commissioners and the number of parole revocation hearings scheduled for deputy commissioners each day. The board also had made progress in evaluating the number of deputy commissioner positions it needed to fulfill its responsibilities, but its failure to implement a time-management system to capture the time that deputy commissioners spent on various activities hampered the board's ability to make a more accurate evaluation. The board's ability to determine how many deputy commissioners it needed to fulfill its responsibilities also was affected by its implementation of a new parole revocation process pursuant to the *Valdivia v. Schwarzenegger* litigation. Consequently, the board lacked historical information necessary for projecting the time required to comply with the new process.

The Office of the Inspector General made three recommendations to the Board of Parole Hearings as a result of the 2005 review. The specific recommendations are listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

As part of its 2007 review, the Office of the Inspector General learned that the Board of Parole Hearings has contracted with a firm to conduct a workload study. The study is underway, and the outcome will assist the board in better estimating the number of deputy commissioner positions it requires to fulfill its mission. In addition, the Board of Parole Hearings is better equipped to supervise its deputy commissioners. Although the board did not develop and implement a time-management system as the Office of the Inspector General had recommended, the board has taken alternative steps to supervise its deputy commissioners. According to the board, its Revocation Scheduling and Tracking System accounts for the deputy commissioners' daily hearing activities. The board also has implemented policies requiring the deputy commissioners to report to their supervisors when their hearing days end early so that the deputy commissioners can be redirected. Furthermore, the board has been authorized two additional associate deputy commissioners, the classification that is responsible for supervising the deputy commissioners.

The steps the Board of Parole Hearings has taken, as described above, result in partial implementation of the two recommendations the Office of the Inspector General made as part of its 2005 follow-up review. As shown in the table that follows, one recommendation is no longer applicable.

FOLLOW-UP RECOMMENDATIONS

The Board of Parole Hearings should take the following actions:

- **Ensure completion of the workload analysis.**

- **Continue its efforts to increase the number of authorized associate chief deputy commissioner positions relative to the number of deputy commissioners they supervise and to make the compensation of the associate chief deputy commissioner position commensurate with the responsibility of the position for supervising deputy commissioners.**

The Office of the Inspector General conducted its work on the Board of Parole Hearings from November 15, 2006, through February 3, 2007.

The following table summarizes the results of the 2007 follow-up review. The findings are numbered and dated in accordance with the report in which they first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 1

The Board of Parole Hearings had significantly overstated the number of deputy commissioner positions it required to fulfill its responsibilities and that the actual number of deputy commissioner positions it needed was only about 39—slightly more than half its deputy commissioner staff. (January 2003)

RECOMMENDATION	STATUS	COMMENTS
The Board of Parole Hearings should:		
Use information from the time-management system proposed in Finding 2 to support future workload analyses. The two critical factors in the workload analysis report—total hours required to complete hearings and total number of hours each deputy commissioner can work in one year—should be updated to accurately reflect current capabilities. (January 2003)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Board of Parole Hearings has engaged an independent management review organization to conduct such a study. The Board of Parole Hearings contracted with Cooperative Personnel Services to do a comprehensive organizational assessment and long-range accountability and workload management strategies for the Board of Parole Hearings. The contractors are currently in the field gathering data.* *Since the initial Office of the Inspector General inquiry, the Board of Parole Hearings significantly altered the method of review and conduct of parole violator proceedings pursuant to implementation of the Valdivia Federal Court remedial sanctions. The Board of Parole Hearings developed economies of scale approach with the Valdivia model by way of consolidating the work center where the majority of the workload occurs into Decentralized Revocation Units in nine state prison reception centers and three county jail locations.* *The Board of Parole Hearings is currently conducting face-to-face Probable Cause Hearings in approximately 50 percent of the 58 counties on a regular basis. The Board of Parole Hearings is in ongoing negotiations with plaintiff's counsel in Valdivia regarding conducting face-to-face hearings. The plaintiffs want the Board of Parole Hearings to conduct face-to-face hearings in all locations. The Board of Parole Hearings has established a modified process to include the use of a speaker phone to conduct Probable Cause Hearings, in the remote and rural locations.*

RECOMMENDATION	STATUS	COMMENTS
		The Revocation Scheduling and Tracking System, which is presently used to track the parole violation process was not developed as a time management reporting tool and it cannot currently be used as such without significant modifications. The Board of Parole Hearings has run ad hoc reports in an attempt to capture workload/caseload data. **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the scope of work for the contracted workload study. The study will help the Board of Parole Hearings identify staff members' critical job tasks and the time it takes to complete those tasks and will form the basis for the board's estimate of future staffing needs. The board's contract indicated that the workload study would be complete in June 2007. The Office of the Inspector General notes that the board's decision to perform a workload study rather than install an ongoing time-management system may result in the need to do another workload study as the board's processes change.

FOLLOW-UP RECOMMENDATION

The Board of Parole Hearings should ensure completion of the workload analysis. (January 2003)

FINDING NUMBER 2

The deputy commissioners of the Board of Parole Hearings, who carry out most of the board's functions, received little supervision and the board had no means of accounting for how they spent their time. (January 2003)

RECOMMENDATIONS	STATUS	COMMENTS
The Board of Parole Hearings should:		
Develop and implement a time-management system for deputy commissioners. (January 2003)	NOT APPLICABLE	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. See Response above.* **Office of the Inspector General's comments:** The California Department of Corrections and Rehabilitation has not developed and implemented a time-management system for deputy commissioners. According to Board of Parole Hearings staff, rather than implementing a time-management system the board has taken alternative measures to ensure that deputy commissioners are accountable for their time. Those measures include implementation of oversight policies so the deputy commissioners can be redirected should their hearing schedules end early. In addition, the Board of Parole Hearings can provide better supervision by using its Revocation Scheduling and Tracking System to monitor the deputy commissioners' activities.
Continue efforts to increase the number of associate chief deputy commissioner positions relative to the number of deputy commissioners they supervise and to make the compensation of the associate chief deputy commissioner position commensurate with the responsibility of the position for supervising deputy commissioners. (January 2003)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. The Board of Parole Hearings concurs with this finding and will continue in our attempts to increase the number of authorized Associate Chief Deputy Commissioners. The original staffing ratio recommended by the Office of the Inspector General is one Associate Chief Deputy Commissioner to every eight Deputy Commissioners. The then Board of Prison Terms took affirmative steps to increase the number of authorized Associate Chief Deputy Commissioner positions and has been successful in obtaining two positions, but has not been able to acquire authorization for the desired 8-to-1 ratio. The Board of Parole Hearings recruited and filled those positions. Subsequent to filling those positions, the Board of Parole Hearings experienced one Associate Chief Deputy Commissioner resignation and one Associate Chief Deputy Commissioner retirement and Board of Parole Hearings is currently waiting to fill those positions. The Board of Parole Hearings is experiencing two obstacles in recruitment and retention of staff for this classification due to the following*

RECOMMENDATIONS	STATUS	COMMENTS
		reasons: 1. *The existing list of eligible candidates is very small (less than five people) due to compaction with pay for this classification.* 2. *The California Department of Corrections and Rehabilitation Exams Unit recently conducted an Associate Chief Deputy Commissioner exam to expand the list; however, there was an error in the manner in which the exam was conducted. The exam was grieved and the Exams Unit has agreed to conduct another exam. The Exams Unit issued the exam as an open spot exam for Sacramento area only and it should have been a promotional statewide exam. This has caused delays in Board of Parole Hearing's ability to fill vacant Associate Chief Deputy Commissioner positions.* **Office of the Inspector General's comments:** The Office of the Inspector General confirmed that the Board of Parole Hearings has obtained two additional associate chief deputy commissioner positions and is conducting promotional exams to fill the vacant positions. The Office of the Inspector General notes, however, that the board did not respond to the part of the recommendation about making compensation of the associate deputy commissioner position commensurate with the responsibility of the position for supervising deputy commissioners.

FOLLOW-UP RECOMMENDATION

The Board of Parole Hearings should continue its efforts to increase the number of authorized associate chief deputy commissioner positions relative to the number of deputy commissioners they supervise and to make the compensation of the associate chief deputy commissioner position commensurate with the responsibility of the position for supervising deputy commissioners. (January 2003)

HEARINGS FOR MENTALLY DISORDERED OFFENDERS

IMPLEMENTATION REPORT CARD

2005 Follow-up recommendations: 1

Fully implemented: 0 (0%)

Substantially implemented: 0 (0%)

Partially implemented: 1 (100%)

Not implemented: 0 (0 %)

The Office of the Inspector General found that the Board of Parole Hearings continues to automatically conduct placement hearings for mentally disordered offenders 60 days after placing them in the custody of the Department of Mental Health. As a result, the board has conducted many unnecessary hearings since 2003 when the Office of the Inspector General first raised the issue. The board has drafted revised hearing procedures that should correct this inefficiency, but it has not yet implemented them.

The Office of the Inspector General's January 2003 review of the Board of Parole Hearings' predecessor, the Board of Prison Terms, found that it was the board's practice to automatically hold a placement hearing for mentally disordered offenders 60 days after placing them into the custody of the Department of Mental Health as a condition of parole. The 60 days, however, did not allow enough time for the medical treatment team to assess the patient's suitability for outpatient treatment, and 99 percent of the 60-day placement hearings resulted in an order that the patient remain in a Department of Mental Health hospital for continued inpatient treatment. State law requires a hearing only if the parolee requests one. A parolee may request a hearing 60 days after arriving in the Department of Mental Health's custody to determine whether he or she is to be treated in custody or in the community. Because the Board of Parole Hearings was holding hearings based on the passage of time rather than on a parolee's request, the board conducted unnecessary hearings, which were an inefficient use of its resources and a waste of taxpayer dollars. The Office of the Inspector General made two recommendations as a result of its review.

During its 2005 follow-up review, the Office of the Inspector General found that the board continued to hold automatic placement hearings for mentally disordered offenders 60 days after placement into the Department of Mental Health's custody. However, the Board of Parole Hearings had corrected a concern regarding the number of deputy commissioners needed to conduct those hearings by reducing that number from two to one. The Office of the Inspector General made one follow-up recommendation.

BACKGROUND

The Board of Parole Hearings may place a parolee in a Department of Mental Health treatment program as a condition of parole. That condition is imposed when clinical evaluations and a review of court documents show that a parolee has a severe mental disorder and poses a substantial danger to others. Parolees may be evaluated more than once to ensure they meet the legal criteria defining mentally disordered offenders. For example, the parolee participates in a "certification hearing" immediately following a Board of Parole Hearings' order and is transferred to a state hospital for treatment. If the Department of Mental Health has not placed the parolee into community treatment within 60 days of assuming custody, it is the board's practice to automatically hold a "placement hearing" to

determine whether the parolee can be released into the community. Mentally disordered offenders also have the right to request an annual review hearing to determine whether treatment in a state hospital or a community outpatient facility is best. The Board of Parole Hearings provided data indicating that in fiscal year 2006-07 it will conduct approximately 1,024 hearings for mentally disordered offenders, of which 228 will be placement hearings.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the July 2005 follow-up review, the Office of the Inspector General determined that one of the two recommendations from the original January 2003 review still had not been addressed adequately.

The Office of the Inspector General found that in 2005 the Board of Parole Hearings continued to hold automatic placement hearings for mentally disordered offenders 60 days after placing them into the Department of Mental Health's custody. The hearings were unnecessary and inefficient because the law does not require the Board of Parole Hearings to automatically hold a placement hearing; rather, the law allows the parolee to request a hearing on his or her behalf once 60 days have passed. The board concurred with the Office of the Inspector General's recommendation to hold these hearings upon request, but it reported that implementation required modification of the California Penal Code.

The Office of the Inspector General made one recommendation to the Board of Parole Hearings as a result of the 2005 review. The specific recommendation is listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

The Office of the Inspector General found that the Board of Parole Hearings continues to automatically conduct placement hearings for mentally disordered offenders 60 days after placing them into the custody of the Department of Mental Health. Consequently, since 2003 when this issue was first raised to the board, the board has conducted many unnecessary placement hearings and inefficiently used its resources, wasting taxpayer dollars. The board has drafted revised hearing procedures that should correct this inefficiency but has not yet implemented them. Rather than holding placement hearings automatically after 60 days, the board is proposing to hold a hearing after nine months have elapsed or upon a parolee's request. In addition, the Board of Parole Hearings determined that it did not need to amend the Penal Code to make this change. Although it has drafted revised hearing procedures, the board must still approve the procedures internally then take the necessary steps to implement the change. The board anticipates approval in April 2007, at which time it will begin implementing the change at the appropriate hearing locations.

The steps the Board of Parole Hearings has taken, as described above, result in partial implementation of the recommendation the Office of the Inspector General made as part of its 2005 follow-up review.

FOLLOW-UP RECOMMENDATION

The Board of Parole Hearings should approve and implement the planned revisions to its mentally disordered offenders hearing process and discontinue the practice of automatically conducting placement hearings for mentally disordered offenders 60 days after placing them into the custody of the Department of Mental Health. Instead, the board should conduct mentally disordered offender placement hearings at the request of the parolee or of the Department of Mental Health.

The Office of the Inspector General conducted its work on the Board of Parole Hearings from November 15, 2006, through March 30, 2007.

The following table summarizes the results of the 2007 follow-up review. The finding is numbered and dated in accordance with the report in which it first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect issues that are ongoing and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 5

The Board of Parole Hearings' practice of automatically scheduling mentally disordered offender placement hearings 60 days after the inmate's arrival in custody was unnecessary and inefficient. (January 2003)

RECOMMENDATION	STATUS	COMMENTS
The Board of Parole Hearings should:		
Discontinue the practice of automatically conducting placement hearings for mentally disordered offenders 60 days after the patient is placed in the custody of the Department of Mental Health. Instead, the board should conduct mentally disordered offender placement hearings at the request of the parolee or of the Department of Mental Health. Depending on the timing of other reforms planned by the Board of Parole Hearings, it may be beneficial for the board to implement this recommendation immediately. If the Board of Parole Hearings deems it necessary to amend the California Penal Code to implement this recommendation, it should amend section 2964(b) rather than section 2966(b). (January 2003)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented.* ***The Board of Parole Hearings no longer automatically conducts this hearing.*** *Pursuant to Penal Code, Section 2960 et al, severely mentally ill parolees meeting statutory criteria receive mental health treatment as a special condition of parole through the Mentally Disordered Offender Program. The treatment is in a state hospital until it is determined that the parolee can be safely and effectively treated in the community. The Department of Mental Health has the authority to place parolees in the outpatient treatment through the Conditional Release Program without a hearing. However, Penal Code, Section 2966(b) provides parolees with the right to request a hearing before the Board of Parole Hearings if Department of Mental Health has not placed the parolee in outpatient treatment 60 days after admission to the state hospital.* ***Past Board of Parole Hearings policy has been to automatically conduct a placement hearing 90-120 days after admission.*** *The data shows that less than one percent of the placement hearings result in an order for outpatient treatment. This is due to the fact that parolees simply are not ready for treatment in the community after a short period of intensive state hospital treatment. Due to the recommendation by the Office of the Inspector General, the Board of Parole Hearings is currently proposing the following modifications in the placement hearing process, which can be accomplished without legislation to change the current statute.* • *The Board of Parole Hearings will conduct the usual certification hearing during which*

RECOMMENDATION	STATUS	COMMENTS
		time the Deputy Commissioner will reiterate that outpatient treatment is part of the Mentally Disordered Offender special condition of parole, as well as a component of the treatment plan. • *The Deputy Commissioner will explain the placement hearing rights and provide the parolee with the "Notice of Right to Placement Hearing" (BPH 1410) and the "Placement Hearing Request" postcard.* • *If the parolee requests a placement hearing by returning the postcard to the Mentally Disordered Offender Unit, the Board of Parole Hearings will assign an attorney and forward the "Placement Hearing Attorney Appointment" and attorney guidelines to the attorney. The attorney will meet with the parolee at the state hospital and explain the placement hearing rights and process.* • *The attorney will provide the signed "Placement Hearing Attorney Appointment" document to the Board of Parole Hearing's Mentally Disordered Offender Unit. A placement hearing will be scheduled using the current hearing scheduling process.* • *If the parolee does not request a hearing or Department of Mental Health placement in outpatient treatment has not occurred, the Board of Parole Hearings will automatically schedule a placement hearing approximately nine months after admission to the state hospital.* • *All other matters pertaining to the placement hearing remain intact.* **Office of the Inspector General's comments:** Although the Board of Parole Hearings reported in its response above that it no longer automatically conducts placement hearings for mentally disordered offenders 60 days after placing them into the custody of the Department of Mental Health, the board subsequently informed the Office of the Inspector General that the new process had yet to be implemented pending final written authorization. The board staff explained that because of the board's involvement with the Department of Mental Health and the Community Correctional Program, the procedural change needs to be finalized in writing so it can be disseminated to the various stakeholders and so training can be provided to the participants. The Office of the Inspector General reviewed

RECOMMENDATION	STATUS	COMMENTS
		the proposed procedural change and found that the new procedures delay the automatic hearing until approximately nine months after a parolee is admitted to the state hospital or when the parolee requests a hearing after staying 60 days in a state hospital. The Board of Parole Hearings anticipates approving the procedures in April 2007 and implementing them at the appropriate hearing locations.

FOLLOW-UP RECOMMENDATION

The Board of Parole Hearings should approve and implement the planned revisions to its mentally disordered offenders hearing process and discontinue the practice of automatically conducting placement hearings for mentally disordered offenders 60 days after placing them into the custody of the Department of Mental Health. Instead, the board should conduct mentally disordered offender placement hearings at the request of the parolee or of the Department of Mental Health. (January 2003)

REVIEW OF BOARD OF PAROLE HEARINGS DECISIONS

IMPLEMENTATION REPORT CARD

2005 Follow-up recommendations: 1

Fully implemented: 0 (0%)

Substantially implemented: 0 (0%)

Partially implemented: 1 (100%)

Not implemented: 0 (0%)

The Office of the Inspector General found that the Board of Parole Hearings has drafted modifications to regulations allowing the board to review a portion of the proposed decisions rather than all. The board, however, has not obtained final approval for the new regulations.

In its January 2003 review, the Office of the Inspector General found that the Board of Parole Hearings' predecessor, the Board of Prison Terms, had not complied with a regulatory requirement to review all proposed decisions for quality.

The Office of the Inspector General conducted a follow-up review of the Board of Parole Hearings in 2005. The follow-up also revealed that, although the board had established a quality control unit responsible for reviewing parole revocation decisions, the board had not amended the *California Code of Regulations* to allow the unit to review a portion of proposed decisions rather than all proposed decisions. The Board of Parole Hearings had, however, corrected a condition regarding deputy commissioners' and associate chief deputy commissioners' need for training.

BACKGROUND

California Code of Regulations, Title 15, sections 2041 and 2042, require the Board of Parole Hearings to review certain decisions before they take effect. The review ensures that the decisions are complete, accurate, consistent, and uniform and that they promote public safety. Decisions subject to review include those resulting from hearings for:

- mentally disordered offenders,
- parole revocations,
- indeterminate sentences,
- sexually violent predator probable cause, and
- serious offenders.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the July 2005 follow-up review, the Office of the Inspector General determined that one of the two recommendations from the original January 2003 review still had not been adequately addressed. Specifically, the Board of Parole Hearings was not complying with state regulations requiring the board to review all proposed decisions to further public safety and ensure the decisions are complete, accurate, consistent, and uniform. During the 2005 follow-up review fieldwork, the Board of Parole Hearings' management reported that in approximately September 2004 it had established a quality

control unit responsible for reviewing parole revocation decisions and that in May 2005 the quality control examinations had begun. The board also stated that the quality control unit examined about 250 randomly selected parole revocation decisions per month. The board considered changing the Title 15 requirement that it review all proposed decisions but reported it had not yet taken action. The Office of the Inspector General recommended that the board modify Title 15, sections 2041 and 2042, to allow review of a portion of proposed decisions rather than all proposed decisions.

The Office of the Inspector General made one recommendation to the Board of Parole Hearings as a result of the 2005 review. The specific recommendation is listed in the table that follows.

SUMMARY OF THE 2007 FOLLOW-UP RESULTS

As part of its 2007 review, the Office of the Inspector General determined that the Board of Parole Hearings had taken steps in 2006 to amend Title 15 to allow for review of a portion of proposed decisions, but those actions were incomplete. Specifically, the board drafted regulations and placed them on the Board of Parole Hearings' 2006 Rulemaking Calendar. According to the board, however, other regulatory matters took priority, and this change was not carried out in 2006.

FOLLOW-UP RECOMMENDATION

The Board of Parole Hearings should ensure that it modifies *California Code of Regulations*, Title 15, section 2041, to allow for review of a portion of proposed decisions rather than all decisions.

The Office of the Inspector General conducted its work on the Board of Parole Hearings from November 15, 2006, through January 23, 2007.

The following table summarizes the results of the 2007 follow-up review. The finding is numbered and dated in accordance with the report in which it first appeared; the numbering may not be sequential because some findings have been resolved and are not included in this follow-up. In addition, when applicable, the Office of the Inspector General has modified the finding text to only reflect ongoing issues and has removed any reference to portions of the finding that the department has resolved. Finally, the date a recommendation was first made is listed in parentheses after the recommendation.

FINDING NUMBER 4

The Board of Parole Hearings had not implemented a regulatory requirement to systematically review its decisions to ensure the decisions are complete, accurate, consistent, uniform, and further public safety. (January 2003)

RECOMMENDATION	STATUS	COMMENTS
The Board of Parole Hearings should:		
Modify *California Code of Regulations,* Title 15, section 2041, to allow for review of a portion of proposed decisions rather than all decisions. (January 2005)	PARTIALLY IMPLEMENTED	**California Department of Corrections and Rehabilitation's response:** *Partially Implemented. While the project was placed on the Board's Rulemaking Calendar for adoption, other regulations projects have consumed the Board's meager policy staff resources. These include implementing Penal Code, Section 3000.1 by adopting a hearing process for parole violations by former life prisoners, necessary for protection of the public safety, and implementing a federal court order by revising due process regulations giving notice of general and special conditions of parole. The Inspector General's reminder of this regulation amendment recommendation has prompted the Board to move it up higher on the list of regulation priorities and the Board expects to finalize the policy and bring it to the Board Meeting for adoption in 2007.* **Office of the Inspector General's comments:** The Office of the Inspector General reviewed the draft regulations and the Board of Parole Hearings' 2006 Rulemaking Calendar and was assured by the board that it will consider the regulatory change in 2007.

FOLLOW-UP RECOMMENDATION

The Board of Parole Hearings should ensure that it modifies *California Code of Regulations*, Title 15, section 2041, to allow for review of a portion of proposed decisions rather than all decisions. (January 2005)

ATTACHMENT

RESPONSE FROM THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

State of California

Department of Corrections and Rehabilitation

Memorandum

Date : July 17, 2007

To : Matthew L. Cate, Inspector General
Office of the Inspector General
P.O. Box 348780
Sacramento, CA 95834-8780

Subject: **RESPONSE TO THE OFFICE OF THE INSPECTOR GENERAL'S DRAFT ACCOUNTABILITY AUDIT REPORT ENTITLED: *ACCOUNTABILITY AUDIT: REVIEW OF AUDITS OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION 2000-2005***

This memorandum is in response to the Office of the Inspector General's (OIG) draft report entitled *Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation (CDCR) 2000-2005.* The report encompasses 15 audit areas relative to the Division of Juvenile Justice (DJJ) and the Board of Parole Hearings (BPH/Board). Due to the uniqueness of program areas, the response relative to each program is addressed under separate headings. As with all audits and special reviews, CDCR appreciates the OIG's continued commitment to improving our programs and operations.

CDCR is mindful that not all of the OIG's original recommendations were fully implemented and of the OIG's concerns that CDCR may have overstated its implementation progress. Though characterized in the Executive Summary as "overstating" facts, this can better be described as a disagreement regarding implementation status. After collaborative discussions between the OIG and CDCR staff, it was acknowledged that a lack of clarity existed regarding the intent of some of the OIG's recommendations which adversely impacted CDCR responses. CDCR is confident that through mutual partnership and clearer communication, future reports will accurately reflect implementation efforts.

Division of Juvenile Justice:

DJJ has made significant progress in recent years to comply with two-thirds of the recommendations presented by the OIG. DJJ staff has devoted countless hours pursuing the recommendations made in previous audits while implementing the largest reform in the history of DJJ. These two dynamics create wonderful opportunities, but also present challenges for CDCR. Every effort is underway to ensure these activities are intertwined to meet the needs of the youth serviced in DJJ.

- While DJJ is making significant improvements in implementing programs for most youth in its care, there is still the on-going challenge to provide meaningful programs for the nine percent of DJJ youth assigned to Restricted Programs based on their disruptive institutional behavior. Under the Farrell Reforms, DJJ has received funding for the creation of behavior treatment programs (BTP), with smaller living units, increased staffing, and expanded treatment space. These changes should go a long way to remedy meaningful programming for the small percentage of youth who present dangerous behavior within the facility. Even prior to the opening of BTPs, DJJ has substantially increased the time youth spend out of their rooms since the 2005 accountability audit and will continue efforts to fully implement the 21 and 3 mandate.

- DJJ diligently pursued teacher recruitment efforts and has made significant progress given the recent salary increase for teachers, however the struggle continues in certain geographical areas to hire permanent and substitute teachers. CDCR is also making progress in adding modular classrooms that are critical to conduct appropriate educational services. Additionally, the *Farrell* Education experts are documenting significant improvement in DJJ facilities regarding compliance with the remedial plans.

- In the past year, the *Farrell* experts assigned to oversee the DJJ Medical Remedial Plan noted several significant accomplishments in the areas of leadership, standardization, access to care, and quality management. The experts acknowledged success related to the licensure of a correctional treatment center for in-patient mental health treatment; development of 32 essential policies to ensure the provision of adequate, timely, and appropriate health care; designed a training plan for all heath care services staff, and filled critical leadership positions to ensure the medical remedial plan is fully implemented.

- Direct management of the Juvenile Parole Board has been returned to the Chief Deputy Secretary, DJJ. In the next six months, the Executive Officer of the Board will focus on many critical areas including implementation of prior OIG recommendations, implementation of the *LH* lawsuit (LH are the initials of the first ward in the class action lawsuit), and substantial training for Board members and Board staff. CDCR is confident that the Board will successfully address all OIG concerns by the end of the year.

- DJJ is pleased that the number of concerns related to facility security was limited. In the next 30 days, a policy revision will be finalized which eliminates the requirement that perimeter fences be placed in concrete. Efforts with CDCR's Office of Correctional Safety to implement a hostage training related to staff conduct and negotiations will continue.

Board of Parole Hearings:

BPH staff and resource allocation resulting from the *Valdivia v. Schwarzenegger* and *Lugo v. Schwarzenegger* (formerly known as *Rutherford v. Schwarzenegger*) lawsuits has challenged the BPH's ability to unilaterally make more concerted progress toward implementing some of the OIG's recommendations. Ongoing negotiations with plaintiffs' counsel continue to be the principal complication, consuming a great deal of time and resources, as the nature of implementing such change require review and approval by *Valdivia* or *Lugo* plaintiff's counsel. Nevertheless, BPH has made considerable progress toward the implementation of the OIG's recommendations.

- The Disability Effective Communication System was deployed on March 26, 2007, and based on available funding BPH will continue to maintain/upgrade the system and assure compliance with the *Armstrong* court order.

- On May 10, 2007, the Marin County Superior Court ruled, for the purpose of the *Lugo* lawsuit, a life prisoner parole consideration hearing is overdue if it does not occur on the date prescribed by the Penal Code. This ruling resolved a conflict between the Penal Code and direction the Legislature had issued in terms of describing the backlog of late hearings as those that did not occur within 30 days after the date prescribed by the Penal Code.

- In April 2007 BPH provisionally approved proposed amendments to California Code of Regulations (CCR), Title 15, Section 2253. The amendments would minimize the number of life prisoner parole consideration hearing postponements, both inmate-initiated and board-initiated. These amendments were generated through a lengthy and extensive meet and confer process with plaintiff's counsel in the *Rutherford/Lugo* case. However, after BPH approved the proposed amendments, several ambiguities were identified. It was determined the most prudent course of action was to further refine the amendments. Plaintiff's counsel objected to these refinements and moved that the previously approved version be submitted to the Office of Administrative Law (OAL). On July 11, 2007, Marin County Superior Court ordered BPH to submit the previously approved regulations to OAL.

- A proposed amendment to CCR, Title 15, Section 2041(h) was placed on the June 2007 Board meeting agenda, which provided for a review of a random sampling of decisions denying parole. Several unanticipated questions arose regarding the role of the chief counsel in decision review, and it was necessary to postpone consideration of the proposed amendment pending clarification. BPH will consider the regulation amendment and response to pertinent questions at its July 2007 public meeting.

- BPH utilizes a speaker phone to conduct Probable Cause Hearings in remote locations only in limited circumstances. Since March 2007 BPH has conducted approximately 85 percent of all Probable Cause Hearings face-to-face. As further deputy commissioner staffing levels outpace attrition, the goal of full implementation will be attained.

- The revised Mentally Disordered Offenders (MDO) Placement Hearing process has been approved by the Executive Officer. A major obstacle continues to be the meet and confer process with *Valdivia* plaintiffs regarding the language on the modified MDO hearing information and rights forms.

- Implementation of the Lifer Scheduling and Tracking System to improve management of the life prisoner parole consideration hearings backlog is on schedule for deployment in November 2007. Counselors, mental health professionals, legal contractors, and case records staff throughout the state, will be able to input information avoiding untimely delays experienced in the past.

CDCR would like to thank the OIG for its continued professionalism and guidance in efforts to improve its operations. Our commitment is evident and while transformation is not always readily apparent, significant progress has been realized and further remedies are underway. If you should have any questions or concerns, please call me at (916) 323-6001.

JAMES E. TILTON
Secretary
California Department of Corrections and Rehabilitation

cc: K. W. Prunty, Undersecretary, Operations
Stephen Kessler, Undersecretary, Program Support
Bernard Warner, Chief Deputy Secretary, Division of Juvenile Justice
John Monday, Executive Officer, Board of Parole Hearings
Oscar Hidalgo, Assistant Secretary, Office of Communications
Richard Krupp, Assistant Secretary, Office of Audits and Compliance
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