2008 ANNUAL REPORT

OFFICE OF THE INSPECTOR GENERAL

David R. Shaw

Inspector General

State of California

2008 Annual Report

EXCELLENCE IN CORRECTIONS THROUGH MODEL OVERSIGHT

A MESSAGE FROM THE INSPECTOR GENERAL

2008 was a year of transition for the Office of the Inspector General. On May 16, 2008, Inspector General Matt Cate was appointed Secretary of the California Department of Corrections and Rehabilitation, and I was appointed Inspector General after heading the Bureau of Independent Review for the previous four years. As I reflect on the past year, I am encouraged by the accomplishments we achieved in fulfilling our core mission to provide oversight and transparency of the correctional system.

Of particular significance in 2008 was the oversight we provided for prison medical care. Given the specter of billions of dollars in prison construction costs and the dramatically increasing annual operating cost for prison medical care, we took on the task of providing independent evaluation of prison medical care at the request of the federal court and the receiver's office. The information our inspections provide is intended to focus the efforts of the receiver and the department on specific items and areas that will result in appropriate corrective action and ultimately an end to the receivership. In addition to the medical inspection unit, a new medical monitoring team began inquiring into every custodial death and reporting on the health care the inmate had received. The broad potential benefits of the medical inspections and monitoring compelled us to take on the challenge to affect positive change in prison medical care to protect inmate rights and minimize cost to the state.

Also noteworthy was the investigation that uncovered time keeping fraud by contract doctors working for the department. The investigation led to the arrest of six doctors who billed the state for time they did not work. The doctors were charged with grand theft and presenting false claims to the State of California.

On behalf of the entire Office of the Inspector General team, I am pleased to present the 2008 Annual Report.

David R. Shaw
Inspector General

DUTIES OF THE OFFICE OF THE INSPECTOR GENERAL

- Conduct investigations, audits, and special reviews of the state correctional system at the request of the Governor, members of the Legislature, the Secretary of the California Department of Corrections and Rehabilitation (CDCR) or upon the initiative of the Inspector General.
- Perform real-time oversight of internal affairs investigations into alleged misconduct by CDCR employees.
- Conduct audits of each correctional institution at least once every four years and a baseline audit of each warden or superintendent one year after appointment.
- Review CDCR policies and procedures for conducting internal investigations and audits.
- Maintain a toll-free public telephone number to allow reporting of administrative wrongdoing, poor management practices, criminal conduct, fraud, or other abuses in the CDCR.
- Investigate complaints of retaliation against those who report misconduct by the CDCR and its employees.
- Evaluate and report to the Governor the qualifications of the Governor's candidates for warden and superintendent positions for the state's adult and juvenile correctional institutions.
- Refer matters involving criminal conduct to law enforcement authorities in the appropriate jurisdiction or to the California Attorney General.
- Investigate the mishandling of sexual abuse incidents within correctional institutions, maintain the confidentiality of sexual abuse victims, and ensure impartial resolution of inmate and ward sexual abuse complaints through the Office of the Sexual Abuse in Detention Elimination Ombudsperson.
- Examine the CDCR's various mental health, substance abuse, educational, and employment programs for inmates and parolees through the California Rehabilitation Oversight Board (C-ROB).
- Conduct semiannual inspections of adult and juvenile correctional institutions to examine systemic issues, identify problem areas that may lead to investigations or audits, and follow up on prior complaints.
- Audit the California Prison Health Care Receivership Corporation's expenditures to ensure transparency and accountability.
- Respond to critical incidents at adult and juvenile correctional institutions, including officer-involved shootings, riots, escapes, and correctional staff member deaths caused by inmates.
- Perform medical inspections to provide independent and objective information regarding the medical delivery to inmates at adult correctional institutions.

- Monitor use-of-force committee meetings conducted monthly at each adult and juvenile correctional institution.

ORGANIZATIONAL OVERVIEW

- The Office of the Inspector General (OIG) is comprised of a skilled team of professionals that includes attorneys with expertise in internal affairs investigations and criminal law, auditors experienced in correctional policy and operations, and investigators drawn from correctional and law enforcement agencies.
- At the end of 2008, the OIG had 135 employee positions, including a staff of attorneys classified as special assistant inspectors general and a team of deputy inspectors general trained in audits and investigations.
- In addition to legal, administrative, and publications staff members, the OIG is organized into two principal bureaus: the Bureau of Audits and Investigations (BAI) and the Bureau of Independent Review (BIR).
- California Penal Code sections 6125 et seq. provide the statutory authority for the OIG's establishment and operation.

KEY ISSUES

SAFETY AND SECURITY

Safety and security have always been the top operational priorities for correctional administrators, government policymakers, and the public. Since its inception, the OIG has identified safety and security deficiencies in California's correctional system. In 2008, OIG attorneys and inspectors continued to identify opportunities for the CDCR to address weaknesses in safety and security.

Quadrennial Audits at CIM, SVSP, and FSP

OIG auditors completed quadrennial audits at three prisons in 2008: Folsom State Prison (FSP), Salinas Valley State Prison (SVSP), and California Institution for Men (CIM). These reviews found a number of conditions that elevate the risk of harm to employees, inmates, and the public:

- Inmate and visitor monitoring was poor at CIM's four-acre visiting center because only two officers were assigned and there were no surveillance cameras. Poor monitoring increases the likelihood that banned items, such as drugs or cell phones, can be introduced to the institution.

- CIM's employees sometimes placed inmates with high or unknown classification scores—a potential indicator of assaultive or disruptive behavior—in a dormitory style housing area better suited for inmates with lower classification scores.

- CIM suffers from dilapidated housing, failing plumbing, leaking roofs, and hazardous materials in need of removal. All of these items create an environment that poses safety and security risks for staff and inmates.

- In the first half of 2008, CIM's supervisors conducted only about half of the fire and emergency evacuation drills required.

- Training lapses and lack of supervision left licensed vocational nurses at FSP ill prepared to function in a prison environment and, in some instances, allowed inmates access to medications and medical supplies.

- Both FSP and SVSP did not complete six daily cell searches, as required by departmental policy. These searches are intended to discover weapons and contraband that undermine institutional safety and security. In addition, officers did not properly conduct the daily "standing count" at FSP. In some instances, the officers failed to ask inmates to stand – a requirement to ensure that the inmates are uninjured.

- A large backlog of use-of-force incident packages delayed prompt review of such incidents at SVSP. Such delays could, in turn, delay retraining of officers or delay potential adverse action against an officer.

- Officers assigned to armed posts, such as those working in watch towers or transporting inmates to hospitals, were not current in their required quarterly firearms qualification. At SVSP, we found that 23 percent of the officers we reviewed who were working in armed posts were not qualified quarterly, as required. In some cases, the officers were eight months behind. Similarly, 29 percent of the officers we reviewed at CIM had not been properly qualified. Poor weapon skills could endanger inmates, employees, or the public if the officer is required to use deadly or less-than lethal force.

Overall, we made 35 recommendations to the institutions and the department to correct the safety and security deficiencies described above.

Investigations and Complaints

The OIG receives about 300 complaints a month by mail and through a toll-free telephone line. Most complaints concern allegations of staff misconduct, the appeals and grievance process, or the quality or lack of access to medical care. Complaints that involve urgent safety and security issues receive priority attention.

As required by California Penal Code sections 6129(c)(2) and 6131(c), cases handled by the Bureau of Audits and Investigations are summarized in quarterly reports posted on the OIG's website: http://www.oig.ca.gov/pages/reports/quarterly.php

In 2008, the intake and investigations arm of the OIG's Bureau of Audits and Investigations (BAI) examined several safety and security concerns. During the year, 37 investigations were initiated into various allegations including income tax fraud, excessive force on inmates, and the release of an inmate to parole who subsequently killed a peace officer.

Review of Deadly Force Against Parolee

The Bureau of Independent Review published a special report in August 2008, regarding the use of deadly force against parolee Delvin Wright by the department. In the report, the bureau reviewed the incident where a parole agent fired his gun while chasing Wright during an arrest operation on May 21, 2007. The bureau found that the operational tactics used by the parole agent unnecessarily endangered the agent and several uniformed police officers who were potentially in the line of fire. Specifically, the plain clothes parole agent

fired his gun at Wright while chasing him in the direction of local converging police officers.

In its report, the bureau identified several concerns regarding the department's response to the incident. First, the department failed to notify the Office of Internal Affairs or the Office of the Inspector General, Bureau of Independent Review of the deadly force incident until two days after the shooting. Second, the department cleared the parole agent of any wrongdoing within 24 hours of the shooting based solely on the agent's account of the incident, while ignoring conflicting reports by local police officers. The department should have conducted a more thorough review of the shooting and considered the outside reports before concluding its review.

Subsequently, the department's own board of law enforcement experts reviewed the shooting and determined that the shooting was within departmental policy; however, the board did provide many important recommendations based on the incident. Although the department failed to respond to these recommendations for almost seven months, it did respond to the bureau's report and agreed to implement the most important recommendations from the board.

In 2008, the Bureau of Independent Review reported on 141 "critical incidents"—incidents at adult and juvenile correctional institutions often involving serious injury or death.

Special Investigations Unit Cases

On May 30, 2007, the OIG initiated a criminal investigation into allegations that on March 25, 2007, a CDCR correctional officer brought a personal firearm into his unarmed post on correctional institution grounds without proper authorization and subsequently discharged it on site. It is illegal to bring an unauthorized firearm into a prison. In addition to not being authorized, the firearm posed a significant threat to the safety and security of the institution, and it was not properly logged in or secured with prison officials.

Based on information uncovered during the above criminal investigation, the OIG initiated additional criminal investigations into allegations that on March 25, 2007, two other correctional officers, acting as union representatives for the accused correctional officer concealed and/or destroyed evidence related to the incident.

The San Bernardino District Attorney's Office filed felony criminal charges of Penal Code section 4574(a), Bringing a Firearm into a Prison, against the officer who brought the weapon onto the institution grounds. However, prosecutors declined to file criminal charges against the other two correctional officers.

Subsequently, we conducted an administrative investigation of the two correctional officers who allegedly concealed and/or destroyed evidence and found a preponderance of evidence to support that the union representatives tampered with evidentiary items related to the incident.

KEY ISSUES

WASTE, FRAUD, AND ABUSE

In a time of mounting prison costs and taxpayer scrutiny, promoting economy and efficiency within the state's correctional system is a crucial responsibility. Part of the OIG's mission is to thoroughly investigate allegations of financial waste, fraud, and abuse by CDCR staff members, supervisors, and management. In 2008, the OIG demonstrated its worth in providing independent oversight by holding the department publicly accountable for its financial mismanagement.

Review of the Expenditures of the California Prison Health Care Receivership

In February 2008, we issued our report summarizing our review of the Receiver's expenditures between April 2006 and June 2007. During the review, we found three examples of wasteful spending on employee benefits and travel expenses. For example, the receivership paid $218,790 to employees as "in-lieu" benefits even after it began providing the benefits to the employees. We also identified weak enforcement of its existing travel reimbursement policies that led to wasteful spending. In this instance, the receivership paid lodging expenses of $10,500 and meal charges of $1,847 even though the expenses did not include proper documentation or exceeded the policy limits. Lastly, we found that the receivership paid a contractor all actual travel expenses, plus a per diem amount of $125. In comparison, the receivership's own employees would have only received $50 per day for meals. Had the consultant received the same rate as employees, the receivership would have paid the consultant $7,200 less.

Quadrennial Audit at SVSP

We found examples of wasteful spending within the education program at SVSP. Specifically, education and work program assignments sometimes went to life

inmates instead of inmates with shorter terms. When that happens, the inmates with shorter terms do not earn sentence-reducing credits, which extends their prison term and increase taxpayer costs. Each inmate who is denied sentence reducing credits cannot reduce their sentence by participating in a work or education program. Each additional year an inmate spends in prison costs the state $44,339.

Fraud Investigation Unit

To uncover waste, fraud, and abuse in the correctional system, save taxpayer dollars, and hold wrongdoers accountable, we created a Fraud Investigations Unit.

The mission of this unit is to protect the taxpayers of the State of California and the financial integrity of the CDCR by actively identifying and investigating the following:

- **Fraud** – Government officials, individuals, groups, businesses/vendors, and contractors that are stealing taxpayer funds from CDCR.

- **Waste** – Government officials, individuals, groups, businesses/vendors, and contractors that are spending taxpayer funds in a manner that does not efficiently further CDCR's mission and goals.

- **Abuse** – Government officials whose actions exceed the authority granted to them by state and CDCR policies and regulations.

The fraud investigation unit is focused on complex, large-scale investigations of medical fraud, contracts and procurements, kickbacks, bribes, unjustified sole-source awards, and product diversion and substitutions. One such investigation resulted in a Monterey County Grand Jury indicting six medical doctors on grand theft, violation of Penal Code Section 487(a), and presenting false claims to the State of California, in violation of Penal Code Section 72, for over-billing of psychiatric and medical services provided to inmates at the Salinas Valley State Prison.

Reorganization of Our Central Intake Process

In order to achieve success with our strategic plan goals, effective January 1, 2009, we implemented a new proactive approach to identify the most serious issues regarding fraud, waste, and abuse within CDCR. In the past, the OIG has used a complaint driven process to direct our resources. While we continue to review the complaints we receive, we have begun to monitor CDCR's own information sources to allow us to choose the most serious issues to audit and investigate. For example, when critical incidents occur, such as fatalities, major security breaches, etc., our inspectors conduct preliminary investigations to identify any issues that may have contributed to the incident. When gross

misconduct, criminal behavior, poor management, or serious systemic issues are discovered, we direct our investigative and auditing resources to uncover the issues. We also make referrals to the CDCR to take appropriate action to solve problems based upon our findings.

KEY ISSUES

ACCOUNTABILITY

Public accountability of the state's correctional system is crucial to enacting reforms and bringing transparency to the CDCR's operations. Therefore, the Legislature has mandated that the OIG publicly release its audit findings. We also investigate retaliation and favoritism complaints, evaluate the Governor's warden candidates both before and after appointment, and assess the department's progress in implementing recommendations. Our efforts ensure that legislators and the public can hold department institutions and employees accountable.

2008 Accountability Audit

In March 2008, we issued an audit of CDCR's progress in implementing past recommendations we made in 37 separate reports that affect the department's Adult Operations and Programs, its Division of Juvenile Justice, and its Board of Parole Hearings. This accountability audit resulted in 17 follow-up recommendations and revealed that the department had implemented 65% of our recommendations from audits performed in 2006. Among the report's findings:

- The department had made notable progress in properly housing maximum custody inmates in its reception centers. We found that prison reception centers had improved their process for identifying potentially dangerous maximum custody inmates and segregating them from general population inmates. Specifically, we found that the department implemented several improvements to its data processing system that allows the system to differentiate maximum custody inmates from inmates who can be safely assigned to the general population. Also, a lockout feature added to the system prevented staff members from completing a housing assignment should they attempt to assign a maximum custody inmate to general population housing.
- The department implemented several recommendations from our 2006 review, but the most important recommendation remained unresolved —collecting overpayments of almost $5.6 million to contractors that coordinate substance abuse services. The department had not yet collected the overpayments because it took almost 14 months to determine the amounts the contractors owed the state.

Quadrennial Audits at CIM, SVSP, and FSP

We completed warden reviews and four-year audits (quadrennial audits) at three prisons in 2008 – Folsom State Prison in January 2008, Salinas Valley State Prison in October 2008, and California Institution for Men in November 2008. Not only did these audits identify safety, security, and rehabilitation issues, but they also provide public accountability by shining light on the performance of the warden.

Unannounced Inspections

Pursuant to the Budget Act SB 77 (Chapter 171, Statutes of 2007), the Office of the Inspector General conducted semi annual inspections of nearly all adult correctional institutions, youth correctional facilities, and community correctional facilities. The inspection program's purpose is for our inspectors to identify unsafe conditions and become more familiar with the institution's physical plant, programs and operations. In addition, inspectors develop staff contacts and seek to identify conditions needing audit, investigation or referral to California Department of Corrections and Rehabilitations executive management for corrective action.

In addition, the Office of the Inspector General initiated inspections at all four parole regional headquarters, including at least one parole unit in each region. Our inspectors interviewed parole management staff and staff working in support units, such as: revocation units, reentry units, parole outpatient clinics, business services and personnel offices. The purpose of the parole inspections is to identify fraud, waste and abuse occurring in parole areas.

The Office of the Inspector General has opened investigations and referrals regarding conditions discovered during inspections, most of which are on-going. In addition, the findings reported in the OIG' s special review titled *Management of the California Department of Rehabilitation's Administrative Segregation Unit Population* were originally discovered as a result of our inspection program.

Medical Monitoring Team

In January, 2008, the OIG established a Medical Monitoring Team with the mission to inquire into every custodial death and report on the health care the inmate received prior to his demise, with particular emphasis on the circumstances surrounding the death of that inmate. The program began a pilot initiative on January 1, 2009, incorporating five local institutions. The team will make immediate, on-scene responses to each in-custody death at Folsom State Prison, California State Prison - Sacramento, Mule Creek State Prison, Deuel Vocational Institution and California State Prison - Solano. The team will look for deficiencies in the areas outlined by the federal court in its remedial orders in *Marciano Plata, et al., v. Arnold Schwarzenegger, et al*. When those deficiencies are identified, the attorney responsible for the custodial death review will author a report addressed to the Inspector General with his or her findings. The Inspector General will share that report with the department Secretary and with the Federal Receiver.

Detailed assessments of the Bureau of Independent Review's case monitoring activities are found in its semi-annual reports posted on the OIG's website: http://www.oig.ca.gov/pages/reports/bir-semi-annual-sar.php

Warden and Superintendent Evaluations

Consistent with the provisions of Penal Code section 6126.6, during 2008 we evaluated the qualifications of seven candidates for prison warden positions and reported the results of our evaluations in confidence to the Governor.

Penal Code section 6126.6 assigns the Inspector General responsibility for evaluating the qualifications of every candidate the Governor nominates for appointment as a state prison warden or a youth correctional facility superintendent. The Inspector General advises the Governor within 90 days whether the candidate is "exceptionally well-qualified," "well-qualified," "qualified," or "not qualified" for the position. To make the evaluation, Penal Code section 6126.6 requires the Inspector General to consider the candidate's experience in effectively managing correctional facilities and inmate or ward populations; knowledge of correctional best practices; and ability to deal with employees, the public, inmates, and other interested parties in a fair, effective, and professional manner.

KEY ISSUES

REHABILITATION

The California Rehabilitation Oversight Board

The OIG's mission was broadened in May 2007 with the signing of Assembly Bill 900 (AB 900), the Public Safety and Offender Rehabilitation Services Act of 2007.

AB 900 was designed to address prison overcrowding and improve rehabilitative programming in California's prisons. In addition, the legislation established the California Rehabilitation Oversight Board (C-ROB) within the OIG. Chaired by the Inspector General, C-ROB is a statewide board of 11 members who have expertise in state and local law enforcement, education, treatment, and offender rehabilitation.

The legislation mandates C-ROB to regularly examine and report biannually to the Governor and the Legislature on rehabilitative programming that the CDCR provides to the adult inmates and parolees under its supervision. By statute, these reports must include findings on

- Effectiveness of treatment efforts for offenders;
- Rehabilitation needs of offenders;
- Gaps in rehabilitation services; and
- Levels of offender participation and success.

C-ROB issued two reports in 2008, both of which detailed the department's planning efforts to implement rehabilitative programming and documented concerns that, if left unaddressed, could threaten the department's success.

Besides chairing C-ROB, AB 900 created another role for the Inspector General as one of three individuals responsible for deciding whether all the AB 900 conditions have been met. Specifically, the legislation requires that the second phase of AB 900 funding cannot be released until a three-member panel, composed of the Inspector General, the State Auditor, and a Judicial Council appointee, has certified that 13 benchmarks have been met. The CDCR has yet to request a hearing from this group.

C-ROB's reports are available on the OIG's website, under the C-ROB link: http://www.oig.ca.gov/pages/c-rob/reports.php

Quadrennial Audit at Salinas Valley State Prison

During our audit at Salinas Valley State Prison (SVSP) we found several problems that reduce rehabilitation opportunities for inmates. Specifically, education and work program assignments frequently went to inmates with life sentences (lifer) instead of inmates with shorter terms. When that happens, the inmates with shorter terms are precluded from earning sentence-reducing credits —which extends their prison term—but they are also less prepared for their eventual parole. Of the 41 inmate assignments we reviewed for May 2008, 32 (78 percent) were given to either lifer inmates or inmates convicted of violent felonies, both of which are ineligible to receive day-for-day credit. These mistakes in inmate assignments reduce the benefit of the limited programming opportunities provided at the institution.

CONCLUSION

The past year has been full of change and adjustment for the Office of the Inspector General. Our mission was expanded, we uncovered significant instances of misconduct, and we continued to refine our methods and operations. As this report has shown, our oversight of CDCR has helped the department improve rehabilitation; increase safety and security; eliminate waste, fraud and abuse; and promote accountability.

Due to the pending decision of a three judge panel regarding prison overcrowding and the federal court's medical receivership, there is great uncertainty surrounding several aspects of the CDCR's operations. Nevertheless, we look forward to 2009 and remain committed to providing ongoing and transparent oversight of the CDCR.

APPENDIX

REPORTS RELEASED IN 2008

Bureau of Audits and Investigations

- Folsom State Prison: Quadrennial and Warden Audit (January 2008)
- Quarterly Report, September-December 2007
- California Prison Healthcare Receivership Review of Disbursement April 2006 through June 2007 (February 2008)
- Quarterly Report, January-March 2008
- Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation 2000-2006 (April 2008)
- Quarterly Report, April-June 2008
- Quarterly Report, July-September 2008
- Salinas Valley State Prison: Quadrennial and Warden Audit (October 2008)
- California Institution for Men: Quadrennial and Warden Audit (November 2008)
- California State Prison, Sacramento: Medical Inspection Results (November 2008)

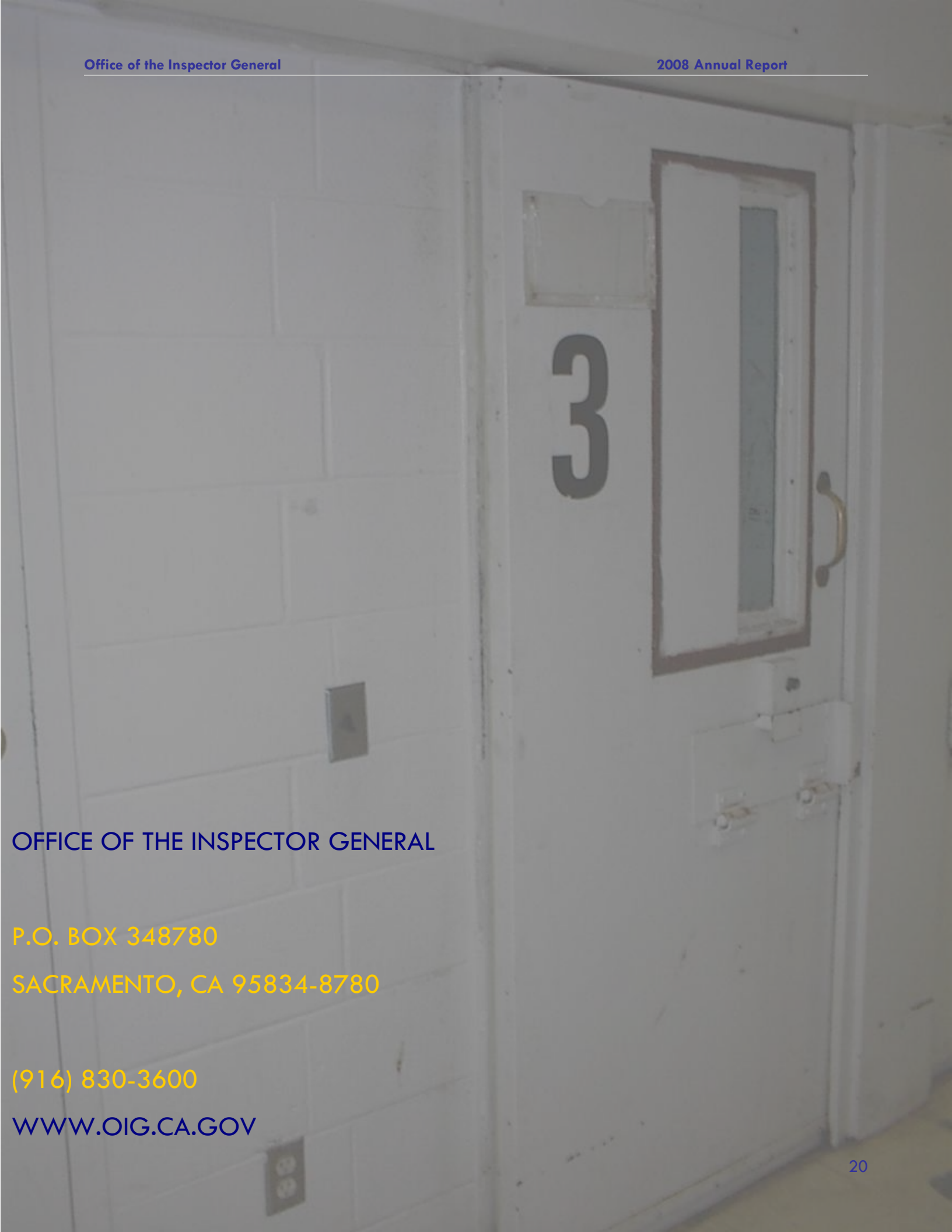
Bureau of Independent Review

- Semi-annual Report, January–June 2007
- Special Report on the Use of Deadly Force Against Parolee Delvin Wright by the California Department of Corrections and Rehabilitation. (August, 2008)

California Rehabilitation Oversight Board

- C-ROB Biannual Report (January 2008)
- C-ROB Biannual Report (July 2008)

For access to all OIG reports please visit: http://www.oig.ca.gov/pages/reports.php



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