Matthew L. Cate, Inspector General

Office of the Inspector General

April 18, 2006

Jeanne S. Woodford, Secretary (A)
California Department of Corrections and Rehabilitation
1515 S Street, Room 502 South
Sacramento, California 95814

Dear Secretary Woodford:

The enclosed report presents the results of the Office of the Inspector General's 2006 accountability audit of the California Department of Corrections and Rehabilitation's adult operations and programs. The audit assessed the department's progress in implementing recommendations resulting from 22 past audits conducted by the Office of the Inspector General between 2000 and 2004.

The accountability audit determined that individual institutions have taken numerous steps to improve operations and security, with wardens and staff at state prisons fully or substantially implementing 84 percent of past recommendations. The department itself, however, has fully or substantially implemented only 69 percent of recommendations directed to non-medical department administrators and only 48 percent of recommendations directed to department medical administrators. Overall, 75 percent of the 394 recommendations resulting from the 22 past audits have been fully or substantially implemented.

The Office of the Inspector General found that although the department has markedly improved its internal affairs operation, it has not addressed three of its most significant and long-standing problems: the need to overhaul its antiquated information technology; the need to provide inmates with adequate medical care in a fiscally sound manner, and the need to fulfill its broader public safety mission by better preparing inmates for release.

The report presents 91 new 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, Undersecretary (A), California Department of Corrections and Rehabilitation
Joe McGrath, Chief Deputy Secretary, Adult Operations, California Department of Corrections and Rehabilitation
Del Sayles-Owen, Chief Deputy Secretary (A), Adult Programs, California Department of Corrections and Rehabilitation

Enclosures

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OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

ACCOUNTABILITY AUDIT

REVIEW OF AUDITS OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION ADULT OPERATIONS AND ADULT PROGRAMS

2000 – 2004

VOLUME I

APRIL 2006

STATE OF CALIFORNIA

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VOLUME II

EXECUTIVE SUMMARY

This report presents an assessment of the progress made by the California Department of Corrections and Rehabilitation in implementing past recommendations affecting the department's adult operations and programs. The recommendations resulted from 22 audits and reviews conducted by the Office of the Inspector General between 2000 and 2004. The report represents the third and final component of a comprehensive follow-up review — an accountability audit — of 33 previous reviews and audits of entities comprising the former Youth and Adult Correctional Agency (now the California Department of Corrections and Rehabilitation). In addition to the 22 audits and reviews conducted by the Office of the Inspector General between May 2000 and September 2004 represented here, the original audits in the accountability audit included nine audits and reviews of the former California Youth Authority (now the Division of Juvenile Justice) and two reviews of the Board of Prison Terms (now the Board of Parole Hearings). The two previous follow-up reviews in the accountability audit were released in January and July 2005, respectively.

The follow-up review of the California Department of Corrections and Rehabilitation's adult operations and programs determined that of 394 recommendations issued in the 22 previous audits and reviews, 241 (61 percent) have been fully implemented; 53 (14 percent) have been substantially implemented; 45 (11 percent) have been partially implemented; 39 (10 percent) have not been implemented; and 16 (4 percent) are no longer applicable. The Office of the Inspector General has issued 91 new recommendations, listed in the body of this report, to address remaining deficiencies.

The review revealed two broad findings. The first is that the staff and management of individual institutions have been highly responsive to recommendations resulting from past audits and reviews and have taken numerous steps to improve operations and security at the state's prisons. The second is that the department itself has been less responsive to past recommendations and, although it has markedly improved its internal affairs operation, has yet to address three of its other most troubling and long-standing problems — the need to overhaul its antiquated information technology system; the need to provide inmates with adequate medical care in a fiscally sound manner; and the need to fulfill its broader public safety mission by better preparing inmates for release. Achieving these goals is the responsibility of department administrators. At the same time, it must be recognized that efforts to address the problems in these areas are severely hampered by inmate population pressures that have prisons straining at nearly twice design capacity, spreading staff resources thin and leaving little facility space available for programming and other purposes. Developing sustainable solutions will require the department, state policymakers, and the public to collectively address the available options: increasing prison capacity; examining sentencing and parole policies; investing additional resources in reducing recidivism; or a combination of all three.

IMPROVEMENTS BY THE INSTITUTIONS

Overall, the 2006 follow-up review determined that recommendations directed to prison wardens and chief medical officers at individual institutions were more often implemented than those directed toward department administrators, even though in some instances, the department has had as long as five years to take action. Of 175 recommendations directed to wardens, 84 percent (148) have been fully or substantially implemented. In contrast, only 69 percent (98) of the 143 recommendations directed to non-medical administrators in the department have been fully or substantially implemented. Worst of all, of the 31 recommendations directed to headquarters medical administrators, only 15 (48 percent) have been fully or substantially implemented. The table shown below illustrates these results.

TABLE 1
IMPLEMENTATION STATISTICS
BY RESPONSIBLE ENTITY

Responsible Entity	Totals	Fully Implemented		Substantially Implemented		Partially Implemented		Not Implemented		Not Applicable	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Department Non-medical	143	78	55%	20	14%	22	15%	15	10%	8	6%
Department Medical	31	10	32%	5	16%	7	23%	9	29%		0%
Warden	175	128	73%	20	11%	10	6%	9	5%	8	5%
Chief Medical Officer	43	23	53%	8	19%	6	14%	6	14%		0%
Department of Forestry and Fire Protection	2	2	100%		0%		0%		0%		0%
Totals	**394**	**241**	**61%**	**53**	**14%**	**45**	**11%**	**39**	**10%**	**16**	**4%**

Institutions have implemented improvements in a wide range of operations, including security requirements, employee disciplinary actions, staff training, and the inmate appeals process. For example:

- ***Sierra Conservation Center.*** A May 2001 audit of the Sierra Conservation Center resulted in 53 recommendations to address a range of deficiencies in safety and security, the inmate disciplinary process, staff training, employee grievances, equal employment opportunity complaints, adverse personnel actions, and the reporting of inmate deaths. The follow-up review determined that the institution has fully or substantially implemented 92 percent of the recommendations, making important improvements in its physical plant and operational procedures.

- ***California State Prison, Solano.*** A March 2003 audit of California State Prison, Solano, resulted in 24 recommendations relating to deficiencies in such areas as the tracking of inmates with tuberculosis; the awarding of sentence reduction credits for classes that

were not held; the reporting of inmate deaths; the retention of inmates in administrative segregation units for periods longer than justified; documentation of employee disciplinary proceedings; and prompt implementation of medical modification orders. The follow-up review determined that the institution has fully or substantially implemented 88 percent of the recommendations.

- ***Leo Chesney Community Correctional Facility.*** An audit of the Leo Chesney Community Correctional Facility, released in October 2001, found deficiencies related to the use of monies from inmate telephone revenues and the inmate welfare fund, as well as deficiencies in staff training, the inmate adult education program, and the processing of inmate appeals. The follow-up review determined that the facility has fully or substantially implemented 73 percent of the 22 recommendations resulting from the audit.

- ***California State Prison, Sacramento.*** A September 2000 audit of California State Prison, Sacramento resulted in 17 recommendations to address deficiencies related to financial management; internal control weaknesses in the handling of inmate trust funds; failure to process inmate appeal forms in a timely manner; the failure to comply with a mandate to remove underground storage tanks; inconsistent handling of inmate rules violation reports; and the failure to complete employee probation and performance reports on time. The follow-up review determined that the institution has fully or substantially implemented 82 percent of the recommendations.

IMPROVEMENTS BY THE DEPARTMENT

The follow-up review determined that the most important improvements affecting the department have occurred in the internal affairs and employee disciplinary process as a result of earlier reviews and the *Madrid v. Woodford* litigation. Reviews by the Office of the Inspector General in October 2001 and March 2002 had found significant deficiencies that prevented internal affairs investigations from being completed within the statutory one-year time limit, which in turn prevented the department from disciplining peace officers found to have engaged in misconduct. The March 2002 review found, for example, that 43 percent of a sample of investigations completed during fiscal years 1999-2000 and 2000-01 in which misconduct allegations were sustained were not completed within one year and therefore did not result in disciplinary action. The department also has been criticized in the past for alleged failure to sufficiently investigate misconduct and to impose discipline in a fair and consistent manner. Under reforms developed through the Madrid Remedial Plan, however, a central intake panel made up of representatives from the Office of Internal Affairs, Office of Legal Affairs, and other department staff now reviews all requests for investigation and either accepts the request as an internal affairs investigation or sends it back to the hiring authority for disposition. The Office of the Inspector General's Bureau of Independent Review monitors the central intake and internal affairs process, and also monitors the investigations. A new electronic case management system tracks the entire employee discipline continuum from the request for investigation to the final hearing and disposition of action. Although deficiencies remain, such as the inability to use the system to identify trends and pervasive problems, the Office of the Inspector General found that as a result of these and other changes, only two percent of 94 investigations with sustained findings conducted by the Office of Internal Affairs for the period December 1, 2004 through May 31, 2005 exceeded the one-year statutory limit.

CONTINUING DEPARTMENT FAILURES

Where institutions have not fully or substantially implemented recommendations, often the reason has been the failure of the department to implement department-level solutions by establishing the necessary statewide policies and procedures or investing in needed resources. The department also has not effectively used its internal audit function and other tools to identify systemic problems. Again, the most significant deficiencies are seen in information technology, medical care, and inmate programming.

Information technology. The department's outdated information technology, with its antiquated mainframes and stand-alone databases lacking integration with other system components, impedes processes at every level. The absence of efficient modern technology — to automate routine procedures, to organize records and make them readily available to designated staff — echoes through programs and institutions and causes inefficiency and waste. Worse, the deficiencies reduce critical procedures to the manual handling of paper documents and sometimes leaves the custody and medical staff at risk of making important decisions based on paper records in files that may not be up-to-date. These deficiencies have been fueled by a long history on the part of the department of poor information technology planning, poor project implementation, and failure to fund needed improvements. Only 42 percent of the Office of the Inspector General's past recommendations relating to information technology covered in this follow-up review, for example, have been fully or substantially implemented. To bring about solutions, the administration, policymakers, the courts, labor representatives, inmate advocates, and other corrections stakeholders should work together to invest in needed improvements and resolve these long-standing problems.

Examples of areas affected by the failures in information technology include the following:

- ***Pharmaceutical expenditures.*** The department continues to waste millions of dollars annually by not implementing recommendations that it replace its outdated, inefficient, 20-year-old pharmacy management system. A July 2003 survey by the Office of the Inspector General found the department's pharmaceutical expenditures were projected to increase 111 percent between 1999-2000 and 2002-03, even though the inmate population decreased two percent and the national consumer price index for pharmaceutical drugs increased only 22 percent during that time.[1] To remedy the problems, the Office of the Inspector General's survey and four comprehensive audits and studies by other entities identified the need for the department to replace the pharmacy management system with an automated health care management system capable of performing essential functions to control costs and prevent waste, fraud, and abuse. Following the July 2003 survey, the Office of the Inspector General estimated that by replacing the system and implementing other management controls, the department could reduce its annual pharmaceutical expenditures— which totaled $122.4 million in fiscal year 2002-03 — by as much as $26 million. In response to the 2006 follow-up review, the department reported that it has made progress toward launching a new automated health care management system, but that statewide implementation has not yet

[1] The actual increase in the department's pharmaceutical expenditures was later reported to have been 94 percent.

been accomplished. The department reported, however, that it nonetheless achieved "cost avoidance" between 2002-03 and 2003-04 because its pharmaceutical expenditures increased only 6 percent, compared to the 18 percent average annual increase over the three preceding fiscal years. Yet, Bureau of Labor Statistics data show that between July 2003 and June 2004, pharmacy prices nationwide increased only 3.3 percent. Meanwhile, the department's pharmaceutical expenditures in fiscal year 2003-04 rose to $129.7 million —an increase of $7.3 million over the previous year. Because of these problems, in March 2006, the U. S. District Court ordered a comprehensive financial and operational audit of the department's pharmaceutical services. That audit will be conducted by a private specialty firm with expertise in correctional pharmaceutical operations.

- ***Inmate appeals.*** The department's Inmate Appeals Branch still has not obtained the information technology needed to enable it to efficiently analyze information from all levels of the inmate appeals process in order to identify systemic problems in the department's operations and practices. The inmate appeals process provides inmates with a means of resolving grievances concerning a range of issues, including requests for reasonable accommodation under the Americans with Disabilities Act and the alleged failure to obtain medical services. The Office of the Inspector General found from a February 2001 review that the department had no automated process for analyzing the appeals to identify deficiencies in policies, procedures, or practices even though the department's operations manual identifies the inmate appeals process as a vehicle for that purpose. In a September 2004 follow-up review, the Inmate Appeals Branch reported that it had developed a new inmate appeals tracking system for use at the institutions and was in the planning stages to extend the reporting capability of the new system to include data that could be used as a tool for identifying systemic problems. In the 2006 follow-up review, however, the Inmate Appeals Branch reported that enhancements scheduled to take place in November 2004 had been delayed because of other department priorities. In December 2005, the Inmate Appeals Branch reported that it was working on a feasibility study for the enhancements, which was scheduled to be completed by December 21, 2005. But the department had not completed the study when the Office of the Inspector General's fieldwork on this issue ended in December 2005.

- ***Local assistance.*** The department's Local Assistance Program, which reimburses local jurisdictions for the costs of detaining state parolees in local facilities, lacks the information technology needed to efficiently verify information on the invoices submitted for those costs. The department reports that its parole revocation scheduling and tracking system cannot be programmed to allow continuous tracking of the movements of individual parolees. As a result, the parole staff cannot confirm that a parolee was detained in the local jurisdiction on an active parole hold during the period claimed. The department reports that it is using a tracking system developed only for Parole Region III, which encompasses Los Angeles County, but has not estimated when such a system might be available statewide. The 2005 state budget for local assistance payments totaled $81.5 million.

Medical services for inmates. Because of the department's long-standing failings in providing inmate medical services, a federal receiver appointed by the U. S. District Court will take over the department's health care operations on April 17, 2006 to create a sustainable health care

system capable of providing constitutionally adequate medical care to inmates. Under the terms of the court's action, the receiver will have broad powers to restructure day-to-day operations and to direct the department's medical administrative, personnel, financial, accounting, contractual, legal, and other operational functions. In working with the receiver, the department should endeavor to address the following long-term deficiencies:

- ***The California Substance Abuse Treatment Facility.*** The second-largest prison in the state system, the California Substance Abuse Treatment Facility and State Prison at Corcoran, reports that a critical shortage of staff physicians to treat its more than 7,300 inmates has prevented the institution from implementing many of the Office of the Inspector General's past recommendations affecting medical services. The institution continues to fail to ensure that inmates see physicians promptly after requesting medical services, and inmates with chronic medical conditions are not adequately monitored. Because of the physician shortage, inmate appeals concerning medical services at the institution are backlogged, creating a domino effect as new appeals are filed to complain that earlier appeals have not been answered. Repeated turnover in other key medical positions also contributes to the deficiencies. The institution reports that six different individuals filled its chief medical officer position between September 2002 and June 2005 when the present incumbent was hired and that since September 2002 its chief dental officer, chief psychologist, chief psychiatrist, director of nurses, and medical records supervisor have all resigned, retired, or transferred. The use of outside medical specialists at the institution also has not been brought under control. In fiscal year 2001-02, the institution exceeded its budget for contracted medical services by more than $5 million — an 81 percent overage. The Office of the Inspector General recommended in January 2003 that the institution establish a process to review all referrals to outside providers, and the institution reports that it did establish an authorization committee to review specialist referrals, but that the physician shortage has limited the review to a cursory examination by the chief medical officer.

- ***Contracting for outside medical services.*** An October 2002 special review by the Office of the Inspector General found the department lacked a comprehensive statewide policy for managing medical services contracts and, because of deficiencies in its medical contracting process, had paid for services not performed and for services with an outside physician that had not been authorized. In response to the Office of the Inspector General's review, the department established a health contract services unit to assist institutions with all medical services contracts. In addition, the department required institutions to solicit medical providers and to prepare market surveys before initiating a contract. Meanwhile, expenditures for medical contracts rose 58 percent between fiscal years 2000-01 and 2004-05 from $200 million to more than $315 million, largely because of medical staff vacancies requiring contracted personnel to fill the void.

  In response to two subsequent audits issued by the California State Auditor in 2004, the Department of General Services tightened the procedures used by the department to contract with outside community hospitals, physicians, nurses, pharmacists and other medical professionals to provide needed services and fill temporary medical staff vacancies and required the department to obtain competitive bids on clinical contracts. According to a correctional expert appointed by the U. S. District Court, however, due in part to insufficient staffing and training necessary to properly implement the new

contracting procedures as well as to the complexity of the procedures, the department has fallen $58 million behind in paying provider claims. The new bidding process instituted to replace single-source contracting also has resulted in a shortage of specialty providers. Because of these developments, on March 30, 2006 the court ordered the department to pay all valid outstanding department-approved claims within 60 days and to establish new medical contracting procedures within 180 days.

Preparing inmates for release. California's prison population grew by 8,245 inmates between 2000 and 2006, tracking almost exactly with the state's annual population growth rate. In February 2000, the total inmate population stood at 160,846 and by March 2006 it had increased to 169,091, making California's prison system among the largest in the world and filling the state's prisons to nearly double design capacity. The department's adult operations budget grew over the same period from $4.4 billion in fiscal year 2000-01 to $5.3 billion in 2003-04 and to a proposed $7.5 billion for fiscal year 2006-07. As the inmate population increases, the department's problems — controlling violence, offering education, delivering health care, managing overcrowding, and controlling costs — become more difficult. While numerous factors are driving the numbers, the department has done little to control recidivism.

Examples of the deficiencies in rehabilitation efforts:

- ***Substance abuse treatment.*** According to the department, 21 percent of the state's more than 169,000 inmates are presently serving prison terms for drug offenses and the one-year recidivism rate for drug offenders is 37 percent. Yet, the effectiveness of the department's largest substance abuse treatment program is still unproven. A September 2002 study by the University of California, Los Angeles of the California Substance Abuse Treatment Facility's 1,478-bed substance abuse treatment program — the largest custody-based substance abuse treatment program, not only in the state correctional system, but also in the United States — showed no difference in recidivism rates between program participants and a control group of inmates from another prison who did not receive treatment. No comprehensive effectiveness studies comparable to the September 2002 study have been conducted. A January 2003 audit by the Office of the Inspector General of the program found numerous problems that impaired the program's effectiveness. The program is administered by the department's Office of Substance Abuse Programs, which screens inmates for the program, and is run by two private contractors. From January 2002 through June 2006, the Office of Substance Abuse Programs contracted to pay each private contractor approximately $29 million for substance abuse program services, for a total of $58 million. Key among the deficiencies identified was the placement of large numbers of inmates into the program who were not suited to the treatment model, including sex offenders and inmates suffering from mental illness. Other deficiencies included a shortage of trained counselors to run the interactive therapeutic community — a proven treatment modality for substance abusers — and the fact that treatment group sizes exceeded contract limits. The department has made improvements since the January 2003 audit by reducing the number of sex offenders and mental health patients in the program, yet the problems of large group size and the shortage of counselors remain. The 2006 follow-up review found that more than 400 general population inmates had been moved into the substance abuse housing units in response to a department-wide bed shortage, causing the substance abuse treatment group

clusters to increase to up to 100 inmates —exceeding the professionally recommended standard for therapeutic communities of 50 to 75 participants per cluster. The follow-up review also found that program staffing was 19 percent short of contract requirements, with only 59 counselors, instead of the 73 entry-level and journey-level counselors provided for under the contracts. The deficiencies appear to result from the continuing failure of the department to adequately monitor program contractors or to include provisions in the contracts that would allow the state to impose sanctions for noncompliance.

- ***Education.*** To its credit, the department has taken steps to institute new education methods for inmates at Level IV institutions, where classroom education models have proven to be unworkable, but the effectiveness of the new programs has not yet been evaluated. A July 2003 survey by the Office of the Inspector General found that delivering academic and vocational classes through a classroom model was ineffective and expensive for Level IV maximum security inmates because frequent institution lockdowns caused classes to be cancelled more than 60 percent of the time. The Office of the Inspector General also found that even if the classes were held 100 percent of the time, they would be able to accommodate only a small percentage of inmates eligible for the programs, in part because of the small number of budgeted teaching positions at Level IV institutions. State law requires the department to make literacy programs available to at least 60 percent of eligible inmates with the goal of ensuring that inmates achieve a ninth-grade reading level by the time they parole, and a survey by the Department of Corrections in November 1996 found that 68 percent of the inmate population scored below the ninth grade level in reading. Yet, at the time of the Office of the Inspector General's July 2003 survey, only 21 percent of eligible inmates at the five Level IV institutions covered in the survey were assigned to education classes. Since the survey, the department reports that it has developed new program models incorporating self-paced independent study, distance education, and other education services to increase inmate participation. It is too early to assess the effectiveness of the new education programs, however, and the department has not developed an effective monitoring system to ensure that institutions are complying with its education policies and procedures. Prison reform advocates have also suggested that the new programs may be too shallow to be effective, but again, population pressures appear to make it difficult to provide more comprehensive educational opportunities, at least in a classroom setting.

Failure to use internal auditing tools. The Department of Corrections and Rehabilitation has failed to make effective use of its own internal auditing function to identify systemic deficiencies and effect needed changes in programs and institutions. An October 2002 audit by the Office of the Inspector General of the Office of Compliance, which is the entity responsible for the department's internal auditing activity, found numerous weaknesses. For example, the office did not target internal audits toward areas of the highest risk; did not monitor audit projects to make sure they were completed in a proper and timely manner; and used a rigid checklist auditing approach that had the potential to miss important issues. The Office of Compliance reports that it has taken preliminary steps toward correcting deficiencies. But, more than three years after the October 2002 audit, the Office of Compliance still has not addressed most of the audit findings and has still not appointed a chief of internal audits with the training and experience to manage an internal auditing unit.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Following is a summary of the findings from each of the 22 follow-up reviews comprising this accountability audit of the California Department of Corrections and Rehabilitation's adult operations and programs. An index to the summaries is included following that section.

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CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN

IMPLEMENTATION REPORT CARD

Previous recommendations: 72

Fully implemented: 38 (53%)

Substantially implemented: 11 (15%)

Partially implemented: 10 (14%)

Not implemented: 12 (17%)

Not applicable: 1 (1%)

The California Substance Abuse Treatment Facility and State Prison at Corcoran has developed needed improvements to policies and procedures affecting medical services, but the institution has not implemented numerous recommendations from a January 2003 audit, citing a shortage of medical personnel and turnovers in its management ranks as major impediments. In addition, the Office of Substance Abuse Programs has not significantly improved its processes for monitoring contracts with private providers of in-prison substance abuse treatment programs, and drug treatment providers continue to fail to provide the number of counselors required under the contracts. Independent evaluations of the effectiveness of the facility's in-prison substance abuse treatment program are inconclusive.

The Office of the Inspector General issued a management review audit of the California Substance Abuse Treatment Facility and State Prison at Corcoran in January 2003. The audit identified numerous problems at the institution, including inadequate management of medical, dental, and pharmacy services; deficiencies in the substance abuse treatment program that prevented the institution from reducing recidivism by helping inmates overcome drug dependency; and the failure of a significant number of staff and managers to fulfill annual training requirements.

The January 2003 management review audit identified numerous problems that impaired the effectiveness of the institution's substance abuse treatment program. Key among these was the placement into the program of large numbers of inmates not suited to the treatment model, including sex offenders and inmates suffering from mental illness. Other deficiencies included a shortage of trained counselors to run the interactive therapeutic community — a proven treatment modality for modifying the behavior of substance abusers — and the fact that treatment group sizes for the therapeutic community exceeded contract limits.

A September 2002 study of the institution's substance abuse treatment program by the University of California, Los Angeles, showed no difference in recidivism rates between program participants and a control group of inmates at another prison who received no treatment. The study raised questions about the advisability of paying contractors millions of dollars for in-prison substance abuse programs not demonstrated to be effective.

As a result of the January 2003 management review audit, the Office of the Inspector General made 72 recommendations to the Department of Corrections, the Health Care Services Division, and the California Substance Abuse Training Facility and State Prison at Corcoran.

BACKGROUND

The California Substance Abuse Treatment Facility and State Prison at Corcoran, which opened in August 1997, houses approximately 7,300 male inmates and has a staff of about 1,700 employees, making it one of the largest prisons in the western world. It is designed for inmates ranging from Level II (low medium security) through Level IV (maximum security), and also includes a small number of Level I (minimum security) inmates. The institution includes a correctional treatment center, which provides medical treatment and recovery, mental health assessment and care, and clinical services. Clinics affiliated with the correctional treatment center provide medical and dental services inside each of the prison's seven facilities. Pharmaceuticals are provided by a pharmacy located in the correctional treatment center. Medical services for the California Department of Corrections and Rehabilitation inmates are the responsibility of the department's Division of Correctional Health Care Services. The health care manager at the Substance Abuse Treatment Facility and State Prison at Corcoran acts as the on-site administrator of health care services for the institution and is responsible for overall management of the institution's medical, mental health, and dental programs.

In addition to its mission of providing custody for state prison inmates remanded to the custody of the Department of Corrections and Rehabilitation, the institution includes a 1,478-bed substance abuse treatment program — the largest custody-based substance abuse treatment facility in the United States. The Department of Corrections and Rehabilitation's Office of Substance Abuse Programs is responsible for administering the substance abuse program, which is run by two private contractors. The Office of Substance Abuse Programs has employees on site to monitor daily program operations and to screen inmates eligible for the substance abuse program to ensure that the program operates at full capacity. The office is also responsible for monitoring the private contractors for compliance with the terms of the contracts to provide treatment services. The institution staff provides custody, security, drug testing, classification reviews, and administrative support to the Office of Substance Abuse Programs and the contractors. From January 2002 through June 2006, the Office of Substance Abuse Programs contracted to pay each private contractor approximately $29 million for substance abuse program services.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In the 2006 follow-up review, the Office of the Inspector General found that although there have been some improvements, the California Substance Abuse Treatment Facility has made generally disappointing progress in implementing needed changes in the three years since the January 2003 management review audit. The institution has been successful in identifying and recruiting a higher proportion of program-eligible inmates into the program, while reducing the proportion of sex offenders and mental health patients. Of the 1,456 inmates assigned to the program on October 20, 2005, less than seven percent were mental health patients and less than one percent of those who were mental health patients were also sex offenders. In comparison, the January 2003 audit found the proportion of sex offenders and mental health patients in the program to be as high as 50 percent.

The Office of the Inspector General also found, however, that the Office of Substance Abuse Programs continues to fail at effectively monitoring its contracts with the private providers of substance abuse program services at the prison. In reviewing the on-site monitoring reports for each provider in the substance abuse program for the 11-month period from December 2004 to October 2005, the Office of the Inspector General found that the monitoring reports continued to lack detail, did not focus on the contractors' compliance with contractual expectations, and did not reflect evidence of substantive review of the providers' records and operations.

The Office of the Inspector General noted in addition that the program providers continue to supply an inadequate number of counselors. During an October 2005 site visit, the Office of the Inspector General found that program staffing was 14 counselors short of the 73 entry-level and journey-level counselors required under the state contracts — a 19 percent shortfall. Moreover, the Office of Substance Abuse Programs still has no language in its provider contracts permitting the state to withhold payment or to exercise other sanctions short of contract cancellation for instances of non-compliance.

The Office of the Inspector General also found that an influx of more than 400 general population inmates into the substance abuse housing units in response to a department-wide bed shortage caused the treatment group cluster sizes to increase from 62 inmates to up to 100 inmates —levels that exceed the professionally recommended standard of 50 to 75 participants for therapeutic community programs and further detract from program effectiveness.

Treatment also appears to be frequently interrupted. On two separate visits in October and November 2005, the Office of the Inspector General attempted without success to observe therapeutic community groups and evaluate group sizes at the institution. On the first visit, all counseling had been suspended for the programs' annual "Sports Week," and on the second visit nearly all group sessions had been suspended to accommodate population movements among the housing units. This inactivity, coupled with recent lockdowns reported by counselors, raises concerns about the continuity of therapeutic community treatment at the institution. It is noteworthy that, with the exception of the lockdowns, none of the monitoring reports by the Office of Substance Abuse Programs discussed the continuing problems found by the Office of the Inspector General during its six days of fieldwork.

The Office of the Inspector General reviewed three subsequent evaluations by the University of California, Los Angeles, of the institution's substance abuse treatment program conducted since the September 2002 evaluation. Although the more recent evaluations, which were issued in September 2003, September 2004, and January 2006, made positive assessments of the effectiveness of post-prison aftercare, none were bona-fide effectiveness studies like the 2002 evaluation because they did not compare the recidivism rates of in-prison program participants against those of inmates from another prison who had not received treatment. Without a comparison of the subject group to a control group, it is not possible to conclude that the institution's program is successful in lowering recidivism.

Medical care. The Office of the Inspector General found that although the institution has made efforts to implement recommendations affecting the institution's medical services and operations, many of the problems identified in the January 2003 management review audit have

not been adequately addressed. The remaining deficiencies include a continuing backlog of inmate medical appeals; lack of an effective means of ensuring that physicians work a full 40-hour-a-week schedule; failure to ensure that inmates see a physician in a timely manner; lack of review of the need for inmate treatment by specialists; and inadequate monitoring of chronic care patients. The institution points to repeated turnover in the chief medical officer position as one cause of the continuing deficiencies. Six different individuals served in the position between September 2002 and June 2005, when the present incumbent was hired. The institution also reports that since September 2002 its chief dental officer, chief psychologist, chief psychiatrist, director of nurses, and medical records supervisor have all resigned, retired, or transferred. The institution further cites a critical shortage of physicians and other medical staff as a barrier to full implementation of the Office of the Inspector General's recommendations. For example:

- The institution reports that it has established an expectation that physicians complete all administrative duties, including notifying the chief medical officer of medical appeals approaching delinquent status, but maintains that the physician shortage precludes aggressive focus on appeals.

- The institution reports it established a medical authorization review committee to review the medical necessity for procedures referred to outside medical providers, but that the committee process has fallen victim to the physician shortage and reviews are limited to a cursory examination by the chief medical officer.

- While physicians' hours and workloads have been adjusted to permit doctors to see more patients, the requirement that inmates see doctors within 14 days after a request for contact as mandated by the *Plata v. Schwarzenegger* court decision is not being met because the institution does not have enough physicians to meet that workload.

In addition, the Office of the Inspector General found that despite establishing a system of accountability for medical personnel, the institution's medical management team has been lax in enforcing a directive that medical personnel log in and out of the correctional treatment center each day by signing the log and recording the actual times of arrival and departure. Instead of recording the time of day, physicians simply sign the log and indicate a status of "in" or "out."

Pharmacy operations. The Office of the Inspector General noted significant improvements in the institution's pharmacy operations. The institution developed improved policies and procedures for control of medications and quality control over prescriptions, as well as for intra-facility transfers of inmate medications. Spending for pharmaceuticals also decreased. As the Office of the Inspector General reported in the January 2003 management review audit, the institution spent $5.4 million in fiscal year 2001-02 for drugs and pharmaceutical supplies, but in fiscal year 2004-05, the institution's reported spending decreased to $3.7 million — a 31 percent reduction. The Department of Corrections and Rehabilitation, however, has still has not made a significant effort to develop an automated pharmaceuticals inventory system for the institutions.

The Office of the Inspector General also found that the Substance Abuse Treatment Facility has made significant progress in staffing its pharmacy with permanent state employees. At the time of the Office of the Inspector General's January 2003 audit, the institution's pharmacy was

staffed entirely by contract employees, but now the pharmacy employs only two contract employees among its full-time staff of nine. The positions currently filled by the two contract employees have been advertised as state civil service job openings since October 30, 2002, and the institution says the current state salary for pharmacists is lower than that offered in the industry, making recruitment difficult.

FOLLOW-UP RECOMMENDATIONS

As a result of the 2006 follow-up review, the Office of the Inspector General is providing 23 recommendations to the Office of Substance Abuse Programs. The main recommendations are listed below, and the remainder are presented in the full report.

- **Conduct systematic, in-depth monitoring of treatment providers for compliance with contract terms. Monitoring reports should reflect all substantive details of the provider's records and operations. The reports should also include the Office of Substance Abuse Programs' analysis and evaluation of the provider's operations.**
- **When drafting contracts for substance abuse treatment services, include provisions for fiscal sanctions to address instances of non-compliance with contract terms, including failure to provide the required number of counselors.**
- **Whether performed by UCLA or by another contractor, ensure that future studies of the effectiveness of the substance abuse program at the institution include a comparison of the treatment group to a control group of similar inmates who did not receive treatment.**
- **Return to using smaller clusters of inmates to conform to the Office of National Drug Control Policy's recommendation that therapeutic community program clusters consist of no more than 50 to 75 inmates.**

The Office of the Inspector General recommends that the Substance Abuse Treatment Facility and State Prison at Corcoran continue to work with the Division of Correctional Health Care Services' department-wide efforts to address the shortage of physicians and other medical staff.

PHARMACEUTICAL EXPENDITURES

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 0 (0%)

Substantially implemented: 1 (14%)

Partially implemented: 2 (29%)

Not implemented: 3 (43%)

Not applicable: 1 (14%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has made some progress in reducing its pharmaceutical expenditures. The department, however, has accomplished only the preliminary steps required to replace its outdated management information system.

In July 2003, the Office of the Inspector General conducted a survey to examine the Department of Corrections pharmaceutical expenditure trends over the four preceding fiscal years and to evaluate the department's efforts to implement changes recommended by previous audits and studies. The survey revealed that the department's pharmaceutical expenditures increased 94 percent, from $63 million in fiscal year 1999-2000 to $122.4 million in 2002-03 despite a slight decrease in inmate population and in stark contrast to a 22 percent increase in the national consumer price index for pharmaceutical drugs during the same period. The department's per-inmate pharmaceutical expenditures also increased, more than quadrupling from $142 in 1997 to $642 in 2002. The survey further identified four comprehensive audits and studies that had previously identified problems in the department's pharmacy program and included specific recommendations to remedy the deficiencies. Particularly critical was the indicated need for the department to replace its Pharmacy Prescription Tracking System, a badly outdated 20-year-old information system that lacked essential functions to control costs and prevent pharmaceutical waste, fraud, and abuse. In its July 2003 survey, the Office of the Inspector General recommended that the department act promptly to implement the recommendations of previous audits and studies of its pharmacy program, noting the department could reduce its annual pharmaceutical expenditures by up to $26 million by doing so. The Office of the Inspector General also recommended that if it appeared that the department would be unable to carry out the implementation on its own, that it consider contracting with a private vendor to institute the necessary improvements.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In the 2006 follow-up review, the Office of the Inspector General found that the department has failed to fully implement the recommendations from the 2003 survey. Until it implements past recommendations in this area, the department continues to waste millions of dollars annually in pharmaceutical expenditures.

The department reported it has developed a strategic plan incorporating recommendations from private consulting, regulatory, and oversight agencies. It also reported that it has revised its statewide procedures for medication administration and distribution; trained personnel on formulary rules; and organized management workgroups. The department rejected recommendations to contract with a private firm to manage pharmacy operations and to centralize its pharmacy distribution system.

Although the department reported it has made progress in launching a project to replace its outdated and inefficient pharmacy management system with an automated health care management system, statewide implementation of that system has not been accomplished. The department reported, however, that it achieved a "cost avoidance" of $14.3 million between *projected* pharmaceutical expenditures for fiscal year 2003-04 ($144 million) and *actual* expenditures for that period. The department's actual pharmaceutical expenditures for fiscal year 2003-04 were $129.7 million — a $7.3 million (6 percent) increase over the previous year, compared to an 18 percent average increase experienced in the three preceding fiscal years. Yet, Bureau of Labor Statistics data show that between July 2003 and June 2004, pharmaceutical prices nationwide increased only 3.3 percent.

Because of these problems, in March 2006, the U. S. District Court ordered a comprehensive financial and operational audit of the department's pharmaceutical services, to be conducted by a private specialty firm with expertise in correctional pharmaceutical operations. In addition, the U. S. District Court-appointed receiver scheduled to take over all aspects of the department's health care system on April 17, 2006, will have authority to acquire and modernize information technology.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following actions:

- **Continue the project to replace the outdated and inefficient Pharmacy Prescription Tracking System with the automated Health Care Management System and implement the new system statewide as soon as practicable.**

- **In light of the flexible options likely to be available under the February 2006 federal court order appointing a receiver over the department's medical health care delivery system, reconsider the option of contracting with a private pharmacy services management firm to implement the recommendations submitted in the reports and studies conducted since 2000.**

OFFICE OF INVESTIGATIVE SERVICES

IMPLEMENTATION REPORT CARD

Previous recommendations: 37

Fully implemented: 19 (52%)

Substantially implemented: 2 (5%)

Partially implemented: 8 (22%)

Not implemented: 6 (16%)

Not applicable: 2 (5%)

The Department of Corrections and Rehabilitation has reorganized and significantly improved its internal affairs operation since an October 2001 special review. The Office of Investigative Services—renamed the Office of Internal Affairs[1]—is now responsible for all of the department's internal affairs investigative functions. Many of the Office of the Inspector General's previous recommendations were implemented in the course of the reorganization and as a result of a federal court-ordered remedial plan. Other recommendations are no longer applicable in the wake of these changes. Yet, several deficiencies identified in the Office of the Inspector General's 2001 review remain, including the lack of a system for prioritizing investigations; inadequacies in completing employee background investigation; and failure to use the department's internal audits function to help identify pervasive problems.

In October 2001 the Office of the Inspector General issued a special review of the management practices and administrative operations of the Office of Investigative Services, which is responsible for all of the department's internal affairs investigative functions. The special review centered on the Office of Investigative Services' effectiveness, its compliance with required procedures, and the quality of its operational practices, identifying numerous deficiencies that impaired the ability of the office to meet its responsibilities. In particular, the review found that a rapidly expanding caseload, coupled with deficient management practices, prevented the Office of Investigative Services from completing investigations within required time limits. That deficiency limited the ability of the department to take appropriate administrative action against employees when misconduct allegations were sustained. The Office of the Inspector General presented 37 recommendations to remedy the deficiencies identified in the October 2001 special review.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General's 2006 follow-up review found that the Office of Internal Affairs has significantly improved its investigative process through creation of a central intake panel that brings consistency to the process of determining whether to accept or reject cases for investigation. In another improvement, the investigative classification system has been streamlined, allowing cases involving minor supervisory issues requiring no additional investigation to be addressed directly by the hiring authorities, while those requiring investigation are conducted or closely supervised by the Office of Internal Affairs. In addition, the former case management information system has been replaced by a new system providing not only for tracking and monitoring active cases, but also for tracking the entire employee discipline continuum from the initial request for investigation to its final disposition. The system

[1] Depending on the context and time-frame discussed, both names — Office of Investigative Services and Office of Internal Affairs — are used in this report.

is being installed at California Department of Corrections and Rehabilitation investigative offices, legal offices, and hiring authorities throughout the state.

Many of the Office of the Inspector General's recommendations from the October 2001 special review were implemented in the course of reorganizing the entities now under the Department of Corrections and Rehabilitation, and also as a result of a federal court-ordered remedial plan. Other recommendations are no longer applicable in the wake of these changes. However, several deficiencies identified in the Office of the Inspector General's 2001 review remain. These include a lack of a system for prioritizing investigations; inadequate management of overtime use; inadequacies in completing background investigations of employees and borrowed investigators; inadequate control over access to the case management information system; deficiencies in evidence handling; and failure to use the department's internal audits function to help identify pervasive problems.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General's 2006 follow-up review makes ten additional recommendations to the Office of Internal Affairs, including the following:

- **Develop policies and procedures for prioritizing investigative cases.**

- **Assign each region a monthly allocation of budgeted overtime and prepare a monthly log for each regional office that begins with monthly allotted hours and is adjusted for each usage. When overtime is granted, the supervisor should immediately e-mail the agent and the overtime timekeeper for the purpose of adjusting monthly balances and providing evidence of previous overtime approval. In order to provide regional supervisors flexibility in managing cases, the Office of Internal Affairs should consider rolling over unused office balances from one month to the next.**

- **Refrain from using investigative services unit investigators until their supplemental background investigations are complete.**

- **Formalize the process for verifying that case management information system access is limited to only authorized users. The process should define the frequency of reviews, require a reconciliation of beginning and ending authorized users for the period, and specify the date when users are added or deleted. Included in this process should be a requirement that an exit document be prepared by the departing staff's supervisor that instructs the information technology staff to remove the user's access.**

- **Prepare a supervisory quality control review sheet that ensures that the investigative package is complete, the investigative plan was followed, all key witnesses were interviewed, required notices were performed, and the final report represents a clear, fair, and unbiased representation of the facts.**

- **Use the Department of Corrections and Rehabilitation internal audit staff to perform field audits to identify trends in complaints against staff so that resources can be focused on the most pervasive problems.**

EMPLOYEE DISCIPLINARY PROCESS

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has improved its employee disciplinary process and has fully or substantially implemented all previous recommendations.

IMPLEMENTATION REPORT CARD

Previous recommendations: 9

Fully implemented: 6 (67 %)

Substantially implemented: 3 (33%)

Partially implemented: 0 (0%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

In March 2002, the Office of the Inspector General conducted a review of the Department of Corrections employee disciplinary process. The purpose of the review was to identify any administrative or procedural weaknesses in the disciplinary process that might affect the department's ability to take appropriate adverse action against employees found to have engaged in misconduct.

The review found that needless complexity sometimes delayed or even impaired disciplinary actions against employees. In addition, there were no clear guidelines defining the one-year period for investigating misconduct and imposing disciplinary action against peace officers. The review found that 43 percent of a sample of investigations completed during fiscal years 1999-00 and 2000-01 in which misconduct allegations were sustained were not completed within one year and therefore did not result in disciplinary action. Further, employee relations officers at institutions were not adequately trained, departmental legal staff were often uninvolved in disciplinary actions, and the department lacked policies and procedures governing settlements with employees. The Office of the Inspector General made nine recommendations to the department to address these findings. Subsequent to the March 2002 review, a special master appointed by the U. S. District Court, Northern District of California has been monitoring efforts to reform the disciplinary process through what is known as the Madrid Remedial Plan. Many of the plan's provisions are consistent with the Office of the Inspector General's March 2002 recommendations.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that the Department of Corrections and Rehabilitation has significantly improved its administration of the employee disciplinary process. The department has developed a case management system to monitor and track disciplinary cases from start to finish to ensure that cases meet statutory deadlines. It has also implemented a new central intake process that provides for representatives from the Office of Internal Affairs, office of Legal Affairs, and other department staff to review requests for investigations and determine appropriate action. The Office of the Inspector General's Bureau of Independent Review monitors the central intake and internal affairs process and also monitors the investigations. The department has also updated its policies and procedures for employee discipline and has provided formal training to its employee relations officers statewide. As a result of these and other changes, only two percent of 94 investigations with sustained findings conducted by the Office of Internal Affairs for the period December 1, 2004 through May 31, 2005 exceeded the one-year statutory limit. No follow-up recommendations are made.

OFFICE OF COMPLIANCE, AUDIT FUNCTIONS

IMPLEMENTATION REPORT CARD

Previous recommendations: 4

Fully implemented: 2 (50 %)

Substantially implemented: 0 (0%)

Partially implemented: 2 (50%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has consolidated its audit functions into a single unit and elevated the chief of the unit to report directly to the undersecretary. Yet, more than three years after an October 2002 review by the Office of the Inspector General, the department still has not corrected most of the deficiencies identified in that review.

In October 2002, the Office of the Inspector General issued a report resulting from a review of the audit functions of the Department of Corrections Office of Compliance. The Office of the Inspector General found that the Office of Compliance did not adhere to appropriate professional standards in performing its internal audit work. The Office of the Inspector General identified several specific weaknesses in the department's management of the Office of Compliance, all of which resulted from the failure of the office to comply with internal auditing standards. The deficiencies included poor communication with executive staff and unresponsiveness to executive requests for audits. As a result of the deficiencies, the Office of the Inspector General questioned the ability of the Office of Compliance to accomplish its objectives and meet its assigned responsibilities. As a result of the October 2002 review, the Office of the Inspector General recommended that the Department of Corrections consolidate all of its auditing activities into a professional internal auditing unit consistent with standards prescribed in *Standards for the Professional Practice of Internal Auditing*. The Office of the Inspector General recommendations specified that the chief of internal audits should possess the training, knowledge, and experience necessary to manage an internal auditing unit and should report to the chief deputy director for Support Services.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that more than three years after the initial audit in October 2002, the department has not addressed most of the audit findings. The department has consolidated its internal audit activities into the Office of Audits and Compliance, which reports directly to the department's undersecretary. That change should allow the department to better coordinate its varied audit activities and provide the appropriate level of organizational independence, as prescribed by the Institute of Internal Auditors. According to the department, once the Office of Audits and Compliance is fully operational, it will address most of the remaining issues raised in the October 2002 review.

Because the Office of Audits and Compliance is not yet fully operational, however, the department has not yet addressed several issues and recommendations raised in the review including:

- The department stated that it has not yet begun to adhere to *Standards for the Professional Practice of Internal Auditing.*

- The department reported that it has not yet developed a quality assurance and improvement program for its internal auditing activity.

- The department stated that it is currently not using a risk-based plan to determine the priorities of its internal audit activity.

- The department acknowledged that the two units that perform audits of internal operations are still not receiving substantive input from senior management in developing their audit plans.

- The department has not yet appointed a permanent assistant secretary as the chief of internal audits who possesses the training, knowledge, and experience to manage an internal auditing unit.

Not only appropriate auditing standards, but also sound business principles require the department to incorporate the features described above into its audit operations. By not adequately addressing the findings of the Office of the Inspector General's October 2002 report, the department has limited the value of its internal audit unit as a tool for identifying department operations needing improvement.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General makes six recommendations, including:

- **The department should continue its efforts to recruit a permanent assistant secretary for the Office of Audits and Compliance, ensuring that the person selected possesses the training, knowledge, and experience to manage an internal auditing unit.**

- **The department should ensure that the Office of Audits and Compliance continues to develop operating policies and procedures that will ensure that its audit activity is consistent with the standards prescribed in the *Standards for the Professional Practice of Internal Auditing.***

- **The policies and procedures should include a process for effective communication with the department's executive staff in planning annual audit activities and reporting audit performance, and a process by which to develop a risk-based comprehensive annual plan for identifying the priorities of the internal audit activity.**

MEDICAL CONTRACTING PROCESS

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 5 (72 %)

Substantially implemented: 1 (14%)

Partially implemented: 1 (14%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has implemented several of the recommendations resulting from an October 2002 special review, but because of continuing problems with its medical contracting procedures, is under court order to develop new procedures within 180 days.

In October 2002, the Office of the Inspector General conducted a special review of the processes and controls used by the department's Health Care Services Division to procure and pay for contract medical services to inmates. In order to provide adequate medical services to the growing inmate population, the department contracts with outside community hospitals, physicians, nurses, pharmacists, and other medical professionals to obtain specialized services its staff and facilities cannot provide. In some instances, the department also contracts with medical professionals to fill temporary staff vacancies in medical classifications where recruitment is difficult. The review determined that the division did not effectively manage its medical services to inmates and that it should adopt statewide policies and procedures to ensure cost-effective contracts, quality case management, and continuity of care.

The October 2002 review found the department lacked a comprehensive statewide policy for managing medical services contracts and had paid for services not performed and for services with an outside physician that had not been authorized because of deficiencies in its medical contracting process. The review found that the process was vulnerable to potentially serious conflicts of interest because the person selecting the contractor was also authorized to approve invoices and payments under the contract, and that these deficiencies in the process may have led to problems in the quality and continuity of inmate medical care.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that the Department of Corrections and Rehabilitation has made a number of changes to its medical contracting process. In response to the Office of the Inspector General's review, the department established a health contract services unit to assist institutions with all medical services contracts. In addition, the department required institutions to solicit medical providers and to prepare market surveys before initiating a contract. Meanwhile, expenditures for medical contracts rose 58 percent between fiscal years 2000-01 and 2004-05 from $200 million to more than $315 million, largely because of medical staff vacancies requiring contracted personnel to fill the void.

In response to two subsequent audits issued by the California State Auditor in 2004, the Department of General Services tightened the procedures used by the department to contract with outside community hospitals, physicians, nurses, pharmacists and other medical professionals to provide needed services and fill temporary medical staff vacancies and required

the department to obtain competitive bids on clinical contracts. According to a correctional expert appointed by the U. S. District Court, however, due in part to insufficient staffing and training necessary to properly implement the new contracting procedures as well as to the complexity of the procedures, the department has fallen $58 million behind in paying provider claims. The new bidding process instituted to replace single-source contracting also has resulted in a shortage of specialty providers. Because of these developments, on March 30, 2006 the court ordered the department to pay all valid outstanding department-approved claims within 60 days and to establish new medical contracting procedures within 180 days.

FOLLOW-UP RECOMMENDATION

As a result of its 2006 follow-up review, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation develop a more effective and efficient system for processing and monitoring medical service invoices, including validation that contractors have performed all services invoiced prior to issuing payment.

EDUCATION PROGRAMS AT LEVEL IV INSTITUTIONS

IMPLEMENTATION REPORT CARD

Previous recommendations: 6

Fully implemented: 1 (17%)

Substantially implemented: 2 (33%)

Partially implemented: 3 (50%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has made progress in developing alternative education programs for Level IV inmates, but the effectiveness of the new programs has not yet been evaluated.

In July 2003, the Office of the Inspector General conducted a survey of education programs at the Department of Corrections Level IV institutions. The survey was prompted by management review audits conducted by the Office of the Inspector General showing that inmates in state correctional institutions received only limited classroom instruction because classrooms were closed for significant periods of time due to lockdowns, teacher vacancies, and other program disruptions.

The survey revealed the classroom education model to be an inefficient and expensive means of delivering education to Level IV inmates because frequent lockdowns cause academic and vocational classes to be closed down more than 60 percent of the time. At the five Level IV institutions locked down for the largest percentages of time, education programs operated an average of only 25 percent of the time. And even with the classes closed for long periods, the survey found that inmates continued to receive day-for-day sentence reduction credits as though they had attended class, and teachers continued to be paid as though they had provided instruction. Meanwhile, the survey also found that institutions had no systematic means of accounting for teachers' activities during lockdown periods or of temporarily assigning them to other duties, and labor agreements hampered the redirection of teachers to other functions during those periods. When lockdowns and other program disruptions were taken into account, the annual per-inmate cost of the education programs at Level IV institutions greatly exceeded the annual per-inmate cost budgeted.

The Office of the Inspector General also found despite the statutory requirement that the Department of Corrections and Rehabilitation make literacy programs available to at least 60 percent of eligible inmates — and even though a statewide survey conducted by the Department of Corrections in November 1996 found that 68 percent of the inmate population scored below the ninth grade level in reading — only 20.8 percent of eligible inmates at the level IV institutions surveyed were assigned to education classes at the time of the survey. Lastly, the Office of the Inspector General found that even if the classes were held 100 percent of the time, they would have been able to accommodate only a small percentage of inmates eligible for the programs, in part because of the small number of budgeted teaching positions at Level IV institutions. The Office of the Inspector General recommended that the Department of Corrections re-evaluate education programs at Level IV institutions to determine whether they warrant continued operation and investigate other methods of delivering academic and vocational instruction. Among the options considered should be eliminating formal classroom instruction and retaining a small educational staff to coordinate in-cell study courses for inmates.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that the Department of Corrections and Rehabilitation has made some progress in developing alternative education programs for its Level IV inmates. In response to a $34.8 million reduction to its education budget, the department evaluated its existing programs and prioritized them to determine those that warranted continued operation. Upon completion of the evaluation, the department eliminated 129 education positions, including many of the Level IV vocational programs, due to their ineffectiveness. The department has since developed alternative education program models designed to increase overall inmate participation through non-traditional methods. The new programs include more self-paced independent study, such as the new Bridging Education Program recently implemented in the reception centers and general population facilities. This new program allows inmates to begin participating in self-paced education programs when they arrive at a reception center. Other programs include short-term vocational certification classes, half-day assignments with a homework component, delivery of educational services via distance education methodologies, and delivery of educational services in the living units. The department recently implemented the majority of the new alternative delivery education models. Therefore, only minimal data is available at this time to evaluate the effectiveness of these programs. Prison reform advocates have suggested that the new programs may be ineffective, but inmate population pressures appear to make it difficult to provide more comprehensive educational opportunities, at least in a classroom setting.

Although the department has made progress in developing new education programs, it still has not developed an effective monitoring system to ensure that institutions are complying with its education policies and procedures.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General recommended that the Department of Corrections and Rehabilitation take the following actions:

- **Systematically evaluate the effectiveness of the new alternative education delivery models. The evaluation should include inmate participation rates, progress in achieving educational goals, and the impact of the programs on recidivism.**

- **The new Office of Correctional Education should dedicate staff to perform periodic on-site reviews to ensure compliance with department policies and procedures. The on-site reviews should include, but not be limited to, verification of educational representatives participating in classification committees, verification of class closures for teacher vacancies beyond 30 days, and the verification of the accuracy of timekeeping for inmate program participation.**

RICHARD A. MCGEE CORRECTIONAL TRAINING CENTER

The Office of the Inspector General found that the Richard A. McGee Correctional Training Center has significantly improved its cadet training program. The academy instituted guidelines for course development that include instructor input, cadet feedback, and Commission on Correctional Peace Officer Standards and Training program approval. Lesson plans for the now-expanded academy are complete and were approved by the commission. Cadet testing protocols are also complete, as are operational procedures governing test results retention.

IMPLEMENTATION REPORT CARD

Previous recommendations: 12

Fully implemented: 11 (92%)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 1 (8%)

Not applicable: 0 (0%)

In April 2000 the Office of the Inspector General conducted an unannounced special review audit of the Richard A. McGee Correctional Training Center (now known as the Richard A. McGee Academy), which conducts the basic correctional officer academy program for all correctional officers training in California. The review was prompted by numerous serious allegations that were reported to the Office of the Inspector General in late March 2000. The allegations called into question the integrity of test results for recent graduates of the basic correctional officer academy located at the center and the overall preparedness of correctional officers graduating from the academy.

As a result of the May 2000 review, the Office of the Inspector General made eight specific findings, including:

- Cadets being trained under the expanded ten-week curriculum even though a significant number of the lesson plans had not been completed.

- Many of the 46 lesson plans, including those for highly essential courses, had not received provisional approval from the Commission on Correctional Peace Officer Standards and Training.

- The department's Staff Development Center and the training center staff failed to coordinate efforts in developing the lesson plans.

- The training center did not maintain the instructor-to-cadet ratios specified in the lesson plans approved by the Commission on Correctional Peace Officer Standards and Training.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that the Richard A. McGee Correctional Training Center has significantly improved its cadet training program. The academy implemented guidelines for course development that include instructor input, cadet feedback, and Commission on Correctional Peace Officer Standards and Training approval. Lesson plans for the now-expanded academy are complete and have been approved by the

Commission on Correctional Peace Officer Standards and Training (now the Corrections Standards Authority). Cadet testing protocols and test retention policy also have been completed. The Office of the Inspector General makes no follow-up recommendations.

CALIFORNIA STATE PRISON, SOLANO

The Office of the Inspector General found that the California State Prison, Solano has improved certain of its operations since a March 2003 management review audit. The facility more closely monitors inmates' tuberculosis status, better manages sentence reduction credits granted to inmates, and has improved its management of both inmates placed in administrative segregation and those taking psychotropic medications. Although it has made significant progress, the facility has only partially implemented recommendations to properly house inmates taking anticonvulsant medications and has not taken steps to monitor its pharmacy inventory.

IMPLEMENTATION REPORT CARD

Previous recommendations: 24

Fully implemented: 19 (79%)

Substantially implemented: 2 (9%)

Partially implemented: 2 (8%)

Not implemented: 1 (4%)

Not applicable: 0 (0%)

In March 2003, the Office of the Inspector General conducted a management review audit of California State Prison, Solano to assess the essential functions of the facility. As a result of the review, the Office of the Inspector General found that California State Prison, Solano was not adequately tracking inmates with tuberculosis, creating the potential of exposing inmates throughout the state to the disease and presenting a risk to the correctional staff and the general public. In addition, the institution allowed inmates to earn sentence reduction credit through education and training classes even when classes were not actually held, and maintained inadequate pharmacy record keeping and physical controls over prescription medications stored in the infirmary and clinics to prevent unauthorized access and theft. The Office of the Inspector General also found that a significant number of inmates taking psychotropic medications were inappropriately housed in buildings lacking air conditioning and some inmates who were taking anticonvulsant medications were not assigned to lower bunks to lessen the possibility of injury in the event of a seizure, and makeshift partitions in the institution's administrative segregation unit buildings created blind spots that limited the view of the control booth officers, compromising the safety and security of correctional staff and inmates. Furthermore, when inmate deaths occurred, the institution did not examine the cause and circumstances surrounding the deaths in a timely manner and the people the institution assigned to conduct the reviews may have had a direct interest in the results. The Office of the Inspector General presented 24 recommendations in its March 2003 report to remedy the findings.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that the California State Prison, Solano has made significant progress in implementing the recommendations made in the March 2003 report. Specifically, the Office of the Inspector General made the following findings:

- The facility has improved its monitoring of inmates who have tested positive for tuberculosis by adding staff and increasing follow-up assessments of those inmates.

- In closing classes with no assigned instructors, the facility has reduced the rate at which it grants sentence-reduction credits to inmates who otherwise did not attend classes.

- The facility installed mirrors that improved visibility in its administrative segregation units.

- The facility has implemented procedures to ensure that inmates taking psychotropic medications—which increase inmates' susceptibility to heat-related illnesses—are appropriately housed and monitored when temperatures are higher than 90 degrees. The facility should, however, improve its monitoring of inmates taking anti-seizure medications to ensure that those inmates are assigned to lower bunks to protect their safety.

- The department implemented new procedures in December 2005 relative to reporting inmate deaths and submitting specific documents related to each death to headquarters for analysis.

- The pharmacy at California State Prison, Solano has improved its security over non-narcotic medications, but still does not have a method to monitor their inventory.

- The department obtained additional resources to improve statewide dental care.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General recommends that the California State Prison, Solano take the following actions:

- **Conduct periodic evaluations of the housing assignments of inmates who have been prescribed seizure medications to ensure that those inmates are housed appropriately.**

- **Develop a method to reconcile the types and quantities of pharmaceuticals shipped from its pharmacy to its clinics and the correctional treatment center with the types and quantities of medications prescribed to inmates.**

In addition, the Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation assess whether additional dental staffing and equipment have improved the availability of dental examinations to inmates across all institutions.

CALIFORNIA STATE PRISON, SACRAMENTO

IMPLEMENTATION REPORT CARD

Previous recommendations: 17

Fully implemented: 12 (70%)

Substantially implemented: 2 (12%)

Partially implemented: 1 (6%)

Not implemented: 2 (12%)

Not applicable: 0 (0%)

The Office of the Inspector General found that California State Prison, Sacramento has corrected various deficiencies identified in a September 2000 management review audit. Financial management has improved, in that actual expenditures are closer to budget allotments; underground storage tanks have been removed, thus avoiding fines and penalties; and internal control weaknesses in the handling of inmate trust funds have been corrected.

In September 2000, the Office of the Inspector General issued a management review audit report of California State Prison, Sacramento focusing on personnel, training, communications, inmate programming, security, and finances. The audit found deficiencies in financial management and internal control weaknesses in the handling of inmate trust funds. Other areas found to be deficient included the institution's electronic security clearance system designed to track the arrival and departure of employees and visitors, inmate dental examinations, the failure to process inmate appeal forms in a timely manner, failure to comply with a mandate to remove underground storage tanks in a timely manner, inconsistent handling of inmate rules violation reports, and the failure to complete employee probation and performance reports on time. The Office of the Inspector General presented 17 recommendations to remedy the deficiencies identified in the September 2000 review.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that the California State Prison, Sacramento has substantially improved its financial management, keeping expenditures aligned with budget allotments and resolving internal control weaknesses relative to inmate trust funds. The institution has also implemented processes improving monitoring of the following: inmate and parolee appeals, the correctional peace officer apprenticeship program, equal employment opportunity case files, and inmate rules violation reports. The institution still needs improvement in tracking institution staff and visitors, providing timely inmate dental examinations, and completing staff performance evaluations.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General makes five recommendations to the department and California State Prison, Sacramento, including:

- **Explore options for a cost-effective electronic system that effectively tracks the entry and departure of staff and visitors at the institution.**

- **Barring a change in Title 15, California Code of Regulations, comply with the requirement to provide dental examinations to inmates within 14 days of their arrival at the institution.**

- **Ensure that employee performance and probationary reports are completed in a timely manner.**

HIGH DESERT STATE PRISON

IMPLEMENTATION REPORT CARD

Previous recommendations: 31

Fully implemented: 18 (58%)

Substantially implemented: 4 (13%)

Partially implemented: 3 (10%)

Not implemented: 5 (16%)

Not applicable: 1 (3%)

The Office of the Inspector General found that High Desert State Prison has addressed most of the recommendations from a November 2001 audit that were under its control, but the Department of Corrections and Rehabilitation has not implemented several recommendations to provide the institution with needed resources or to take other actions affecting both High Desert State Prison and other institutions.

In November 2001, the Office of the Inspector General conducted a management review audit of High Desert State Prison. The audit determined that the institution was generally well run, but identified a number of deficiencies affecting safety and security, the inmate appeals process, the inmate disciplinary system, employee performance reports, and inmate medical and dental care. The audit also identified issues affecting safety and security and inmate dental care that required action from the Department of Corrections.

Specifically, the Office of the Inspector General noted a number of health care deficiencies, including poor documentation of chronically ill inmates, inmates taking psychotropic medications not being properly managed for heat risks, a risk that inmate medications could be tampered with before administration and were not adequately documented in the medical files, that inmates were not receiving required dental services, and poor controls over prescription drugs. Additionally, problems were found in institutional programs, such as the inmate appeals process, administrative segregation housing units, and inmate discipline process. As a result of the November 2001 audit, the Office of the Inspector General made 31 recommendations to the management of High Desert State Prison and to the Department of Corrections.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General found in its follow-up audit that High Desert State Prison has made significant progress in implementing recommendations affecting areas under the warden's control, but a number of issues requiring additional funding and policy direction from the Department of Corrections and Rehabilitation central office have not been addressed. The institution has addressed the timeliness of the inmate appeals process, monitoring of inmate modification orders, and ensuring that inmates comply with administrative segregation policies. The institution has also made improvements in the inmate disciplinary process, in documenting services provided during lockdowns, in completing staff performance reports, and in completing mandated training requirements. In contrast, the Department of Corrections and Rehabilitation has made minimal progress in performing security modifications, including installing security cameras on the main yards, and in pursuing additional release allowance funding for inmates paroling from rural areas.

A number of the recommendations affecting the health care program, which is under the direction of the health care manager, have also been addressed. In particular, the institution has

made progress in documenting inmate medical histories before issuing medications; in providing additional escorts for dental services; and in implementing policies and procedures to improve distribution and tracking of inmate medications. But the institution's medical department still has not developed a system to ensure that inmates on psychotropic medications are included in the mental health care delivery system. Also, the department has not eliminated inconsistencies in regulations concerning minimum dental service requirements and has not developed an automated system to schedule and track dental services.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General made six recommendations, including the following:

- **The High Desert State Prison medical department develop a system to ensure that inmates requiring psychotropic medications are included in the mental health delivery system before they receive the medications.**

- **The Department of Corrections and Rehabilitation eliminate inconsistencies between California Code of Regulations, Title 15 and the *Department of Corrections and Rehabilitation Operations Manual* concerning inmate dental care.**

- **The Department of Corrections and Rehabilitation implement an automated inventory system to track and monitor prescription drugs.**

VALLEY STATE PRISON FOR WOMEN

The Office of the Inspector General found that Valley State Prison for Women has improved employee morale and the timeliness and completion of important administrative processes, such as Category I investigations, inmate appeals, and rules violation reports. The institution remains deficient in areas involving employee performance and probation reports, weapons qualification for armed staff, drug disposal, and drug interdiction training.

IMPLEMENTATION REPORT CARD

Previous recommendations: 35

Fully implemented: 24 (68%)

Substantially implemented: 2 (6%)

Partially implemented: 5 (14%)

Not implemented: 1 (3%)

Not applicable: 3 (9%)

The Office of the Inspector General conducted a January 2001 management review audit of Valley State Prison for Women focused on institutional processes relating to communications, personnel, investigations, training, security, and financial matters. As a result of the review, the Office of the Inspector General found that poor morale among the institution staff was pervasive. The Office of the Inspector General also found a number of administrative deficiencies, such as incomplete and untimely investigations of employee misconduct and rules violation reports involving inmate conduct, untimely completion of inmate appeals and employee performance and probation reports, and inadequate control over drug disposal.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General's 2006 follow-up review found that Valley State Prison for Women has taken measures to improve employee morale and various important administrative procedures, including investigations of employee misconduct, rules violation reports, inmate appeals, adverse personnel actions, and equal employment opportunity complaints. The institution has improved its tracking systems for these administrative processes and has established bi-monthly employee advisory council meetings. However, the institution remains deficient in preparing timely employee performance and probation reports; ensuring that staff assigned to armed posts meet quarterly weapons qualification requirements; providing drug interdiction training; and complying with Department of Corrections and Rehabilitation drug disposal guidelines.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General makes seven additional recommendations to Valley State Prison for Women, including:

- **Hold staff members with responsibility for preparing performance and probation reports accountable for completing and submitting the reports on the required date and use progressive discipline to ensure compliance.**

- **Follow the updated evidence control procedure for the destruction of drugs.**

- **Conduct a quarterly audit of staff members assigned to armed posts to ensure compliance with the quarterly range qualifications.**

SIERRA CONSERVATION CENTER

IMPLEMENTATION REPORT CARD

Previous recommendations: 53

Fully implemented: 38 (71%)

Substantially implemented: 11 (21%)

Partially implemented: 1 (2%)

Not implemented: 1 (2%)

Not applicable: 2 (4%)

The Office of the Inspector General found that the Sierra Conservation Center has successfully addressed nearly all of the deficiencies identified in a May 2001 management review audit. The institution has enhanced the safety and security of its physical plant and has improved procedures relating to inmate appeals, the inmate disciplinary process, staff training, adverse personnel actions, employee grievances, equal employment opportunity complaints, and the reporting of inmate deaths.

The Office of the Inspector General issued a May 2001 management review audit report of Sierra Conservation Center, which is situated on 420 acres near Jamestown, California, and one of only two institutions in the state responsible for the training and placement of inmates into the conservation camp program. While the institution's principal mission is to provide housing, programs, and services for minimum and medium custody inmates, it also administers 22 conservation camps — 19 camps for male inmates and three camps for female inmates — located in rural and wilderness areas. The audit identified safety and security deficiencies focused on physical conditions of the institution such as the use of privacy curtains by inmates in their living areas, gun coverage on a recreational yard, physical deterioration of prison dormitories, the need for an additional strip search facility, and the need to secure utility closets in the administrative segregation unit. The audit also found deficiencies related to the institution's inmate appeals process, inmate disciplinary system, employee grievance process, equal employment opportunity complaints, inmate death reporting, staff training, and the tracking of adverse personnel actions. As a result of its May 2001 management review audit, the Office of the Inspector General made 53 recommendations to the management of the Sierra Conservation Center.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General's 2006 follow-up review found that the Sierra Conservation Center made improvements in its physical plant and operational procedures, thereby limiting the use of privacy curtains in inmate living areas, enhancing gun coverage of the recreational yard, constructing a strip search area, securing utility closets in the administrative segregation unit; and making needed repairs to inmate dormitories. The institution has also developed monitoring tools to ensure that inmate appeals and inmate disciplinary actions are processed in a timely fashion, taken steps to ensure that staff training requirements are fulfilled, improved monitoring and tracking of adverse personnel actions and employee grievances, improved organization of equal employment opportunity complaints, and improved reporting of inmate deaths.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General's 2006 follow-up review makes five recommendations to the Sierra Conservation Center, including:

- **Continue to enforce the order that the staff remove all sheets and makeshift privacy curtains in housing units that would obstruct the view of officers.**

- **Hold managers and supervisors accountable for failure to follow through with their responsibilities.**

- **Ensure that letters of instruction are issued when merited.**

- **Maintain a tracking log with complete and up-to-date information on the disposition of letters of instruction.**

LEO CHESNEY COMMUNITY CORRECTIONAL FACILITY

The Office of the Inspector General found that most of the recommendations from a 2001 audit of the Leo Chesney Community Correctional Facility have been fully implemented, but that the Department of Corrections and Rehabilitation has not addressed deficiencies identified in the audit relating to the need for written policies governing investigations into alleged misconduct at community correctional facilities by non-department employees.

IMPLEMENTATION REPORT CARD

Previous recommendations: 22

Fully implemented: 15 (68%)

Substantially implemented: 1 (5%)

Partially implemented: 2 (9%)

Not implemented: 1 (5%)

Not applicable: 3 (13%)

In October 2001, the Office of the Inspector General issued an audit report of the Leo Chesney Community Correctional Facility, operated by Cornell Corrections of California, Inc. under a contract with the Department of Corrections and Rehabilitation. The California Penal Code authorizes the California Department of Corrections and Rehabilitation to establish, operate, and contract for "community correctional centers" for the housing, supervision, and counseling of inmates. The Leo Chesney Community Correctional Facility, the only facility for female inmates in the community correctional facility program, is located in the community of Live Oak, approximately 50 miles north of Sacramento.

The audit identified problems with the facility's operations and with the department's management of the facility, the most significant of which included an absence of formal policies and procedures for investigating inmate and staff misconduct; failure by the department's Office of Investigative Services to adequately respond to allegations of sexual misconduct; and a lack of clear guidelines governing the use of revenues generated from inmate telephone calls.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General's 2006 follow-up review found that Cornell Corrections has improved the investigative process by developing procedures for investigating allegations of inmate or employee misconduct. These improved procedures provide for investigations of inmate misconduct to be conducted jointly by Cornell Corrections and the Department of Corrections and Rehabilitation's Office of Internal Affairs. But the department still does not have clear policies to guide the investigative process in cases of misconduct involving the contractor's employees.

The Office of the Inspector General's follow-up review also found that the Community Correctional Facility Administration provided for better approval and control of inmate telephone revenues earned by the contractor by negotiating an amendment to its contract. The amendment addresses how revenues may be spent, but does not address the ownership of any unspent balance that may remain at the end of the contract period. The department reported that this important issue will be addressed in an arrangement that will cover all future contracts. Under that arrangement, inmate telephone services will be provided through a statewide contract that will result in the state general fund being paid the telephone revenues generated under the contracts.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General makes three recommendations to the Department of Corrections and Rehabilitation which include the following:

- **Develop and implement clear policies to guide the investigative process for investigations of misconduct at community correctional facilities by individuals who are not department employees.**

- **Continue to use the new statewide Inmate Telephone System agreement to provide inmate telephone services for all future community correctional facility contracts.**

LOCAL ASSISTANCE PROGRAM

IMPLEMENTATION REPORT CARD

Previous recommendations: 6

Fully implemented: 4 (66 %)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 1 (17%)

Not applicable: 1 (17%)

The Office of the Inspector General found that the Parole and Community Services Division has made significant improvements in its oversight of the Local Assistance Program, but still lacks the information technology needed to efficiently verify information on invoices submitted to reimburse local jurisdictions for services provided to state parolees.

In January 2002, the Office of the Inspector General conducted a special review of the Parole and Community Services Division's Local Assistance Program, which reimburses local jurisdictions for the costs of detaining state parolees in local facilities. The review determined that the program had overpaid local jurisdictions $8.2 million in the previous two fiscal years by reimbursing for services at rates exceeding the maximum daily rate allowed under the State Budget Act. The review also found that the program did not adequately monitor non-routine medical services provided to state parolees in Los Angeles County and that the department's procedures for processing invoices from local jurisdictions were deficient. The Office of the Inspector General made six recommendations to the Department of Corrections to address these findings.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General's 2006 follow-up review found that the Parole and Community Services Division has improved its monitoring of the Local Assistance Program. The Department of Corrections cooperated with the Department of Finance and the California Sheriffs' Association to revise the method for calculating the daily jail rate and to amend the state budget act language for reimbursement to local jurisdictions. The resulting agreement excludes non-routine medical costs from the daily jail rate calculation, while the amended budget language resolves previous confusion over interpretation of California Penal Code requirements for calculating reimbursements to local jurisdictions. The Parole and Community Services Division has also improved its procedures and monitoring efforts to reduce associated non-routine medical costs. The Parole and Community Services Division's information system, however, needs further improvement to efficiently verify and process invoices from local jurisdictions. The State Budget Act of 2005 provides for expenditures of up to $81.5 million in payments for local assistance. The department reports that its parole revocation scheduling and tracking system cannot be programmed to allow continuous tracking of the movements of individual parolees. As a result, the parole staff cannot confirm that a parolee was detained in the local jurisdiction on an active parole hold during the period claimed. The department reports that it is using a tracking system developed only for Parole Region III, which encompasses Los Angeles County, but has not estimated when such a system might be available statewide.

FOLLOW-UP RECOMMENDATION

As a result of its 2006 follow-up review, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation continue to pursue development of an information system to improve the Local Assistance Program's invoice verification process.

INMATE APPEALS BRANCH

IMPLEMENTATION REPORT CARD

Previous recommendations: 1

Fully implemented: 0 (0 %)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 1 (100%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation Inmate Appeals Branch has made efforts to enhance its inmate appeals tracking system to integrate appeals at the third-level review but other department priorities have hampered its efforts.

A special review of the Department of Corrections Inmate Appeals Branch, issued by the Office of the Inspector General in February 2001, identified serious deficiencies in the third-level inmate appeals process. The problems had caused unacceptable delays in the processing of inmate appeals and had created a significant and growing backlog of appeals that had not been completed within the 60-day time frame required by California Code of Regulations, Title 15, which provides inmates with a system and process for filing complaints.

The process usually begins with an informal attempt to resolve the issue but can escalate to a three-step formal appeal process beginning with the institution's appeals office, which logs appeals into a database before assigning the appeal to a staff member for action. Second level appeals are typically decided by the warden or chief medical officer and third level appeals are decided by the Inmate Appeals Branch in Sacramento. In addition, the inmate appeals process is intended to serve as a vehicle for improving department policies and procedures. *The California Department of Corrections and Rehabilitation Operations Manual* specifies that the appeals process is designed to audit the internal practices and operation of the Department of Corrections and Rehabilitation to "identify, modify, or eliminate practices which may not be necessary or may impede the accomplishment of correctional goals."

In September 2004, the Office of the Inspector General conducted a follow-up review that determined the Inmate Appeals Branch had made significant progress in addressing the deficiencies identified in the February 2001 review. In particular, the follow-up review found that the Inmate Appeals Branch was meeting required deadlines in responding to third-level appeals; had virtually eliminated its former backlog of overdue appeals; and had developed a formal training manual and written guidelines for new appeals examiners. The Inmate Appeals Branch also had developed a system for tracking inmate appeals for use at all institutions, but at the time of the follow-up review, online interconnectivity between the prisons and the Inmate Appeals Branch was still in the planning stage. After its 2004 review, the Office of the Inspector General recommended that the Inmate Appeals Branch continue to work with the Information Systems Division to develop and enhance the new inmate appeals tracking system to include third-level appeals and statewide reporting of first- and second-level appeals. These enhancements are also needed to provide for a review of institution appeals and elevation of granted and partially granted appeals as a vehicle for identifying department policies and procedures needing revision.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General completed a follow-up review in 2006 and found that the Inmate Appeals Branch has made continuous efforts to enhance its inmate appeals tracking system. As recently as December 2005, the Inmate Appeals Branch reported that it was working on a feasibility study for the enhancements, which was scheduled to be completed by December 21, 2005. But the department had not completed the study when the Office of the Inspector General's fieldwork ended in December 2005. Notwithstanding the passage of six years, the Information Systems Division continues to assign a low priority to this project.

FOLLOW-UP RECOMMENDATION

As a result of its 2006 follow-up review, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation require the Information Systems Division to either integrate the inmate appeals tracking system with the third-level appeals or contract with a private firm to do so.

SALINAS VALLEY STATE PRISON, INMATE APPEALS AND DISCIPLINARY PROCESSES

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 3 (44%)

Substantially implemented: 1 (14%)

Partially implemented: 1 (14%)

Not implemented: 1 (14%)

Not applicable: 1 (14%)

The Office of the Inspector General found that the number of overdue inmate appeals at Salinas Valley State Prison has increased since a September 2003 review, primarily because of a significantly higher volume of appeals from inmates. In addition, although the institution has improved its inmate disciplinary process, it has not developed a corrective action plan to address deficiencies in the process identified in the September 2003 review.

In September 2003, the Office of the Inspector General conducted a follow-up review of the inmate appeals and disciplinary processes at Salinas Valley State Prison. Since its opening, the institution has had problems with staff turnover and inmate unrest. Problems with inmates have led to a significant number of total or partial lockdowns, impairing the institution's ability to provide academic and vocational programs. In response to the problems, the Office of the Inspector General conducted an audit of the inmate appeals and inmate disciplinary processes at the institution in March 2000. The audit found significant deficiencies in both processes and made recommendations to correct the problems. In response to an inmate's complaint, the Office of the Inspector General returned to Salinas Valley State Prison during January 2003 to initiate an investigation of certain aspects of the inmate disciplinary process. As a result of that investigation, the Office of the Inspector General found that the prison had violated the rights of more than 80 inmates in administering the inmate disciplinary process following an inmate work stoppage in October 2002. The Office of the Inspector General subsequently conducted a follow-up review of the March 2000 audit to assess the institution's progress in addressing the earlier findings. The results of the follow-up review were published in September 2003.

The September 2003 review found that the institution had significantly improved the inmate appeals process since the earlier audit, but that problems remained in the inmate disciplinary process. Specifically, the Office of the Inspector General found that the inmate appeals process had significantly improved but the Salinas Valley State Prison had made little progress in improving its inmate disciplinary process. The Office of the Inspector General made seven recommendations to the management of Salinas Valley State Prison for improving the inmate disciplinary process.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that Salinas Valley State Prison has improved its inmate disciplinary process by requiring chief disciplinary officers to maintain independent registry logs and to regularly audit the logs for compliance. However, the institution has not developed a corrective action plan to address the deficiencies in the disciplinary process identified in the September 2003 follow-up review, and the disciplinary system procedures developed by the institution still fail to hold staff members accountable for the quality of their work. Moreover, the Office of the Inspector General found that the number of

overdue appeals has increased since the March 2000 follow-up review. The rise in the number of overdue appeals is attributable to a significantly higher volume of appeals from inmates, the process of logging informal appeals, and a lack of staffing to handle the increase in appeals.

FOLLOW-UP RECOMMENDATIONS

As a result if the 2006 follow-up review, the Office of the Inspector General recommended that Salinas Valley State Prison take the following actions:

- **Develop an alternative method of tracking informal inmate appeals instead of logging each informal appeal in the appeals tracking system.**
- **Provide for staff accountability in the inmate disciplinary system procedures.**
- **Prepare and execute a corrective action plan to address deficiencies in the inmate disciplinary process.**

CALIFORNIA REHABILITATION CENTER, INMATE APPEALS PROCESS

IMPLEMENTATION REPORT CARD

Previous recommendations: 5

Fully implemented: 4 (80 %)

Substantially implemented: 0 (0%)

Partially implemented: 1 (20%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the California Rehabilitation Center has improved its process for handling inmate appeals by maintaining adequate staffing in the inmate appeals office, providing orientation on the appeals process to new inmates, and having management monitor inmate complaints against staff. The institution continues to experience problems with transferring inmate property.

In August 2000, the Office of the Inspector General completed its review of the inmate appeals process at the California Rehabilitation Center. The inmate appeals process is prescribed under Title 15 of the California Code of Regulations to provide inmates with a system and process for filing complaints. The process usually begins with an informal attempt to resolve the issue but can escalate to a three-step formal appeal process beginning with the institution's appeals office, which logs appeals into a database before assigning the appeal to a staff member for action. Second level appeals are typically decided by the warden or chief medical officer and third level appeals are decided by the Inmate Appeals Branch in Sacramento.

As a result of the August 2000 review, which was prompted by a letter from an inmate reporting a backlog in the inmate appeals process, the Office of the Inspector General found that the institution had taken action to significantly reduce the number of overdue appeals and that the backlog was manageable. The review also found that a high percentage of inmate appeals at the institution concerned the forwarding of inmate property and trust funds to other institutions. The Office of the Inspector General made five recommendations to the California Rehabilitation Center, including that it review and analyze a representative sample of appeals categorized as complaints against staff to determine the cause of their frequency and implement corrective action. In addition, the Office of the Inspector General recommended that the institution discontinue its practice of waiting for an inmate appeal from a transferred inmate before sending property to the new institution.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its February 2006 follow-up review, the Office of the Inspector General found that the California Rehabilitation Center has fully implemented the recommendations to adequately staff the inmate appeals office, incorporate inmate appeals information in its orientation process, investigate increased staffing for the inmate trust fund office, and review and analyze staff complaints to identify systemic problems. The Office of the Inspector General found, however, that the California Rehabilitation Center has not adequately addressed the timely transfer of inmate property when an inmate is transferred to another institution.

FOLLOW-UP RECOMMENDATION

As a result of its 2006 follow-up review, the Office of the Inspector General recommends that the California Rehabilitation Center consider initiating procedures to transfer inmate property at the time of the inmate's relocation rather than waiting for the inmate to return a form once he or she is permanently housed at another institution.

DEUEL VOCATIONAL INSTITUTION, INMATE APPEALS PROCESS

IMPLEMENTATION REPORT CARD

Previous recommendations: 2

Fully implemented: 2 (100 %)

Substantially implemented:0 (0%)

Partially implemented:0 (0%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that Deuel Vocational Institution has improved its inmate appeals process by implementing both of the Office of the Inspector General's recommendations from a September 2000 review. Specifically, the institution upgraded the software used for the inmate appeals tracking system and began including informal level inmate appeals in the tracking system.

The September 2000 review of the inmate appeals process at Deuel Vocational Institution by the Office of the Inspector General determined that the process was generally efficient and well-run, but that the computer system in the inmate appeals office needed to be upgraded with the most recent version of the inmate appeals tracking system software. The Office of the Inspector General also noted that the institution was not tracking informal inmate appeals. The inmate appeals process is prescribed under Title 15 of the California Code of Regulations to provide inmates with a system and process for filing complaints. The process usually begins with an informal attempt to resolve the issue but can escalate to a three-step formal appeal process beginning with the institution's appeals office, which logs appeals into a database before assigning the appeal to a staff member for action. Second level appeals are typically decided by the warden or chief medical officer and third level appeals are decided by the Inmate Appeals Branch in Sacramento.

The Office of the Inspector General made the following two recommendations as a result of the September 2000 findings:

- The California Department of Corrections should consider upgrading the computer system used by the institution's inmate appeals office with the most recent version of the inmate appeals tracking system software. The inmate appeals office staff also should be provided with training and manuals for the new version of the software.

- Although the institution had strong management controls that mitigated the need for a tracking system for informal appeals, the inmate appeals staff and the warden should continue to diligently monitor all informal appeals to ensure that the informal process works as designed and that a tracking system remains unnecessary.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General's 2006 follow-up review found that both recommendations issued by the Office of the Inspector General in September 2000 concerning the Deuel Vocational Institution's inmate appeals process have been fully implemented, with the institution upgrading the inmate appeals tracking system software to the current version, and instituting tracking of informal inmate appeals. Accordingly, the Office of the Inspector General makes no follow-up recommendations.

CORRECTIONAL FACILITY MAIL PROCESSING

IMPLEMENTATION REPORT CARD

Previous recommendations: 27

Fully implemented: 14 (51%)

Substantially implemented: 10 (37%)

Partially implemented: 1 (4%)

Not implemented: 1 (4%)

Not applicable: 1 (4%)

The Office of the Inspector General found that the California Department of Corrections and Rehabilitation has reported making significant progress in implementing the recommendations from the July 2002 review of correctional facility mail processing. Eighty-eight percent of the recommendations have been reported as either fully or substantially implemented.

In July 2002, the Office of the Inspector General conducted a review to determine whether mail handling procedures and processes could be changed to improve efficiency and reduce costs while maintaining mandated service levels and institution security. Department of Corrections and Rehabilitation inmates and staff send and receive millions of pieces of mail through the U.S. Postal Service each year. Inmates consider mail a vital link to family, friends, and the outside world, as well as a vehicle for communicating with legal advisers, government officials, and clergy.

The Office of the Inspector General reviewed the California Code of Regulations, Title 15 and the correctional facility plans of operations for mail handling for nine institutions, and conducted in-depth site visits to the California State Prison, Solano; the California Institution for Men; and the California Institution for Women. As a result of its July 2002 review, the Office of the Inspector General found a number of problems, including that institutions were not taking advantage of services provided by U.S. Postal Service, some prisons were inefficient in searching incoming mail, and standard mail was often delayed by mail requiring special processing. The Office of the Inspector General estimated that implementing the recommendations at all of the department's institutions could generate $1.3 million in operational savings and provide timelier mail delivery.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In January 2006, the Office of the Inspector General completed a follow-up audit of the 27 recommendations issued in July 2002. The Office of the Inspector General found that implementation of the recommendations had been delayed because the previous departmental administration neglected to provide direction to the institutions on implementing the needed improvements. It was only after the Office of the Inspector General's follow-up audit that instructions and guidelines were issued to the institutions.

FOLLOW-UP RECOMMENDATIONS

As a result of its 2006 follow-up review, the Office of the Inspector General makes eight recommendations, including the following:

- **The Department of Corrections and Rehabilitation ensure that California State Prison, Sacramento use automatic letter openers and that the California Institution for Men**

and Salinas Valley State Prison develop a list of acceptable publications that can be immediately placed in housing unit mailbags.

PRISON INDUSTRY AUTHORITY OPTICAL PROGRAM AT THE RICHARD J. DONOVAN CORRECTIONAL FACILITY

IMPLEMENTATION REPORT CARD

Previous recommendations: 2

Fully implemented: 2 (100 %)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the optical program laboratory at the Richard J. Donovan Correctional Facility resumed operations during August 2000. The Prison Industry Authority also implemented a process to confirm that inmates applying for jobs in the optical laboratory meet the eligibility requirements set forth in Penal Code section 5071.

The Office of the Inspector General's May 2000 audit of the Prison Industry Authority optical program at the Richard J. Donovan Correctional Facility found that in May 1999, the California Department of Corrections closed the optical laboratory operation at the Richard J. Donovan Correctional Facility because inmate workers had gained access to the personal information of Medi-Cal beneficiaries. The department also closed the remaining optical laboratories until corrective action was taken and then authorized the re-opening of each optical laboratory, except the Richard J. Donovan optical laboratory, soon after the Prison Industry Authority developed new policies and procedures to prevent inmate access to sensitive information. The Office of the Inspector General evaluated the corrective action taken by the Prison Industry Authority and found that it developed new policies and procedures that could effectively prevent inmate access to Medi-Cal beneficiary information in all areas of the optical program. The Office of the Inspector General recommended that the optical laboratory at the Richard J. Donovan Correctional Facility resume full operations and that inmate workers should be screened to ensure they meet eligibility requirements.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General's 2006 follow-up review found that both of the recommendations made in May 2000 have been fully implemented and that the optical laboratory program at the Richard J. Donovan Correctional Facility re-opened during August 2000. No follow-up recommendations are made.

KONOCTI CONSERVATION CAMP NUMBER 27

IMPLEMENTATION REPORT CARD

Previous recommendations: 8

Fully implemented: 5 (63%)

Substantially implemented: 0 (0%)

Partially implemented: 2 (25%)

Not implemented: 0 (0%)

Not applicable: 1 (12%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has clarified rules and procedures governing the use of inmate labor for conservation camp work projects; has improved accountability over reimbursements for work projects; and has instituted limits on reimbursement amounts.

In April 2001, the Office of the Inspector General conducted a special review into allegations of misappropriation of state funds and inappropriate use of inmates on work projects and in the vocational auto body program at the Konocti Conservation Camp, which was operated by the former Department of Corrections. The department jointly operates 31 fire-fighting conservation camps with the California Department of Forestry and Fire Protection. Sixteen of the camps, including Konocti, are under the direct supervision of the California Correctional Center in Susanville, which receives, houses, and trains minimum-custody inmates for placement into one of the Northern California conservation camps. As a result of the 2001 review, the Office of the Inspector General found that some of the work projects conducted by the Konocti Conservation Camp violated state laws, regulations, and department policy and that the camp had received inappropriate reimbursements for those projects. The review also determined that the management of the Konocti Conservation Camp circumvented fiscal controls, failed to maintain proper accounting for reimbursements obtained through inmate labor, and failed to observe requirements governing the vocational auto body program. The Office of the Inspector General made eight recommendations to the Department of Corrections and the Department of Forestry and Fire Protection.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

In its 2006 follow-up review, the Office of the Inspector General found that the Department of Corrections and Rehabilitation has clarified rules and procedures governing the use of inmate labor for conservation camp work projects; has improved accountability over reimbursements for work projects; and has instituted limits on reimbursement amounts. No follow-up recommendations are made.

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INTRODUCTION

This report presents the results of a comprehensive follow-up audit of 22 previous audits and reviews conducted by the Office of the Inspector General of the former California Department of Corrections (now Adult Operations and Adult Programs of the California Department of Corrections and Rehabilitation) between 2000 and 2004. The purpose of the audit was to assess the progress of the California Department of Corrections and Rehabilitation 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.

BACKGROUND

The stated mission of the California Department of Corrections and Rehabilitation is to "improve public safety through evidence-based crime prevention and recidivism reduction strategies." The department operates 33 prisons for adult offenders, oversees 12 community correctional facilities, and supervises state parolees in local communities. In February 2000, the state prison inmate population totaled 160,846; by February 2004, the population had increased to 161,449; and as of March 2006, the population stood at 169,091— an increase of 8,245 over the February 2000 total. At present, the institutions are filled to nearly twice design capacity. Department staff consists of 55,050 employees, including 46,759 employees assigned to institutions, 3,126 assigned to parole, and 4,513 assigned to department administration. The department's budget for adult operations and programs increased from $4.4 billion in fiscal year 2000-01 to $5.3 billion in 2003-04, and the governor's proposed budget for adult operations and programs for fiscal year 2006-07 is approximately $7.5 billion.

Effective July 1, 2005, the Youth and Adult Correctional Agency was dissolved and its former entities were reorganized under the new Department of Corrections and Rehabilitation. The department now consists of Adult Operations and Programs (formerly the Department of Corrections); the Division of Juvenile Justice (formerly the California Youth Authority); the Corrections Standards Authority (formerly the Board of Corrections and the Commission on Correctional Peace Officer Standards and Training); the Board of Parole Hearings (formerly the Youthful Offender Parole board, the Board of Prison Terms, and the Narcotic Addict Evaluation Authority); the State Commission on Juvenile Justice; the Prison Industry Authority; the Prison Industry Board; and the California Council on Mentally Ill Offenders.

The Department of Corrections and Rehabilitation has come under consistent criticism for its prison overcrowding; in-prison violence; failure to provide constitutionally adequate medical care and mental health services to inmates; failures in employee discipline; and for a recidivism rate that is one of the highest in the country. A series of

class-action lawsuits have been filed against the department as a result of some of those problems, addressing in particular, health care services and employee discipline.

The department's failure to provide adequate medical services to inmates was the subject of the class-action lawsuit, *Plata v. Schwarzenegger.* The case resulted in a settlement agreement that required the department to implement specified changes in inmate medical services over an eight-year period beginning in 2003. In February 2006, dissatisfied with the department's progress in implementing improvements, the U. S. District Court appointed a receiver over the department's health care operations. Under the terms of the court's action, the receiver, who is scheduled to assume duties on April 17, 2006, will have broad powers for "restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all class members as soon as practicable." The receiver's powers include the duty to control and direct "all administrative, personnel, financial, accounting, contractual, legal, and other operational functions of the medical delivery component of the department."

A federal civil rights lawsuit, *Madrid v. Hickman,* filed by inmates at Pelican Bay State Prison, alleging misconduct by correctional officers and corruption in internal affairs investigations, has resulted in the court-ordered Madrid Remedial Plan to correct deficiencies in the internal affairs process. The Office of the Inspector General's Bureau of Independent Review was established in 2004 as part of that plan to monitor the department's internal affairs investigations.

OBJECTIVES, SCOPE AND METHODOLOGY

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

- Reviewed 22 audits and reviews conducted by the Office of the Inspector General of California Department of Corrections programs and institutions between 2000 and 2004.[1]

- 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 information and documentation on the department's progress in implementing the Office of the Inspector General's recommendations.

[1] Audits of discontinued programs were not included in the follow-up review.

- Based on its assessment of the information and documents received, the Office of the Inspector General either conducted site visits to conduct interviews, make observations, and review records—performing tests as necessary using audit sampling techniques — or relied on the documents and other information provided by the department to assess the department's progress in implementing the Office of the Inspector General's recommendations.

- Evaluated the information developed from the audit procedures and classified the progress of the department and the institutions 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 has successfully addressed the problems by implementing alternative solutions, and wherever that has occurred, those achievements are acknowledged in the report. The original 22 reports covered in this follow-up accountability audit had dates of issue ranging from May 2000 through September 2004. The California Department of Corrections and Rehabilitation, therefore, had a significant amount of time to implement the Office of the Inspector General's recommendations before the follow-up audit was conducted. The large number of audits and recommendations that required follow-up for the accountability audit caused the fieldwork completion dates for this follow-up audit to range from August 2005 through March 2006. (The specific completion date for fieldwork is indicated in each chapter.) It is therefore possible that in some cases the California Department of Corrections and Rehabilitation 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.

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FINDINGS AND RECOMMENDATIONS

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CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN

IMPLEMENTATION REPORT CARD

Previous recommendations: 72

Fully implemented: 38 (53%)

Substantially implemented: 11 (15%)

Partially implemented: 10 (14%)

Not implemented: 12 (17%)

Not applicable: 1 (1%)

The California Substance Abuse Treatment Facility and State Prison at Corcoran has developed needed improvements to policies and procedures affecting medical services, but the institution has not implemented numerous recommendations from a January 2003 audit, citing a shortage of medical personnel and turnovers in its management ranks as major impediments. In addition, the Office of Substance Abuse Programs has not significantly improved its processes for monitoring contracts with private providers of in-prison substance abuse treatment programs, and drug treatment providers continue to fail to provide the number of counselors required under the contracts. Independent evaluations of the effectiveness of the facility's in-prison substance abuse treatment program are inconclusive.

The Office of the Inspector General issued a management review audit of the California Substance Abuse Treatment Facility and State Prison at Corcoran in January 2003. The audit identified numerous problems at the institution, including inadequate management of medical, dental, and pharmacy services; deficiencies in the substance abuse treatment program that prevented the institution from reducing recidivism by helping inmates overcome drug dependency; and the failure of a significant number of staff and managers to fulfill annual training requirements.

BACKGROUND

The California Substance Abuse Treatment Facility and State Prison at Corcoran, which opened in August 1997, houses approximately 7,300 male inmates and has a staff of about 1,700 employees, making it one of the largest prisons in the western world. It is designed for inmates ranging from Level II (low medium security) through Level IV (maximum security), but houses a small number of Level I (minimum security) inmates as well.

Medical, dental, mental health, and pharmacy services. The institution's correctional treatment center is the hub of medical, dental, and mental health services. Located inside the institution's secured perimeter, the correctional treatment center is responsible for medical treatment and recovery, mental health assessment and care, and clinical services. The correctional treatment center is used for providing in-patient care, treating respiratory illnesses, and providing care to inmates with mental health problems. Clinics affiliated with the correctional treatment center provide medical and dental services within each of the prison's seven facilities. Pharmaceuticals are provided by a pharmacy located in the correctional treatment center.

Medical services for the California Department of Corrections and Rehabilitation's inmates are the responsibility of the department's Division of Correctional Health Care Services. The health care manager at the Substance Abuse Treatment Facility and State Prison at Corcoran reports to the regional health care administrator of the Division of Correctional Health Care Services and acts as the on-site administrator of health care services for the institution, with responsibility for overall management of the institution's medical, mental health, and dental programs. Division personnel, along with various contract employees, operate the correctional treatment center.

In addition to the health care manager, the medical management team consists of a chief physician and surgeon, a chief psychiatrist, a chief dental officer, and the director of nursing, who collectively supervise a staff of physicians, dentists, psychiatrists, psychologists and other medical employees.

Substance abuse program. In addition to its mission of providing custody for state prison inmates remanded to the custody of the Department of Corrections and Rehabilitation, the institution includes a 1,478-bed substance abuse treatment program — the largest custody-based substance abuse treatment facility in the United States. The Department of Corrections and Rehabilitations' Office of Substance Abuse Programs is responsible for administering the substance abuse program, which is run by two private contractors. The Office of Substance Abuse Programs has employees on site to monitor daily program operations and to screen inmates eligible for the substance abuse program to ensure that the program operates at full capacity. The office is also responsible for monitoring the private contractors for compliance with the terms of the contracts to provide treatment services. The institution staff provides custody, security, drug testing, classification reviews, and administrative support to the Office of Substance Abuse Programs and the contractors. From January 2002 through June 2006, the Office of Substance Abuse Programs contracted to pay each private contractor approximately $29 million for substance abuse program services.

In recent years, providing adequate health care to inmates has been increasingly problematic for the Department of Corrections and Rehabilitation. In February 2006, the U.S. District Court for the Northern District of California appointed a receiver over the department's health care operations in connection with a class action suit, *Plata v. Schwarzenegger*. Under the terms of the court's action, the receiver has broad powers to achieve the goal of "restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all class members as soon as practicable." The receiver's powers include the duty to control and direct "all administrative, personnel, financial, accounting, contractual, legal, and other operational functions of the medical delivery component" of the department.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the January 2003 management review audit, the Office of the Inspector General identified 10 findings encompassing a wide array of the institution's operations. The findings included observations of deficiencies in the substance abuse treatment

program, medical and dental care, pharmacy operations, staff training, safety and security, and hiring procedures. Among the most significant findings from the January 2003 management review audit were the following:

- Deficiencies in the substance abuse treatment program were preventing the institution from reducing recidivism by helping inmates overcome drug dependency.

- Inadequate management of the institution's medical, dental, and pharmacy services placed the health of inmates and safety of staff at risk and exposed the state to possible legal liability.

- A significant number of staff and managers were not fulfilling annual training requirements.

As a result of the January 2003 management review audit, the Office of the Inspector General made 72 recommendations to the Department of Corrections, the Health Care Services Division, and the California Substance Abuse Training Facility and State Prison at Corcoran to address these and other findings.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Department of Corrections and Rehabilitation, the Division of Correctional Health Care Services, and the California Substance Abuse Training Facility and State Prison at Corcoran had implemented the recommendations from the Office of the Inspector General's January 2003 management review audit. To conduct the follow-up review, the Office of the Inspector General provided the department, the institution, and the Division of Correctional Health Care Services with a table listing the January 2003 findings and recommendations and asked management to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with supplementary documentation provided, and evaluated the degree of compliance or noncompliance with the recommendations. The Office of the Inspector General completed follow-up field work at the institution in November 2005. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 72 recommendations issued by the Office of the Inspector General in January 2003 concerning the California Substance Abuse Treatment Facility and State Prison at Corcoran, 38 have been fully implemented, 11 have been substantially implemented, 10 have been partially implemented, 12 have not been implemented, and one is no longer applicable.

Substance abuse treatment program. The Office of the Inspector General's January 2003 management review audit identified numerous problems that impaired the effectiveness of the institution's substance abuse treatment program. Key among these was the placement into the program of large numbers of inmates not suited to the treatment

model, including sex offenders and inmates suffering from mental illness. Other deficiencies included a shortage of trained counselors to run the interactive therapeutic community — a proven treatment modality for modifying the behavior of substance abusers — and the fact that group sizes for the therapeutic community exceeded contract limits.

A September 2002 UCLA study of the institution's substance abuse treatment program, cited in the Office of the Inspector General's audit report, showed no difference in recidivism rates between program participants and a control group of inmates at another prison who received no treatment. The study raised questions about the advisability of paying contractors millions of dollars for in-prison substance abuse programs not demonstrated to be effective.

In the 2006 follow-up review, the Office of the Inspector General found that the California Substance Abuse Treatment Facility has made generally disappointing progress in implementing needed changes in the three years since the January 2003 management review audit, although there have been some improvements. The institution has been successful in identifying and recruiting a higher proportion of program-eligible inmates into the program, while reducing the proportion of sex offenders and mental health patients. Of the 1,456 inmates assigned to the program on October 20, 2005, fewer than seven percent were mental health patients and fewer than one percent of those who were mental health patients were also sex offenders. In comparison, the January 2003 audit found the proportion of sex offenders and mental health patients in the program to be as high as 50 percent.

The Office of the Inspector General also found, however, that the Office of Substance Abuse Programs continues to fail at effectively monitoring its contracts with the private providers of substance abuse program services at the prison. In reviewing the on-site monitoring reports for each provider in the substance abuse program for the 11-month period from December 2004 to October 2005, the Office of the Inspector General found that the monitoring reports continued to lack detail, did not focus on the contractors' compliance with contractual expectations, and did not reflect evidence of substantive review of the providers' records and operations.

The Office of the Inspector General noted in addition that the program providers continue to supply an inadequate number of counselors. During an October 2005 site visit, the Office of the Inspector General found that program staffing was 14 counselors short of the 73 entry- and journey-level counselors required under the state contracts —a 19 percent shortfall. Contributing to this condition, the Office of Substance Abuse Programs still has no language in its contracts with the providers permitting the state to withhold payment or exercise other sanctions short of contract cancellation for such instances of non-compliance.

The Office of the Inspector General also found that an influx of more than 400 general population inmates into the substance abuse housing units in response to a department-wide bed shortage caused the treatment "cluster" sizes to increase from 62 inmates to up to 100 inmates. The higher population clusters exceed the professionally recommended

standard of 50 to 75 participants for therapeutic community programs and further detract from program effectiveness.

Treatment also appears to be frequently interrupted. On two separate visits in October and November 2005, the Office of the Inspector General attempted without success to observe therapeutic community groups and evaluate group sizes at the institution. On the first visit, all counseling had been suspended for the programs' annual "Sports Week," and on the second visit nearly all group sessions had been suspended to accommodate population movements among the housing units. This inactivity, coupled with recent lockdowns reported by counselors, raises concerns about the continuity of therapeutic community treatment at the institution. It is noteworthy that, with the exception of the lockdowns, none of the monitoring reports by the Office of Substance Abuse Programs discussed the continuing problems found by the Office of the Inspector General during its six days of fieldwork.

The Office of the Inspector General reviewed three subsequent evaluations by UCLA of the institution's substance abuse treatment program conducted since the September 2002 evaluation. Although the more recent evaluations, which were issued in September 2003, September 2004, and January 2006, made positive assessments of the effectiveness of post-prison aftercare, none were bona-fide effectiveness studies like the 2002 evaluation because they did not compare the recidivism rates of in-prison program participants against those of inmates from another prison who had not received treatment. Without a comparison of the subject group to a control group, it is not possible to conclude that the institution's program is successful in lowering recidivism.

Medical care. The Office of the Inspector General found that although the institution has made efforts to implement recommendations affecting the institution's medical services and operations, many of the problems identified in the January 2003 management review audit have not been adequately addressed. The remaining deficiencies include a continuing backlog of inmate medical appeals; lack of an effective means of ensuring that physicians work a full 40-hour-a-week schedule; failure to ensure that inmates see a physician in a timely manner; lack of review of the need for inmate treatment by specialists; and inadequate monitoring of chronic care patients. The institution points to repeated turnover in the chief medical officer position as one cause of the continuing deficiencies. Six different individuals served in the position between September 2002 and June 2005, when the present incumbent was hired. The institution also reports that since September 2002, its chief dental officer, chief psychologist, chief psychiatrist, director of nurses, and medical records supervisor have all resigned, retired, or transferred. The institution also cites a critical shortage of physicians and other medical staff as a barrier to full implementation of the Office of the Inspector General's recommendations. For example:

- The institution reports that it has established an expectation that physicians complete all administrative duties, including notifying the chief medical officer of medical appeals approaching delinquent status, but maintains that the physician shortage precludes aggressive focus on appeals.

- The institution reports it established a medical authorization review committee to review the medical necessity for procedures referred to outside medical providers, but that the committee process has fallen victim to the physician shortage and reviews are limited to a cursory examination by the chief medical officer.

- While physicians' hours and workloads have been adjusted to permit doctors to see more patients, the requirement that inmates see doctors within 14 days after a request for contact as mandated by the *Plata v. Schwarzenegger* court decision is not being met because the institution does not have enough physicians to meet that workload.

In addition, the Office of the Inspector General found that despite establishing a system of accountability for medical personnel, the institution's medical management team has been lax in enforcing a directive that medical personnel log in and out of the correctional treatment center each day by signing the log and recording the actual times of arrival and departure. Instead of recording the time of day, physicians simply sign the log and indicate a status of "in" or "out."

Pharmacy operations. The Office of the Inspector General noted significant improvements in the institution's pharmacy operations. The institution developed improved policies and procedures for control of medications and quality control over prescriptions, as well as for intra-facility transfers of inmate medications. Spending for pharmaceuticals also decreased. As the Office of the Inspector General reported in the January 2003 management review audit, the institution spent $5.4 million in fiscal year 2001-02 for drugs and pharmaceutical supplies, but in fiscal year 2004-05, the institution's reported spending decreased to $3.7 million — a 31 percent reduction. The Department of Corrections and Rehabilitation, however, has still has not made a significant effort to develop an automated pharmaceuticals inventory system for the institutions.

The Office of the Inspector General also found that the Substance Abuse Treatment Facility has made significant progress in staffing its pharmacy with permanent state employees. At the time of the Office of the Inspector General's January 2003 audit, the institution's pharmacy was staffed entirely by contract employees, but now the pharmacy employs only two contract employees among its full-time staff of nine. The positions currently filled by the two contract employees have been advertised as state civil service job openings since October 30, 2002, and the institution says the current state salary for pharmacists is lower than that offered in the industry, making recruitment difficult.

Dental services. The institution's dental management has instituted systems for tracking dentists' productivity and for monitoring patient backlog, showing improvements in both areas, but has still not updated the chief dental officer's duty statement or provided formal management training. In addition, while the Office of the Inspector General found improvement in the institution's local management of dental operations, it found no evidence of regular site inspections by the Division of Correctional Health Care Services.

Administration and custody. The Office of the Inspector General found improvement in the institution's procedures and controls over evidence storage, as well as in its system for administering and monitoring mandatory employee training. But the institution still had not implemented the Office of the Inspector General's recommendations to conform to departmental regulations concerning recording inmate movements and other significant events in the administrative segregation units.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Office of Substance Abuse Programs take the following actions:

- **Conduct systematic, in-depth monitoring of treatment providers for compliance with contract terms. Monitoring reports should reflect all substantive details of the provider's records and operations. The reports should also include the Office of Substance Abuse Programs' analysis and evaluation of the provider's operations.**
- **When drafting contracts for substance abuse treatment services, include provisions for fiscal sanctions to address instances of non-compliance with contract terms, including failure to provide the required number of counselors.**
- **Whether performed by UCLA or by another contractor, ensure that future studies of the effectiveness of the substance abuse program at the institution include a comparison of the treatment group to a control group of similar inmates who did not receive treatment.**
- **Return to using smaller clusters of inmates to conform to the Office of National Drug Control Policy's recommendation that therapeutic community program clusters consist of no more than 50 to 75 inmates.**

The Office of the Inspector General recommends that the Substance Abuse Treatment Facility and State Prison at Corcoran continue to work with the Division of Correctional Health Care Services' department-wide efforts to address the shortage of physicians and other medical staff.

Within the framework of that limitation the Office of the Inspector General recommends that the Substance Abuse Treatment Facility and State Prison at Corcoran take the following actions:

- **Develop methods to reduce or eliminate inmate medical appeal backlogs without placing inmates at risk.**
- **Hold medical staff responsible for completing administrative activities, including responding to inmate medical appeals in a timely manner.**

- **Review all medical procedures currently referred to contracted specialist clinics or outside providers to identify those that could be performed by institution doctors.**

- **Establish procedures and systems to ensure that all inmate requests for reasonable accommodation and medical verification of disabilities under the Americans with Disabilities Act are processed in a timely manner and that all appropriate accommodations or modifications are implemented without delay.**

- **Track pending actions on Americans with Disabilities Act requests to ensure completion within established time limits and ensure that medical chronologies or modifications are implemented without delay.**

- **Systematically identify inmates with chronic medical conditions and ensure that those inmates are monitored through regular appointments with institution doctors.**

- **Establish policies and procedures to require periodic laboratory work and measurement of vital signs for chronic care inmates. Ensure that this information is available to doctors at the time of examinations so they may adequately assess chronic medical conditions.**

The Office of the Inspector General further recommends that the California Substance Abuse Treatment Facility and State Prison at Corcoran take the following actions:

- **Enforce the August 2004 memorandum from the health care manager instructing medical personnel to sign in and out of the institution and record actual times of arrival and departure.**

- **Establish procedures to comply with Title 15 of the California Code of Regulations, requiring that dentists examine inmates within 14 days of the date inmates arrive at the assigned institution from the reception center, and develop a reporting and monitoring system to track compliance.**

- **Review the chief dental officer's duty statement and either require the chief dental officer to devote 40 percent of his or her time to clinic work as described in the current duty statement, or revise the duty statement as necessary.**

- **Provide management training to on-site dental management staff, including training on planning and goal setting; performance measurement; interpersonal communication; and principles of supervision.**

- **Continue efforts to reduce the dental backlog.**

- **Have the health care manager and the chief dental officer establish policies and procedures for local operation of dental services.**

- **The Office of the Inspector General recommends that the California Substance Abuse Treatment Facility and State Prison at Corcoran record inmate movements, unusual incidents, and other noteworthy conditions in the administrative segregation isolation log (CDC-Form 114) as they occur.**

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following actions:

- **Continue to develop an automated system combining individual patient medical records with pharmacy tracking information.**

- **Develop a barcode system for tracking the inventory and movement of pharmaceutical products within the institutions.**

- **Work with the receiver recently appointed by the federal court to develop a competitive salary structure for pharmacy professionals, while continuing efforts to hire full-time pharmacy staff at present salary levels.**

- **Improve support of the dental function at the California Substance Abuse Treatment Facility and State Prison at Corcoran by conducting site visits, both scheduled and unannounced, to inspect dental operations, provide guidance, and meet with the institution's dental management to discuss areas of concern.**

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that deficiencies in the substance abuse treatment program were preventing the institution from reducing recidivism by helping inmates overcome drug dependency.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections take the actions listed below to improve the substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison at Corcoran.		
Develop a process for recruiting eligible inmates from other institutions into the program, including those who may be receiving fire camp, facilities maintenance, and similar assignments in lieu of substance abuse treatment program assignments.	FULLY IMPLEMENTED	The Office of Substance Abuse Programs reported that it has developed a number of strategies to recruit eligible inmates into the program. For example, contracts that began April 1, 2005 enable the Office of Substance Abuse Programs to screen, assess, and orient inmates with a history of substance abuse at intake. Program staff members then recommend participants to the most appropriate treatment option. Center Point, Inc., was the successful competitor for the in-reception-center substance abuse programs at North Kern State Prison (200 slots) and Wasco State Prison (300 slots). The Office of the Inspector General contacted the Office of Substance Abuse Programs staff member assigned to the reception center substance abuse programs at North Kern and Wasco State Prisons and requested information on inmates the representatives have endorsed to the substance abuse program at the Substance Abuse Treatment Facility and State Prison at Corcoran. The Office of the Inspector General verified that between May 3, and October 9, 2005, the staff endorsed 89 participants to the program at the Substance Abuse Treatment Facility and State Prison at Corcoran. The Office of the Inspector General also verified that 61 of the 89 participants (69 percent) were actually participating in the substance abuse program as of October 9, 2005.

		The Office of Substance Abuse Programs reported that as of January 2004, the substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison in Corcoran also serves as the alternate placement site for disabled in-custody drug treatment program parolees who volunteer for treatment in lieu of parole revocation. The Office of Substance Abuse Programs reported that as of May 22, 2003, inmates eligible for work-furlough are also eligible for placement in substance abuse treatment programs and for subsequent transition into community treatment. Previously, such inmates were ineligible, and were assigned to fire camps, facilities maintenance, and similar assignments. The Office of the Inspector General verified that 314 work furlough inmates (22 percent of the 1,456 inmates assigned to the program) were participating in the institution's substance abuse treatment program as of October 20, 2005.
Cease the policy of requiring inmates to participate in the substance abuse treatment program involuntarily.	**NOT IMPLEMENTED**	The Office of Substance Abuse Programs informed the Office of the Inspector General that it does not agree with this recommendation and will not pursue a policy change, citing clinical research supporting the effectiveness of involuntary program participation.
Develop alternative methods of providing substance abuse treatment to sex offenders, perhaps by grouping them into specially designated clusters.	**PARTIALLY IMPLEMENTED**	The Office of Substance Abuse Programs reported that it is exploring funding options for establishing in-prison programs for sex offenders and correctional clinical case management system inmates in fiscal year 2007-08. The Office of Substance Abuse Programs also reported that since May 14, 2004, inmates convicted of Penal Code section 288 sex offenses are excluded from placement in substance abuse treatment programs. According to the Office of Substance Abuse Programs, the deputy director of institutions implemented the exclusion because there are virtually no continuing care facilities in the state for individuals convicted of such offenses. The Office of the Inspector General determined that 87 inmates identified as sex offenders were assigned to the substance abuse treatment program at the

		Substance Abuse Treatment Facility and State Prison at Corcoran as of October 20, 2005. The Office of the Inspector General also reviewed the commitment and controlling offenses of each of these inmates and found that eight of the 87 inmates had received a Penal Code section 288 conviction. According to the May 14, 2004 exclusionary policy, only inmates assigned to the substance abuse treatment program before that date could remain in the program. The Office of the Inspector General verified that two of the eight inmates were assigned to the program before May 14, 2004. Six of the eight inmates were assigned to the program after May 14, 2004, and therefore should not have been included in the program.
Limit the percentage of correctional clinical case management system inmates and sex offenders that contractors must accept into the substance abuse treatment program.	**FULLY IMPLEMENTED**	The Office of Substance Abuse Programs reported that the percentage of correctional clinical case management system (mental health) inmates continues to average eight percent of the substance abuse treatment program participants at the Substance Abuse Treatment Facility and State Prison at Corcoran. The Office of Substance Abuse Programs also reported that it will move these special groups to the aforementioned new programs if they are implemented, thus minimizing the need to include these groups in existing substance abuse treatment programs. The Office of the Inspector General obtained a list of the correctional clinical case management system inmates assigned to the substance abuse treatment program at the California Substance Abuse Treatment Facility and State Prison at Corcoran as of October 20, 2005 and found 93 of these inmates, including 12 who were also "R" suffix inmates. Of the 1,456 inmates assigned to the program on October 20, 2005; therefore, 6.4 percent were correctional clinical case management system inmates and fewer than one percent were also "R" suffix inmates. In comparison, the Office of the Inspector General's January 2003 audit found the proportion of sex offenders and correctional clinical case management system inmates to be as high as 50 percent, demonstrating that the Office of Substance Abuse Programs has been successful in reducing the number of such inmates assigned to the program.

Conduct systematic, in-depth monitoring of providers for contract compliance. Deficiencies noted should require corrective action plans with deadlines and include follow-up monitoring to verify that satisfactory corrective action has been taken.	**NOT IMPLEMENTED**	The Office of Substance Abuse Programs reported that it has a number of in-depth tracking and technical assistance efforts in place to monitor contract compliance. These efforts include the development of a monitoring handbook to address standards for program services; a monitoring instrument for the drug treatment furlough program; an audit tool to assess classification, security, and contractual compliance of substance abuse program sites; and a Continuing Quality Improvement Subcommittee comprised of Office of Substance Abuse Programs and treatment provider executives. The Office of Substance Abuse Programs also reported that it conducts a minimum of one site visit per month at the Substance Abuse Treatment Facility and State Prison at Corcoran's substance abuse treatment program to evaluate program operations and provider compliance with contract terms. The staff member conducting the site visit prepares a report on observations as well as on areas of concern and accomplishments. The Office of Substance Abuse Programs allows each provider sufficient time to correct any deficiencies noted in the report and develops a corrective action plan if the provider does not resolve deficiencies within the timeframes allowed. The Office of Substance Abuse Programs monitors the corrective action plan and conducts monthly meetings until the providers resolve all areas of concern. The Office of the Inspector General obtained and reviewed the on-site monitoring reports of each of the substance abuse treatment program providers at the Substance Abuse Treatment Facility and State Prison at Corcoran for the period December 2004 to October 2005. During the period, Phoenix House had site visit reports prepared for visits during December 2004 and January, June, July, August, and October 2005. Walden House, had site visit reports completed for visits during December 2004 and March, April, May, and September 2005. The Office of the Inspector General concluded that monitoring by the Office of Substance Abuse Programs of providers for contract compliance continues to lack evidence of systematic, in-depth analysis of contract compliance. The reports the Office of the Inspector General reviewed continued to lack detail and did not reflect substantive review of provider records and operations.

Investigate methods of helping providers retain counselors and other staff members.	**PARTIALLY IMPLEMENTED**	The Office of Substance Abuse Programs reported that it has taken steps to ensure higher minimum pay for entry-level counselors by specifying a minimum and maximum bid amount in the competitive request for proposal. Career paths are built into contractors' budgets so that entry-level counseling staff with the requisite education and experience can progress to journey-level counselors and into management positions. The Office of Substance Abuse Programs reported in addition that its Continuing Quality Improvement Subcommittee studied staff retention strategies as an example of 'best practices" during a visit to the substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison at Corcoran and intended to share its findings with other treatment providers. The Office of Substance Abuse Programs also reported that it provides workforce development training and cross-training for treatment, institution, and headquarters staff and enables contractors to budget for on-going staff training. Despite these steps by the Office of Substance Abuse Programs, the Office of the Inspector General found there continues to be an inadequate number of counselors working for the providers of the substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison at Corcoran. The Walden House contract stipulates that Walden House should have 19 entry-level counselors, nine journey-level I counselors, and 13 journey-level II counselors. As of November 15, 2005, Walden House employed the required number of journey-level I and II counselors, but three entry level counselor positions were vacant. Similarly, the Phoenix House contract requires Phoenix House to employ 12 entry-level counselors and 20 journey-level counselors. As of October 21, 2005, Phoenix House employed three entry-level counselors and 18 journey-level counselors —11 counselors fewer than the required number. Executives from both providers informed the Office of the Inspector General that a number of counselors transferred to the substance abuse treatment program at the newly opened Kern Valley State Prison and they have not yet been able to fill the open positions at the Substance Abuse Treatment Facility and State Prison at Corcoran. The Office of the Inspector General interviewed various Walden House counselors and learned that while the counselors generally liked their jobs, they were dissatisfied with the low pay.

Evaluate all possible means of increasing aftercare participation, including possible legislation to mandate aftercare as a condition of parole for substance abuse treatment program inmates.	**FULLY IMPLEMENTED**	The Office of Substance Abuse Programs reported that it met with the new Board of Parole Hearings to open discussions about moving civil addicts into drug treatment furlough programs 120 days before the end of their commitment terms. In the drug furlough program, inmates serve the final days of their commitment term in a residential-type setting where substance abuse treatment is provided. The Office of Substance Abuse Programs noted that the furlough program is less restrictive than an institution and therefore more closely resembles the aftercare experience. According to the Office of Substance Abuse Programs, the discussions included requiring mandatory aftercare for those in the drug treatment furlough programs as well as mandating aftercare as a condition of parole for in-prison substance abuse treatment program participants. The Office of Substance Abuse Programs reported that the drug treatment furlough program for non-serious, non-violent substance abuse treatment program inmates was activated on January 26, 2004. The program opened up 1,500 slots in community-based residential treatment facilities, enabling inmates to volunteer to transition from the in-prison substance abuse treatment program to the drug treatment furlough program 120 days before their release on parole. Fifty percent of the participants are budgeted to receive up to 150 days of aftercare following parole from the drug treatment furlough program. The Office of Substance Abuse Programs reported in addition that it has collaborated with the Parole and Community Services Division on a program in which parolees volunteer to participate in a 30-day jail-based drug education program in lieu of parole revocation. Participating parolees must agree to complete 90 days of non-residential aftercare upon release from the jail program.
In future contracts with providers, include withholding of payments or other fiscal sanctions as alternatives to contract termination in the event of non-compliance.	**NOT IMPLEMENTED**	The Office of Substance Abuse Programs reported that the contract monitoring handbook under development will include graduated sanctions for contractor non-compliance.
Review and evaluate the recommendations of the UCLA evaluation of the substance abuse	**PARTIALLY IMPLEMENTED**	The Office of Substance Abuse Programs reported that it will be working jointly with UCLA on controlled studies of the program participants at the Substance

treatment program.		Abuse Treatment Facility and State Prison at Corcoran. The Office of Substance Abuse Programs has a formal process for reviewing contracted evaluations and recommendations and adopts those recommendations that are based on sound findings and appropriate for implementation in a correctional facility. According to the office, UCLA studies have identified significant reductions in return-to-custody rates for substance abuse treatment program parolees who complete at least 90 days of aftercare, preferably in residential treatment. As a result, on June 25, 2003, the chief of the Office of Substance Abuse Programs directed substance abuse treatment providers to take the steps necessary to place program graduates in residential treatment within 90 days of release from prison. The Office of Substance Abuse Programs provided studies of the substance abuse treatment program performed by UCLA in September 2003, September 2004, and January 2006 for review by the Office of the Inspector General. The Office of the Inspector General's review determined, however, that unlike the September 2002 evaluation described in the original audit report, the more recent studies did not compare recidivism rates of parolees who completed the substance abuse treatment program with those of inmates from another prison who did not receive substance abuse treatment. While the more recent evaluations did report lower recidivism rates than those reported in the September 2002 evaluation, without such a comparison, it is not possible to conclude that the substance abuse treatment program at the Substance Abuse Treatment Facility and State Prison at Corcoran has succeeded in lowering recidivism rates. The Office of Substance Abuse Programs also reported that it disagrees with a conclusion by the UCLA study authors that the treatment clusters at the Substance Abuse Treatment Facility and State Prison at Corcoran are too large. The Office of Substance Abuse Programs reported that the two contract substance abuse treatment program providers each have three housing units consisting of 246 inmates divided into four treatment clusters of approximately 62 inmates each. That cluster size would be consistent with the Office of National Drug Control Policy's suggestion that large therapeutic community programs be subdivided into clusters no larger than 50 to 75 inmates.

		The Office of the Inspector General determined, however, that some of the treatment clusters at the institution exceed the recommended limits because general population inmates not participating in the program have been placed in the substance abuse treatment housing units in response to a department-wide bed shortage. As of mid-June 2005, 431 general population inmates were occupying five of the substance abuse treatment program's 24 treatment clusters. As of October 20, 2005, 1,456 inmates were participating in the substance abuse treatment program and were occupying the remaining 19 treatment clusters. In site visits to the substance abuse treatment program housing units on October 24, 2005 and November 14, 2005, the Office of the Inspector General verified that instead of the 62 inmates per treatment cluster reported by the Office of Substance Abuse Programs, some clusters had between 84 to 100 inmates. The Office of Substance Abuse Programs also reported that it disagrees with findings by UCLA researchers that there was no significant difference in return-to-custody rates between Substance Abuse Treatment Facility treatment subjects and Avenal State Prison subjects who did not receive treatment. According to the Office of Substance Abuse Programs, further analysis by its staff determined that the population of non-treatment subjects was over-represented by drug traffickers compared to the treatment subjects' higher population of drug possession offenders, arguing that drug traffickers generally return to prison at a lesser rate than drug possession offenders. The Office of the Inspector General discussed this argument with the principal investigator who worked on the September 2002 UCLA evaluation. According to the principal investigator, the Office of Substance Abuse Programs raised this argument during the drafting of the UCLA report. Accordingly, the final UCLA report specifically addressed the issue, finding that while the control group of non-treatment inmates convicted of drug offenses did have a higher percentage of drug traffickers than the treatment group, the one-year return-to-custody percentages between the treatment and control groups, sorted by type of offense, was not statistically significant. UCLA, therefore, stands by its findings.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Office of Substance Abuse Programs take the following actions:

- **Conduct systematic, in-depth monitoring of treatment providers for compliance with contract terms. Monitoring reports should reflect all substantive details of the provider's records and operations. The reports should also include the Office of Substance Abuse Programs' analysis and evaluation of the provider's operations.**
- **When drafting contracts for substance abuse treatment services, include provisions for fiscal sanctions to address instances of non-compliance with contract terms, including failure to provide the required number of counselors.**
- **Whether performed by UCLA or by another contractor, ensure that future studies of the effectiveness of the substance abuse program at the institution include a comparison of the treatment group to a control group of similar inmates who did not receive treatment.**
- **Return to using smaller clusters of inmates to conform to the Office of National Drug Control Policy's recommendation that therapeutic community program clusters consist of no more than 50 to 75 inmates.**

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found serious deficiencies in the medical care provided to inmates at the Substance Abuse Treatment Facility and State Prison at Corcoran, placing the health of inmates and staff at risk and exposing the State to possible legal action.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections and the medical management of the California Substance Abuse Treatment Facility and State Prison at Corcoran take the actions listed below to improve medical services and operations.		

Develop a plan for re-activating medical operations at the institution. The plan should include the following: a component for recruiting, training, and retaining adequate professional staff; written department and institution-specific policies and procedures covering all areas of operation, including nursing; and provisions for regular on-site monitoring and assistance by the Health Care Services Division.	**PARTIALLY IMPLEMENTED**	The institution noted that since September 2002 its chief medical officer, chief dental officer, chief psychologist, chief psychiatrist, director of nurses, and medical records supervisor have resigned, retired, or transferred. Health care management remains problematic, with the institution experiencing a succession of six different chief medical officers since September 2002 until the present incumbent was hired in June 2005. The institution reports hiring a chief dental officer in July 2005. Meanwhile, according to the institution, recruitment for all health care classifications has been assigned to the Selections and Standards Branch. The institution reported that policies and procedures for its correctional treatment center have been revised; the inmate medical services program (known informally as the *"Plata"* decision) has been activated; appropriate local operating procedures have been implemented; and staff training has been completed. As part of its overall quality management program, the institution says it has established an inmate medical services subcommittee that meets monthly to advise the quality management committee regarding ongoing medical issues. Issues that cannot be resolved locally are addressed through the local governing body meeting (institution staff and headquarters staff are members). The institution reported a continuing critical shortage of physicians at the institution.
Develop a plan to bring the institution's correctional treatment center into compliance with all licensing requirements. The institution medical management team should establish and staff all required committees and ensure that the committees meet as required. The	**SUBSTANTIALLY IMPLEMENTED**	The institution reports that its correctional treatment center underwent a full licensing survey by the Department of Health Services in February 2003, which resulted in a corrective action plan being submitted to the Department of Health Services. This process was repeated in April 2005. The Office of the Inspector General confirmed that the Department of Health

medical management team should also ensure that the functions of the pharmacist-in-charge and the radiology physician are being performed.		Services April 2005 survey shows fewer corrective action items than the February 2003 survey. The correctional treatment center remains licensed, subject to renewal in June 2006. Required licensing committees are being held as required and records maintained. The duties of both the pharmacist-in-charge and radiology physician are being performed through contractual agreements.
Obtain the resources to establish a management information system by which to track and monitor backlogs in pharmacy, radiology, medical records, specialist clinics, and medical appeals. The system should prioritize backlogged items according to urgency.	**FULLY IMPLEMENTED**	The institution reported that it put a system in place in May 2003 to track and monitor backlogs for laboratory, radiology, medical records, medical appeals and specialty clinics. The system generates a monthly backlog report that is reviewed by health care management. Areas identified as problematic or showing a significant increase in backlogs are addressed with health care management and additional resources are directed to the problem.
Develop methods to reduce or eliminate backlogs without placing inmates at risk.	**PARTIALLY IMPLEMENTED**	The institution reported that its expectation is that physicians see 25 scheduled patients and five additional sick call patients per day, with daily statistics recorded and maintained. Due to a critical shortage of physicians, however, the institution reported that it has been unable to meet the timeframes for seeing patients required by the *Plata* decision, and that medical appeals have fallen behind. The Office of the Inspector General noted that the institution's physicians averaged 16 patients per day in September 2005. The institution asserted that it has nonetheless resolved backlogs in x-ray, labs, pharmacy, and specialty clinics.
Ensure that doctors work required hours and are fully productive during working hours.	**PARTIALLY IMPLEMENTED**	According to the institution, the current work schedule for physicians is eight hours per day, five days per week, and a sign-in/sign-out log has been implemented for accountability. In addition, the institution reported that it compiles daily statistics to provide productivity information to the chief medical officer.

		The Office of the Inspector General's examination of the sign-in log for February through October 2005 revealed minimal compliance by the institution's doctors in adhering to the health care manager's August 2004 memorandum instructing medical personnel to sign in and out of the institution. Instead of recording their actual times of arrival and departure as instructed, doctors were simply signing the log and indicating a status of "in" or "out."
Review the number of hours scheduled for doctors' lines to ensure that enough time is scheduled to address inmate medical needs.	**SUBSTANTIALLY IMPLEMENTED**	The institution reports that it changed physicians' work schedules from four 10-hour days to five eight-hour days to allow more consistent coverage and provide an extra day on which physicians see patients. The chief medical officer used to hold a weekly physicians' meeting in an open forum as an avenue for communication and problem resolution, but the critical shortage of physicians currently precludes these meetings.
Establish a quality control procedure to ensure that entries into inmate medical files are complete, accurate, and timely.	**FULLY IMPLEMENTED**	The institution reported that it stresses the importance of timely, complete, and accurate documentation through physician's meetings, monthly nursing meetings, pharmacy meetings, and health record reviews, with relevant findings reported to health care management.
Hold the medical staff responsible for completing administrative activities, including responding to inmate medical appeals, in a complete and timely manner.	**NOT IMPLEMENTED**	While the institution reports having established an expectation that physicians complete all administrative duties in a timely manner and that procedures for notifying the chief medical officer of medical appeals that will become delinquent at the end of each week, the physician shortage precludes aggressive focus on appeals and contributes to a continuing backlog of appeals.
Foster effective communication and coordination of medical activities between medical and custody staff.	**FULLY IMPLEMENTED**	The institution reported that implementation of a quality management program provides an avenue for ongoing communication, problem identification, and resolution of common issues between medical staff and custody staff.

Actively manage the medical function by establishing goals, setting priorities, defining expectations, and communicating these to the medical staff.	**SUBSTANTIALLY IMPLEMENTED**	With the January 2004 implementation of the inmate medical services program, the institution reports that policies and procedures for delivery of health care are in place, with audits performed to ensure compliance with the program and Title 22 requirements. Audit findings are reported to health care management at supervisor meetings, held twice per month, and at monthly nursing meetings.
Perform periodic audits and reviews of all medical activities, including nursing, to monitor compliance with policies, procedures, and regulations.	**FULLY IMPLEMENTED**	The institution reports that nursing audits are performed to ensure compliance with medication management policy and procedures (Operating Procedure 430). Other nursing audits performed include evaluation of physician orders, nursing assessment, and charting content.
Ensure that all staff members, including temporary nursing registry staff, are thoroughly trained in delivering health care in a custody environment.	**FULLY IMPLEMENTED**	According to the institution, all staff members, including registry nursing staff, are required to attend orientation classes on institutional safety and security as well as an overview of correctional health care. Training is documented and records maintained.
Provide resources to allow clinics to remain open for more hours per day and more days per week for sick call and doctors' lines to allow more inmates to receive care.	**FULLY IMPLEMENTED**	According to the institution, physicians' work schedules changed from four 10-hour days to five eight-hour days per week, allowing for more consistent coverage and an extra day on which to see additional patients. Physicians are expected to see 25 scheduled patients, leaving time to see at least five sick call patients each day. The Office of the Inspector General confirmed the improvement to physicians' work schedules, but noted that the physicians averaged 16 patients per day during September 2005.
Ensure that treatment in the emergency room meets minimum standards of care before inmates are released to housing facilities with instructions to return to facility doctor's lines.	**FULLY IMPLEMENTED**	According to the institution, a tracking procedure has been implemented to ensure that all inmates returning from outside medical facilities receive appropriate follow-up care pursuant to the inmate medical services program *("Plata")* guidelines and the correctional treatment center policies and procedures. Because the June 2004 *Plata* review identified this as an area of concern, the institution notes that follow-up care is closely monitored and additional staff training has been conducted.

Establish an automated on-line medical records system to allow the medical staff access to inmate pharmaceutical records and medical histories. The system should also record and track follow-up appointments to ensure that these appointments occur.	**NOT IMPLEMENTED**	Although an automated on-line medical record system incorporating pharmaceutical data has not been established, the institution reported that medical staff can obtain inmate pharmaceutical records by contacting the pharmacy and that patient medication profiles are provided to staff before all scheduled appointments. A computer-based appointment scheduling and tracking system is in place, and the institution reports that the Department of Corrections and Rehabilitation is developing an automated system that will incorporate each patient's medical records and pharmacy tracking information.
Review all medical procedures currently referred to contracted specialist clinics or outside providers in order to evaluate which of those procedures can be performed by institution doctors.	**NOT IMPLEMENTED**	The institution reported that a medical authorization review committee was implemented in April 2004 to review the medical necessity of procedures referred to contracted specialists or outside providers of medical treatment. With the current critical shortage of physicians at the institution, however, such review is limited to a cursory examination by the chief medical officer, who does not formally document the decision process.
Review current backlogs of cases referred to specialist clinics to assess the appropriateness of providing specialist clinics more often.	**FULLY IMPLEMENTED**	According to the institution, the chief medical officer is provided with a monthly report of the number of inmates awaiting specialty services appointments (optometry, orthotics, surgery, urology, etc.), allowing management to request additional clinics or provide other resources to prevent excessive treatment delays.
Establish procedures and systems to ensure that all inmate requests for reasonable accommodation and medical verification of disabilities under the Americans with Disabilities Act are processed in a timely manner and that all appropriate accommodations or modifications are implemented without delay.	**SUBSTANTIALLY IMPLEMENTED**	The institution reported that its administrative staff closely monitors appeals to ensure compliance with requirements for timely responses to appeals filed under the Americans with Disabilities Act. The institution further reported that it has assigned an appeals coordinator to work with medical appeals and to complete all of the institution's second-level appeals filed under the Americans with Disabilities Act. As a result, according to the institution, the improvement has caused third-party monitoring groups *("Armstrong"* monitors) to put the institution on "paper tour" status for the next scheduled review, although the recent critical shortage of physicians has made it difficult to meet the response deadlines required by the *Armstrong* litigation.

Track pending actions on Americans with Disabilities Act requests to ensure completion within established time limits and follow up on medical chronologies or modifications to ensure that these are implemented without delay.	**SUBSTANTIALLY IMPLEMENTED**	(See above)
Systematically identify inmates with chronic medical conditions and ensure that these inmates are monitored through regular appointments with institution doctors.	**PARTIALLY IMPLEMENTED**	The institution reported that its chronic care program was established as part of the inmate medical services program in September 2004, and that its "SATSLITE" scheduling and tracking system tracks and monitors chronic care appointments. However, the institution advised the Office of the Inspector General that the critical shortage of physicians has impaired the institution's ability to meet program time frames for care of inmates with chronic medical issues.
Establish policies and procedures to require periodic laboratory work and measurement of vital signs for chronic care inmates. Ensure that this information is available to doctors at the time of examinations so they may adequately assess chronic medical conditions.	**PARTIALLY IMPLEMENTED**	(See above).

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the institution continue to work with the Division of Correctional Health Care Services' department-wide efforts to address the shortage of medical staff as cited by a federal court monitor.

The Office of the Inspector General also reiterates the following recommendations to the institution:

- **Develop methods to reduce or eliminate inmate medical appeal backlogs without placing inmates at risk.**

- **Hold medical staff responsible for completing administrative activities, including responding to inmate medical appeals in a timely manner.**

- **Review all medical procedures currently referred to contracted specialist clinics or outside providers to identify those that could be performed by institution doctors.**

- **Establish procedures and systems to ensure that all inmate requests for reasonable accommodation and medical verification of disabilities under the Americans with Disabilities Act are processed in a timely manner and that all appropriate accommodations or modifications are implemented without delay.**

- **Track pending actions on Americans with Disabilities Act requests to ensure completion within established time limits and ensure that medical chronologies or modifications are implemented without delay.**

- **Systematically identify inmates with chronic medical conditions and ensure that those inmates are monitored through regular appointments with institution doctors.**

- **Establish policies and procedures to require periodic laboratory work and measurement of vital signs for chronic care inmates. Ensure that this information is available to doctors at the time of examinations so they may adequately assess chronic medical conditions.**

- **Enforce the August 2004 memorandum from the health care manager instructing medical personnel to sign in and out of the institution and record actual times of arrival and departure.**

Finally, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation continue to develop an automated system combining individual patient's medical record with pharmacy tracking information.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that pharmacy operations at the Substance Abuse Treatment Facility and State Prison at Corcoran were seriously deficient.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the medical management Team at the institution take the actions listed below to improve administrative controls over pharmacy operations.		
Develop written institution policies and procedures, consistent with Title 22 of the California Code of Regulations, governing the institution's pharmacy operations and comply with existing department policies and procedures. The institution policies and procedures should include the physical controls and accounting controls necessary to correct the problems identified by this audit.	FULLY IMPLEMENTED	The institution reported, and the Office of the Inspector General confirmed, that policies and procedures consistent with Title 22 of the California Code of Regulations for pharmacy services are in place and that the institution's pharmacy services committee meets quarterly to address pharmacy issues and review the quarterly pharmacy report.
Consider implementing an automated barcode system for tracking the inventory and movement of pharmaceutical products within the institution. Bar-coding improves accuracy in identifying items and in determining quantities on hand, thus increasing efficiency by reducing the staff time required to prepare replenishment orders.	NOT IMPLEMENTED	The institution reported that the Division of Correctional Health Care Services is working to obtain a more sophisticated automated pharmacy system for implementation statewide, but that no such system presently exists.
Develop a systematic means of transferring inmate medications when inmates change housing assignments at the institution.	FULLY IMPLEMENTED	The institution reported that Operating Procedure 418 concerning intra-facility inmate medication transfer was implemented in October 2003. The policy governs the method for transferring medications with inmates between yards within the facility, and has contributed to a reduction in the institution's pharmacy expenditures of more $1 million from fiscal year 2002-03 to fiscal

		year 2004-05. Audits are performed to ensure compliance.
Staff the pharmacy with full-time employees hired by the Department of Corrections in order to minimize the turnover in those positions and enhance the quality of service.	**SUBSTANTIALLY IMPLEMENTED**	The institution reported that it currently employs two state pharmacists, five pharmacy technicians, two contract pharmacists, and a contracted pharmacist-in-charge. This represents an improvement over conditions found in the January 2003 audit when the pharmacy was staffed entirely by contract employees. While recruitment of pharmacists has proven difficult throughout the state's correctional institutions, the Substance Abuse Treatment Facility and State Prison at Corcoran has two pharmacist vacancies that have been advertised for more than 40 months. The institution said the current salary levels offered by the state are not competitive with those of private industry.
Ensure that the current pharmacist-in-charge is present at the pharmacy as required until a permanent pharmacist-in-charge can be hired.	**FULLY IMPLEMENTED**	According to the institution, the current pharmacist-in-charge works a 40-hour-per-week schedule under contract with a private agency, while recruitment efforts to hire a permanent state employee continue.
Develop management information systems, on-site monitoring methods, and management reports to more directly monitor pharmacy operations.	**SUBSTANTIALLY IMPLEMENTED**	The institution reports that it has established a pharmacy services committee to be responsible for overall direction of pharmacy services, along with a standards compliance coordinator to audit pharmacy services for compliance with Title 22 regulations. Deficiencies noted by the audits are brought to the attention of the pharmacy services committee and health care management for resolution. The institution reports that these actions have resulted in improvements noted by a recent *Plata* monitoring tour. The improvements depend primarily on manual processes, however.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Division of Correctional Health Care Services take the following actions:

- **Continue to develop and implement an automated barcode system for tracking the inventory and movement of pharmaceutical products within the institutions.**

- **Work with the court-appointed federal receiver to develop a competitive salary structure for pharmacy professionals, while continuing efforts to hire full-time pharmacy staff at present salary levels.**

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that the dental care program at the Substance Abuse Treatment Facility and State Prison at Corcoran was seriously deficient and that inmates were not receiving dental services required under state regulations.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Division of Correctional Health Care Services take the actions listed below to improve dental services at the California Substance Abuse Treatment Facility and State Prison at Corcoran.		
Develop a plan for "re-activating" the dental operation at the institution. The plan should provide the dental function with the number of dental professionals necessary to provide a minimum standard of care consistent with Title 15 of the California Code of Regulations. The plan should also include detailed policies and procedures for the efficient delivery of dental services. To this end, the policies and procedures should include methods for ensuring that dentists examine inmates within 14 days of arrival at the institution and for	PARTIALLY IMPLEMENTED	The institution reported that policies and procedures for dental services have been developed and approved. According to the institution, dental management has been a problem because the chief dental officer position was vacant from September 2002 until July 2005. The institution reported that meanwhile, dental department meetings are held monthly, and a dental program subcommittee reports its significant findings to the Quality Management Committee for resolution. The institution reported that its dentists continue to make an effort to examine inmates within 14 days of arrival by using a process that notifies dentists of new

developing individual treatment plans, based on regular examinations, within the framework of preventative dentistry.		arrivals, but the institution also asserted its belief that the 14-day requirement in Title 15 pertains to reception centers only and not to other institutions. The Office of the Inspector General notes, however, that Title 15 of the California Code of Regulations clearly states, in section 3355.1(b), "Each newly committed inmate shall within 14 days following transfer from a reception center to a program facility receive a complete examination by a dentist who shall develop an individualized treatment plan for the inmate." The Office of the Inspector General noted that the institution had six dentists and six dental assistants at the time of the audit fieldwork — only one fewer in each category than the institution's staffing allotment for these positions.
Improve communication with and support of the institution's dental function by conducting scheduled as well as unannounced site visits to monitor and inspect dental operations, and by holding regular meetings with on-site managers to discuss issues of concern to both headquarters and on-site staff.	**PARTIALLY IMPLEMENTED**	As noted above, the institution reports that it has established a dental program subcommittee as part of its quality management program, and that the subcommittee meets monthly and forwards any concerns to the quality management committee for resolution. Issues that cannot be resolved by institution personnel alone are addressed through the local governing body, which is comprised of institution staff and headquarters staff. Although the institution has internal communication and monitoring processes for its dental operations, the Office of the Inspector General found no evidence of regular site visits by the Division of Correctional Health Care Services to inspect dental operations.
Address and resolve the issue of institution dentists not reviewing or using the dental assessments completed by reception center dentists. Institution dentists should either use the screening as part of the continuum of care or the Health Care Services Division should eliminate the screening and its attendant costs.	**FULLY IMPLEMENTED**	According to the institution, dental assessments performed during the reception center screening process are reviewed if they are in the unit health record at the time dental services are performed.
Obtain the resources to develop a management	**SUBSTANTIALLY**	The institution reported that a monthly report on dental services is provided to

information and reporting system to monitor key indicators of the efficiency and effectiveness of the dental function. These indicators should include, but not be limited to, the following: backlogs in inmate requests for dental services at the various clinics; number of patients seen by dentists; number of patients examined (and not examined) within the 14-day limit established by Title 15; number of individual treatment plans developed; number of fillings and other preventive procedures compared to the number of extractions and denture procedures.	**IMPLEMENTED**	institution and headquarters management. The report provides statistics on the number of patients to whom services were provided, the percentage of the total inmate population seen, and details about the types of services provided, such as restorative procedures, extractions, periodontal, prosthodontics, and endodontics, in relation to the total number of patients scheduled for appointments. According to the institution, sick call is held each morning in all clinics to handle dental emergencies.
Develop a strategy to eliminate the backlog within a reasonable period based on the urgency of each request.	**SUBSTANTIALLY IMPLEMENTED**	The Office of the Inspector General noted that the institution maintains weekly statistics for dental workload, including patient backlog, and found that the backlog during September and October 2005 was approximately three months, compared to the five-month backlogs the Office of the Inspector General observed in the January 2003 audit. In addition, the institution has taken steps to enhance the productivity of its dental operations, as discussed below.
Hold the health care manager and the chief dental officer accountable for managing dental operations at the correctional treatment center, including the following: ensuring that dentists work appropriate hours and are fully productive during scheduled working hours; reviewing the number of hours scheduled for dental sick call and clinics to ensure sufficient time is allotted to address inmate dental problems; establishing a quality control procedure to ensure that entries into inmate medical files are complete and accurate;	**SUBSTANTIALLY IMPLEMENTED**	The institution reports that its dentists, who work five days per week, are required to sign in and out daily, that management reviews their productivity using the monthly dental report and daily appointment lists, and that any problems are discussed at monthly dental department meetings. The institution noted again that it has formed a dental program subcommittee that reports to the institution's quality management committee, and that dental appeals are handled in a timely manner under the monitoring of the Correctional Health Services Administrator II. The Office of the Inspector General noted a slight improvement in the productivity of the institution's dentists since the January 2003 audit. Dentists saw an average of 11 patients per day during February and March 2005,

ensuring that staff respond to inmate medical appeals in a complete and timely manner.		compared to only eight patients per day for the same months in 2002.
Review the chief dental officer's duty statement and either require him to devote 40% of his time to clinic work or change the duty statement.	**NOT IMPLEMENTED**	The institution advised the Office of the Inspector General that since the chief dental officer was hired in July 2005, the duty statement for that position has not been revised since the January 2003 management review audit.
Provide management training to the on-site dental management staff. The training should include: planning and goal setting; performance measurement; interpersonal communication; and principles of supervision.	**NOT IMPLEMENTED**	According to the institution, the chief dental officer has not been scheduled to attend management training since being hired in July 2005.
Require the health care manager and the chief dental officer to develop policies and procedures for local operation of dental services. These policies and procedures should include the following: • Longer and more frequent hours of clinic operations, and the posting of these hours in the facilities. • A system of accountability for the time worked by dentists, dental assistants, and other dental staff. • Alignment of the work schedules of dentists and dental assistants to maximize the efficiency of clinic operations.	**NOT IMPLEMENTED**	The institution reported that formal policies and procedures are being developed at department headquarters and have not been officially released, although final approval and distribution is expected soon. According to the institution, the institution's chief dental officer, meanwhile, is working on local policies and procedures.

• Use of benchmarking and minimum standards of productivity for dental staff, including number of patients seen daily, weekly, and monthly by dentists. • Use of progressive discipline for employees who fail to comply with policies, procedures, and minimum productivity standards.		

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Substance Abuse Treatment Facility and State Prison at Corcoran take the following actions:

- **Establish procedures to comply with Title 15 of the California Code of Regulations, requiring that dentists examine inmates within 14 days of the date inmates arrive at the assigned institution from the reception center, and develop a reporting and monitoring system to track compliance.**

- **Review the chief dental officer's duty statement and either require the chief dental officer to devote 40 percent of his or her time to clinic work as described in the current duty statement, or revise the duty statement as necessary.**

- **Provide management training to on-site dental management staff, including training on planning and goal setting; performance measurement; interpersonal communication; and principles of supervision.**

- **Continue efforts to reduce the dental backlog.**

- **Have the health care manager and the chief dental officer finalize the policies and procedures for local operation of dental services.**

In addition, the Office of the Inspector General recommends that the Division of Correctional Health Care Services improve its support of the dental function at the institution by conducting site visits, both scheduled and unannounced, to inspect dental operations, provide guidance, and meet with the institution's dental management to discuss areas of concern.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that a projected deficit of $8.4 million in the 2002-03 budget for the Substance Abuse Treatment Facility and State Prison, Corcoran could significantly affect institution operations.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections take the actions listed below to better manage the operating budgets of the institutions.		
Continue to request resources to address the issues driving deficits in the institutions.	FULLY IMPLEMENTED	The department reported that it has been aggressively pursuing additional resources to address structural deficiencies and was successful in receiving additional funding for the following: ***Sick leave for posted positions.*** In fiscal year 2003-04, the department received $4.8 million in funding to increase its posted sick leave relief factor. The sick leave relief factor is now funded at the employee's accrual rate. In fiscal year 2004-05, additional funding was received to fully fund absences under the Family Medical Leave Act /California Family Rights Act. ***Workers' compensation***. The department reported that it has received base budget augmentations of $158.3 million over the last three fiscal years to cover its annual workers' compensation deficits.

		Medical guarding and transportation. The department reported that it received approval for a fiscal year 2004-05 budget augmentation of 114.9 positions and $18.1 million to meet increased costs of medical guarding and transportation, increasing the base overtime funding for medical guarding and transportation costs to $9.9 million. ***Overtime for posted positions***. The department reported that it received an augmentation of $36.6 million in overtime funding for fiscal year 2001-02 and that provisions were included in the budget bill specifying that the funding is available only for expenditures for overtime and temporary help to reduce holiday and vacation leave credits and for costs associated with filling authorized positions. The funding can be converted to 504 permanent positions when excess vacancies are filled. The initial allocation of 124.28 positions was distributed to the various institutions in July 2003 and the remaining 379.61 positions were allocated in August 2004 to reduce overtime use. An approved budget change proposal for fiscal year 2004-05 addressed the unfunded relief needed to cover posted positions. ***Administrative segregation overflow***. For fiscal year 2004-05, the department reported receiving an augmentation of 195.6 positions and $16.8 million in funding to provide additional staffing for administrative segregation unit overflow. The augmentation was based on the minimum overflow levels experienced during calendar year 2003, and future adjustments were expected to be addressed after the fall population projection and May 2006 budget revision. ***Utilities costs***. For fiscal year 2002-03, the department reported that it received additional funding of $13.1 million through various policy proposals and population related adjustments. For fiscal year 2003-04, the department's utilities base was increased, with permanent funding of $27.8 million and one-time population-related adjustments. ***Population increases***. The department reports that it uses data from its Offender Information Services Branch in conjunction with any legislative changes to estimate the fiscal impact of population changes. Through the fall

		population projection and the May budget revision process, the department adjusts its projections of funding required to accommodate population changes. ***New base budget methodology***. The department reports that its Financial Services Division, in conjunction with the Department of Finance, developed a new budget allotment methodology to align funding with expenditure levels more realistically and continues to work on refinements. While budgets are tight, the department reports that it continues to submit requests addressing the need for additional resources.
Prepare cost estimates of all changes to employee bargaining unit contracts before committing to changes in the contracts.	**FULLY IMPLEMENTED**	The department reports that its budget management branch is instructed to estimate the impact of labor agreements that have been negotiated by the department in consultation with the Department of Finance and the Department of Personnel Administration. In addition, the department director issued a memorandum in July 2002, requiring that any labor agreements having a fiscal impact on either local operations or the department's budget must have the prior approval of the budget management branch.
Request additional funding to mitigate the effect of increased sick leave usage in future fiscal years.	**FULLY IMPLEMENTED**	For fiscal year 2004-05, the department reports that it received approval for $99.5 million and 1,238.8 positions to address insufficient funding for relief coverage for absences caused by training, bereavement leave, military leave, jury duty, the Family Medical Leave Act, and the Family-School Partnership Act.
Provide institutions with adequate resources before initiating policy changes, such as designating an institution for dialysis treatment.	**FULLY IMPLEMENTED**	The department notes that its existing policies prohibit implementation of any new program before appropriate funding is secured. In the specific case of hemodialysis, the department reports that it has budgeted, funded, and constructed an on-site hemodialysis unit at the California Substance Abuse Treatment Facility and State Prison at Corcoran, which is pending activation, The unit will involve a contract with a private vendor to operate dialysis chairs.

Assist the institution in improving the control and monitoring of pharmaceuticals.	**FULLY IMPLEMENTED**	The department reported that its Division of Correctional Health Care Services has provided the following services to institutions to assist in managing pharmacy and pharmaceutical operations: ***Management Systems*** • Imposed a quality management structure to facilitate continuous improvement, information management and analysis, and corrective action. The quality management structure involves institutional and departmental pharmacy improvement teams, pharmacy and therapeutics subcommittees, quality management committees, governing bodies, and associated reporting systems. • Developed a process to monitor the utilization and costs of certain drug categories that produces both institution-specific and aggregate management reports. The reports were disseminated for use in the quality management process, with quarterly reports, including an executive summary and analysis available. • Procured the Health Care Management System to replace the outdated Pharmacy Prescription Tracking System. The Health Care Management System was piloted at the California Medical Facility in September 2004 with statewide implementation anticipated to occur over the next two to three years. The system includes a comprehensive modern pharmacy prescription information management capability and is designed to assist institutions with tracking and managing pharmacy operations more easily and rapidly. The department will provide field training to staff at its institutions as the system is implemented statewide over the next two to three years. ***Contract and Formulary Management*** • Developed and distributed formularies and updates to guide appropriate drug purchases and prescriptions. Non-formulary drug requests are reviewed for appropriateness and policy compliance by the institution; and in certain cases, department management. The Division of Correctional Health Care Services generates, reviews, and

		distributes a monthly formulary compliance report through the quality management process. • Developed and distributed monthly contract compliance reports that facilitate cost-effective purchasing by identifying non-contract purchases that are generally more expensive than items purchased through a contract. The Division of Correctional Health Care Services produces and analyzes these reports and provides them to the institutions through the quality management process. • Developed and distributed periodic discount and rebate reports to ensure that institutions are taking advantage of available pharmaceutical discounts and rebates. The Division of Correctional Health Care Services provides information regarding available discounts and rebates and advises institution on corrective measures as necessary through informational e-mail bulletins and the quality management process. ***Medication Utilization and Disease Management*** • Developed and implemented the Hepatitis C Virus Clinical Management Program to assist the institution in improving control and monitoring of related antiviral drug costs. The program includes a utilization management database to assist with monitoring hepatitis-C treatment and tracking. • Developed protocols and provided training to appropriate health care staff in March 2004 on the utilization and management of the five high-volume/high-cost drug categories that are responsible for more than 50 percent of the department's pharmaceutical expenses. ***Pharmacy Operations and Medication Management*** • Developed and completed the first turn-rate report in 2003 to determine how frequently pharmacies replace their stock, with a high turn-rate generally reflective of efficient inventory management. The department requested that institution pharmacies measure turn rates

		while the department conducts annual turn-rate reviews. • Facilitated inventory management training for pharmacy field staff in August and September of 2004, and scheduled annual inventories of institution pharmacies. • Implemented comprehensive transfer and medication management policies in 2003 that improved continuity of care and reduced waste. According to the department, as a result of the initiatives noted above, the rate of increase in the department's pharmaceutical expenditures slowed to six percent during fiscal year 2003-04 from a 17.7 percent average over the previous three years. The department interprets this declining trend as a "cost avoidance" in excess of $14 million, noting that it is 50 percent less than the industry standard rate of increase of 12 percent.[1] The Office of the Inspector General did not audit these figures, but, if they are accurate, recognizes them as a commendable trend. The Office of the Inspector General believes the department can achieve further savings if it fully implements past recommendations to replace outdated information technology systems that lack the capacity to control costs and manage waste. [1] The 12 percent industry standard rate is stated in Hoffman, Nilay, et al. "Projecting Future Drug Expenditures-2004." *American Journal of Health-System Pharmacy* (2004): 61:145-157.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that a significant percentage of employees and managers of the Substance Abuse Treatment Facility and State Prison at Corcoran were not fulfilling annual training requirements.

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ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the management of the California Substance Abuse Treatment Facility and State Prison at Corcoran take the actions listed below to ensure that employees receive required training.		
The in-service training unit should periodically review each employee's training records to ensure that all employees meet departmental training requirements and should notify appropriate supervisors of instances of non-compliance. For those employees consistently not attending "7k" training, the in-service training unit should determine the cause of the employee's inability to attend and make training schedule adjustments if necessary.	FULLY IMPLEMENTED	The Office of the Inspector General confirmed a statement from the institution that a block training program was implemented for all department employees in September 2004, with training months designated for every employee two months before the employee's birth month. A 40-hour block of required and site-specific training is offered weekly during that month. In addition, employees receive a 12-hour self-study packet, which they are required to complete to supplement the 40 hours of block training. The in-service training unit automatically provides each employee with a training audit during the employee's birth month, and the personnel department sends the audit results to the employee's supervisor for evaluation and follow up.
As a part of the annual performance evaluation process, supervisors should work with employees to include specific plans to meet training requirements for the following year.	NOT APPLICABLE	Under the annual block training process, it is no longer necessary for supervisors to meet with employees to plan training. Each employee's training evaluation is provided to the employee's supervisor upon completion of training.
Develop a systematic means of acquiring the training records of newly arrived employees from the sending institution or agency.	FULLY IMPLEMENTED	According to the institution, the in-service training unit and the personnel office implemented a process in August 2003 in which a listing of all new employees is sent to the in service training office weekly to assist in tracking and obtaining new employees' training files.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that the Investigative Services Unit was not following proper procedures for the temporary storage of evidence.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the management of the California Substance Abuse Treatment Facility and State Prison at Corcoran take the actions listed below to improve the integrity of temporary evidence storage at the institution.		
Re-locate the sub-evidence area to a separate room, unexposed to extraneous pedestrian traffic. All persons entering the room should be required to sign the logbook documenting the date, time, and purpose of their visit. The storage refrigerator should be fitted with a lock if it cannot be moved to a secured and locked room.	FULLY IMPLEMENTED	The Office of the Inspector General verified that the sub-evidence lockers and the refrigerator have been relocated to the central services building. Anyone entering the room is required to sign the logbook documenting the date, time, and purpose of the visit.
Replace the current loose-leaf evidence log with hardbound logbooks with pre-numbered pages. The logbook for urinalysis samples should be separate from the logbook used for	FULLY IMPLEMENTED	The Office of the Inspector General noted during a follow-up tour that the logbooks are now manufactured by the investigative services unit staff using a durable plastic spiral binding, with sequentially-numbered pages, allowing for individual books unique to an incident number. Separate urinalysis logbooks are

other evidence. Information recorded in the logs should include date and time of access, the badge number (or other identification), name of the person submitting the evidence, the subject's name and identifying number, a description of the evidence, and the locker number in which it is stored. When an evidence officer retrieves the evidence, the log entry should include the date and time evidence was removed from the sub-evidence locker, the name of the evidence officer, and the final disposition of the evidence.		being used and information recorded in the logs includes date and time of access, the badge number (or other identification) and name of the person submitting the evidence, the subject's name and identifying number, a description of the evidence, and the locker number in which it is stored. When an evidence officer retrieves the evidence, the log entry includes the date and time evidence was removed from the sub-evidence locker, the name of the evidence officer, and the final disposition of the evidence.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that the institution was not properly documenting inmate activity in the administrative segregation units.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the management of the California Substance Abuse Treatment Facility and State Prison at Corcoran require the administrative segregation unit staff to take the actions listed below to comply with regulations and policies governing inmate activity in the administrative segregation unit.		

Record inmate movements and other activities in the CDC-114 as they occur, rather than waiting for the first watch administrative segregation floor officer to update the log. .	NOT IMPLEMENTED	The institution reported that training has been provided to all staff in the administrative segregation units and that all unusual incidents and inmate movements are documented contemporaneously on the inmate's individual CDC- 114D, as well as in the administrative segregation isolation log . In discussing the matter with institutional management, however, the Office of the Inspector General learned that supervisors responsible for implementing the original recommendation misinterpreted it, believing that the recommendation focused on the CDC-Form 114A, which is the record of activity for an individual inmate (used for recording such events as feeding, showers, and medical treatment). Accordingly, the institution's training was directed toward improving records in the individual inmate files rather than toward the isolation log (Form CDC-Form 114).
Record unusual incidents and other noteworthy conditions in the CDC-114 instead of exclusively in the sergeant's log.	NOT IMPLEMENTED	Institution management acknowledged that inmate movement is not consistently being recorded in the isolation log as it occurs and that this will become a subject of training.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Substance Abuse Treatment Facility and State Prison at Corcoran record inmate movement in the administrative segregation isolation log (CDC-Form 114) as it occurs and that this document also be used to record unusual incidents and other noteworthy conditions.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that the institution had not consistently followed required state hiring procedures.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management take the actions listed below to improve employee hiring.		
In consultation with the department's Office of Personnel Management, develop a policies and procedures manual for the hiring process. The manual should incorporate the applicable provisions of the California Department of Corrections Operations Manual, department policy memoranda, and state laws and regulations.	FULLY IMPLEMENTED	The institution reports that it has in place a recruitment and hiring process that will ensure that all State Personnel Board rules and regulations are observed. The Office of the Inspector General examined records at the institution and noted evidence of improved compliance with each of the elements discussed below.
Advertise all vacancies for at least 14 days in accordance with the Department Operations Manual and other department policy memoranda.	FULLY IMPLEMENTED	The institution advised the Office of the Inspector General that all vacancies are advertised for the required 14 days and that the advertisement bulletin is maintained as part of the recruitment file.
Provide training to appropriate managerial personnel on the hiring process and on the responsibilities and duties of interview panel members.	FULLY IMPLEMENTED	According to the institution, an orientation is provided to panel members and the panelists' acknowledgment forms are maintained in the recruitment file.
For each examination, have all members of interview panels document the candidates' interview performance and rate each candidate using a pre-determined scoring system and a standardized scoring sheet.	FULLY IMPLEMENTED	According to the institution, a standardized rating format is used for all interviews, and the ratings are reflected on the interview questions sheet.

Use interview panels consisting of at least three members whenever possible.	**FULLY IMPLEMENTED**	The institution reported that interview panels consist of at least three members approved by the staff services manager I when feasible, and a note is made to the file if there is a deviation from this requirement.
Interview a minimum of three candidates for each vacancy whenever possible.	**FULLY IMPLEMENTED**	According to the institution all interviews consist of at least three candidates unless fewer than three candidates respond to the notice.
Have the warden date all documents at the time of signature.	**FULLY IMPLEMENTED**	The institution reports that the warden's executive assistant and the staff services manager I confirm that documents are dated when the signature is obtained.
In addition, the Office of the Inspector General recommended that the Department of Corrections conduct periodic reviews of institution hiring policies and procedures to ensure they are used consistently.	**FULLY IMPLEMENTED**	The department reported that the institution's delegated testing office conducts monitoring reviews of all interview packets for evidence that all requirements of the hiring process are met.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found while institution employees generally regarded the warden's communication and management skills to be satisfactory, some described his management style as "reactive," and said that he does not communicate adequately with managers and line staff.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
To improve communication among the warden, his executive staff, employees, and inmates, the Office of the Inspector General recommended that the warden take the actions listed below.		
Conduct regularly scheduled staff meetings with employees, permitting them to identify and define important issues.	FULLY IMPLEMENTED	According to the institution, the warden hosts informal open forums scheduled at various times throughout the day to allow all interested staff members an opportunity to attend and ask questions or voice concerns. In addition, the institution reports that monthly meetings are scheduled with collective bargaining unit representatives to address issues and concerns.
Within the framework of institution security and existing policy, respond promptly to as many employee and inmate concerns as practicable. When the warden's commitment to an action is made, ensure that a "tickler system" is used to monitor implementation of the commitment.	FULLY IMPLEMENTED	According to the institution, all assignments are currently tracked by an office technician, and pending issues are continuously monitored for follow-up, with the office technician generating weekly due lists and overdue reports for use by the warden during morning briefings. The warden's administrative assistant tracks issues resulting from inmate council meetings.
Form a committee of representatives from various employee areas (administration, custody, facilities, programming, etc.) to provide a forum for identifying factors relating to employee morale, recommending solutions, and monitoring the effectiveness of the solutions implemented.	FULLY IMPLEMENTED	The institution reported that several committees comprised of managerial staff, union representatives, and non-custody personnel are in place to address employee concerns. According to the institution, the warden has an "open door" policy, allowing an employee to communicate concerns directly to the warden after exhausting remedies available through the appropriate chain-of-command.
Conduct regular walking tours of the institution, visiting all work sites to talk with	FULLY IMPLEMENTED	According to the institution, the warden or chief deputy wardens conduct weekly tours as time and schedules permit.

employees about the institution's mission and to receive feedback directly from employees responsible for carrying out that mission.		
Meet with the inmate advisory councils at least once a month.	**FULLY IMPLEMENTED**	The institution reports that the associate wardens meet with the inmate advisory councils monthly, while the warden meets with the councils quarterly. Issues raised during these meetings are followed-up through the appropriate facility captain. The warden's administrative assistant routinely monitors unresolved issues.
In addition, the Office of the Inspector General recommended that the warden take the actions listed below.		
Arrange with facility captains to provide the inmate advisory councils access to dedicated office space and the necessary office equipment and supplies to conduct approved council activities and business.	**SUBSTANTIALLY IMPLEMENTED**	The institution reported that although there is no permanent workspace dedicated exclusively for the purpose, office space, supplies. and equipment are provided to the inmate advisory councils as available.
Have an appropriate staff person appointed as the institution's inmate advisory council coordinator.	**FULLY IMPLEMENTED**	According to the institution the associate warden of each complex has been designated to serve as the inmate advisory council coordinator.

FOLLOW-UP RECOMMENDATIONS

None.

PHARMACEUTICAL EXPENDITURES

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 0 (0%)

Substantially implemented: 1 (14%)

Partially implemented: 2 (29%)

Not implemented: 3 (43%)

Not applicable: 1 (14%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has made some progress in reducing its pharmaceutical expenditures. The department, however, has accomplished only the preliminary steps required to replace its outdated management information system.

In July 2003, the Office of the Inspector General conducted a survey to examine the department's pharmaceutical expenditure trends over the four preceding fiscal years to analyze practices contributing to those trends and to evaluate the department's efforts to implement changes recommended by previous audits and studies.

The survey revealed that despite a two percent decrease in inmate population between fiscal years 1999-2000 and 2002-03, the department's pharmaceutical expenditures increased 94 percent, from $63 million in 1999-00 to $122.4 million in 2002-03. During the same period, the national consumer price index for pharmaceutical drugs increased only 22 percent. The Office of the Inspector General found that the department's pharmaceutical expenditures were also significantly higher than those of two comparably sized prison systems—the U.S. Bureau of Prisons and the Texas state prison system—and had increased at a much faster rate.

Problems contributing to the department's high pharmaceutical expenditures had been well-documented in four comprehensive audits and studies conducted by the Bureau of State Audits, by the California State Senate Advisory Commission on Cost Control in State Government, and by a private consulting firm, FOX Systems, Inc., under a contract with the department. All of these audits and studies identified similar problems in the department's pharmacy program and included specific recommendations to remedy the deficiencies. Particularly critical was the indicated need for the department to replace its Pharmacy Prescription Tracking System, a badly outdated 20-year-old information system without the capacity to perform essential functions to control costs and prevent pharmaceutical waste, fraud, and abuse.

Although the Legislature mandated in July 2001 that the department implement the recommendations contained in the 117-page FOX Systems, Inc. report, the Office of the Inspector General found that, as of July 2003, the department had made only minimal progress in carrying out the implementation.

The Office of the Inspector General recommended that the department act promptly to implement the recommendations of previous audits and studies of its pharmacy program and, if it appeared that the department would be unable to carry out the implementation on its own, that it consider contracting with a private vendor to institute the necessary improvements.

BACKGROUND

The California Department of Corrections and Rehabilitation is required to provide health care services, including pharmaceutical services, to inmates incarcerated in state correctional institutions. Each institution operates its own pharmacy under the direction of the department's Division of Correctional Health Care Services (formerly the Health Care Services Division), which is responsible for administering health care services to inmates. Until January 2003, however, when the division hired three pharmacy service managers, no individual at the department level was assigned to actively manage the pharmacy program. As a result, pharmacy operations at the institutions lacked standardization because purchasing, dispensing, and administrative processes varied significantly. Each institution also maintained an independent pharmacy database using the Pharmacy Prescription Tracking System, a severely outdated information system with limited capabilities.

In February 2006, the U.S. District Court for the Northern District of California appointed a receiver over the department's health care operations in connection with a class action suit, *Plata v. Schwarzenegger*. Under the terms of the court's action, the receiver has broad powers of "administration, control, management, operation, and financing" over all aspects of the department's health care system, including the power to acquire and modernize information technology.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General's survey indicated that, although the department could have reduced its annual pharmaceutical expenditures by up to $26 million by implementing such management controls as those recommended in the four previous audits and studies, it had, in fact, made only minimal progress in implementing the recommendations.

As a result, despite a decrease in inmate population during the period covered by the Office of the Inspector General's survey, the department's pharmaceutical expenditures continued to grow dramatically. Between fiscal years 1999-2000 and 2002-03, the department's pharmaceutical expenditures increased 94 percent, from $63 million to $122.4 million, while inmate population declined two percent, from 162,000 to 159,000, and the national consumer price index for prescription drugs increased only 22 percent.[1] Similarly, between fiscal years 1996-97 and 1998-99, pharmaceutical expenditures increased from $24 million to $51 million — an annual growth rate of 28 percent — while the inmate population grew by about six percent and the cost of prescription drugs increased only 13 percent. The department's per-inmate pharmaceutical expenditures also increased, more than quadrupling from $142 in 1997 to $642 in 2002.

[1] At the time of the July 2003 survey, the department's pharmaceutical expenditures were projected to increase 111 percent between 1999-2000 and 2002-03.

The Office of the Inspector General issued seven recommendations to the department in its July 2003 survey addressing these and other findings.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Department of Corrections and Rehabilitation, through its Division of Correctional Health Care Services, has implemented the seven recommendations from the Office of the Inspector General's July 2003 survey of pharmaceutical expenses. To conduct the follow-up review, the Office of the Inspector General provided the department and the Division of Correctional Health Care Services with a table listing the July 2003 findings and recommendations and asked management to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the department's responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations. The results are presented in the tables following this narrative and reflect the department's responses as of September 2005, when the Office of the Inspector General completed its fieldwork.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the seven recommendations issued by the Office of the Inspector General in July 2003 concerning the department's pharmaceutical expenditures, one recommendation has been substantially implemented; two recommendations have been partially implemented; three recommendations have not been implemented; and one is no longer applicable.

The Department of Corrections and Rehabilitation reported it has developed a strategic plan that incorporates recommendations from private consulting, regulatory, and oversight agencies. The department also reported that it has revised its statewide procedures for medication administration and distribution; trained personnel on formulary rules; and organized management workgroups. The department rejected recommendations to contract with a private firm to manage pharmacy operations and centralize its pharmacy distribution system.

Although the department reported it has made progress in launching a project to replace its outdated and inefficient pharmacy management system with an automated health care management system, statewide implementation of that system has not been accomplished. The department reported, however, that it achieved a "cost avoidance" of $14.3 million between *projected* pharmaceutical expenditures for fiscal year 2003-04 ($144 million) and *actual* expenditures for that period. The department's actual pharmaceutical expenditures for fiscal year 2003-04 were $129.7 million — a $7.3 million (6 percent) increase over the previous year, compared to an 18 percent average increase experienced in the three preceding fiscal years. Yet, Bureau of Labor Statistics data show that between July 2003 and June 2004, pharmaceutical prices nationwide increased only 3.3 percent.

Until the department implements past recommendations in this area, it continues to waste millions of dollars annually in pharmaceutical expenditures. Because of these problems,

in March 2006, the U. S. District Court ordered a comprehensive financial and operational audit of the department's pharmaceutical services, to be conducted by a private specialty firm with expertise in correctional pharmaceutical operations. In addition, the U. S. District Court-appointed receiver scheduled to take over all aspects of the department's health care system on April 17, 2006, will have authority to acquire and modernize information technology.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following actions:

- **Continue the project to replace the outdated and inefficient Pharmacy Prescription Tracking System with the automated Health Care Management System and implement the new system statewide as soon as practicable.**

- **In light of the flexible options likely to be available under the February 2006 federal court order appointing a receiver over the department's medical health care delivery system, reconsider the option of contracting with a private pharmacy services management firm to implement the recommendations submitted in the reports and studies conducted since 2000.**

The following table summarizes the results of the follow-up review.

ORIGINAL OBSERVATION NUMBER 1

The Office of the Inspector General found that the Department of Corrections has failed to implement recommendations from four recent audits and studies at a cost of millions in potential pharmaceutical expenditure savings.

ORIGINAL OBSERVATION NUMBER 2

The Office of the Inspector General estimates that the Department of Corrections could reduce its annual pharmaceutical costs by at least 20 percent—saving upwards of $26 million a year—by implementing effective management controls such as those recommended in recent audits and studies.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections begin immediate implementation of the recommendations made by FOX Systems, Inc. To accomplish the implementation, the department was to select one of the following two options.		
Option 1 Direct the Health Care Services Division to begin implementing the FOX Systems, Inc. recommendations.	SUBSTANTIALLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that it has developed a strategic plan incorporating audit recommendations advocated by the Bureau of State Audits, the Senate Advisory Commission on Cost Control in State Government, FOX Systems Inc., and recent legislative mandates to improve pharmacy management. The department reported that it had completed the following FOX Systems, Inc. recommendations: • Appointed three pharmacy services managers.

		• Reorganized the Division of Correctional Health Care Services. • Revised and distributed the department's formulary. • Established pharmacy and therapeutics subcommittees. • Participates in the inter-agency Common Drug Formulary Committee and Pharmacy Advisory Board. • Secured a rebate for a high-cost atypical antipsychotic medication. • Implemented a tier structure for atypical antipsychotic medications. • Implemented a Hepatitis C Clinical Management Program. • Revised and distributed medication management and intra-system medication transfer policies. • Completed e-mail and Internet connectivity in all pharmacies. • Completed local area network and wide-area network connectivity in all institution administration buildings. • Acquired the Veterans Affairs Information System and Technology Architecture (VISTA) system from the U. S. Department of Veterans Affairs to improve pharmacy and clinical management operations. Designated as the Health Care Management System, it will be integrated with the Clinical Management System (a system developed by staff at the California Medical Facility) and the Parole Division's Transitional Case Management Program-Mentally Ill (TCMP-MI) to provide comprehensive pharmaceutical information management and ancillary functions. • Initiated implementation of the Health Care Management System by linking the Division of Correctional Health Care Services and all

		institutional pharmacies, including those at Division of Juvenile Justice facilities, through a central file server.
Reduce the fiscal year 2003-04 budget of the Health Care Services Division by an amount equal to 20 percent of its annual pharmaceutical expenses.	**NOT IMPLEMENTED**	The department reported that it did not reduce the Division of Correctional Health Care Services budget by an amount equal to 20 percent of its annual pharmaceutical expenses because the reduction could not be achieved without jeopardizing statutory- and court-mandated inmate health care services. The department reported, however, that it had completed several initiatives to accomplish the Office of the Inspector General's recommendation. According to the department, these achievements include over $14 million in "pharmaceutical cost avoidance" for fiscal year 2003-04. The department reported that its pharmaceutical expenditures exhibited significant cost avoidance between fiscal years 2002-03 and 2003-04. Total expenditures reportedly increased by only six percent, considerably less than both the 17.7 percent average increases over the three previous years and the industry standard increase of 12 percent. As a result, the department maintains that it has avoided over $14 million in pharmaceutical expenses by slowing the rate of increase from 17.7 percent to six percent. Moreover, despite court-mandated levels of patient care, a high concentration of such diseases as the hepatitis C virus, and mental illnesses that require expensive treatments, the department asserted that this cost avoidance trend will continue to be evidenced through the following managed care initiatives: monitoring, review, and quality management of the drug formulary; prescription protocols for high-volume/high-cost pharmaceuticals; utilization management reporting; health transfer processes; chronic care programs; and compliance auditing.
Reallocate a sufficient portion of the budgetary reduction to pay for specific information technology improvements.	**NOT IMPLEMENTED**	The department reported that its pharmacy program's budget was reduced by $8 million in fiscal year 2002-03 and by a subsequent $4.8 million in fiscal year 2003-2004 because of negative-impact budget change proposals directed at reducing pharmaceutical expenditures through more efficient prescription procedures. The department reported that it is currently requesting funding to implement the two-phase pilot of the Health Care Management System. The department acquired

		the program technology at no cost from the U.S. Department of Veteran's Affairs and will allocate the funding to staff time, system consultants, program adaptation, and hardware. The department reported that it is also requesting funding to complete statewide implementation of the Health Care Management System.
Provide appropriate support to the Health Care Services Division to expedite the required technology procurement.	**PARTIALLY IMPLEMENTED**	The department reported that it continues to pursue a modern information technology infrastructure for its pharmacy operations and that it is aggressively implementing the Health Care Management System — which combines integral elements of existing software applications obtained from the U.S. Department of Veteran's Affairs, the California Medical Facility, and the Parole and Community Services Division — to meet the department's needs in a cost-effective manner. The department reported that it had launched the Health Care Management System at the California Medical Facility and that it intends to complete statewide system implementation. The department also reported that, to meet pressing needs within the budgetary constraints, the Division of Correctional Health Care Services has proactively developed several interim data applications, completed e-mail and Internet connectivity for all institutional pharmacies, and linked all 33 institutions on a wide area network or local area network in May 2004. Although the interim data applications enable tracking, monitoring, and reporting of medication errors; of physician prescribing practices; and of targeted high-cost and high-risk drugs, the applications are presently dependent on data that emanates from the problematic Pharmacy Prescription Tracking System, which the new Health Care Management System is designed to replace. The department reported that it will achieve central file server connectivity between prison pharmacies and the Division of Correctional Health Care Services with implementation of the Health Care Management System.

Ensure that the Health Care Services Division establishes specific goals and objectives to implement the FOX Systems, Inc. recommendations, and that the Health Care Services Division management adequately monitors the implementation.	**PARTIALLY IMPLEMENTED**	The department reported that it has improved overall pharmacy management by using a matrix management structure to implement its strategic plan. The plan's purpose is to enhance operations through more effective and efficient pharmaceutical procurement and delivery. The department reported that it has used a systematic approach to achieve the following five goals: 1. Secure a fully integrated medication management information system. 2. Improve pharmacy operations by instituting centralized pharmacy management and maintaining a community standard. 3. Improve negotiated discounts for high-cost, high-volume pharmaceuticals. 4. Optimize prescribing targeted high-cost medications. 5. Reduce medication waste through improved distribution and inventory controls. The department reported that it has implemented several mechanisms to monitor overall initiative progress, including a project management matrix, management reports to track drug utilization, and contract and inventory management.
Option 2 (preferred) Contract with a private pharmacy services management firm to implement the FOX Systems, Inc. recommendations. The contractor would perform the following functions: • Assume management of the day-to-day operations of the Health Care Services Division pharmacy operations.	**NOT APPLICABLE**[2]	The department reported that it reviewed this option and determined that the most effective course of action was to permit the Division of Correctional Health Care Services to implement a managed care model, drug use controls, and a quality management structure to replicate the recommendations of FOX Systems, Inc.

[2] Because the Division of Correctional Health Care Services elected to implement Option 1, the Office of the Inspector General has listed this recommendation as "Not Applicable." As noted in the follow-up recommendations, however, the Office of the Inspector General recommends that the Division of Correctional Health Care Services reconsider implementing Option 2.

• Assume responsibility for promptly implementing the information technology improvements recommended by FOX Systems, Inc. • Begin the business process re-engineering activities recommended by FOX Systems, Inc.		According to the department, three Division of Correctional Health Care Services pharmacy services managers, supported by the quality management structure, control day-to-day pharmacy operations. A multidisciplinary Pharmacy Focus Improvement Team provides issue-targeted analysis and planning, concurrent with multidisciplinary and administrative review from the Pharmacy and Therapeutics Subcommittee. A parallel quality management structure exists at each correctional institution.
Regardless of the option chosen, the department should also change the pharmacy program structure from a decentralized system with pharmacies in each prison to a system with two or three regional pharmacies or one large central pharmacy, consistent with the model used in other states. That change would provide the following benefits: • Allow more efficient operations, using automated dispensing machines. • Reduce inventory shrinkage and spoilage. • Increase standardization of operations and prescribing practices. • Reduce the impact of staff turnover and vacancies in hard-to-recruit pharmacist positions located in	**NOT IMPLEMENTED**	The department reported that it had reviewed options that included mail-order pharmacy services and regional pharmacies serving several prisons. The department maintained that it had found these options impractical, given the remote locations of some institutions and the specific pharmacy service requirements set by the state Department of Health Services for licensed health care facilities within most corrections institutions. The department reported, however, that it was still reviewing other alternatives. The department reported that it has made progress through other methods and cited as an example its participation since April 2003 in activities of the Pharmaceutical Prime Vendor Technology Committee, a subcommittee of the California Pharmacy Advisory Board, through which it has worked with the Department of General Services to improve prime vendor contract specifications, mail-order prescription services, automated dispensing systems, and operations consolidation. The department reported that it installed an automated dispensing system in one of its prisons in October 2000 to increase efficiency and reduce waste. The department has determined that automated dispensing systems should be tailored to the needs of individual institutions and to permissible medication packaging for the inmate populations served. The department reported that it had implemented a second automated dispensing system in 2002 in another institution to evaluate the project's effectiveness.

remote geographic areas. • Reduce prescription errors.		The department reported that it had distributed a revised statewide pharmacy services policy and procedures for medication administration and distribution, prescribing practices, intra-system transfers, and inventory control in August 2003. The department reported that it had also developed a lesson plan and audit tool in May 2004 to train pharmacy staff in pharmacy operations. The department reported that it has developed formulary and drug use guidelines, forms, and protocols and has: Implemented an ongoing training program for the updated formulary and formulary compliance in April 2003. Provided policy training on videoconference pharmacy services to field medical staff in February 2004. Developed a lesson plan and audit tool to train pharmacy staff in pharmacy operations in May 2004. The department reported that, in November 2003, it had implemented the Hepatitis C Clinical Management Program, which standardizes hepatitis C virus (HCV) medication management through a court-approved protocol to ensure effective and efficient application of costly HCV drug therapies. By using a scientifically based, data-driven approach to identify those individuals likely to benefit from testing and treatment, the department maintains that it has reduced the margin for unnecessary and potentially dangerous therapies, while at the same time providing quality care where such testing and treatment are appropriate. The department reported that it initiated a pharmacist recruitment mailer program in February 2003, prepared a salary adjustment package for the appropriate control agencies in February 2004, and continues to actively recruit to fill full-time pharmacy positions.

		The department reported that it began implementation of its Department of Health Services-approved medication error reduction plan on July 17, 2003 to comply with California Health and Safety Code section 1339.63, which mandates medication error reduction plans at general acute care hospitals. The plan includes processes for collecting and reviewing data on medication errors and corrective actions to eliminate or substantially reduce medication errors. In addition, the department has reported implementation of the new clinical management software at the California Medical Facility. This Clinical Management System enables physicians to write orders on-line, monitors appropriate dosage rates, and averts duplicate therapies and potential drug reactions—resulting in more efficient patient care and fewer prescription errors. It will eventually be used by correctional institutions statewide.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following actions:

- **Continue the project to replace the outdated and inefficient Pharmacy Prescription Tracking System with the automated Health Care Management System and implement the new system statewide as soon as practicable.**

- **In light of the flexible options likely to be available under the February 2006 federal court order appointing a receiver over the department's medical health care delivery system, reconsider the option of contracting with a private pharmacy services management firm to implement the recommendations submitted in the reports and studies conducted since 2000.**

OFFICE OF INVESTIGATIVE SERVICES

IMPLEMENTATION REPORT CARD

Previous recommendations: 37

Fully implemented: 19 (52%)

Substantially implemented: 2 (5%)

Partially implemented: 8 (22%)

Not implemented: 6 (16%)

Not applicable: 2 (5%)

The Department of Corrections and Rehabilitation has reorganized and significantly improved its internal affairs operation since an October 2001 special review. The Office of Investigative Services—renamed the Office of Internal Affairs[1]—is now responsible for all of the department's internal affairs investigative functions. Many of the Office of the Inspector General's previous recommendations were implemented in the course of the reorganization and as a result of a federal court-ordered remedial plan. Other recommendations are no longer applicable in the wake of these changes. Yet, several deficiencies identified in the Office of the Inspector General's 2001 review remain. These include a lack of a system for prioritizing investigations; inadequate management of overtime use; inadequacies in completing background investigations of employees and borrowed investigators; inadequate control over access to the case management information system; deficiencies in evidence handling; and failure to use the department's internal audits function to help identify pervasive problems.

In October 2001 the Office of the Inspector General issued a special review of the management practices and administrative operations of the Office of Investigative Services. At the time of the special review, the Office of Investigative Services was responsible for investigating allegations of serious employee misconduct only within the Department of Corrections. Since renamed the Office of Internal Affairs, the office is now responsible for conducting employee misconduct investigations for all entities within the new Department of Corrections and Rehabilitation. The October 2001 review, which centered on the effectiveness of the office, compliance with required procedures, and the quality of operational practices, identified numerous deficiencies that impaired the ability of the Office of Investigative Services to meet its responsibilities. In particular, the review found that a rapidly expanding caseload and deficient management practices prevented the Office of Investigative Services from completing investigations within required time limits. That deficiency limited the ability of the department to take appropriate administrative action when misconduct allegations were sustained. The Office of the Inspector General noted that some of the issues raised in the review were beyond the control of the Office of Investigative Services and required action by the Department of Corrections management.

[1] Depending on the context and time-frame discussed, both names — Office of Investigative Services and Office of Internal Affairs — are used in this report.

BACKGROUND

The Office of Investigative Services was established in July 1997 by the California Department of Corrections for the purpose of investigating allegations of serious employee misconduct within the department. Until that time, local hiring authorities — prisons and parole regions — conducted most internal investigations. That arrangement raised questions from the Legislature and the public about the appropriateness of hiring authorities investigating their own employees. The Office of Investigative Services was therefore created to fulfill the following responsibilities:

- Perform fair and impartial investigations;
- Ensure the consistent application of policies and procedures throughout the Department of Corrections;
- Provide highly trained staff with specialized skills to perform administrative and criminal investigations, particularly those related to incidents involving the use of force, officer-involved shootings, and sexual assaults; and
- Provide oversight for investigations of less serious misconduct performed by the institutions.

With the July 2005 reorganization of the former Youth and Adult Correctional Agency into the newly created Department of Corrections and Rehabilitation, the Office of Investigative Services was renamed the Office of Internal Affairs and assigned responsibility for internal affairs investigative functions for all organizations inside the new department. Additional organizational and operational changes have resulted in the implementation of some of the Office of the Inspector General's October 2001 recommendations, or have altered operations so significantly that other recommendations are no longer applicable. The department has made additional changes under a remedial plan developed to address deficiencies in the employee disciplinary process identified by a U. S. District Court special master in connection with the *Madrid v. Schwarzenegger* case. The Madrid Remedial Plan presently forms the basis for significant changes affecting employee discipline in the 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 October 2001 special review:

- The Office of Investigative Services could not effectively manage its caseload with its existing staffing levels without significant changes to its management practices.
- The management information system for the Office of Investigative Services was inaccurate and unreliable and did not contain information needed for the agency to effectively manage its resources and caseload.

- The Office of Investigative Services lacked adequate controls to prevent overtime abuse.

- Background checks of Office of Investigative Services agents were inadequate because of a departmentally imposed 11-hour limit on conducting background investigations.

- The Office of Investigative Services did not conduct background checks of staff borrowed to conduct internal affairs investigations.

- The Office of Investigative Services did not have a formalized plan for training special agents.

- The Office of Investigative Services case tracking system did not have adequate controls to prevent unauthorized access.

- The Office of Investigative Services investigations lacked sufficient documentation to show that investigations were conducted in accordance with established guidelines.

- The Office of Investigative Services did not have procedures to ensure that the regional offices processed Category II case rejections consistently and properly.

- The Office of Investigative Services was not adequately fulfilling its responsibility for overseeing Category I investigations.

- Procedures used by the Office of Investigative Services for handling evidence did not comply with regulatory requirements or the agency's own guidelines.

- The Office of Investigative Services was not in compliance with prescribed armory policies and procedures.

The Office of the Inspector General presented 37 recommendations to remedy the deficiencies identified in the October 2001 special review.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Office of Internal Affairs has implemented the 37 recommendations from the Office of the Inspector General's October 2001 special review. To conduct the follow-up review, the Office of the Inspector General provided the Office of Internal Affairs with a table listing the October 2001 findings and recommendations and requested the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the Office of Internal Affairs, and evaluated the degree of compliance or noncompliance with the recommendations. Fieldwork for the follow-up review concluded in March 2006. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 37 recommendations issued by the Office of the Inspector General in October 2001, 19 recommendations have been fully implemented; two have been substantially implemented; eight have been partially implemented; six have not been implemented; and two recommendations are no longer applicable.

The Office of the Inspector General found that the Office of Internal Affairs has significantly improved its investigative process. No longer are requests for investigations considered at each regional office; instead, nearly all requests are forwarded to a central intake panel for review. Before creation of the central intake panel, each of the Office of Internal Affairs regions decided which cases were accepted and which were rejected. Establishment of the central intake panel brings consistency to the decision. In another improvement, the investigative classification system, which formerly designated minor offenses as Category I investigations and allegations of serious offenses as Category II investigations, has been eliminated. Instead, cases involving minor supervisory issues requiring no additional investigation are addressed directly by the hiring authorities, while those that require investigation are conducted or closely supervised by the Office of Internal Affairs. In addition, the former case management information system has been replaced by a new system that provides not only for the tracking and monitoring of active cases, but also for tracking the entire employee discipline continuum from the request for investigation to the final hearing and disposition of action. The system is being installed at California Department of Corrections and Rehabilitation investigative offices, legal offices, and hiring authorities throughout the state.

Despite these important improvements, several deficiencies identified in the Office of the Inspector General's October 2001 special review remain. The deficiencies include the lack of a system for prioritizing investigations, inadequate management of overtime use; inadequacies in completing employee background investigations and background investigations of borrowed investigators; inadequate control over access to the case management information system; inadequate documentation of supervisory review of investigations; failure to ensure that case rejection letters are issued in a timely manner; deficiencies in policies and procedures for the handling of evidence; physical deficiencies in the evidence room; and failure to use the department's internal audits function to assist in identifying systemic and pervasive problems and in focusing resources accordingly.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Office of Internal Affairs take the following additional actions:

- **Develop policies and procedures for prioritizing investigative cases.**

- **Assign each region a monthly allocation of budgeted overtime and prepare a monthly log for each regional office that begins with monthly allotted hours and is adjusted for each usage. When overtime**

is granted, the supervisor should immediately e-mail the agent and the overtime timekeeper for the purpose of adjusting monthly balances and providing evidence of previous overtime approval. In order to provide regional supervisors flexibility in managing cases, the Office of Internal Affairs should consider rolling over unused office balances from one month to the next.

- **Reevaluate whether the proposed budget increase to 40 hours per background investigation for potential employees of the Office of Internal Affairs is justified, given that investigators are obtaining 75 percent of the required information using only 11 hours per investigation.**

- **Ensure that background investigation files contain evidence that potential employees of the Office of Internal Affairs have not been the subject of past or pending adverse actions, as mandated by California Penal Code sections 6065(b)(1) and 6126.2.**

- **Refrain from using investigative services unit investigators until their supplemental background investigations are complete.**

- **Formalize the process for verifying that case management information system access is limited to only authorized users. The process should define the frequency of reviews, require a reconciliation of beginning and ending authorized users for the period, and specify the date when users are added or deleted. Included in this process should be a requirement that an exit document be prepared by the departing staff's supervisor that instructs the information technology staff to remove the user's access.**

- **Prepare a supervisory quality control review sheet that ensures that the investigative package is complete, the investigative plan was followed, all key witnesses were interviewed, required notices were performed, and the final report represents a clear, fair, and unbiased representation of the facts.**

- **Establish procedures to ensure that case rejection letters are issued within the prescribed 10-day time-frame.**

- **Use the Department of Corrections and Rehabilitation internal audit staff to perform field audits to identify trends in complaints against staff so that resources can be focused on the most pervasive problems.**

- **Install a dedicated alarm system for the southern regional office evidence room.**

The Office of the Inspector General also recommends that the California Department of Corrections and Rehabilitation standardize evidence policy and procedures throughout the department and include the standards in the Office of Internal Affairs' Investigation Policy and Procedures Manual, and train staff to ensure that the policies and procedures are properly implemented and followed.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the Office of Investigative Services could not effectively manage its caseload with its existing staffing levels without significant changes in its management practices.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order for the agency/department to take appropriate administrative action when allegations are sustained and effectively fulfill its responsibilities, the Office of the Inspector General recommended that the California Department of Corrections and the Office of Investigative Services take the actions listed below.		
Address the present inability of the Office of Investigative Services to fulfill its responsibilities. As part of this effort, reassess the mission and responsibilities of the Office of Investigative Services and, from that reassessment, allocate sufficient resources to the Office of Investigative Services to allow it to meet its mandate.	FULLY IMPLEMENTED	The Office of Internal Affairs reported that it has undergone several changes in leadership since the October 2001 special review and that the employee disciplinary process has been the focus of legislative hearings, audits by external parties, recommendations by the California Independent Review Panel, and scrutiny by the U. S. District Court special master. To respond to the deficiencies reported by these entities, the department was required by the federal court to develop a corrective action plan, known as the "Madrid Remedial Plan" to rectify problems in the department's disciplinary continuum – including the investigative process. The Office of the Inspector General's recommendation to reassess the mission and responsibilities of the Office of Internal Affairs is incorporated in the Madrid Remedial Plan. Many of the Madrid Remedial Plan objectives provide for the reassessment of the roles and responsibilities of the Office of Internal Affairs and for specific processes by which to meet those objectives. To fulfill its revised mission, the Office of Internal Affairs hired seven additional special agents, two information technology employees, and two office technicians. It also reported that a budget change proposal was submitted for fiscal year 2006-07 to align staffing levels with proposed structural and functional changes resulting from the California Department of Corrections and Rehabilitation's reorganization plan and consolidation of investigative functions.

		The Office of the Inspector General reviewed the remedial plan and concluded that the department has initiated a significant reassessment of the Office of Internal Affairs.
Review the Office of Investigative Services' organizational structure and administrative processes to ensure standardization in the operation of the regional offices. As a part of the process, develop a formalized system for prioritizing cases.	**SUBSTANTIALLY IMPLEMENTED**	The Office of Internal Affairs reported that it has established a central intake process that alleviates the former disparities among accepted and rejected cases when the regional offices acted autonomously in vetting investigation requests. The new system also ensures consistency in the type and severity of allegations accepted for investigation and ensures the sufficiency of the evidence used to determine whether or not to proceed. The Office of Internal Affairs also reported that its new case management system promotes case prioritization by including a classification field that identifies a case as "high" or "normal" priority. The case management system also allows case activity to be monitored by Office of Internal Affairs administrators in headquarters and identifies specific categories of cases for monitoring. Implementation of the new case management system also contributes to the standardization of operations throughout the regional offices. The Office of the Inspector General noted that while the new case management system allows for case prioritization, and the central intake process has improved the organizational structure, the Office of Internal Affairs has not developed policies and procedures to provide for consistency in the prioritization process.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Office of Internal Affairs develop policies and procedures for prioritizing investigative cases.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the management information system of the Office of Investigative Services was inaccurate and unreliable and did not contain the information needed for the agency to effectively manage its resources and caseload.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
In order to ensure that the system fully meets management information needs and department requirements, the Office of the Inspector General recommended that the Office of Investigative Services, in concert with the Information Systems Division, review and modify the case-tracking system. The recommendation specified that if system modification was not feasible, the Office of Investigative Services should replace the system.	FULLY IMPLEMENTED	The Office of Internal Affairs reported and the Office of the Inspector General verified that, as of July 2004, the Office of Internal Affairs had implemented a new case management system in each of its regional offices, headquarters, and various institutions. Implementation of the case management system will provide needed information for all stakeholders in the employee disciplinary process to facilitate tracking of cases from start to finish.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that the Office of Investigative Services lacked adequate controls to prevent overtime abuse.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
In order to prevent overtime abuse, the Office of the Inspector General recommended that the Office of Investigative Services implement appropriate control measures governing overtime payments. The process should require prior authorization of overtime, supervisor approval before payment, and management oversight through review of payment trends and patterns. Management should also investigate discrepancies and take appropriate action to rectify problems.	PARTIALLY IMPLEMENTED	According to the Office of Internal Affairs, overtime is approved by supervisors in the regional offices. The Office of the Inspector General confirmed that these approvals are largely in place, but the approvals are granted and documented after the overtime is incurred. The Office of the Inspector General also observed a variety of processes for authorizing overtime at the various regional offices. For example, one regional office used standard state overtime authorization forms and maintained the highest level of compliance of all regions — 43 percent. Another regional office, where none of the overtime hours met the "prior authorization standard," used the employee timesheet for overtime authorization. Oversight monitoring at regional offices also varied. One regional office

		prepared a monthly tracking schedule that allocated 100 hours of overtime for the entire office, with the 100 hours based upon earlier budget-based overtime estimates. The tracking log was adjusted for overtime incurred and provided a method for monitoring overtime on a daily basis. No other regional office used such a tool. In lieu of individual regional offices reporting monthly overtime, the budget officer monitors monthly overtime reports prepared by the California Department of Corrections and Rehabilitation personnel office. Any unusual trends or usages are reported to Office of Internal Affairs management. This provides for centralized oversight of overtime usage.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Office of Internal Affairs assign each region a monthly allocation of budgeted overtime and prepare a monthly log for each regional office that begins with monthly allotted hours and is adjusted for each usage. When overtime is granted, the supervisor should immediately e-mail the agent and the overtime timekeeper for the purpose of adjusting monthly balances and providing evidence of previous overtime approval. In order to provide regional supervisors flexibility in managing cases, the Office of Internal Affairs should consider rolling over unused office balances from one month to the next.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that background checks of Office of Investigative Services agents were inadequate because of a departmentally imposed 11-hour limit on conducting background investigations.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to improve the quality of the background checks, the Office of the Inspector General recommended that the California Department of Corrections take the actions listed below.		

Remove the 11-hour limit on performing background investigations.	**NOT IMPLEMENTED**	According to the Office of Internal Affairs, the Department of Corrections and Rehabilitation is considering preparing a budget change proposal to increase the background investigation time-frame to 40 hours for all peace officer staff; but no increase in the allotted time for background checks has been implemented. The Office of the Inspector General's testing of background investigations concluded that 75 percent of the required investigation elements were fulfilled within the 11-hour budget. Consequently, the Office of Internal Affairs should be able to conduct complete and thorough background investigations with budgets of between 11 and 40 hours per candidate.
Require background investigations to be conducted in accordance with Commission on Peace Officer Standards and Training guidelines.	**SUBSTANTIALLY IMPLEMENTED**	The Office of Internal Affairs reported that to the extent possible within the 11 hour limit, the background investigations are conducted in accordance with the guidelines set by the Commission on Peace Officer Standards and Training. If funding for this activity is provided in the future, the department will be able to spend 40 hours for each background investigation, increasing compliance with the guidelines. The Office of the Inspector General reviewed the six most recent background investigations for Office of Internal Affairs hires and found deficiencies similar to those reported in the 2001 special review. The investigations reviewed still failed to include credit checks and face-to-face contacts with personal references, neighbors, or landlords. Despite those deficiencies, however, two background investigations contained 95 percent of the investigative elements required by the Commission on Peace Officer Standards and Training guidelines. The six background investigations collectively contained 75 percent of the applicable elements from the Commission on Peace Officer Standards and Training guidelines. Improvements were noted in preparation of background reports and evidence of medical and psychological examinations.

Require background investigation files to contain evidence to verify that candidates have not been the subject of past or pending serious adverse actions as mandated by California Penal Code sections 6065(b)(1) and 6126.2.	**PARTIALLY IMPLEMENTED**	Review by the Office of the Inspector General of hiring packages for six recent special agent hires determined that four files did not contain evidence of testing for compliance with California Penal Code section 6126.2 and that three files lacked evidence of testing for compliance with California Penal Code section 6065(a)(1). California Penal Code section 6126.2 prohibits the hiring of any internal affairs investigator candidate who is indirectly or directly involved in an open internal affairs investigation, and California Penal Code section 6065 (a) (1) prohibits the hiring of an internal affairs investigator candidate who has ever had allegations sustained pertaining to a serious disciplinary action.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Office of Internal Affairs take the following additional actions:

- **Reevaluate whether the proposed budget increase to 40 hours per background investigation for potential employees of the Office of Internal Affairs is justified, given that investigators are obtaining 75 percent of the required information using only 11 hours per investigation.**

- **Ensure that background investigation files contain evidence that potential employees of the Office of Internal Affairs have not been the subject of past or pending adverse actions, as mandated by California Penal Code sections 6065(b)(1) and 6126.2.**

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that the Office of Investigative Services did not conduct background checks of staff borrowed to conduct internal affairs investigations.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
To comply with statutory requirements and improve the integrity of investigations, the Office of the Inspector General recommended that the California Department of Corrections conduct background checks on employees borrowed to conduct internal affairs investigations. The recommendation noted that because of the time and cost associated with background investigations, the Office of Investigative Services could identify a pool of employees borrowed for internal affairs investigations and perform background checks for those employees.	NOT IMPLEMENTED	In July 2005, the Office of Internal Affairs reported that the recommendation is no longer applicable because it no longer uses borrowed staff to perform internal affairs investigations. The Office of the Inspector General determined, however, that in September 2005, the Office of Internal Affairs began delegating case assignments to prison investigative services units. Of 10 investigative services unit investigators reviewed by the Office of the Inspector General, none had had a supplemental background investigation completed, although nine were reportedly in the process of receiving such an investigation.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Office of Internal Affairs refrain from using investigative services unit investigators until their supplemental background investigations are complete.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that the Office of Investigative Services did not have a formalized plan for training special agents or sufficient means to monitor and track the training progress of special agents to ensure compliance with prescribed training policies.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to improve the training program for Office of Investigative Services special agents and ensure compliance with prescribed training policies, the Office of the Inspector General recommended that the California Department of Corrections and the Office of Investigative Services take the actions listed below.		

Allow the Office of Investigative Services to develop and manage its own training budget.	**FULLY IMPLEMENTED**	According to the California Department of Corrections and Rehabilitation, the Office of Internal Affairs now has its own training budget. The Budget Management Branch reported that the training budget for the Office of Internal Affairs in fiscal year 2005-06 totaled $84,573. The Office of the Inspector General confirmed that the Office of Internal Affairs now maintains it own training budget.
Allow Office of Investigative Services staff members to comply with the 40-hour training requirement on a calendar year or fiscal year basis instead of basing compliance on each staff member's performance appraisal period.	**NOT APPLICABLE**	The Office of Internal Affairs reported that although it may seem easier to track employee training on a calendar year basis, the *California Department of Corrections and Rehabilitation Operations Manual* requires that training plans be created and updated during an employee's annual appraisal period, which coincides with the employee's birthday. The Office of Internal Affairs reported that further discussion is planned to determine whether the policy should be changed or an exception provided for Office of Internal Affairs employees. Upon further review, the Office of the Inspector General concluded that the training review cycle based on the employee's birth date is adequate.
Establish minimum training requirements for each job classification to ensure that employees possess the minimum skills needed to perform assigned duties and to ensure comparability in the proficiency of staff members among various offices.	**FULLY IMPLEMENTED**	The Office of Internal Affairs issued a memorandum in November 2001 that outlines the recommended training requirements for sworn and non-sworn staff and prescribes the frequencies with which courses must be repeated. The Office of Internal Affairs management also developed a training program in accordance with the Madrid Remedial Plan. The Office of the Inspector General reviewed the draft training plan submitted to the federal court in October 2005 and noted that it provides detailed training requirements by classification, time-frames for completion of training, and an organizational structure to monitor and direct training requirements.
Prepare an annual training plan that identifies and summarizes training needs by employee, office, and topical area.	**FULLY IMPLEMENTED**	As part of the Madrid Remedial Plan, the Office of Internal Affairs has completed a training assessment to align its training with the "industry standard." The training plan was completed and submitted to the federal court in October 2005.
Establish a separate training database for Office of Investigative Services staff members	**FULLY IMPLEMENTED**	According to the Office of Internal Affairs, each regional office implemented a staff training database in January 2002. The Office of the Inspector General

and maintain the training database at the Office of Investigative Services headquarters.		confirmed that each regional office maintains a training database and that these databases can be merged at Office of Internal Affairs headquarters as needed. In accordance with the proposed training plan, the Office of Internal Affairs will select a training advisory committee, a training manager, and regional training coordinators. The regional coordinators maintain training records and are responsible for ensuring that training mandates are fulfilled at the local level. Each year regional coordinators will prepare a training needs assessment for development of the annual training plan.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that the internal affairs case tracking system did not have adequate controls to prevent unauthorized access.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to reduce the inherent risk associated with unauthorized access and improve controls over access to the internal affairs case tracking system, the Office of the Inspector General recommended that the California Department of Corrections and the Office of Investigative Services take the actions listed below.		
Purge log-on identifications for employees no longer working for the Office of Investigative Services or not otherwise required to have access to the office network and systems. Once the system is purged of unauthorized log-on identifications, the office should formalize a process for purging log-on identifications as	PARTIALLY IMPLEMENTED	According to the Office of Internal Affairs, log-on identifications were purged in response to the Office of the Inspector General's report. The Office of Internal Affairs also reported that when employees leave the Office of Internal Affairs, their network accounts are deleted. Yet the Office of Internal Affairs does not have a formalized process for the elimination of unauthorized users. In particular, there is no checkout process to eliminate system user identifications when an employee departs the Office of Internal Affairs. Instead the network

part of the standard separation process when employees leave.		administrators access the user list as part of their daily activities, and in so doing, according to the Office of Internal Affairs, would recognize the name of an unauthorized user. The process assumes that the system administrator is immediately aware of any employees, including regional staff, who leave Office of Internal Affairs. It was the failure to remove former staff members from user lists that resulted in the initial finding and recommendation. Because the process is not formalized, the potential for failures continues.
Require the Office of Investigative Services system administrator to meet monthly or quarterly with the network manager from the Information Services Division to reconcile the list of authorized users maintained by the Information Services Division to the list of authorized users maintained by the Office of Investigative Services.	**PARTIALLY IMPLEMENTED**	While the case information system has changed since the 2001 recommendation, the need for reconciliation of authorized users still exists. The Office of Internal Affairs reported in July 2004 that the system administrator was working with the network management team for the Information Systems Division to develop a quarterly reconciliation process for all authorized users. The first reconciliation was anticipated to be complete by September 30, 2004. The Office of Internal Affairs reported, however, that the Information Services Division had not prepared a listing of authorized users by July 2004 and that, consequently, the Office of Internal Affairs had not completed a user reconciliation. In January 2006, the Office of Internal Affairs claimed that audits of users accessing their domain, servers, and computers were conducted several times a month. A log of monthly reconciliations provided by the Office of Internal Affairs dated back to September 2005. The Office of the Inspector General learned, however, that staff from the Department of Corrections and Rehabilitation's Information Services Division monitors user accounts that have no activity and coordinate with the Office of Internal Affairs only when unusual activity is observed. In summary, the Office of Internal Affairs took no action to implement the Office of the Inspector General's recommendation to conduct access reconciliations until four years had passed. Furthermore, the Office of Internal Affairs still has no formal policy specifying frequency, procedures, or reporting to keep unauthorized users from accessing confidential information assets.
Require separate passwords for the network and the case tracking system.	**FULLY IMPLEMENTED**	Since the October 2001 special review, the Office of Internal Affairs has undergone numerous changes and revisions to its case management systems and

		in security measures to protect information assets. Initially the Office of Internal Affairs disagreed with the recommendation, stating that Microsoft did not recommend dual passwords (one for the network and another for the case management system) for its Windows authentication software. As technology, computer security software and the complexity of the case management system evolved, however, the Office of Internal Affairs chose to abandon Microsoft Windows authentication software for SQL authentication software. With the deployment of SQL authentication software, the dual password format is now in place.
Establish expiration dates for both network and case tracking system passwords.	FULLY IMPLEMENTED	According to the Office of Internal Affairs, its network now requires staff to change computer passwords on a quarterly basis.
Retain at least a 30-day history of user access to the system.	FULLY IMPLEMENTED	With the implementation of the new case management system, the Office of Investigative Service now has the capability of permanently tracking and archiving all users who access the system.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Office of Internal Affairs formalize the process for verifying that case management information system access is limited to only authorized users. The process should define the frequency of reviews, require a reconciliation of beginning and ending authorized users for the period, and specify the date when users are added or deleted. Included in this process should be a requirement that an exit document be prepared by the departing staff's supervisor that instructs the information technology staff to remove the user's access.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that a significant number of investigation files lack sufficient documentation to show that the investigation was conducted in accordance with established guidelines.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
In order to ensure uniformity in the maintenance and documentation of	PARTIALLY IMPLEMENTED	The Office of Internal Affairs reported it did not conclude that a checklist is the best method to ensure that investigations are conducted in accordance with

investigative case files, the Office of the Inspector General recommended that the Office of Investigative Services establish a managerial review checklist. The recommendation specified that the checklist should be signed and dated by the senior special agent responsible for reviewing the case files.		established guidelines and instead will develop a policy and procedure manual and an investigator's manual and review adherence to these standard practices. The Office of the Inspector General disagrees with that position. While a policy and procedure manual and supervisory review are important, a methodical and carefully prepared quality control guide for case file reviews would provide a helpful tool for the reviewer, thus ensuring a level of consistency among all investigation files. Further, a checklist would create a record that the case file was reviewed for key attributes required by the policy and procedure manual. A review by the Office of the Inspector General of case files in the Office of Internal Affairs southern region office determined that a checklist is being used in that office. The checklist delineates standard investigative documents with a date completed and a line for agent initials.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Office of Internal Affairs prepare a supervisory quality control review sheet that ensures that the investigative package is complete, the investigative plan was followed, all witnesses were interviewed, required notices were performed, and the final report represents a clear, fair, and unbiased representation of the facts.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that the Office of Investigative Services did not have procedures in place to ensure that the regional offices process Category II case rejections consistently and properly.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to ensure consistency in accepting and rejecting Category II cases and to improve the processing of Category II investigation requests, the Office of the Inspector General recommended that the California Department of Corrections and the Office of Investigative		

Services take the actions listed below.		
Amend the *California Department of Corrections Operations Manual* to provide for centralized review and acceptance or rejection of investigation requests.	**FULLY IMPLEMENTED**	The Department of Corrections and Rehabilitation has instituted a central intake process in which all requests for investigations are directed to the Office of Internal Affairs headquarters and presented before a panel of agents, attorneys, management representatives, and the Office of the Inspector General's Bureau of Independent Review.
Adopt a policy and procedures for assigning priority for case acceptance or rejection.	**PARTIALLY IMPLEMENTED**	The new case management system does provide for identifying cases as "normal" or "high" priority once the case is accepted by central intake. The criteria for determining priority include whether a subject is on administrative time off, the subject is high profile, or the statute completion time-frame is short. The case management system allows monitoring of high priority cases through specialized management reports. The Office of the Inspector General notes, however, that while the Office of Internal Affairs has developed a case management system that allows for prioritizing cases, it has not developed policies and procedures to provide for consistency in the prioritization process.
Provide refresher training for special agents in-charge and senior special agents on the definitions of Category I and Category II misconduct.	**NOT APPLICABLE**	The Office of Internal Affairs has eliminated the Category I and Category II case distinctions. Consequently, the recommendation no longer is relevant. All requests for investigations are handled through the central intake process, which provides a thorough assessment of the allegations and specific violations of policy or law. Because the process eliminated the subjectivity of Category I and II determination, the need for definition training is no longer applicable.
Establish procedures to ensure that case rejection letters are issued within the prescribed 10-day timeframe.	**NOT IMPLEMENTED**	According to the Office of Internal Affair, no procedures have been implemented that would ensure compliance with the California *Department of Corrections and Rehabilitation Operations Manual* required 10-day time-frame. Rather, the Office of Internal Affairs will consider adding audit procedures to periodically monitor compliance. The Office of the Inspector General conducted a test of the turn-around time-frames for 36 rejection letter and found that 47 percent of the responses did not meet the 10-day criterion. The late rejection letters averaged 19 days between receipt and response.

Implement a review process providing for independent review of the rejection letters to ensure that the letters adequately explain why the case was rejected.	FULLY IMPLEMENTED	The Office of the Inspector General reviewed nine rejection memoranda and found they were thorough in presenting specific details about the reasons the case was rejected. Rejection letters are now prepared by the central intake unit — a change that contributes to a more consistent level of detail in the rejection letters.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Office of Internal Affairs establish procedures to ensure that case rejection letters are issued within the prescribed 10-day time-frame.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that the Office of Investigative Services was not adequately fulfilling its responsibility for overseeing Category I investigations.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to effectively oversee Category I investigations, the Office of the Inspector General recommended that the Office of Investigative Services take the actions listed below.		
Perform an analysis of the workload and resources necessary to implement an effective tracking system, perform data analysis, and conduct audits of the Category I investigations. The office should also develop a work plan to identify the initial objectives and timelines for implementing a legitimate oversight process.	FULLY IMPLEMENTED	The Office of Internal Affairs no longer classifies investigations as Category I and Category II. All requests for investigations are reviewed by a panel in the central intake unit at the Office of Internal Affairs headquarters. Accepted requests are assigned to an Office of Internal Affairs regional office. As with the former Category I cases, the regional office can assign investigations to an Office of Internal Affairs special agent or delegate them to an institution's investigative services unit. Cases assigned to the institution's investigative services unit are supervised by a senior special agent at the Office of Internal Affairs and are monitored on the new case management system.

		The case management system also provides a periodic case aging report that allows the senior special agent to monitor the age of a case. This feature prevents cases from exceeding statutory completion time-frames without sufficient warning to management.
If additional resources cannot be obtained, the Office of Investigative Services should use the information developed to determine the best way to provide at least minimal oversight of Category I investigations using existing resources. Potential improvements include the following:	**FULLY IMPLEMENTED**	The Office of Internal Affairs has obtained additional manpower and electronic data processing resources. The new case management system is a database system that provides a single source for monitoring requests for investigations, investigations, and employee disciplinary actions. The system incorporates hiring authorities, employee relations officers, institutional investigative services units, the Office of Internal Affairs, legal affairs staff, and the Office of the Inspector General's Bureau of Independent Review.
Develop an improved management information system to track and monitor investigations and identify trends so as to focus resources on the most pervasive problems.	**FULLY IMPLEMENTED**	The case management system classifies approximately 43 different types of offenses for the purpose of stratifying and trending allegations. The system can sort by allegation, providing such information as the case region, institution, subject, statutory completion date, and case conclusion. As of February 2006, all requests for investigation and all direct employee actions for the California Department of Corrections and Rehabilitation are reviewed by the central intake panel. These requests are posted into the case management system, which provides a mechanism for monitoring the decisions to investigate allegations or to proceed with direct corrective or adverse actions. All hiring authorities post their activities to the case management system, which allows for proper monitoring of employee actions imposed.
Centralize the oversight function and redirect staff to perform oversight.	**FULLY IMPLEMENTED**	According to the Office of Internal Affairs, the case management system will be expanded to all California Department of Corrections and Rehabilitation hiring authorities to provide proper monitoring of investigations and employee disciplinary processes.
Perform reviews on a sample basis. Perform both desk reviews and field reviews.	**FULLY IMPLEMENTED**	The Office of Internal Affairs reported that it established an administrative support unit to help monitor and track investigations and identify trends. The administrative support unit will also develop a self-audit process and perform reviews.
Use Department of Corrections internal audit	**NOT**	The Office of Internal Affairs reported that it will consider using the

staff to perform field audits.	IMPLEMENTED	department's internal audit staff in conjunction with the reorganization proposed by the Corrections Independent Review Panel to evaluate the merits of this recommendation.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Office of Internal Affairs Use the Department of Corrections and Rehabilitation internal audit staff to perform field audits to identify trends in complaints against staff so that resources can be focused on the most pervasive problems.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that the procedures used by the Office of Investigative Services for handling evidence did not comply with regulatory requirements or the agency's own guidelines.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to ensure compliance with regulatory and agency requirements, the Office of the Inspector General recommended that the Office of Investigative Services, at a minimum take the actions listed below.		
Provide training to all staff on general evidence-handling policies and procedures.	NOT IMPLEMENTED	In response to this recommendation, the Office of Internal Affairs reported that the evidence handling problem identified by the Office of the Inspector General was isolated at one regional office and was rectified immediately. The Office of Internal Affairs also reported that as part of the Madrid Remedial Plan, it would rewrite the Policy and Procedures Manual and Investigator's Guide (tasks 2.5.2 and 2.5.3), which will also clarify evidence handling policies and procedures. A review by the Office of the Inspector General of the original policy and procedures manual, however, failed to identify any reference to evidence handling. Furthermore, the proposed training plan drafted for the U. S. District Court failed to cite any courses specifically addressing evidence handling. A

		review of numerous staff in-service training reports from all regional offices revealed that 24 special agents at one regional office received preservation of evidence training consisting of a 30-minute in-house training session.
Provide specialized training for evidence custodians and alternates.	**NOT IMPLEMENTED**	The Office of the Inspector General reviewed the training records of the evidence officers for the office referred to in the Office of Internal Affairs' response, the southern regional office. While these special agents participated in training for some general investigation topics, the Office of the Inspector General could not locate training records that satisfy the recommendation for specialized training for evidence custodians and alternates. Furthermore, documents show that repeated requests for formal evidence handling training dating back to 1999 have been denied.
Make physical modifications, as necessary, to the regional evidence rooms to ensure that they meet all requirements.	**PARTIALLY IMPLEMENTED**	The Office of Internal Affairs stated that the evidence handling procedures were isolated to one regional office and were rectified. The Office of the Inspector General confirmed that, while some minor physical modifications were made, the southern regional office has not installed an alarm system dedicated to the evidence room.
Re-key evidence rooms to limit access to the evidence custodian, the alternate, and the regional special agent in-charge.	**FULLY IMPLEMENTED**	The Office of Internal Affairs reported, and the Office of the Inspector General confirmed, that the deficiency reported existed in only one regional office and was corrected at that location.
Use bound evidence logs that provide space for all mandatory information.	**FULLY IMPLEMENTED**	The Office of Internal Affairs reported, and the Office of the Inspector General confirmed, that the deficiency reported existed in only one regional office and was corrected at that location.
Perform periodic audits at each of the regions to ensure compliance with policies and procedures.	**PARTIALLY IMPLEMENTED**	The Office of Internal Affairs had not conducted any internal audits at the time the Office of the Inspector General conducted its fieldwork, but had assembled a self-audit program. This recommendation has also been incorporated into the federal court remedial plan.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation standardize evidence policy and procedures throughout the department and include the standards in the Office of Internal Affairs' Investigation Policy and Procedures Manual, and train staff to ensure that the policies and procedures are properly implemented and followed.

The Office of the Inspector General also recommends that the Office of Internal Affairs install a dedicated alarm system for southern regional office evidence room.

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found that the Office of Investigative Services was not in compliance with prescribed armory policies and procedures.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
In order to ensure compliance with armory policies and procedures, the Office of the Inspector General recommended that the Office of Investigative Services review the operations of the armories at all of its regional offices and address all areas of non-compliance, including those related to physical design, fire safety, and record maintenance and retention.	FULLY IMPLEMENTED	The Office of the Inspector General conducted a follow-up site review of the regional office that was responsible for the October 2001 finding and found that the areas of non-compliance previously identified have been corrected.

FOLLOW-UP RECOMMENDATIONS

None.

EMPLOYEE DISCIPLINARY PROCESS

IMPLEMENTATION REPORT CARD

Previous recommendations: 9

Fully implemented: 6 (67 %)

Substantially implemented: 3 (33%)

Partially implemented: 0 (0%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has improved its employee disciplinary process and has fully or substantially implemented all previous recommendations.

In March 2002, the Office of the Inspector General conducted a review of the Department of Corrections employee disciplinary process. The purpose of the review was to identify any administrative or procedural weaknesses in the disciplinary process that might affect the department's ability to take appropriate adverse action against employees found to have engaged in misconduct. The review found a number of systemic deficiencies in the department's disciplinary process that jeopardized the department's ability to administer appropriate adverse action against peace officers within the one-year statutory deadline.

BACKGROUND

The Department of Corrections and Rehabilitation employs a workforce of approximately 50,000 to fulfill its responsibility for more than 165,000 state prison inmates and 114,000 parolees. Ensuring appropriate conduct of employees and taking disciplinary action against those found to have engaged in misconduct is one of the department's essential functions.

The department's employee disciplinary process has been the subject of a lawsuit, *Madrid v. Woodford,* and as a result, a special master appointed by the U. S. District Court, Northern District of California has been monitoring efforts to reform the disciplinary process through the Madrid Remedial Plan. Many of the plan's provisions are consistent with the Office of the Inspector General's March 2002 recommendations.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the March 2002 review, the Office of the Inspector General made the following specific findings:

- The needless complexity of the employee disciplinary process caused delays that impaired the ability of the Department of Corrections to take appropriate action against employees found to have engaged in misconduct.

- Forty-three percent of a sample of investigations completed during fiscal years 1999-2000 and 2000-01 in which misconduct allegations were sustained were not completed within one year and therefore did not result in disciplinary action.

- There were no clear guidelines for defining the prescribed one-year period for investigating alleged misconduct and imposing disciplinary action against peace officers or for identifying the required 30-day notification period.

- Employee relations officers at institutions did not receive adequate training and often lacked the experience necessary to properly handle employee disciplinary actions.

- Most of the employee disciplinary actions proceeded all the way through settlement and hearing before the State Personnel Board without advice or assistance from the department's legal staff.

- There were no established policies or procedures governing settlement of employee disciplinary actions and the department had no means of monitoring or evaluating the settlement process.

The Office of the Inspector General issued nine recommendations as a result of the March 2002 review.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the California Department of Corrections has implemented the nine recommendations from the Office of the Inspector General's March 2002 review of the employee disciplinary process. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the March 2002 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations. Review fieldwork was completed on January 30, 2006. The results are summarized in the table that follows this section.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the nine recommendations issued by the Office of the Inspector General in March 2002 concerning the employee disciplinary process, six recommendations have been fully implemented and three have been substantially implemented.

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has significantly improved its administration of the employee disciplinary process. The department has developed a case management system to monitor and track disciplinary cases from start to finish to ensure that cases meet statutory deadlines. It has also implemented a new central intake process that provides for representatives from the Office of Internal Affairs, Office of Legal Affairs, and other department staff to review requests for investigations and determine appropriate action. The Office of the Inspector General's Bureau of Independent Review monitors the central intake and internal affairs process and also monitors the investigations. The department has also updated its policies and procedures for employee discipline and has provided formal training to its employee

relations officers statewide. As a result of these and other changes, only two percent of 94 investigations with sustained findings conducted by the Office of Internal Affairs in the period December 1, 2004 through May 31, 2005 exceeded the one-year statutory limit. The Office of the Inspector General makes no follow-up recommendations.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the needless complexity of the employee disciplinary process caused delays that impaired the ability of the Department of Corrections to take appropriate action against employees found to have engaged in misconduct.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections establish a centralized system to monitor and track the status of employee disciplinary cases. The Office of the Inspector General recommended that the department consider modifying either the personnel operations information management system or the Employment Law Unit information management system to include this tracking capability and that the system include an early warning mechanism for cases in danger of exceeding statutory time limits.	SUBSTANTIALLY IMPLEMENTED	The California Department of Corrections and Rehabilitation has developed a centralized case management system that monitors and tracks the status of employee disciplinary cases. When the system is fully implemented, it will incorporate information from the information management systems of both the Employment Law Unit and department personnel operations. The system will include an early warning mechanism for cases in danger of exceeding statutory time limits. Most of the department's hiring authorities, including the Office of Internal Affairs and the Employment Advocacy and Prosecution Team, now have access to the case management system. Efforts to give all hiring authorities access are continuing. Under the Madrid Remedial Plan, full rollout of the case management system is scheduled for June 2006. The Office of the Inspector General reviewed the timeliness of investigations conducted by the Office of Internal Affairs for the period December 1, 2004 through May 31, 2005 and found that only two (2 percent) of the 94 sustained cases reviewed exceeded the one-year statute, preventing the hiring authority from taking disciplinary action against the employee. By comparison, the original Office of the Inspector General review found 43 percent of the sustained cases reviewed exceeded the one-year statute.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the California Department of Corrections had no clear guidelines for defining the prescribed one-year period for investigating alleged misconduct and imposing disciplinary action against peace officers or for identifying the required 30-day notification period.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections issue clear guidelines defining what constitutes the date of discovery, who is "authorized to initiate an investigation," and the date the department makes its decision to impose discipline.	SUBSTANTIALLY IMPLEMENTED	*The Department of Corrections and Rehabilitation Operations Manual,* section 3, article 22, covering employee discipline, has been revised and was accepted by the federal district court on December 22, 2005. Article 22 outlines sections relating to employee misconduct investigations and employee discipline. The department has implemented a central intake process that includes representatives from the Office of the Inspector General's Bureau of Independent Review and the department's Legal Affairs Division and Office of Internal Affairs to review requests for investigations and determine whether to authorize internal affairs investigations. More than half of the department's hiring authorities use the central intake process, and the department achieved statewide implementation on January 30, 2006. Auditors from the Office of the Inspector General observed and participated in the central intake process during the follow-up review. Under the new process, central intake examines requests for investigations and reviews the supporting documentation provided by the requestor. Central intake then either accepts the request as an internal affairs investigation or returns the request for direct disciplinary or corrective action at the hiring authority level. Central intake can also return the request if it identifies no misconduct. The process allows the department to concentrate investigative resources on cases that have merit while requiring the hiring authorities to take direct corrective action in matters that do not warrant a formal investigation. According to the department, specific guidelines governing the date of discovery and internal affairs investigations will be included in the *Department of Corrections and Rehabilitation Operations Manual,* article 14 – *Employee Misconduct Investigations/Inquiries.* Revisions to article 14 have been completed and are part of the Madrid Remedial Plan. The department consulted with the

		Office of the Inspector General Bureau of Independent Review to develop the following mutually agreed-upon definition of investigatory timeframes: "The CDC shall normally conclude all of its investigations of peace officer misconduct and provide notice of its proposed disciplinary action within one year. This time period shall begin on the date that an uninvolved supervisor learns facts, which if true, would constitute employee misconduct." At the end of the fieldwork, October 18, 2005, the Department of Corrections and Rehabilitation had received an extension from the court to have article 14 completed by December 9, 2005.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that employee relations officers at institutions did not receive adequate training and often lacked the experience necessary to properly handle employee disciplinary actions.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections establish a formalized training program for employee relations officers at the institutions.	FULLY IMPLEMENTED	The Department of Corrections and Rehabilitation has developed a formalized training program for employee relations officers that consists of fourteen lesson plans covering the following topics: Overview of employee relations officer advocacy curriculum Analysis of investigations Drafting adverse actions Rejection during probation and non-punitive actions Serving adverse actions *Skelly* hearings and due process Settlements Administrative time off Subpoenas and witness preparation Evidence Order of evidence at SPB hearings, discovery, and pre-hearing motions Examination of witnesses Argument

		Case preparation The Office of the Inspector General reviewed training records and confirmed that as of July 27, 2005, 54 employees had completed formal training. The total included at least one employee from each of the 33 institutions, one from each of the four parole regions, and seven from the central office. The department reported it will continue to provide formal training to ensure that newly hired employee relations officers receive the required training. The department is also developing a computer-based training program for employee relations officers and anticipates the new training to be available to employees by April 2006. The Office of Internal Affairs, the Employment Advocacy and Prosecution Team, and the Bureau of Independent Review also provided training to employee relations officers and investigative services unit staff in September and October 2005. The training covered the following topics: New central intake process Investigator training plans Providing assistance to outside agencies Peace Officers Bill of Rights Overview of the Bureau of Independent Review Overview of the vertical advocate program Investigative review and initiation of discipline Hiring authority review of investigation Justification of penalty
The Office of the Inspector General recommended that the department convert the employee relations officer positions from temporary training assignments to permanent positions.	**SUBSTANTIALLY IMPLEMENTED**	The Department of Corrections and Rehabilitation received approval through the budget process to establish 20 correctional sergeant positions for four-year rotations as disciplinary officers (formerly referred to as employee relations officers). The department reported to the court monitor in October 2005, however, that it had reached agreement with the Department of Personnel Administration to use the staff services manager I classification for the disciplinary officer positions in order to establish permanent assignments. The department informed the court it may continue to use the training and development process as necessary to hire a correctional sergeant or to extend an existing assignment for up to four years in cases where using a staff services manager I candidate is not feasible.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that most of the employee disciplinary actions at the Department of Corrections proceeded all the way through settlement and hearings before the State Personnel Board without advice or assistance from the department legal staff.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections establish formalized policies and procedures to expand the role and responsibility of the Employment Law Unit in the preparation of employee disciplinary actions.	FULLY IMPLEMENTED	*The Department of Corrections and Rehabilitation Operations Manual,* section 3, article 22, *Employee Discipline,* now implemented statewide, has been revised to include the vertical advocacy model. The vertical advocacy model establishes formalized policies and procedures to expand the role and responsibility of the Employment Advocacy and Prosecution Team in the preparation of employee disciplinary actions. Vertical advocates will assist with disciplinary actions, draft the adverse action, and prosecute most cases involving staff integrity or dishonesty, abuse of authority, sexual misconduct, use of force in which an inmate suffers death or serious injury, use of deadly force, serious allegations against supervisors, high-profile cases, and any case for which the penalty is dismissal. Vertical advocates were assigned and attended training concurrently with the respective hiring authorities on the vertical advocacy model and disciplinary procedures.
The Office of the Inspector General recommended that as part of that effort, the department implement a process for monitoring court decisions and State Personnel Board rulings affecting employee disciplinary actions.	FULLY IMPLEMENTED	According to the department, court decisions, State Personnel Board rulings, and employee disciplinary actions are monitored using the following systems and processes: • Case management system • Vertical advocacy policy • PROLAW database Vertical advocates use the PROLAW database to monitor disciplinary actions and State Personnel Board decisions. The PROLAW database has been installed

		statewide and all vertical advocates have been trained on its use.
The Office of the Inspector General also recommended that the department provide Internet access to employee relations officers and conform to standard management practices by instituting a comprehensive e-mail system to improve communication between headquarters staff and institution employees.	FULLY IMPLEMENTED	According to the department, all employee relations officers at the adult institutions have been provided with Internet access and have e-mail capability to communicate with headquarters employees.
In addition, the Office of the Inspector General recommended that the department review its policies and procedures for evaluating and appealing cases to ensure that it vigorously defends its right to discipline employees guilty of serious misconduct.	FULLY IMPLEMENTED	The revised *Department of Corrections and Rehabilitation Operations Manual,* section 3, article 22, *Employee Discipline*, outlines the procedure for appealing State Personnel Board decisions to the Superior Court. Employees from the Office of the Inspector General's Bureau of Independent Review participate in the new process.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Department of Corrections had not established policies and procedures governing settlement of employee disciplinary actions and had no means of monitoring or evaluating the settlement process.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections establish policies and procedures governing employee disciplinary action settlements and require that the necessary documentation be maintained for monitoring and evaluating the settlement process.	FULLY IMPLEMENTED	The revised *Department of Corrections and Rehabilitation Operations Manual,* section 3, article 22, *Employee Discipline*, now includes a settlement policy that requires documentation, monitoring, and evaluation throughout the process. The case management systems and PROLAW database will be used to document and monitor the settlement process.

FOLLOW-UP RECOMMENDATIONS

None.

OFFICE OF COMPLIANCE, AUDIT FUNCTIONS

IMPLEMENTATION REPORT CARD

Previous recommendations: 4

Fully implemented: 2 (50 %)

Substantially implemented: 0 (0%)

Partially implemented: 2 (50%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has consolidated its audit functions into a single unit and elevated the chief of the unit to report directly to the undersecretary. Yet, more than three years after the Office of the Inspector General issued its initial report, the internal audit organization still does not adhere to appropriate internal auditing standards in performing its work.

In October 2002, the Office of the Inspector General issued a report resulting from a review of the audit functions of the Department of Corrections' Office of Compliance. The Office of the Inspector General found that the Office of Compliance did not adhere to appropriate professional standards in performing its internal audit work. The Office of the Inspector General identified several specific weaknesses in the department's management of the Office of Compliance, all of which resulted from the failure of the office to comply with internal auditing standards. The deficiencies included poor communication with executive staff, unresponsiveness to executive requests for audits, and inadequate monitoring of the audit status. As a result of the deficiencies, the Office of the Inspector General questioned the ability of the Office of Compliance to accomplish its objectives and meet its assigned responsibilities.

BACKGROUND

When the Office of the Inspector General issued its October 2002 report, the Office of Compliance was comprised of three organizational units: The Program and Fiscal Audits Branch, the Inmate Appeals Branch, and the Information Security Unit. The primary audit functions of the department were established within the Program and Fiscal Audits Branch. The department established these audit activities to fulfill the requirements of California Penal Code, section 5057, which provides:

> *Subject to the powers of the Department of Finance under Section 13300 of the Government Code, the director must establish an accounting and auditing system for all of the agencies and institutions including the prisons which comprise the department, except the Youth Authority, in such form as will best facilitate their operation, and may modify the system from time to time.*

In addition, *California Department of Corrections and Rehabilitation Operations Manual*, section 11010.26.1 provides as follows:

> *The Program and Fiscal Audits Branch exists to independently audit program contracts for compliance to terms and conditions of the contract. And review, evaluate, and better assure that institutions, parole regions, and headquarters are operated in accordance with department standards, state and federal law, and court mandates.*

The Department of Corrections and Rehabilitation reorganized its audit functions into the Office of Audits and Compliance in July 2005

State law requires all state agencies having their own internal auditors to adhere to the *Standards for the Professional Practice of Internal Auditing* of the Institute of Internal Auditors. The Institute of Internal Auditors promulgates these standards to provide guidance for conducting internal auditing. It divides the standards into two groups: attribute standards, which address the characteristics of organizations and parties performing internal audit activities; and performance standards, which describe the nature of internal audit activities and provide criteria against which the performance of these services can be evaluated. In addition, the Institute of Internal Auditors maintains a third set of standards–implementation standards—which apply only to specific types of audit activity.

In response to the Office of the Inspector General's October 2002 report, the department disagreed with the Office of the Inspector General's conclusion that the activities of the department's Program and Fiscal Services Branch were internal audit activities, and were therefore subject to the state law that requires it to adhere to the *Standards for the Professional Practice of Internal Auditing*. Rather, the department asserted that alternate auditing standards promulgated for external auditors were the appropriate auditing standards for it to follow.

The Institute of Internal Auditors describes internal auditing as follows:

> *Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.*

The Office of the Inspector General continues to maintain that the department's audit activities are consistent with the Institute of Internal Auditors' description of internal auditing, and that the department therefore should ensure that its audits are conducted in accordance with the *Standards for the Professional Practice of Internal Auditing*.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the October 2002 review:

- The Office of Compliance did not adhere to appropriate professional standards, calling into question its ability to accomplish its objectives and meet its assigned responsibilities.

- Audit planning and communication with the department executive staff was inadequate.

- The management of the Program and Fiscal Audits Branch did not target internal audit activity toward issues posing the highest risk.

- The Program and Fiscal Audits Branch of the Office of Compliance was not responsive to executive management requests for special audits.

- The Office of Compliance did not adequately monitor the status of audit projects.

- The Program Compliance Unit of the Program and Fiscal Audits Branch used a highly structured auditing approach that could fail to reveal important issues relating to the entities under audit.

- The audit functions of the California Department of Corrections were fragmented, with a lack of coordination of audit activities and incomplete coverage of areas requiring audit, resulting in a failure to comply with state law governing financial accountability.

As a result of the October 2002 review, the Office of the Inspector General recommended that the Department of Corrections consolidate all of its auditing activities into a professional internal auditing unit consistent with standards prescribed in *Standards for the Professional Practice of Internal Auditing*. The recommendations specified that the chief of internal audits should possess the training, knowledge, and experience necessary to manage an internal auditing unit and should report to the chief deputy director for Support Services.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the California Department of Corrections and Rehabilitation has implemented the recommendations from the Office of the Inspector General's October 2002 review. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the October 2002 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendation. The fieldwork for the follow-up review was completed in August 2005. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The department has fully implemented two of the four recommendations issued by the Office of the Inspector General in October 2002 concerning the audit functions of the Office of Compliance, and has only partially implemented the two remaining recommendations.

The Office of the Inspector General found that more than three years after the initial audit in October 2002, the department has not addressed most of the audit findings. The department has consolidated its internal audit activities into the Office of Audits and Compliance, which reports directly to the department's undersecretary. That change should allow the department to better coordinate its varied audit activities and provide the appropriate level of organizational independence, as prescribed by the Institute of Internal Auditors. According to the department, once the Office of Audits and Compliance is fully operational, it will address most of the remaining issues raised in the October 2002 review. Because the Office of Audits and Compliance is not yet fully operational, however, the department has not yet addressed several issues and recommendations raised in the review. Specifically:

- The department stated that it has not yet begun to adhere to *Standards for the Professional Practice of Internal Auditing*, but asserts that where applicable, the new office will be operated consistent with these standards.

- The department reported that it has not yet developed a quality assurance and improvement program for its internal auditing activity. However, it also reports that the Office of Audits and Compliance will include a quality assurance and improvement function that will evaluate the effectiveness of the internal audit activity.

- The department stated that it is currently not using a risk-based plan to determine the priorities of its internal audit activity, but asserts that its new Office of Audits and Compliance will develop a comprehensive annual work plan based on input from senior management. The department adds that it plans to assign the Office of Risk Management responsibility for developing a risk analysis plan for the department, which senior management will use in determining the priorities of the internal audit activity.

- The department acknowledged that the two units that perform audits of internal operations — the Correctional Business Audit Unit and the Program Compliance Unit — are still not receiving substantive input from senior management in developing their audit plans. However, the department stated that the deputy director of the Risk Management Division does provide a semi-annual report of auditing activities to the executive staff. The department reported that its new Office of Audits and Compliance will develop a comprehensive annual work plan that will be based on substantive input from senior management through a process it has yet to develop, and will provide reports of auditing activities to a new executive management team.

- Although the department reported completing 19 audits as part of its biennial internal control certification as required by the State Administrative Manual, it did not conduct these audits in accordance with appropriate internal auditing standards, as required by state law.

- The department has not yet appointed a permanent assistant secretary as the chief of internal audits who possesses the training, knowledge, and experience to manage an internal auditing unit. It has assigned an acting chief of internal audits who has some narrowly focused auditing experience. The acting chief does not have experience in

applying internal auditing standards, procedures and techniques, however, and has not demonstrated such proficiency by obtaining an appropriate professional certification, such as the Certified Internal Auditor designation. Therefore, the Office of the Inspector General questions whether that person is qualified for the position of chief of internal audits.

Not only appropriate auditing standards, but also sound business principles require the department to incorporate the features described above into its audit operations. By not adequately addressing the findings of the Office of the Inspector General's October 2002 report, the department has limited the value of its internal audit unit as a tool for identifying department operations needing improvement.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation continue its efforts to recruit a permanent assistant secretary for the Office of Audits and Compliance, ensuring that the person selected possesses the training, knowledge, and experience to manage an internal auditing unit.

In addition, the department should ensure that the Office of Audits and Compliance continues to develop operating policies and procedures that will ensure that its audit activity is consistent with the standards prescribed in the *Standards for the Professional Practice of Internal Auditing.* The policies and procedures should include the following:

- **A process for effective communication with the department's executive staff in planning annual audit activities and reporting audit performance.**
- **A process by which to develop a risk-based comprehensive annual plan for identifying the priorities of the internal audit activity.**
- **A process for entering into the audit monitoring system the data necessary to adequately monitor the status of audits.**
- **A system to monitor the amount of time the staff spends on audits.**

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1:
The Office of the Inspector General found that the Program and Fiscal Audits Branch did not adhere to professional standards for internal auditing.

ORIGINAL FINDING NUMBER 2:
The Office of the Inspector General found that the Program and Fiscal Audits Branch, which performed most of the department's audit work, was not effectively communicating with the department's executive staff in planning annual audit activities and in reporting audit performance.

ORIGINAL FINDING NUMBER 3:
The Office of the Inspector General found that the management of the Program and Fiscal Audits Branch did not target internal audit activity toward issues posing the highest risk.

ORIGINAL FINDING NUMBER 4:
The Office of the Inspector General found that the Program and Fiscal Audits Branch was not responsive to executive management requests for special audits.

ORIGINAL FINDING NUMBER 5:
The Office of the Inspector General found that the Office of Compliance did not monitor the status of audit projects.

ORIGINAL FINDING NUMBER 6:
The Office of the Inspector General found that the Program Compliance Unit of the Program and Fiscal Audits Branch used a highly structured auditing approach that could fail to reveal important issues relating to the entities under audit.

ORIGINAL FINDING NUMBER 7:
The Office of the Inspector General found that the audit functions of the California Department of Corrections were fragmented, with a lack of coordination of audit activities and incomplete coverage of areas requiring audit, resulting in a failure to comply with state law governing financial accountability.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections take the actions listed below.		
Consolidate all department auditing activities into a professional internal auditing unit.	FULLY IMPLEMENTED	As part of its recent restructuring, the department created an Office of Audits and Compliance. According to the department, the coordination and performance of all department audits, reviews, and quality assurance functions have been consolidated into this office.
The audit unit should be operated consistent with standards prescribed in *Standards for the Professional Practice of Internal Auditing.*	PARTIALLY IMPLEMENTED	The department reported that it has not yet begun to adhere to *Standards for the Professional Practice of Internal Auditing*, but stated that as the new Office of Audits and Compliance is developed, it will be operated consistent with these standards where applicable. The Office of the Inspector General's original report addressed a number of specific standards with which the Program and Fiscal Audits Branch of the Office of Compliance was not complying. A discussion of each of the specific standards addressed in the Office of the Inspector General's October 2002 report follows. *Organizational Independence* — This standard requires that the chief audit executive report to a level within the organization that allows the internal audit activity to fulfill its responsibilities. As discussed below, the department has reorganized its audit activities to provide the appropriate level of organizational independence. *Proficiency* — This standard states that internal auditors, including the chief audit executive, should possess the knowledge, skills, and other competencies needed to perform their individual responsibilities. As discussed later in this matrix, the department has not yet appointed a permanent assistant secretary as chief of its internal audits. *Quality Assurance and Improvement Program* — This standard requires the chief audit executive to develop and maintain a quality assurance and

		improvement program that covers all aspects of internal audit activity and continuously monitors its effectiveness. The department reported that a quality assurance and improvement program has not yet been developed and implemented. However, the department stated that the Office of Audits and Compliance will include a quality assurance and improvement function that will evaluate the effectiveness of the internal audit activity. *Managing the Internal Audit Activity* — This standard requires the chief audit executive to effectively manage the internal audit activity to ensure it adds value to the organization. As part of these responsibilities, the standards require the chief audit executive to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organization's goals. The department stated that it is currently not using a risk-based plan to determine the priorities of its internal audit activity. The department added, however, that its new Office of Audits and Compliance will develop a comprehensive annual work plan based on input from senior management. The department plans to assign its Office of Risk Management the task of developing a risk analysis plan for the department, which senior management will use in determining the priorities of the internal audit activity. *Resource Management* — This standard requires the chief audit executive to ensure that internal audit resources are appropriate, sufficient, and effectively deployed to achieve the audit plan. The Office of the Inspector General found in its October 2002 report that the Program and Fiscal Audits Branch lacked an adequate audit tracking system. The department reported that it has developed and implemented an audit tracking system called the Standardized Correspondence Control System. It describes the system as one that tracks each audit, including various milestone dates, and provides a weekly report for audit management.

		The Office of the Inspector General reviewed a sample management report produced by the tracking system and found that with some modification, the system would provide information the department could use to monitor the status of audits. However, the sample report reviewed revealed that key information had not been entered into the tracking system's data fields and that there was no field for time spent on each audit. For example, several audits listed on the sample report did not have a date in the "Date Assigned" field, even though the report showed that the audit had been completed—signified by a date in the "Date Approved" field. According to the deputy director, the "Date Assigned" field reports the date the audit was commenced and the "Date Approved" field is the date the final audit report was signed by the chief of the audits branch. Therefore, several audits on the sample report showed that even though the audit had not been commenced, the audit had been completed and the final report signed by the chief of the audits branch. In addition, the department acknowledged that the system does not track the time spent on audits by staff. As a result, the department is still unable to determine whether assignments are completed within designated budgetary timeframes. Unless and until all key data is entered into the system and the system tracks time spent on audits, the report's usefulness to department management is limited. *Reporting to the Board and Senior Management* — This standard requires the chief audit executive to report periodically to senior management on the internal audit activity's purpose, authority, responsibility, and performance relative to its plan. According to the department, the two units that perform audits of internal department operations are not receiving substantive input from senior management in developing their audit plans. The department also reported that the deputy director of the Risk Management Division provides a semi-annual report of auditing activities to the department's executive staff. The department added that the new Office of Audits and Compliance will develop a comprehensive annual work plan that will be based on substantive input from senior management through a process it has yet to develop and will provide reports of auditing activities to a new executive management team.

The chief of internal audits should possess the training, knowledge, and experience to manage an internal auditing unit.	**PARTIALLY IMPLEMENTED**	The department reported that it has not yet appointed a permanent chief of internal audits, adding that when it selects a chief, the person will possess the training, knowledge, and experience to manage an internal auditing unit. It has assigned an acting chief of internal audits who has some narrowly focused auditing experience. However, the acting chief does not have experience in applying internal auditing standards, procedures, and techniques, and has not demonstrated such proficiency by obtaining an appropriate professional certification, such as the Certified Internal Auditor designation. Therefore, the Office of the Inspector General questions whether that person is qualified for the position of chief of internal audits.
The chief of internal audits should report to the chief deputy director for Support Services.	**FULLY IMPLEMENTED**	As part of its recent restructuring, the department created an Office of Audits and Compliance. According to the department's July 2005 organization chart, this office reports directly to the department's undersecretary. That reporting relationship should provide the appropriate level of organizational independence, as prescribed by the Institute of Internal Auditors.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation continue its efforts to recruit a permanent assistant secretary for the Office of Audits and Compliance, ensuring that the person selected possesses the training, knowledge, and experience to manage an internal auditing unit.

In addition, the department should ensure that the Office of Audits and Compliance continues to develop operating policies and procedures that will ensure that its audit activity is consistent with the standards prescribed in the *Standards for the Professional Practice of Internal Auditing.* The policies and procedures should include the following:

- **A process for effective communication with the department's executive staff in planning annual audit activities and reporting audit performance.**
- **A process by which to develop a risk-based comprehensive annual plan for identifying the priorities of the internal audit activity.**

- **A process for entering into the audit monitoring system the data necessary to adequately monitor the status of audits.**
- **A system to monitor the amount of time the staff spends on audits.**

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MEDICAL CONTRACTING PROCESS

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 5 (72 %)

Substantially implemented: 1 (14%)

Partially implemented: 1 (14%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

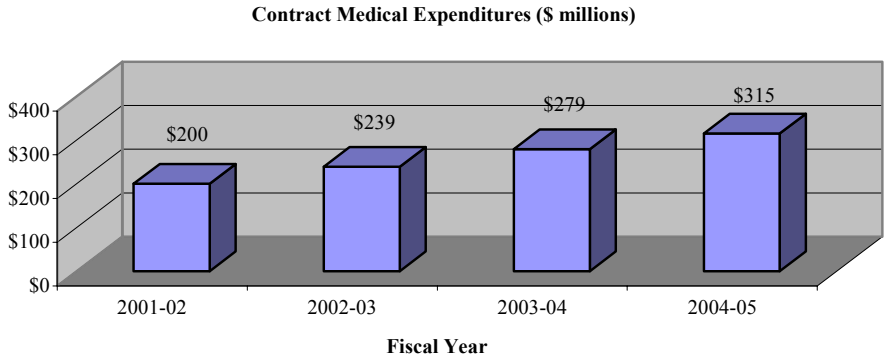
The Office of the Inspector General found that the Department of Corrections and Rehabilitation has remedied nearly all of the deficiencies in its medical contracting process but must continue to take steps to control its medical contract expenditures.

In October 2002, the Office of the Inspector General conducted a special review of the processes and controls used by the department's Health Care Services Division to procure and pay for contract medical services to inmates. The review determined that the division did not effectively manage its medical services to inmates and that it should adopt statewide policies and procedures to ensure cost-effective contracts, quality case management, and continuity of care.

BACKGROUND

The Department of Corrections and Rehabilitation established the Health Care Services Division in 1992 to manage and oversee the delivery of health care services to inmates. In order to provide adequate medical services to the growing inmate population, the department contracts with outside community hospitals, physicians, nurses, pharmacists, and other medical professionals to obtain specialized services its staff and facilities cannot provide. In some instances, the department also contracts with medical professionals to fill temporary staff vacancies in medical classifications where recruitment is difficult.

As shown in the chart below, the total cost for contracted medical services continues to rise annually, from $200 million in fiscal year 2000-01 to more than $315 million in fiscal year 2004-05—an increase of 58 percent.



The Health Care Services Division has oversight responsibility for all medical contracts. In response to external audits, the division established the Health Contract Services Unit to establish new contract policies, assist with contract negotiations, and provide support

to institutions for all medical service contracts. Until recently, the Department of Corrections and Rehabilitation was not required to competitively bid the majority of its medical service contracts and often it contracted with a sole provider. Prompted by the Bureau of State Audits, the Department of General Services issued Management Memorandum 05-04 on January 26, 2005, which requires competitive bids for all medical services except those in which departments can justify the need for an exemption.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the October 2002 review, the Office of the Inspector General made the following specific findings:

- The Department of Corrections lacked a comprehensive statewide policy for managing its medical services contracts.

- Lack of sound contract management by the Department of Corrections resulted in payments of more than $77,000 for clinical services not performed and of more than $1 million for services not authorized under a California Medical Facility contract with an outside physician.

- The contracting process of the Department of Corrections was vulnerable to potentially serious conflicts of interest because the person selecting the contractor was also authorized to approve invoices and payments under the contract.

- The deficiencies identified in the department's contracting process may have led to problems in the quality and continuity of inmate medical care.

As a result of the October 2002 review, the Office of the Inspector General made the following seven recommendations:

- The Office of the Inspector General recommended that the Department of Corrections adopt statewide policies and procedures for contract management, including but not limited to advertising and soliciting proposals; and awarding, monitoring, and enforcing contracts to provide cost-effective medical services to inmates. The recommendation specified that the policies and procedures should include the following:

  - A requirement that institutions advertise the need for medical service providers and solicit proposals from their local communities.

  - A requirement that institutions document their efforts to advertise and solicit proposals before approving any contract.

  - Implementation of a statewide survey every three to four years to determine what constitutes a reasonable hourly fee for various medical specialties in selected regions of the state. The results of this survey can be used to develop reasonable contract expenditures for specific services in various geographical regions.

  - A requirement that the cost of custody and support staff be included in calculations of the cost of providing medical care to inmates outside an institution, and that the cost be applied in developing a "reasonable" rate for care inside the institution.

- The Department of Corrections establish tight controls to ensure compliance with contract provisions, including monitoring and authorizing payment. The controls should be effectively communicated to staff through special training in contract language and the proper procedures for authorizing payments. The department should also strengthen its procedures for amending existing contracts to avoid confusion and misunderstanding.

- The Department of Corrections include provisions in its contracting policies to ensure that the individual who selects and approves a contractor does not also authorize payment by approving invoices under that contract.

- Pending resolution of contract issues, the Department of Corrections take any necessary interim steps to ensure that inmates receive good-quality medical care that is uninterrupted by contract problems.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the California Department of Corrections and Rehabilitation has implemented the seven recommendations from the Office of the Inspector General's October 2002 special review of the medical contracting process. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the October 2002 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations. Review fieldwork was completed on November 7, 2005. The results are summarized in the table that follows this section.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the seven recommendations issued by the Office of the Inspector General in October 2002 concerning the medical contracting process, five recommendations have been fully implemented; one has been substantially implemented; and one has been partially implemented.

As a result of the 2006 follow-up review, the Office of the Inspector General found that the Department of Corrections and Rehabilitation has made a number of changes to its medical contracting process. In response to the Office of the Inspector General's 2002 review, the department established a health contract services unit to assist institutions with all medical services contracts. In addition, the department required institutions to solicit medical providers and to prepare market surveys before initiating a contract.

Meanwhile, expenditures for medical contracts rose 58 percent between fiscal years 2000-01 and 2004-05 from $200 million to more than $315 million, largely because of medical staff vacancies requiring contracted personnel to fill the void.

In response to two subsequent audits issued by the California State Auditor in 2004, the Department of General Services tightened the procedures used by the department to contract with outside community hospitals, physicians, nurses, pharmacists and other medical professionals to provide needed services and fill temporary medical staff vacancies and required the department to obtain competitive bids on clinical contracts. According to a correctional expert appointed by the U. S. District Court, however, due in part to insufficient staffing and training necessary to properly implement the new contracting procedures as well as to the complexity of the procedures, the department has fallen $58 million behind in paying provider claims. The new bidding process instituted to replace single-source contracting also has resulted in a shortage of specialty providers. Because of these developments, on March 30, 2006 the court ordered the department to pay all valid outstanding department-approved claims within 60 days and to establish new medical contracting procedures within 180 days.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation develop a more effective and efficient system for processing and monitoring medical service invoices, including validation that contractors have performed all services invoiced prior to issuing payment.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Department of Corrections lacked a comprehensive statewide policy for managing its medical services contracts.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections adopt statewide policies and procedures for contract management, including but not limited to advertising and soliciting proposals and awarding, monitoring, and enforcing contracts to provide cost-effective medical services to inmates. The policies and procedures should include the following:		
A requirement that institutions advertise the need for medical service providers and solicit proposals from their local medical communities.	SUBSTANTIALLY IMPLEMENTED	According to the department, the Health Care Services Division has implemented new procedures that require completing market surveys for the majority of its medical services contracts. The division conducted meetings with all institutions except Pelican Bay State Prison, California State Prison, Corcoran, and the California Substance Abuse Treatment Facility and State Prison at Corcoran to discuss the new contract procedures. Institution contract analysts, health care cost and utilization program analysts, and health care managers attended the meetings for an understanding of how to complete market surveys for medical contracts. The department reported that the remaining three institutions will receive contract training as part of the new statewide contract negotiation training to be completed by May 2006. Under the January 2005 Management Memorandum 05-04 issued by the Department of General Services, all departments are now required to bid for medical services, with the exception of emergency hospital and ambulance provider services. When it is difficult to obtain services, such as in rural locations or for specific medical specialties, departments can submit a special

		category request/non-competitive bid exemption request to the Department of General Services. The Department of Corrections and Rehabilitation has prepared 16 special category requests and had received approval for 14 at the time review fieldwork was completed on November 7, 2005. According to the department, the Health Contract Services Unit also uses the following as benchmarks for determining the reasonableness of potential contract provisions: ➢ Department sector rates for Relative Value for Physicians ➢ Medicare Diagnostic Related Group code information ➢ Data reflecting cost-to-change ratios obtained from the Office of Statewide Health Planning and Development The department provided the Office of the Inspector General with draft procedures addressing hospital negotiations, completion of physician contracts, contract renewal requests, and contract approval. The Health Contract Services Unit had not presented the procedures for approval at the time fieldwork was completed.
A requirement that institutions document their efforts to advertise and solicit proposals before approving any contract.	**FULLY IMPLEMENTED**	The department reported that it implemented a process effective July 1, 2004 requiring all non-bid contract requests to be submitted to the Health Contract Services Unit for approval. The Health Contract Services Unit maintains all documentation relating to solicitation and now-mandatory market surveys. The unit also prepares solicitation letters targeting areas in which preferred provider master contracts are desirable and performs cost analyses, including such factors as medical guarding and inmate transportation, for each proposal received under preferred provider master contracts. All negotiation efforts are documented in Health Contract Services Unit contract files. The department continues to develop policies and procedures to address contract issues. The Office of the Inspector General reviewed eight contract requests that institutions had submitted to the Health Contract Services Unit to verify completion of market surveys; all eight were in compliance with this requirement.

Implementation of a statewide survey every three to four years to determine what constitutes a reasonable hourly fee for a range of medical specialties in selected regions of the state. The results of the survey could be used to develop equitable contract expenditures for specific services in various geographical regions.	**FULLY IMPLEMENTED**	According to the department, the Health Contract Services Unit has completed a survey of four specialty services the department frequently uses—cardiology, neurology, orthopedics, and gastroenterology—to determine the current rates for these services and identify whether patients can be directed to providers with favorable rates. The Health Contract Services Unit reported that it will employ the surveys to determine the reasonableness of proposed rates. The department provided the Office of the Inspector General with documentation of its neurology survey.
A requirement that the cost of custody and support staff be included in calculations of the cost of providing medical care to inmates outside an institution and that the cost be applied in developing a reasonable rate for care inside the institution.	**FULLY IMPLEMENTED**	The Health Contract Services Unit provided the Office of the Inspector General with a medical guarding cost analysis worksheet it had prepared with input from the Institutions Division. The analysis identifies the costs associated with medical guarding in both medical-guarded and non-medical-guarded hospital units. Medical-guarded units have correctional officers permanently assigned to provide ongoing security coverage for inmates receiving medical care, while non-medical-guarded facilities must temporarily assign correctional staff to the hospital while an inmate receives treatment. The Health Contract Services Unit completed the project in December 2003 but continued to work with the Institutions Division in updating the worksheet to include necessary revisions. According to the department, the unit employees use the worksheet routinely to establish appropriate rates.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

Lack of sound contract management by the Department of Corrections resulted in payments of more than $77,000 for clinical services not performed and of more than $1 million for services not authorized under a California Medical Facility contract with an outside physician.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections establish stringent controls for monitoring and authorizing payments for contract health care services. The controls should be effectively communicated to staff through special training on contract language and the proper procedures to be followed when authorizing and processing invoices for payment. The department should also improve the procedures for amending existing contracts to avoid confusion and misunderstanding.	PARTIALLY IMPLEMENTED	At the time the Office of the Inspector General conducted its original review, the Health Care Services Division had disbanded the contract unit due to budget reductions. After audits by the Office of the Inspector General and the Bureau of State Audits revealed deficiencies in the department's medical contracting procedures, however, the department received additional funding to re-establish the unit, now known as the Health Contract Services Unit. The unit assists institutions with medical contract negotiations, develops contracting policies and procedures specific to health care contracts, and performs contract-monitoring services for the department. The unit is comprised of 15 positions, including three managers and 12 analysts. Most of the analysts in the unit have attended training related to cost benefit analysis and analytical skills development, and those new to the unit will attend training in the near future. According to the department, in April 2005 it awarded Managed Care Consulting Inc. a contract to provide contract negotiation skills training to the Health Contract Services Unit. The contractor is currently reviewing staff skill levels to determine training needs. The Health Care Services Division distributed a memorandum to all institutions on June 29, 2004 outlining the new contract procedures for institutional health care services. The memorandum covers procedures for contract requests, renewal of exiting contracts, and the new "medical and return" process (when an inmate must be transferred to another facility to receive appropriate medical services). According to the Health Contract Services Unit, the staff meets with institutions and medical contractors on a regular basis to monitor the quality of services and resolve any contractual issues. The department reported that it has contacted various providers and is considering contracting out the medical invoice review. Currently, the health care cost and utilization analysts at the institutions perform medical invoice reviews, but they are able to perform detailed audits only on a limited sample due to the high volume of medical invoices and the absence of an automated system. The department stated that it is still in the early planning stages of transferring the invoice review function to an automated system and the costs of doing so have not yet been determined.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The contracting process of the Department of Corrections was vulnerable to potentially serious conflicts of interest because the person selecting the contractor was also authorized to approve invoices and payments under the contract.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended the department include provisions in its contracting policies to ensure that the individual who selects and approves a contractor does not also authorize payment by approving invoices under that contract.	FULLY IMPLEMENTED	The new procedures provided on June 29, 2005 to all institution health care managers require that initial and renewal contract requests be submitted to the Health Contract Services Unit for approval. In addition, the unit reviews market surveys and utilization data before recommending approval of a specific contractor. The new medical contract procedures have eliminated the previous potential for conflicts of interest.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The current deficiencies in the department's contracting process may lead to problems in the quality and continuity of inmate medical care.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
Pending resolution of contract issues, the Office of the Inspector General recommended that the Department of Corrections take any necessary interim steps to ensure that inmates receive good-quality, fundamental medical care that is uninterrupted by contract issues.	FULLY IMPLEMENTED	The department reported that it instructed all institutions to transfer patients to other facilities if services were not readily available because of contract issues. In addition, the Health Contract Services Unit has developed a network of service providers and affirms that it provides ongoing assistance to the institutions in determining the availability of medical services. The memorandum submitted on June 29, 2004 advises all department health care

		managers to contact the Health Contract Services Unit for assistance if there is no existing local or regional contract for a particular medical service. Through its network, the unit can determine if services are available at another institution. The department can then transfer the inmate to the appropriate location for medical services ("medical and return process").

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation develop a more effective and efficient system for processing and monitoring medical service invoices, including validation that contractors have performed all services invoiced prior to issuing payment.

EDUCATION PROGRAMS AT LEVEL IV INSTITUTIONS

IMPLEMENTATION REPORT CARD

Previous recommendations: 6

Fully implemented: 1 (17%)

Substantially implemented: 2 (33%)

Partially implemented: 3 (50%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has made progress in developing alternative education programs for Level IV inmates.

In July 2003, the Office of the Inspector General conducted a survey of education programs at the Department of Corrections Level IV institutions. The survey was prompted by management review audits conducted by the Office of the Inspector General showing that inmates in state correctional institutions received only limited classroom instruction because classrooms are closed for significant periods of time due to lockdowns, teacher vacancies, and other program disruptions. The survey revealed the classroom education model to be an inefficient and expensive means of delivering education to Level IV inmates because frequent lockdowns cause academic and vocational classes to be closed down more than 60 percent of the time. At the five Level IV institutions locked down for the largest percentages of time, education programs operated an average of only 25 percent of the time. And even with the classes closed for long periods, the survey found that inmates continued to receive day-for-day sentence reduction credits as though they had attended class, and teachers continued to be paid as though they had provided instruction. The Office of the Inspector General also found that even if the classes were held 100 percent of the time, they would be able to accommodate only a small percentage of inmates eligible for the programs, in part because of the small number of budgeted teaching positions at Level IV institutions. The survey found in addition that institutions had no systematic means of accounting for teachers' activities during lockdown periods or of temporarily assigning them to other duties.

BACKGROUND

Declaring that "there is a correlation between prisoners who are functionally literate and those who successfully reintegrate into society upon release," the Legislature in 1987 enacted the Prisoner Literacy Act, which required the Department of Corrections to provide literacy programs at every state prison. Codified as California Penal Code section 2053 *et seq*., the act required the department to make the programs available to at least 60 percent of eligible inmates in the state prison system by January 1, 1996, with the goal of ensuring that inmates achieve a ninth-grade reading level by the time they parole. Accordingly, the Department of Corrections provides an education program consisting of both academic classes and vocational training for inmates at state correctional institutions. A November 1996 survey by the Department of Corrections found that 68 percent of the inmate population scored below the ninth grade level in reading.

The budget for the Department of Corrections for fiscal year 2004-05 included $12.3 million for academic and vocational education for the five Level IV institutions that were

part of the Office of the Inspector General's original survey. As of April 30, 2005, there were 20,059 inmates, 18 percent of the eligible population, enrolled in academic and vocational education programs statewide.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific observations as a result of the July 2003 survey:

- Only 21 percent of eligible inmates at the five Level IV institutions covered in the survey were enrolled in education classes and the classes were closed a large percentage of the time because of lockdowns and other disruptions.

- The low level of inmate participation is explained partly by budget constraints. In fiscal year 2002-03, the number of academic teaching positions budgeted at the five Level IV institutions surveyed averaged 16, with an average of only 13 of those positions actually filled. At a ratio of one teacher for every 27 students, therefore, the academic program were able to accommodate an average of only 351 inmates at each of the institutions — 11.8 percent of the eligible inmate population (with "eligible" defined as those able to participate in a classroom setting).

- The Department of Corrections and the institutions had no means of accounting for the activities of teachers during lockdowns, and labor agreements hampered the redirection of teachers to other functions during those periods.

- When lockdowns and other program disruptions were taken into account, the annual per-inmate cost of the education programs at Level IV institutions greatly exceeded the annual per-inmate costs budgeted.

As a result of the July 2003 survey, the Office of the Inspector General recommended that the Department of Corrections re-evaluate education programs at Level IV institutions to determine whether they warrant continued operation and investigate other methods of delivering academic and vocational instruction. Among the options considered should be eliminating formal classroom instruction and retaining a small educational staff to coordinate in-cell study courses for inmates. Instruction through cable television and correspondence courses could also be developed to assist inmates in achieving educational goals.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Department of Corrections and Rehabilitation has implemented the six recommendations from the Office of the Inspector General's July 2003 survey of education programs at Level IV institutions. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the July 2003 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General

reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations.

Fieldwork for the review was completed in September 2005. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the six recommendations issued by the Office of the Inspector General in July 2003 concerning the education programs at Level IV institutions, one recommendation has been fully implemented; two recommendations have been substantially implemented; and three recommendations have been partially implemented.

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has made some progress in developing new education methods for Level IV inmates, but the effectiveness of the new programs has not yet been evaluated. In response to a $34.8 million reduction to its education budget, the department evaluated its existing programs and prioritized them to determine those that warranted continued operation. Upon completion of the evaluation, the department eliminated 129 education positions, including many of the Level IV vocational programs, due to their ineffectiveness. The department has since developed alternative education program models designed to increase overall inmate participation through non-traditional methods. The new programs include more self-paced independent study, such as the new Bridging Education Program recently implemented in the reception centers and general population facilities. This new program allows inmates to begin participating in self-paced education programs when they arrive at a reception center. Other programs include short-term vocational certification classes, half-day assignments with a homework component, delivery of educational services via distance education methodologies, and delivery of educational services in the living units. The majority of the new alternative education delivery models have only recently been implemented; therefore, only minimal data is available at this time to evaluate the programs' effectiveness. The department also has not developed an effective monitoring system to ensure that institutions are complying with its education policies and procedures. Prison reform advocates have also suggested that the new programs may be too shallow to be effective, but inmate population pressures appear to make it difficult to provide more comprehensive educational opportunities, at least in a classroom setting.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following actions:

- **Systematically evaluate the effectiveness of the new alternative education delivery models. The evaluation should include inmate participation rates, progress in achieving educational goals, and the impact of the programs on recidivism.**

- **The new Office of Correctional Education should dedicate staff to perform periodic on-site reviews to ensure compliance with department policies and procedures. The on-site reviews should include, but not be limited to, verification of educational representatives participating in classification committees, verification of class closures for teacher vacancies beyond 30 days, and the verification of the accuracy of timekeeping for inmate program participation.**

The following table summarizes the results of the follow-up review.

ORIGINAL OBSERVATION NUMBER 1

The Office of the Inspector General found that only a small percentage of inmates at Level IV institutions were enrolled in education classes and that the classes were closed a large percentage of the time because of lockdowns and other disruptions.

ORIGINAL OBSERVATION NUMBER 2

The Office of the Inspector General found that the department and institutions had no means of accounting for the activities of teachers during lockdowns and that labor agreements hampered the redirection of teachers to other functions during those periods.

ORIGINAL OBSERVATION NUMBER 3

The Office of the Inspector General found that when lockdowns and other program disruptions were taken into account, the annual per-inmate cost of the education programs at Level IV institutions greatly exceeded the annual per-inmate cost budgeted.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections re-evaluate education programs at Level IV institutions to determine whether they warrant continued operation and investigate other methods of delivering academic and vocational instruction.	FULLY IMPLEMENTED	According to the department, the Education and Inmate Programs Unit evaluated all Level IV institutions as part of a $34.8 million reduction to the department's education budget. The evaluation included inmate program participation, program viability, teacher assignments, inmate assignments, and waiting lists. In addition, the department looked at the *Ten-Year Employability Outlook* published by the Employment Development Department to determine the projected employment growth for vocational programs. The evaluation completed by the department noted that Level IV institutions of 180- design[1] and Level IV institutions of 270-design[2] evidenced the following: • Excessive class closures averaging 77 percent • Low enrollment of approximately 20 percent • Fifteen percent of the teachers assigned to programs other than those for which they were hired to teach

[1] High Desert State Prison, Pelican Bay State Prison, California State Prison, Sacramento, and Salinas Valley State Prison.
[2] California State Prison, Los Angeles County and Salinas Valley State Prison.

		• Seventeen vocational programs deemed as low growth by the *Ten-Year Employability Outlook* • Programs not well suited as correctional education vocational programs Upon completion of the evaluation, the Education and Inmate Programs Unit recommended that the department eliminate 129 education positions at the Level IV institutions. The department approved the recommendations and eliminated the positions and programs effective March 1, 2004.
The Office of the Inspector General recommended that among the options considered should be eliminating formal classroom instruction and retaining a small educational staff to coordinate in-cell study courses for inmates.	**SUBSTANTIALLY IMPLEMENTED**	Along with the recommended position cuts noted above, the Education and Inmate Programs Unit, now renamed the Office of Correctional Education, also reported that it had developed alternative means of delivering educational services. These alternatives include short-term vocational certification, half-day assignments with homework, delivery of educational services during lockdowns via distance education methodologies, and delivery of educational services in living units. The Office of Correctional Education had expected to fully implement these new programs by October 2005. The department was still negotiating with labor union representatives on the implementation of the new alternative education delivery models during the Office of the Inspector General's fieldwork. The new alternative delivery models include both distance education and independent study. According to the department, these models are appropriate for higher-level learners, and teachers will be assigned 90 to 120 students, thereby greatly expanding educational services. In response to the ongoing security measures under lockdown and modified program conditions, the alternative education delivery model has a component that includes providing educational services during lockdowns and modified programs. According to the department, each institution has developed a plan for how it will deliver services during lockdowns and modified programs. The Office of Correctional Education reported that it has recently implemented industry certification in all of the vocational construction trade programs, using the *National Center of Construction Education and Research* text and instructional materials. This curriculum addresses short-term vocational certification and is delivered in modules that run from three to six weeks. Completion of the program results in industry certification. The program

complements the aforementioned half-time educational programs that are part of the alternative education and delivery model. The Office of Correctional Education continues to support traditional classroom instruction as a viable method of instructional delivery when it is feasible.

The Office of the Inspector General reviewed the inmate participation statistics provided by the Department of Corrections and Rehabilitation for fiscal year 2004-05 and found the following:

Institution	Inmate Participation[3]	Total Hours Possible[4]	Percentage of Participation
California State Prison, Sacramento	159,174	260,022	61%
Calipatria State Prison	221,697	527,355	42%
High Desert State Prison	266,784	673,539	40%
Pelican Bay State Prison	113,568	237,273	48%
Salinas Valley State Prison	139,677	483,811	29%
Totals/average percentage	900,900	2,182,000	41%

The original survey of the above institutions indicated an average participation rate of 25 percent. Although the department has improved, the 41 percent participation rate ultimately results in the closure of education programs 59 percent of the time. It is too early to evaluate the effectiveness of the new alternative delivery models because the department only recently implemented these programs. Nevertheless, the data clearly demonstrates that the department must continue to improve its delivery of education services to the Level IV inmate population.

The Office of the Inspector General recommended that instruction through cable television and correspondence courses could also be developed to assist inmates in achieving educational goals.	**SUBSTANTIALLY IMPLEMENTED**	According to the department, every institution is connected to the corrections learning network. The corrections learning network is a distance learning initiative, administered by Educational District 101 and funded through the United States Department of Education. The network provides free interactive instructional programming for the nation's correctional facilities. Educational programming is available through satellite/television downlink for the offender population (youth and adult) and to correctional employees. The department reported that it uses the corrections learning network to supplement curricula in the traditional classroom programs and in its Bridging Education Program. The institutions distribute the network programming to the housing units, where inmates can directly connect with the correctional learning network. Each institution has been permitted program flexibility in its distribution. The department stated that it has obtained more traditional and distance college courses. The department considered budget change proposals to improve the infrastructure for reception centers in order to accommodate additional electrical and cable connections and thereby make available more television units in housing units/cells to receive educational and self-help information through distance learning models. The department reported, however, that the excessive cost of providing the additional cable connections became evident. As an alternative, the department decided to concentrate on purchasing television sets and video cassette recorders for use in the reception center dayrooms to facilitate the distance learning efforts. The department stated that it is currently ordering television carts to enable staff to secure the equipment when not in use and provide mobility to different locations as needed. The department affirmed that it has significantly increased the availability of college programs to the inmate population, including some Level IV institutions, without additional allocations from the state general fund. The department stated that it has cooperated fully with the California community colleges to expand the availability of college programs. The department also provided the following examples of new educational programs now being offered at level IV institutions: • Pelican Bay State Prison operates a small television studio that records teacher classroom lectures for distribution across the institutional

		television network, allowing inmates who are unable to attend school to continue their studies. The network also provides other programs, including general educational development, community college courses, and self-help programming. • Salinas Valley State Prison provides re-entry information through educational packets, which include anger management and substance abuse videos. In addition, the adjunct teacher coordinates general education development and the corrections learning network programming. The institution recently installed computer labs with educational software in all four yards. • California State Prison, Sacramento uses an adjunct teacher who coordinates general education development and corrections learning network programming for inmates who cannot attend traditional classrooms. In addition, the institution gives inmates access to re-entry and general education development materials through educational packets. • High Desert State Prison coordinates with the work of its television specialist and two academic teachers, who manage coursework offered through the corrections learning network. Inmates who complete the course receive completion certificates. • Calipatria State Prison uses the corrections learning network to offer general education development coursework to all institution inmates. After completing the course, inmates may sign up through the education department to take the general education development exam.

If the department decides to continue formal classroom instruction, the Office of the Inspector General recommended that the department take the following actions: Ensure that classification committees include an education representative for the purpose of evaluating appropriate education placement for inmates.	**PARTIALLY IMPLEMENTED**	The Department of Corrections and Rehabilitation provided the Office of the Inspector General with a memorandum entitled "Student Class Assignment Policy," dated February 7, 2003 and signed by W. A. Duncan, former Deputy Director, Institutions Division. The purpose of the memorandum, which was sent to all institutions, was to reiterate departmental policy and to ensure that an education representative was present at initial classification committee and unit classification committee hearings. The memorandum also provided guidelines for appropriate inmate education placement, assessment, and equal access to inmates with special needs. The Office of Correctional Education affirmed that it has never deviated from its position — that inmates receive an education appropriate to their individual needs. In addition, the new Bridging Education Program mandates that an educational representative be part of the classification committee to directly interview participants and ensure their appropriate placement. The Office of the Inspector General recognizes that the Department of Corrections and Rehabilitation has officially notified the institutions of the policy requiring educational representatives to participate in classification committee hearings. The department, however, could not provide evidence to indicate that it has monitored whether educational representatives actively participate in classification committee hearings, as required. Moreover, the department stated in its response that, because of budget cuts, it no longer retains staff to perform on-site compliance reviews.

Develop a more efficient process for removing from classes inmates who are disruptive or who fail to attend class and for removing inmates from classes that are closed because of teacher vacancies and other reasons.	**PARTIALLY IMPLEMENTED**	According to the department, it has convened with the teachers' and vocational instructors' union pursuant to an understanding of the existing sections of the California Code of Regulations, Title 15 and the *Department of Corrections and Rehabilitation Operations Manual,* which delineate the discipline process and define education staff authority to effectively handle classroom discipline problems. The department also states that it will continue training supervisors of correctional education programs to ensure that education staff members are aware of the disciplinary process. Recommended changes to the California Code of Regulations are being sought relative to the section that reads, "A classification committee action shall not be required to remove inmates from Bridging Education Programs if no other changes in work/training group, privilege group, custody designation or work waiting list is required." The department stated that the Title 15 revisions encompass new classification and disciplinary processes with the implementation of the Bridging Education Program. The Office of the Inspector General reviewed the revisions to Title 15 and found no significant changes that constitute a more efficient process for teachers to remove disruptive inmates from education programs. The department also stated that it notified wardens and supervisors of correctional education programs in writing of the policy regarding class closures. The policy requires that inmates be temporarily unassigned from classes in which the teacher or instructor is unavailable beyond 30 days.
Institute quality-control measures to ensure that inmate class attendance is accurately reported.	**PARTIALLY IMPLEMENTED**	The Department of Corrections and Rehabilitation stated that each instructor is required to keep a permanent class record on inmate attendance. In addition, the department stated that all instructors are required to follow timekeeping policies as articulated in the California Code of Regulations, Title 15, Crime Prevention and Corrections, Article 3.5. The supervisors of academic instruction and vocational instruction at each institution review the permanent class record for accuracy and apply proper corrective action procedures if an inmate fails to attend. The supervisor of correctional education program maintains all permanent class records in the education office. The assignment office is provided copies to maintain accountability under the department's new timekeeping system.

		According to the department, the new education strategic plan it has adopted includes a mandated accountability model. In addition, the department will hire an associate governmental program analyst at each institution for education data collection and reporting needs. The department states that it is also developing a new monthly report that will provide better enrollment accountability. The Office of the Inspector General recognizes that the Department of Corrections and Rehabilitation has made efforts to officially notify institutions of the policy requirements. Nevertheless, without performing periodic on-site institution audits, the department cannot ensure compliance with its policies.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following actions:

- **Systematically evaluate the effectiveness of the new alternative education delivery models. The evaluation should include inmate participation rates, progress in achieving educational goals, and the impact of the programs on recidivism.**
- **The new Office of Correctional Education should dedicate staff to perform periodic on-site reviews to ensure compliance with department policies and procedures. The on-site reviews should include, but not be limited to, verification of educational representatives participating in classification committees, verification of class closures for teacher vacancies beyond 30 days, and verification of the accuracy of timekeeping for inmate program participation.**

RICHARD A. MCGEE CORRECTIONAL TRAINING CENTER

IMPLEMENTATION REPORT CARD

Previous recommendations: 12

Fully implemented: 11 (92%)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 1(8%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Richard A. McGee Correctional Training Center has significantly improved its cadet training program. The academy instituted guidelines for course development that include instructor input, cadet feedback, and Commission on Correctional Peace Officer Standards and Training program approval. Lesson plans for the now-expanded academy are complete and were approved by the commission. Cadet testing protocols are also complete, as are operational procedures governing test results retention.

In April 2000 the Office of the Inspector General conducted an unannounced special review audit of the Richard A. McGee Correctional Training Center. The review was prompted by numerous serious allegations that were reported to the Office of the Inspector General in late March 2000. The allegations called into question the integrity of test results for recent graduates of the basic correctional officer academy located at the center and the overall preparedness of correctional officers graduating from the academy.

BACKGROUND

Established in the early 1970s, the Richard A. McGee Correctional Training Center (now known as the Richard A. McGee Academy) conducts the basic correctional officer academy program for all correctional officers training in California. Cadets who complete the training are credentialed by the academy as certified correctional peace officers. In addition to basic correctional officer training, the center provides advanced peace officer and correctional officer training, parole agent training, management training, and a leadership institute.

Before the Office of the Inspector General's 2000 audit, the basic correctional officer certification training program consisted of a six-week course given at the academy in Galt, California. In fiscal year 1999-00, the Department of Corrections obtained a $5 million budget increase to expand the program to a ten-week course. The ten-week curriculum required developing 77 new lesson plans, all of which were to have been launched in January 2000. (Effective September 30, 2000, legislation further expanded the ten-week course to 16 weeks.)

The Office of the Inspector General's May 2000 audit reported a range of deficiencies in the implementation of the new ten-week academy. Among other findings, it revealed incomplete lesson plans, lesson plans that failed to receive Commission on Correctional Peace Officer Standards and Training approval, academy courses that did not adhere to specified lesson plan instructor-to-cadet ratios, testing and cadet evaluations that lacked strict controls, and academy instructors who were insufficiently qualified.

Effective July 1, 2005, the Commission on Correctional Peace Officer Standards and Training was dissolved and responsibility for academy oversight was transferred to the Corrections Standards Authority. Legislated by Senate Bill 737, this transfer of authority included the oversight to "develop, approve, and monitor standards for the selection and training of state correctional peace officers." The bill also renamed the training center the Richard A. McGee Academy.

Although the Corrections Standards Authority is accountable for oversight of the academy, the Department of Corrections and Rehabilitation is still required to design and deliver training programs, conduct validation studies, and provide program support—areas in which critical deficiencies were found in the May 2000 audit. These deficiencies are the focus of this follow-up review.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the May 2000 review, the Office of the Inspector General made the following specific findings:

- Cadets were being trained under the expanded ten-week curriculum even though a significant number of the lesson plans had not been completed. The Department of Corrections was able to completely develop only 46 of the required 77 new lesson plans before January 2000, the start of the ten-week curriculum.

- Many of the 46 lesson plans, including those for highly essential courses, had not received provisional approval from the Commission on Correctional Peace Officer Standards and Training. At the start of the January 2000 academy, only 23 completed lesson plans had been submitted to the commission for approval, and only a portion of the 23 had received provisional approval.

- The Department of Corrections Staff Development Center and the training center staff failed to coordinate efforts in developing the lesson plans. The training center staff members informed the Office of the Inspector General that their suggestions for lesson plans were consistently ignored. Consequently, the training staff found some of the commission-approved training plans to be unacceptable and significantly modified the plans without the knowledge of either the Staff Development Center or the commission.

- The training center did not maintain the instructor-to-cadet ratios specified in the lesson plans approved by the Commission on Correctional Peace Officer Standards and Training.

- Guidelines for presenting lesson plans and administering tests were not prepared. No written guidelines were developed for administering the lesson plans, presenting them to a class, or evaluating their effectiveness. Likewise there were no written guidelines for administering and securing the tests associated with each lesson plan.

- The academy's process for testing and certifying cadets under the ten-week curriculum was seriously flawed. For example, the overall passing score for cadets was, without justification, arbitrarily lowered from 85 percent to 80 percent; cadets were permitted to retake tests more than once to increase scores; cadets were not administered comprehensive examinations required by the *California Department of Corrections Operations Manual*; the training center nullified a particular quiz because the failure rate was too high; test questions were altered without commission approval; students who failed firearms testing were allowed to graduate; written evaluations of cadets by company commanders were not specific to individual cadets, as intended; and cadets received disparate treatment relative to opportunities to improve performance and to disciplinary actions for similar offenses.

- Except for the quiz on radio communications, test results had not been destroyed. The staff at the training center's examination unit initially informed the Office of the Inspector General that all test and quiz results had been destroyed at the completion of the first ten-week course. However, other training center staff members later produced test and quiz results, except for those pertaining to the radio communications class. According to the training center staff, the radio communications quiz was destroyed because the quiz was nullified.

- Instructor qualifications and class preparation time were deficient. Because certification of many of the instructors at the academy had not been evaluated by an objective certifying agency, some may not have been qualified in the subjects they taught. Also, they were required to teach eight to 12 hours a day on a variety of subjects, and the Staff Development Center was often tardy in supplying lesson plans. As a result, instructors had inadequate time for class preparation. These factors were further exacerbated by the academy's overall instructor shortage. The training center estimated that nine additional instructors were needed to effectively institute the lesson plans.

As a result of the May 2000 review, the Office of the Inspector General recommended that the Richard A. McGee Correctional Training Center, in consultation with the Staff Development Center and the Commission on Correctional Peace Officer Standards and Training, take the following actions:

- Complete all lesson plans.

- Obtain lesson plan approval from the Commission on Correctional Peace Officer Standards and Training.

- Develop lesson plans in a collaborative effort between the Staff Development Center and the Correctional Training Center.

- Adhere to lesson plan staff-to-cadet ratios.

- Prepare guidelines for presenting lesson plans and administering tests.

- Establish a clearly defined testing protocol that measures cadet performance.

- Handle and dispose of test results appropriately.
- Develop an action plan.
- Provide instructors with approved lesson plans and written guidelines.
- Follow prescribed guidelines in administering tests.
- Ensure that instructors are fully qualified.
- Determine the need for remedial training of cadets who had recently completed the new ten-week curriculum.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Richard A. McGee Academy has implemented the 12 recommendations from the Office of the Inspector General's May 2000 review. To conduct the follow-up review, the Office of the Inspector General provided the California Department of Corrections and Rehabilitation Office of Departmental Training and the Richard A. McGee Academy with a table listing the May 2000 findings and recommendations and requested the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the academy, and evaluated the degree of compliance or noncompliance with the recommendations. Review fieldwork was completed in November 2005. The results are presented in the table that follows this section.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 12 recommendations issued by the Office of the Inspector General in May 2000 concerning the academy's administration of its correctional cadet training program, 11 recommendations have been fully implemented and one recommendation, relating to the possible need for remedial training of cadets who had recently completed the ten-week curriculum, has not been implemented.

The Office of the Inspector General found that the Richard A. McGee Academy has significantly improved its cadet training program. The academy implemented guidelines for course development that include instructor input, cadet feedback, and Commission on Correctional Peace Officer Standards and Training approval. Lesson plans for the now-expanded academy are complete and have been approved by the Commission on Correctional Peace Officer Standards and Training (now the Corrections Standards Authority). Cadet testing protocols and test retention policy also have been completed.

FOLLOW-UP RECOMMENDATIONS

None.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that cadets were being trained under the expanded ten-week curriculum even though a significant number of the lesson plans had not been completed.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections Staff Development Center complete all lesson plans.	FULLY IMPLEMENTED	According to the Department of Corrections and Rehabilitation Office of Training and Professional Development, the ten-week curriculum was expanded to 16 weeks and all lesson plans were completed as of June 11, 2003.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that many of the lesson plans, including those for highly essential courses, had not received provisional approval from the Commission on Correctional Peace Officer Standards and Training.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections Staff Development Center, in consultation with the training center, obtain Commission on Correctional Peace Officer Standards and Training approval of lesson plans.	FULLY IMPLEMENTED	The Department of Corrections and Rehabilitation Office of Training and Professional Development reported that all lesson plans comprising the 16-week Basic Correctional Officer Academy curriculum were approved by the Commission on Correctional Peace Officer Standards and Training as of June 11, 2003. The approval is still valid under the new Corrections Standards Authority.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that the Department of Corrections Staff Development Center and the training center staff failed to coordinate efforts in developing the lesson plans.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections Staff Development Center and the Correctional Training Center develop lesson plans in a collaborative effort.	FULLY IMPLEMENTED	With the July 1, 2005 reorganization of the Department of Corrections and Rehabilitation, instructional designers have been relocated to the Basic Peace Officer Institute at the Richard A. McGee Academy. According to the Office of Training and Professional Development, as lesson plans are developed and revised, designers will rely on instructor and cadet evaluations, classroom visitation, and pilot testing to coordinate materials used in the lesson plans. Academy instructors have been apprised of this process and have been encouraged to provide input.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that the training center did not maintain the instructor-to-cadet ratios specified in the approved lesson plans.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections Staff Development Center ensure adherence to lesson plans and written guidelines including maintaining specified lesson plan ratios.	FULLY IMPLEMENTED	According to the Office of Training and Professional Development, one of the chief priorities of the basic academy's scheduling office is to ensure that courses are in compliance with required staff-to-cadet ratios specified by approved lesson plans.

FOLLOW-UP RECOMMENDATIONS
None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that guidelines for presenting lesson plans and administering tests were not prepared.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections Staff Development Center prepare guidelines for presenting lesson plans and administering tests.	FULLY IMPLEMENTED	The Department of Corrections Staff Development Center informed the Office of the Inspector General that guidelines for presenting lesson plans are complete and were approved by the Commission on Correctional Peace Officer Standards and Training. All academy instructors receive a *Correctional Sergeant/Instructor Handbook* containing instructional guidelines that include the following: • Course length • Prerequisites • Recommended maximum number of students • Related courses • Required resources • Instructional goal • Core tasks • Learning objectives • Learning activities • Evaluation methodology • Outline of the course presentation • PowerPoint slides used, if applicable In addition, guidelines were established for administering basic academy tests. Testing falls into two categories: written objective testing and skills demonstration testing. The Curriculum Testing and Evaluation Section at the academy administers all written examinations; skills testing is predicated on individual lesson plans.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that the academy's process for testing and certifying cadets under the ten-week curriculum was seriously flawed.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections Staff Development Center establish and clearly define a testing protocol that measures cadet performance.	FULLY IMPLEMENTED	According to the Office of Training and Professional Development, the basic academy uses five separate instruments to gauge cadet performance: practice exercises, major exams, performance tests, the California Penal Code 832 test, and on-the-job observation. The protocol sets guidelines for the development of each of these measuring instruments, including establishing pass points, continuous improvement, test administration procedures, and test security.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that except for the quiz on radio communications, test results had not been destroyed.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Richard A. McGee Correctional Training Center handle and dispose of test results appropriately.	FULLY IMPLEMENTED	On August 22, 2005 the academy approved Operational Procedure #B-038, which mandates that all hard copies of cadet tests and scantrons be destroyed upon graduation, unless a cadet is involved in any administrative action relative to poor academics or testing irregularities, whereupon those tests and scantrons will be

		maintained on-site for two years. The records will then be archived off-site for three years. Cadet academic scores, range scores, participation logs, and related class materials are securely maintained on-site for two years in the testing office and three years at the off-site archives location. After five years' storage, the documents are confidentially shredded. At the conclusion of each academy, a password-protected copy of the testing files for each class is created and archived. A chronological electronic history of academy classes is maintained indefinitely in the testing office.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that instructor qualifications and class preparation time were deficient.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended the actions listed below.		
The California Department of Corrections Staff Development Center, in consultation with the training center and the Commission on Correctional Peace Officer Standards and Training develop an action plan.	FULLY IMPLEMENTED	The academy developed an action plan following the Office of the Inspector General's May 2000 report. The latest version of the action plan submitted to the Office of the Inspector General, dated September 16, 2000, indicated that 35 of the 37 action items had been completed. The remaining two action items were not related to the Office of the Inspector General's recommendations.
The California Department of Corrections Staff Development Center should provide approved lesson plans and written guidelines to academy instructors.	FULLY IMPLEMENTED	The Office of the Inspector General was informed that copies of approved lesson plans have been provided to basic correctional academy instructors. Further, in March 2005 the academy revised its *Correctional Sergeant/Instructor Handbook* to include guidelines for training cadets.

The Richard A. McGee Correctional Training Center follow prescribed guidelines in administering tests.	FULLY IMPLEMENTED	Operational procedures applying to major exam administration and scoring instructions were approved in March 2005. According to the academy, the center administration will review these procedures annually for any necessary amendments.
The Richard A. McGee Correctional Training Center ensure that instructors are fully qualified.	FULLY IMPLEMENTED	The academy reported that it maintains training files for all instructors. According to the academy, every basic academy instructor's in-service training file has been analyzed and a complete accounting of instructor certification training has been made. A certification spreadsheet has been created and the academy's scheduling office uses the spreadsheet to ensure that instructors are assigned to teach only courses for which they have the necessary certificates.
The California Department of Corrections should determine the need for remedial training of cadets recently completing the new ten-week curriculum.	NOT IMPLEMENTED	The academy observed that several years have elapsed since the last class of the Basic Correctional Officer Academy graduated under the circumstances identified by the May 2000 audit. There is no documentation of follow-up work to determine the need for remedial training. Further, the academy suggests that any deficiencies in the training of cadets in the original ten-week academy would likely have been addressed by corrective action tied to performance problems or by ongoing service training.

FOLLOW-UP RECOMMENDATIONS

None.

CALIFORNIA STATE PRISON, SOLANO

IMPLEMENTATION REPORT CARD

Previous recommendations: 24

Fully implemented: 19 (79%)

Substantially implemented: 2 (9%)

Partially implemented: 2 (8%)

Not implemented: 1 (4%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the California State Prison, Solano has improved certain of its operations since a March 2003 management review audit. The facility more closely monitors inmates' tuberculosis status, better manages sentence reduction credits granted to inmates, and has improved its management of both inmates placed in administrative segregation and those taking psychotropic medications. Although it has made significant progress, the facility has only partially implemented recommendations to properly house inmates taking anticonvulsant medications and has not taken steps to monitor its pharmacy inventory.

In March 2003, the Office of the Inspector General conducted a management review audit of California State Prison, Solano pursuant to its authority under California Penal Code, section 6051. The review was conducted to assess the essential functions of the facility. As a result of the review, the Office of the Inspector General found deficiencies in tracking inmate tuberculosis status, improper assignment of sentence reduction credits, ineffective monitoring of the length of time inmates spend in administrative segregation, unsafe modifications to the administrative segregation buildings, and inappropriate housing for inmates taking psychotropic and anticonvulsant medications.

BACKGROUND

California State Prison, Solano opened in August 1984 and is a medium-security institution covering 146 acres in Vacaville, California. The prison was initially administered by the warden of the California Medical Facility, the adjacent institution, but beginning in January 1992 it was administered as a separate institution under its own warden. California State Prison, Solano was designed to house 2,658 inmates, but it currently houses about 5,800 Level II and Level III inmates. The prison provides a comprehensive work/training program that offers academic and vocational training as well as industry assignments.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the March 2003 review, the Office of the Inspector General made the following specific findings:

- California State Prison, Solano was not adequately tracking inmates with tuberculosis, creating the potential of exposing inmates throughout the state to the disease and presenting a risk to the correctional staff and the general public.

- California State Prison, Solano inmates were allowed to earn sentence reduction credit through education and training classes even when classes were not actually held.

- Makeshift partitions in the institution's administrative segregation unit buildings created blind spots that limited the view of the control booth officers, compromising the safety and security of correctional staff and inmates.

- A significant number of inmates taking psychotropic medications were inappropriately housed in buildings lacking air conditioning and some inmates who were taking anticonvulsant medications were not assigned to lower bunks to lessen the possibility of injury in the event of a seizure.

- When inmate deaths occurred, the cause and circumstances surrounding the deaths were not examined in a timely manner and those assigned to conduct the reviews may have had a direct interest in the results.

- California State Prison, Solano retained inmates in administrative segregation units longer than justified.

- California State Prison, Solano was not complying with state regulations governing inmate dental care and as a result may have been exposed to the risk of litigation.

- California State Prison, Solano did not adequately document employee disciplinary proceedings, and the warden inappropriately served as the Skelly hearing officer in appeals of adverse action decisions.

- Pharmacy record keeping and physical controls over prescription medications stored in the infirmary and clinics were inadequate to prevent unauthorized access and theft.

- California State Prison, Solano did not promptly implement medical modification orders and many were significantly overdue at the time of the audit.

- The institution was not properly documenting inmate activity in the administrative segregation units and in some instances events were logged before they occurred.

- California State Prison, Solano prepared an excessive number of daily meals for inmates, resulting in unnecessary added costs for food and related services.

The Office of the Inspector General presented 24 recommendations to remedy the deficiencies identified in the March 2003 review.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the California State Prison, Solano has implemented the 24 recommendations from the Office of the Inspector General's March 2003 management review audit. To conduct the follow-

up review, the Office of the Inspector General provided the California State Prison, Solano with a table listing the March 2003 findings and recommendations and asked management to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the facility, and evaluated the degree of compliance or noncompliance with the recommendations. In addition, the Office of the Inspector General visited the facility in October 2005 to conduct on-site verification and interviews with staff members. The fieldwork for the follow-up review was completed during February 2006. The results are presented in the table following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 24 recommendations issued by the Office of the Inspector General in March 2003 concerning the California State Prison, Solano, 19 recommendations have been fully implemented; two have been substantially implemented; two have been partially implemented; and one has not been implemented.

The Office of the Inspector General found that the California State Prison, Solano has made significant progress in implementing the recommendations made in the March 2003 report. Specifically, the Office of the Inspector General made the following findings:

- The facility has improved its monitoring of inmates who have tested positive for tuberculosis by adding staff and increasing follow-up assessments of those inmates.

- In closing classes with no assigned instructors, the facility has reduced the rate at which it grants sentence-reduction credits to inmates who otherwise did not attend classes.

- The facility installed mirrors that improved visibility in its administrative segregation units.

- The facility has implemented procedures to ensure that inmates taking psychotropic medications—which increase inmates' susceptibility to heat-related illnesses—are appropriately housed and monitored when temperatures are higher than 90 degrees. The facility should, however, improve its monitoring of inmates taking anti-seizure medications to ensure that those inmates are assigned to lower bunks to protect their safety.

- The department implemented new procedures in December 2005 relative to reporting inmate deaths and submitting specific documents related to each death to headquarters for analysis.

- In July 2005, the department obtained additional resources to improve statewide dental care. It is too early, however, for the Office of the Inspector General to determine whether those additional resources will improve inmate dental care.

- The pharmacy at California State Prison, Solano has improved its security over non-narcotic medications, but still does not have a method to monitor their inventory.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California State Prison, Solano take the following additional actions:

- **Conduct periodic evaluations of the housing assignments of inmates who have been prescribed seizure medications to ensure that those inmates are housed appropriately.**

- **Develop a method to reconcile the types and quantities of pharmaceuticals shipped from its pharmacy to its clinics and the correctional treatment center with the types and quantities of medications prescribed to inmates.**

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation take the following additional actions:

- **Assess whether the increased dental staffing and equipment have improved the availability of dental examinations to inmates across all institutions.**

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found evidence that California State Prison, Solano was not adequately tracking inmates with tuberculosis, creating the potential of exposing inmates throughout the state to the disease and presenting a risk to the correctional staff and the general public.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that California State Prison, Solano take the actions listed below to improve the identification and tracking of inmate tuberculosis status.		
Allocate additional personnel resources to the task of monitoring and recording inmate tuberculosis status.	FULLY IMPLEMENTED	California State Prison, Solano reported that the medical department has provided additional resources to assist the public health nurse and infection control nurse in monitoring inmates' tuberculosis (TB) status. Specifically, it assigned a TB manager to oversee the project, updated its TB policies and procedures, and assigned additional clerical staff to medical records. It also assigned a staff physician to oversee auditing of the TB alert program. The facility also reports that nursing supervisors daily review TB testing of incoming inmates. The Office of the Inspector General interviewed the chief medical officer and verified that additional staff members have been assigned to oversee the facility's TB alert program. According to the chief medical officer, a physician oversees the TB alert program and two public health nurses work nearly full-time monitoring TB alert program information in inmate medical records. Additionally, an infection control nurse and a health program coordinator work part-time on the TB alert program.

Require the public health nurse to collect all records for inmates who have completed a tuberculosis treatment regimen to ensure that those inmates receive a post-treatment evaluation by a physician.	**SUBSTANTIALLY IMPLEMENTED**	The facility reported that the public health nurse is required to monitor and ensure that all inmates, including new arrivals, are processed, evaluated, and receive a post-treatment physician evaluation and follow-up. This process is audited by a staff physician and nursing supervisors. The Office of the Inspector General interviewed the chief medical officer, who stated that the institution is closely monitoring 186 inmates who previously tested positive for the TB skin test. In addition, the physician who monitors the TB alert program stated that, beginning in March 2006, all inmates previously testing positive, but who refused to take or stopped taking medication, will be counseled and strongly advised to begin or complete the prophylactic medication series. According to the chief medical officer, inmates who test positive for the TB skin test have a 50 percent chance of developing infectious TB within two years. The physician further informed the Office of the Inspector General that inmates receive evaluations over the course of treatment to ensure that there is no adverse reaction to the medication, although post-treatment evaluation is not administered in all cases. Alternatively, post-treatment evaluation typically occurs in light of a separate clinical need, such as if the inmate has other medical issues that require follow-up. The chief medical officer also affirmed that the facility will shortly initiate new procedures to assess the clinical need for a chest x-ray for new inmates who had previously tested positive for TB but who had either refused to take or had not completed taking the prophylactic medication series. For these inmates, a chest x-ray would be considered if the inmate's previous chest x-ray had been taken more than three months earlier and if such clinical symptoms as night sweats, coughing, fever, or recent weight loss were evident.

Require the public health nurse to ensure that tuberculosis codes are properly updated in inmate medical records and in the department's system-wide database and that a CDC Form 128-C (medical chrono) is forwarded to the central records staff for inclusion in the inmate's central file.	**FULLY IMPLEMENTED**	The facility reported that the department's Division of Correctional Health Care Services developed a standardized statewide inmate TB alert system. The facility's public health nurse monitors the system daily for compliance and ensures that a completed CDC Form 128-C (medical chrono) is forwarded to the records office for inclusion in the inmate's central file. The physician who oversees the TB alert system at the facility also affirmed to the Office of the Inspector General that, between January and June 2005, she audited medical records monthly to ensure that inmates' TB status (coding) and TB-related documents concur with their medical records. She reported further that she had observed a substantial improvement in record-keeping monitored by the public health nurses. In addition, the chief medical officer reported that the public health nurse has fully reconciled the TB codes recorded in inmate medical records with those in the system-wide database.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that California State Prison, Solano inmates were allowed to earn sentence-reduction credit through education and training classes even when classes were not actually held.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that California State Prison, Solano refer all inmates currently assigned to programs without instructors to the classification committee for reassignment in accordance with the May 16, 2002 memorandum from the Department of Corrections Institutions Division and discontinue awarding "S" time to these inmates.	FULLY IMPLEMENTED	California State Prison, Solano reported that the education supervisor is monitoring these issues. When long-term class closures are anticipated, they are communicated to the inmate assignment lieutenant for temporary deactivation. Additionally, monthly education reports itemize specific reasons for "S" time to guide supervisors in rectifying deficiencies. The Office of the Inspector General found that the facility closed eight classes in 2005. The facility also reduced the percentage of inmate "S" time credits. (Regulations authorize the department to award inmates sentence-reduction credit under certain circumstances, such as when instructors are absent and no relief instructor is available. These time credits are referred to as "S" time credits.) In fiscal year 2001-02, 62 percent of the time credits granted for education were "S" time hours, whereas in fiscal year 2004-05, the percentage of "S" time hours decreased to 46 percent.
The Office of the Inspector General also recommended that California State Prison, Solano immediately identify which classes should be closed and take formal steps to do so.	FULLY IMPLEMENTED	California State Prison, Solano reported that inmates assigned to education classes identified as permanently closed are referred to the work incentive coordinator for reassignment as appropriate. The classes are then documented as closed and inmates are no longer assigned to those classes. The Office of the Inspector General found that the facility closed eight classes in 2005.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that makeshift partitions in the institution's administrative segregation unit buildings created blind spots that limited the view of the control booth officers, compromising the safety and security of correctional staff and inmates.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that California State Prison, Solano remove the makeshift barriers in the administrative segregation unit and develop alternatives for creating meeting space.	SUBSTANTIALLY IMPLEMENTED	California State Prison, Solano reported that the floors have been painted with a red line, convex mirrors have been installed, partitions are currently secured to the floor, and obstructions have been removed from cabinet tops. In addition, the facility reported that the institutional staff reviewed the Office of the Inspector General's recommendation to remove the partitions and decided to retain them because they furnish privacy for inmate mental health and medical evaluation interviews. Although the partitions still present blind spots to the control booth officer, the Office of the Inspector General believes that the facility's modifications have improved control booth officers' visibility and are the most feasible solution to the original recommendation.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that a significant number of inmates taking psychotropic medications were inappropriately housed in buildings lacking air conditioning and that some inmates who were taking anticonvulsant medications were not assigned to lower bunks to lessen the possibility of injury in the event of a seizure.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution conduct periodic evaluations of the housing assignments of inmates who have been prescribed psychotropic medications or whose medical conditions indicate particular housing needs. When a housing assignment is found to be incompatible with an inmate's medical condition, the institution should take immediate measures to reassign the inmate to appropriate housing.	PARTIALLY IMPLEMENTED	California State Prison, Solano reported that its extreme weather plan (institutional operations plan CSPS-CS/AD-04-015) requires specific staff procedures to minimize health risks to inmates who could be adversely affected if exposed to high ambient temperatures. In addition, the facility reported that inmates who suffer from seizure disorders are required to be identified by unit staff to ensure compliance with lower bunk requirements. The Office of the Inspector General reviewed the extreme weather plan and related documents. The Office of the Inspector General found that the facility medical staff generates a daily list of heat-risk inmates, and that custody staff monitors inside and outside air temperatures hourly. Further, the facility extreme weather plan outlines specific steps to be followed when temperatures exceed 90 and 95 degrees. When inside temperatures exceed 95 degrees, medical staff members visually monitor heat-risk inmates every two hours and must contact the chief medical officer for a diagnosis when a heat-risk inmate appears to be suffering from heat exposure. The Office of the Inspector General also analyzed pharmacy records for September 2005 and identified eight inmates who had been prescribed seizure medications, yet records indicated that the inmates were not assigned to lower bunks, putting them at risk of a fall-related injury in the event of a seizure. The Office of the Inspector General requested that the chief medical officer assess whether these inmates had health conditions that required placement in lower bunks; according to the chief medical officer, five of the eight did require lower bunks. In response, the Office of the Inspector General alerted the warden's office, which determined that two of the five were currently housed in lower bunks, leaving three remaining inmates in upper bunks.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the institution conduct periodic evaluations of the housing assignments of inmates who have been prescribed seizure medications to ensure that these inmates are housed appropriately.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that when inmate deaths occurred, the cause and circumstances surrounding the deaths were not examined in a timely manner and that those assigned to conduct the reviews may have had a direct interest in the results.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections develop procedures to require the Health Care Services Division to take the steps listed below to improve review of inmate deaths.		
Coordinate review of inmate deaths with the warden and the institution's chief medical officer. The procedures should provide for communication throughout the review process to coordinate the assignment of staff and collection of evidence by the investigative staff when necessary.	FULLY IMPLEMENTED	On December 30, 2005, the department's director over the Division of Correctional Health Care Services issued a directive requiring that all inmate death-related documents be submitted to the division within seven calendar days following the date of death. Division staff also told the Office of the Inspector General that, beginning January 2006, all inmate deaths are reviewed by a headquarters-based death review committee comprised of division staff, medical professionals, and representatives from the Office of Internal Affairs. At present, the death review committee is monitored by the Office of the Inspector General's Bureau of Independent Review. The committee meets every two weeks and can issue referrals for peer reviews and/or internal affairs investigations. Referrals for internal affairs investigations related to inmate deaths can also be initiated by the institution's chief medical officer or the warden. Because the death review process and peer review process are new, the Office of the Inspector General did not assess their effectiveness during this audit. It, anticipates, however, that it will provide comments to the division and

		appropriate departmental officials as part of its ongoing monitoring of the death review process.
Forward pertinent information gathered by the investigations unit of the institution to the morbidity and mortality review committee.	**FULLY IMPLEMENTED**	According to the director of the division's medical program implementation, the morbidity and mortality review committee has been replaced. Inmate deaths are now reviewed by the death review committee described above, and inmate suicides are reviewed by staff members who have clinical, psychological, and custodial expertise. The December 30, 2005 directive provides that all information related to inmate deaths is forwarded to the division. As noted above, the death review committee includes representatives from the Office of Internal Affairs and is presently monitored by the Office of the Inspector General's Bureau of Independent Review.
Ensure that those conducting peer reviews are independent of the incident and the individuals involved.	**FULLY IMPLEMENTED**	According to the division's director of medical program implementation, peer reviews are now coordinated through the regional medical directors and the professional practice executive committee. These peer reviews can be initiated by the death review committee or health care managers, and are conducted either by regional staff or external University of California experts.
Ensure that peer reviews are completed in a timely manner.	**FULLY IMPLEMENTED**	The division reported to the Office of the Inspector General that, because they are now coordinated through headquarters division staff, peer reviews are monitored for timely completion by headquarters staff.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that California State Prison, Solano retained inmates in administrative segregation units longer than justified.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden take the actions listed below.		
Develop a standard tracking system for use by all of the housing facilities to monitor inmates retained in administrative segregation. The tracking system should record all critical actions, including communication with employees and other units within the institution, to ensure that casework is completed in a timely manner.	FULLY IMPLEMENTED	The institution reported that its inmate classification information system is currently being used to monitor inmates retained in administrative segregation. This local information system tracks all critical actions, including communication with employees and other units, to ensure that casework is completed in a timely manner.
Emphasize the importance of completing casework before presenting cases at the institution classification committee hearing or submitting cases to the classification services representative for review and approval.	FULLY IMPLEMENTED	The institution reported that caseworkers can now prepare the appropriate documentation before presenting cases to the institutional classification committee by using the inmate classification information system. The Office of the Inspector General's review of institutional classification committee actions relative to administrative segregation inmates confirmed that casework is completed before cases are presented to the institution classification committee.
Provide training to correctional counselors and other members of the institution staff to ensure that all actions required in administrative segregation cases are completed and the results documented and communicated to the appropriate staff.	FULLY IMPLEMENTED	The institution reported that it provides training to correctional counselors and other institutional staff weekly or monthly. It furnished the Office of the Inspector General with copies of weekly agenda meeting topics supported by sign-in sheets for training conducted in 2004 and 2005, indicating that the topic of administrative segregation had been included.
Identify all cases that have been deferred pending action or returned by the classification services representative for completion of additional casework and monitor these cases	FULLY IMPLEMENTED	The institution generates a deferral list of administrative segregation inmates whose institution classification committee hearings have been deferred pending results from investigations, parole hearings, district attorney requests, rules violation reports, or other administrative issues. This list is provided to

closely to ensure that tasks are completed by the institution staff in a timely manner.		the chief deputy warden for review and forwarded to division heads to ensure that the pending circumstances are monitored.
The Office of the Inspector General further recommended that the Department of Corrections follow the procedural requirements for amending regulations as required by the *California Government Code*.	**FULLY IMPLEMENTED**	The Department reported that it follows the procedural requirements for amending regulations as required by the *California Government Code*. The Office of the Inspector General originally found that the department's Institutions Division disseminated a department-wide memo in November 2001, directing institutions to re-evaluate an inmate's retention in administrative segregation every 90 to 180 days, depending on the reason for the retention, instead of the mandate of at least every 30 days. Since the Office of the Inspector General's original audit, the department's Regulation and Policy Management Branch processed the formal regulation change, and effective December 15, 2005, the regulation change became permanent.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that California State Prison, Solano was not complying with state regulations governing inmate dental care and as a result may have been exposed to the risk of litigation.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections examine policies and regulatory requirements governing inmate dental care and consider revising requirements to a level achievable under present conditions.	PARTIALLY IMPLEMENTED	The department reported that it is examining its policies and regulatory requirements in the course of drafting a dental policy and procedure manual. The department also reported its submission of a fiscal year 2005-06 finance letter to secure additional positions and equipment specifically for department-wide dental care. The Office of the Inspector General found that inmates did not receive the required dental examinations under California Code of Regulations, Title 15, which requires that inmates receive an initial dental examination within 14 days of arrival from the reception center. Further, inmates under age 50 are to receive a dental examination every two years; all other inmates are to receive a dental examination annually. The Office of the Inspector General also found that the drafted dental policy and procedure manual does not address the inmate dental care issues identified in the audit. Also, the department does not offer any proposed or pending changes to Title 15 that would alter the frequency of inmate dental examinations. The finance letter to increase department-wide dental care was approved in July 2005, adding 63 positions and $13.3 million. It is too early, however, for the Office of the Inspector General to determine whether these additional resources will improve the availability of inmate dental care examinations.

FOLLOW-UP RECOMMENDATION

The California Department of Corrections and Rehabilitation should assess whether the increased dental staffing and equipment have improved the availability of dental examinations to inmates across all institutions.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that California State Prison, Solano did not adequately document employee disciplinary proceedings and that the warden inappropriately served as the Skelly hearing officer in appeals of adverse action decisions.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that California State Prison, Solano take the actions listed below.		
Take steps to ensure that the employee relations officer and all others involved in possible employee disciplinary proceedings document their actions thoroughly and completely in the adverse action files to provide a complete and accurate history of critical steps in the disciplinary process and assist the employee relations officer in developing consistent disciplinary recommendations in future cases.	FULLY IMPLEMENTED	California State Prison, Solano reported that the employee relations officer uses a checklist contained within each adverse action file for an overview of the critical steps taken in employee disciplinary proceedings, ranging from a review of circumstances for possible adverse action to taking adverse action through the appeal process. The completed adverse action files also contain supporting documentation. As part of its follow-up review, the Office of the Inspector General examined samples of adverse action files and found that they were supported by documentation of the disciplinary steps taken.

Discontinue the practice of the warden acting as the Skelly hearing officer in personnel matters involving California State Prison, Solano.	**FULLY IMPLEMENTED**	California State Prison, Solano reported that it no longer engages the warden or chief deputy warden to conduct Skelly hearings. Alternatively, associate wardens who are not within the chain of command of the affected employee conduct these hearings. As part of its follow-up review, the Office of the Inspector General reviewed samples of adverse action files and found that the hearing officer was a non-involved manager. In addition, as discussed in the chapter of this audit which relates to the employee disciplinary process, the Office of the Inspector General's follow-up review to its initial March 2002 review of the department's employee disciplinary process found that the Department of Corrections and Rehabilitation has made significant improvements in administering the employee disciplinary process by updating its policies and procedures for employee discipline, providing formalized training to its statewide employee relations officers, and developing a case management system to monitor the comprehensive stages of disciplinary cases. It has also implemented a new central intake process that includes legal representatives from both the Department of Corrections and Rehabilitation and the Office of the Inspector General's Bureau of Independent Review to review requests for investigations and determine appropriate action.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that pharmacy record keeping and physical controls over prescription medications stored in the infirmary and clinics were inadequate to prevent unauthorized access and theft.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the health care manager at California State Prison, Solano take the actions listed below to improve control over pharmaceuticals.		
Institute measures to ensure that medications are securely stored at all times consistent with their value and potential for misuse. Medications in the infirmary and clinics should be stored in secured areas under a supervisor's control.	FULLY IMPLEMENTED	California State Prison, Solano reported that narcotic medications are stored in secured containers in the pharmacy, clinics, and the correctional treatment center. In addition, licensed pharmacists monitor the handling and storage of narcotics and perform routine audits of these functions. During its follow up review, the Office of the Inspector General observed that both narcotic and non-narcotic medications are stored in secured containers and that medications in the correctional treatment center and clinics are secured under a supervisor's control.
Record the quantity of pharmaceuticals shipped to the infirmary and clinics and periodically compare these records to the quantities prescribed by doctors. Investigate any material variations between the two amounts. Physical inventories of drugs should be conducted periodically and compared to perpetual inventory records maintained by the health care manager.	NOT IMPLEMENTED	California State Prison, Solano reported that the pharmacy maintains both individual binders with accountability log sheets for each medication and a controlled medication log for narcotics. For narcotics secured in locked cabinets, a running inventory log is also updated whenever medications are added or removed and an inventory of each cabinet is conducted at every shift change. The Office of the Inspector General verified that the pharmacy maintains a medication log for narcotics, but that a similar perpetual inventory system is not maintained for non-narcotic medications. According to the pharmacy manager, the current pharmacy computer system is incapable of generating inventory records, making a reconciliation between physical inventory amounts and perpetual inventory records unfeasible.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California State Prison, Solano develop a method to reconcile the types and quantities of pharmaceuticals shipped from its pharmacy to its clinics and the correctional treatment center with the types and quantities of medications prescribed to inmates.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that California State Prison, Solano did not promptly implement medical modification orders and that many were significantly overdue at the time of the audit.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the chief medical officer at California State Prison, Solano assign a staff member to monitor the timely completion of medical modification orders, with priority on resolving the oldest orders first. That staff member should also periodically reconcile the information on the overdue modification orders list with information in the inmate appeals office records to ensure accuracy of the list.	FULLY IMPLEMENTED	California State Prison, Solano reported that a medical appeals coordinator is assigned to monitor the timely completion of medical modification orders. The medical appeals coordinator reconciles this information monthly with the inmate appeals office, which prepares a weekly overdue list that is distributed to the warden, chief deputy warden, and division heads. In its October 2005 follow-up review, the Office of the Inspector General examined a list of medical modification orders and found that the facility had no overdue orders.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that the institution was not properly documenting inmate activity in the administrative segregation units and that in some instances events were logged before they occurred.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that administrative segregation custody personnel institute a practice of recording inmate movements in CDC Form 114 and CDC Form 114-A as they occur, rather than waiting for the first watch administrative segregation floor officer to update the movements after the fact or recording events before they take place.	FULLY IMPLEMENTED	California State Prison, Solano reported that it had trained all administrative segregation custody personnel to record inmate movements as they occur on the CDC Form 114, Disciplinary Detention Log, and the CDC Form 114-A, Detention/Segregation Record. The administrative segregation lieutenant additionally monitors this practice.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found that California State Prison, Solano prepared an excessive number of daily meals for inmates, resulting in unnecessary added costs for food and related services.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden and the food manager review the food service process at the institution to identify areas in which controls should be established or strengthened. Controls should include an accurate cost accounting system to record actual meals served, re-cycled, and wasted to assist in estimating future daily meal requirements and in controlling associated costs. The institution should also strengthen custody controls over food service operations to lessen opportunities for inmates to obtain more than one meal.	FULLY IMPLEMENTED	California State Prison, Solano reported that it is difficult to predict exactly how many inmates will be participating in each meal because such factors as the menu, weather conditions, sports events, and inmate incidents can affect meal participation. The facility further reported that its food services department developed a tracking system reflecting daily meals prepared versus wasted; this data—including dates, menus, and events suspected to have contributed to food waste fluctuations—is submitted monthly to management and is also evaluated in food services supervisory and staff meetings. The facility also took measures to reduce inmates' ability to "double back" through food lines to receive more than one meal and in addition modified the feeding system to minimize inmates' opportunities to request extra portions of food. The Office of the Inspector General reviewed monthly monitoring sheets prepared by the food services manager for January through August 2005. During this period, the monthly food waste ranged between 2 and 5.4 percent and averaged 3.1 percent—a significant improvement over the 7.5 percent average noted by the Office of the Inspector General in its 2003 audit.

FOLLOW-UP RECOMMENDATIONS

None.

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CALIFORNIA STATE PRISON, SACRAMENTO

The Office of the Inspector General found that California State Prison, Sacramento has corrected various deficiencies identified in a September 2000 management review audit. Financial management has improved in that actual expenditures are closer to budget allotments; underground storage tanks have been removed, thus avoiding fines and penalties; and internal control weaknesses in the handling of inmate trust funds have been corrected.

IMPLEMENTATION REPORT CARD

Previous recommendations: 17

Fully implemented: 12 (70%)

Substantially implemented: 2 (12%)

Partially implemented: 1 (6%)

Not implemented: 2 (12%)

Not applicable: 0 (0%)

In September 2000, the Office of the Inspector General issued a report presenting the results of a management review audit of California State Prison, Sacramento. The audit focused on personnel, training, communications, inmate programming, security, and finances. The review found several deficiencies in financial management, including budgeting and staffing issues. Other areas found to be deficient included security, inmate dental examinations, and tracking and filing systems pertaining to various operational areas.

BACKGROUND

California State Prison, Sacramento, which opened in 1986, covers 1,200 acres adjacent to Folsom State Prison. When it first opened, the institution was administered by the Folsom warden and was called New Folsom. In October 1992, the institution's name was changed to the California State Prison, Sacramento and it began operating as a separate institution with its own warden.

California State Prison, Sacramento is a multi-mission institution that houses maximum security inmates serving long-term sentences and other inmates who have proved to be management problems at other institutions. The institution also serves as a medical hub for northern California institutions, with a psychiatric services unit, an enhanced outpatient unit, and an enhanced outpatient administrative segregation unit. The institution currently operates an outpatient housing unit and a correctional treatment center, the latter of which was licensed in February 2003. The institution also provides Prison Industry Authority inmate work programs, inmate academic and vocational education programs, and other inmate programs.

At present, the institution houses approximately 2,900 Level IV (high-security) inmates and 400 Level I (low-security) inmates. For fiscal year 2005-06, the institution has an operating budget of approximately $161 million and 1,420 staff positions.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the September 2000 review:

- The institution's budget deficit continued to increase. This trend was expected to continue unless the institution's budget was adjusted to reflect its realistic needs.
- Inmate and parolee appeal forms were not processed in a timely manner.
- There was inadequate documentation to demonstrate that the apprentices in the Correctional Peace Officer Standards and Training apprentice program fully complied with prescribed standards.
- The warden's busy schedule limited time spent in custody areas.
- The Identix Touchlock II System did not work properly and, apparently, some of the institution staff members did not use it.
- The institution faced potentially highly significant fiscal liability for failing to remove underground storage tanks in a timely manner.
- The institution was not in compliance with the regulatory requirement for providing dental examinations to inmates.
- The equal employment opportunity complaint and investigation case files contained inadequate documentation.
- Employee probation and performance reports were not completed in a timely manner.
- The emergency operations plan was not submitted in a timely manner.
- The various facilities did not manage and process the inmate rules violation reports in a consistent manner.
- California State Prison, Sacramento incurred high costs in workers' compensation expenditures and related service fees paid to the State Compensation Insurance Fund.
- There were internal control weaknesses in accounting for the inmate trust funds.

The Office of the Inspector General presented 17 recommendations to remedy the deficiencies identified in the September 2000 review.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which California State Prison, Sacramento has implemented the 17 recommendations from the Office of the Inspector General's September 2000 audit. To conduct the follow-up review, the Office of the Inspector General provided the California State Prison, Sacramento with a table listing the September 2000 findings and recommendations and asked the institution to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the institution, and evaluated the degree of compliance or noncompliance with the recommendations. Additional field work was completed in September 2005. The results are presented in the table following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 17 recommendations issued by the Office of the Inspector General in the September 2000 management review audit, 12 recommendations have been fully implemented; two have been substantially implemented; one has been partially implemented; and two have not been implemented.

The Office of the Inspector General found that the California State Prison, Sacramento has substantially improved its financial management. The institution has kept expenditures aligned with budget allotments; avoided fines and penalties by removing underground storage tanks in a timely manner; and resolved internal control weaknesses relative to inmate trust funds. The institution has also benefited from departmental changes that have increased funding and staff levels to address high workers' compensation expenditures. The institution has implemented processes that have improved timely monitoring of the following: inmate and parolee appeals, the correctional peace officer apprenticeship program, equal employment opportunity case files, and inmate rules violation reports. In addition, the institution has improved custody operations by providing the appropriate level of warden involvement and updating its emergency operations plan. The institution still needs improvement in the following areas: tracking institution staff and visitors, providing timely inmate dental examinations, and completing staff performance evaluations.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation take the following additional action:

- **In conjunction with the institution wardens, implement measures to lower workers' compensation costs through enhanced case monitoring, thereby minimizing service fees paid to the State Compensation Insurance Fund.**

The Office of the Inspector General recommends that the warden of California State Prison, Sacramento take the following additional actions:

- **Explore options for a cost-effective electronic system that effectively tracks the entry and departure of staff and visitors at the institution.**

- **Barring a change in Title 15, California Code of Regulations, comply with the requirement to provide dental examinations to inmates within 14 days of their arrival at the institution.**

- **Ensure that performance and probationary reports are completed in a timely manner.**

- **In conjunction with the California Department of Corrections and Rehabilitation, implement measures to lower workers' compensation costs through enhanced case monitoring, thereby minimizing service fees paid to the State Compensation Insurance Fund.**

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the institution's budget deficit continued to increase. The trend was expected to continue unless the institution's budget was adjusted to reflect its realistic needs.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections perform a custody staffing audit to determine the appropriate level of staffing required to maintain the safety and security of the institution and the programming needs of the institution's specialized population. It was further recommended that the Department of Finance and the Legislature should participate in the audit to ensure that the institution's budget is balanced permanently and safely. Until this is accomplished, it is difficult to hold the warden solely accountable for the budget deficit.	SUBSTANTIALLY IMPLEMENTED	The Office of the Inspector General reviewed budgetary and expenditure reports to determine whether the institution has continued to incur a budget deficit. The reports concentrated on the program 21 budget, which is the portion of the institution's budget controlled by the warden. Review of the last fiscal year (2004-05) expenditures indicated that the institution exceeded its mid-year projected expenditures of $118.4 million by only $289,000, which amounts to one-quarter of a percent, a deficit that was incurred after the mid-year fiscal review adjustment had reduced the budget allotment by $453,000. The California Department of Corrections and Rehabilitation administration reported that staff from the department's headquarters worked with staff from the Department of Finance to develop a new base budget methodology to fund institutions based on their individual missions and functions. The goal was to develop an achievable budget for each institution and to hold institution management accountable for operating within that budget. The department also reported that it would continue to seek additional funding for inmate population-related issues and operating cost adjustments. The department administration reported that it received $450,000 during fiscal year 2003-04 to initiate a standardized institutional staffing study. It affirmed, however, that due to contractual freezes, the project was delayed and the funding was subsequently re-appropriated in fiscal year 2004-05 when the Standardization Review Unit was established. It also reported that the Standardization Review Unit has gathered preliminary data to complete the staffing and operations reviews and contracted with the California State University, Sacramento for consultation services. According to the administration, department need dictates that the reviews begin in the

		institution case records office and mailrooms statewide and that project funding has been extended through fiscal year 2006-07, although it is anticipated that project funding and completion will continue through fiscal year 2007-08. The Office of the Inspector General reviewed the Standardization Review Unit's work plan, which identified that preliminary data collection for the custody review was to take place January 2006 through May 2006. The custody review site visits are scheduled to begin June 2006, with findings and recommendations to be completed by October 2006. The review of those areas in the custody operations not included in the initial review is scheduled to begin November 2006.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that inmate and parolee appeal forms were not processed in a timely manner.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden take the actions listed below.		
Implement effective monitoring processes to ensure that inmate/parolee appeals are processed promptly. The warden should review the status of the appeal reports weekly until the appeal backlog is eliminated. Once the appeal backlog is eliminated, the warden should continue to periodically review the	SUBSTANTIALLY IMPLEMENTED	California State Prison, Sacramento reported that the inmate appeals process is monitored and reviewed weekly by the warden and that an updated overdue appeals list is prepared and distributed weekly to each division head, the chief deputy warden, and the warden. The appeals status or backlog is addressed by the warden during the Monday executive staff meeting with managers. The institution also reported that a correctional sergeant's position had been reclassified to a correctional counselor II specialist to better address the

status of appeals and ensure timely resolution. If additional resources are necessary, the warden should address this issue either through redirection of staff or through the budgetary process.		appeals workload and that the appeals office has added a second appeals coordinator to the staff. The Office of the Inspector General reviewed an overdue appeals report dated, August 4, 2005. The report identified 50 overdue appeals, with 39 at the first level and 11 at the second level. Eleven of the overdue appeals, however, were medically related, cases in which ultimate oversight responsibility lies with the chief medical officer. Nine of the overdue appeals had been generated by other institutions from which inmates had transferred. Nonetheless, 50 overdue appeals demonstrate a clear improvement over the 108 overdue inmate appeals found in the original audit.
Ensure that a standard informal appeals log book is developed to define information required to be used consistently by all facilities.	**FULLY IMPLEMENTED**	California State Prison, Sacramento reported that a designated staff member in each facility collects daily appeals and maintains the informal appeals logbook, after which the appeals are either forwarded to the appeals coordinator or logged and assigned to the appropriate staff member with an expected due date. Informal appeals are returned through the designated staff member to document the response date in the logbook and are also returned to the inmate. The standard logbooks are used to maintain the informal logs. The institution further reported that the informal appeals logbooks are not required by department procedures or law; that notwithstanding, staff continues to collect and track informal appeals to ensure their appropriate and timely management. Essential information is maintained in the logs by all facilities. Although the logs themselves are not identical across all facilities, the information gathered is the same.
Provide additional training, if necessary, in California State Prison, Sacramento's policies and procedures for processing inmate appeals.	**FULLY IMPLEMENTED**	California State Prison, Sacramento reported that inmate appeals training had been provided annually to all staff during the 7K training schedule. The 7K training has now been eliminated and the inmate appeals training is conducted on the job by the supervisors.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found there was inadequate documentation to demonstrate that the apprentices in the Correctional Peace Officer Standards and Training apprentice program fully complied with prescribed standards.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
To mitigate the potential for exposing the institution and the department to civil liability, the Office of the Inspector General recommended that the institution's in-service training unit develop policies, procedures, and controls to monitor apprentices' progress and completion of the Correctional Peace Officer Standards and Training apprenticeship program. The procedures should provide for the reconciliation of apprentice time sheets with total reported program hours. The procedures should also ensure that documentation of all required program milestones (probation reports, for example) is included in the apprentice files in accordance with statute and with the terms of the memorandum of understanding for Bargaining Unit 6.	FULLY IMPLEMENTED	California State Prison, Sacramento reported that the apprenticeship program and all participant information is tracked by an apprenticeship tracking and maintenance computer program used by the department and the institutions. Apprentice progress is monitored through data in the computer program as well as through hard copies of monthly reports in apprentice files. In the capacity of the Local Apprenticeship Subcommittee chairperson, the in-service training manager maintains the apprenticeship program. The subcommittee secretary documents the monthly meetings. The Office of the Inspector General reviewed a copy of a monthly meeting report, which includes the status of enrollees by classification and the activity of each classification. It also provides current information on individuals who have completed, been terminated from, or resigned from the program since the last meeting. The report identified one correctional officer who had completed the mandatory hours in the following categories: (a) maintaining security, (b) supervising inmates, (c) escorting/transporting inmates, (d) report writing/record keeping, and (e) additional experience. It also identified an individual who had resigned because of a disability. The institution reported that the reconciliation of apprentice time sheets occurs monthly and that the generated reports reflect current work hours. Apprentice files and related information are housed in the in-service training manager's office. Although the original finding identified deficiencies in the verification of training hours and documentation of probation reports, reconciling apprentice

		time sheets and maintaining apprentice training documentation should resolve those issues.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that the warden's busy schedule limited time spent in custody areas.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden prioritize the workload to allow for greater involvement in custody matters.	FULLY IMPLEMENTED	California State Prison, Sacramento reported that the warden is intimately involved in all of the institution's custody operations. The warden participates in two weekly executive staff meetings and two weekly lockdown meetings; chairs weekly institutional classification committees; attends most major program meetings; and regularly tours the institution and communicates with staff. The warden has made active involvement in custody operations a top priority.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that the Identix Touchlock II System did not work properly and, apparently, some of the institution staff members did not use it.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden continue to	FULLY IMPLEMENTED	California State Prison, Sacramento reported in its initial response to the audit that it was working with department headquarters to resolve the problem.

work cooperatively with the Department of Corrections to make the necessary corrective changes to the Identix Touchlock II system to ensure that it is fully operational at California State Prison, Sacramento.		Trans Tech was commissioned to address the software and equipment failures. The software was subsequently sent to Oregon but the problem could not be remedied. Since that time, the institution reported that the Identix Touchlock II system has been discontinued. Although the institution worked with the department in attempting to resolve the problem, the ultimate resolution was to terminate the system's operation. Nevertheless, an electronic system to track the entry and departure of staff and visitors remains critical to enhance the institution's safety and security operations.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that California State Prison, Sacramento explore options for a cost-effective electronic system that effectively tracks the entry and departure of staff and visitors at the institution.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that the institution faced potentially highly significant fiscal liability for failing to remove underground storage tanks in a timely manner.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that California State Prison, Sacramento continue to expedite the underground fuel storage tank filling and removal process. At the same time, the institution should negotiate with Sacramento County to either extend the final deadline by approximately one month or waive all fines and penalties to mitigate their impact on an already significant budget deficit.	FULLY IMPLEMENTED	In its initial response to the audit, California State Prison, Sacramento reported that its ability to comply with the mandates for removing the underground fuel storage tanks was limited. It also reported that the process would be completed by November 2000 and that its compliance with Sacramento County requirements appeared to preclude the imposition of any fines or penalties. Since that time, the institution reported that the underground storage tank filling and removal process was completed.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that the institution was not in compliance with the regulatory requirement for providing dental examinations to inmates.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that California State Prison, Sacramento comply with the requirement to examine inmates within 14 days of their transfer from the reception center to the institution. Although the chief medical officer would be directly responsible for implementing this finding, the warden should monitor progress in resolving the problem.	NOT IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that the Division of Correctional Health Care Services has developed dental policies and procedures to standardize dental services at all correctional facilities. The proposed dental policies and procedures will require the dental examinations to be completed within 90 days of the inmate's arrival at the assigned institution, which will necessitate a revision to the 14-day mandate in the California Code of Regulations, Title 15. The Office of the Inspector General reviewed the draft dental policies and procedures dated October 2003. It determined that the chapters related to dental issues retain the 14-day requirement for dental examinations. Specifically, chapter nine, which covers inmate dental care, requires that a comprehensive dental examination be completed within 14 days of assignment to a given facility. The Office of the Inspector General reviewed the California Code of Regulations, Title 15, section 3355.1 regarding dental examinations and determined that, as of February 10, 2006, the institution is still required to provide a complete dental examination to inmates within 14 days of their transfer from a reception center. The California State Prison, Sacramento provided no evidence to indicate that it is complying with this requirement. The California Department of Corrections and Rehabilitation also reported that additional resources to augment staffing of the statewide dental program

		had been acquired through a fiscal year 2005-06 finance letter. The Office of the Inspector General reviewed the fiscal year 2005-06 finance letter, wherein the department had requested a total of 88.5 positions and $17.3 million to correct the base dental staffing deficiencies, assess the dental staffing and operational deficiencies, and begin the planning activities to implement major policy changes in the dental program. Review of the Final Change Book for fiscal year 2005-06 showed that the Legislature had reduced the finance letter amount by $4 million to accommodate the purchase of equipment over a two-year period. Given that 50.0 of the positions authorized by the Legislature were to have been instituted January 1, 2006, an assessment of the benefits afforded by these additional resources would be premature, as would assessment of the potential effects of the protracted delay in equipment funding. The California State Prison, Sacramento was scheduled to acquire three office technicians and one dental assistant.

FOLLOW-UP RECOMMENDATION

Barring a change in Title 15, California Code of Regulations, the Office of the Inspector General recommends that California State Prison, Sacramento comply with the requirement to provide dental examinations to inmates within 14 days of their arrival at the institution.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that the equal employment opportunity complaint and investigation case files contained inadequate documentation.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution's equal employment opportunity coordinator develop a system to track and monitor equal employment opportunity cases to assure that cases are resolved in a timely fashion, and that all	FULLY IMPLEMENTED	California State Prison, Sacramento reported that the equal employment opportunity coordinator deploys a system for tracking equal employment opportunity cases to assure that cases are resolved in a timely manner and that critical information is complete. The coordinator regularly monitors the caseload to identify and apprise the warden of those cases requiring immediate attention.

critical documentation is complete.		The Office of the Inspector General reviewed an excerpt from an equal employment opportunity log and found the information documented to be appropriate for case monitoring.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that employee probation and performance reports were not completed in a timely manner.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden should take steps to ensure that performance and probationary reports are completed on time.	NOT IMPLEMENTED	California State Prison, Sacramento reported that the completion of performance evaluations outside of overtime remains a challenge. The current overdue list is unacceptable and the process for tracking performance evaluations is flawed. The personnel officer has been instructed to prepare a plan that ensures timely tracking and completion of performance evaluations. The personnel section generates the report notices, which the in-service training and personnel assignment sections forward through the division heads to the appropriate supervisors. The personnel officer has implemented a tracking system report to monitor the progress and completion of performance and probationary reports. The Office of the Inspector General reviewed a current report of outstanding performance evaluations. The list identified 668 employees whose performance evaluations were delinquent. With a budget for approximately 1,420 positions, this amounts to a delinquency rate of 47 percent.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the warden take steps to ensure that performance and probationary reports are completed in a timely manner.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that the institution's emergency operations plan was not submitted in a timely manner.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden should implement procedures to ensure that the emergency operations plan is updated and ready to be submitted to the Department of Corrections for review each January.	FULLY IMPLEMENTED	California State Prison, Sacramento reported that the emergency operations plan is current. A report from the Emergency Operations Unit of department headquarters indicates that the plan had been submitted and contained all the required resource supplements. The headquarters report also identified specific areas that require further clarification. The administration reported that the follow-up work was being completed and that its plan had been approved by headquarters. The Office of the Inspector General reviewed a copy of the report from headquarters and found that California State Prison, Sacramento's emergency operations plan was consistent with the requirements set forth in the *California Department of Corrections and Rehabilitation Operations Manual* and encompassed all required resource supplements. The headquarters report did not indicate that the institution's emergency operations plan was delinquent.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that the various facilities did not manage and process the inmate rules violation reports in a consistent manner.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden's office implement a monitoring system to ensure that CDC-115 forms are processed promptly and uniformly among the facilities. Specifically, the Office of the Inspector General recommended that the warden take the actions listed below.		
The inmate disciplinary process requires due process and consistency in disposition. On a weekly basis, either the warden or the chief deputy warden should review the status of the reports with Facilities A, B, and C, taking appropriate action when necessary to ensure prompt resolution of inmate disciplinary cases.	FULLY IMPLEMENTED	California State Prison, Sacramento reported that the chief disciplinary officers—the associate wardens assigned to each facility—are responsible for the disciplinary systems within those facilities. Under the supervision of the facility lieutenants, the chief disciplinary officers track and maintain disciplinary processes. Staff utilizes the standardized facility logbooks to monitor the progress of each CDC-115, Rules Violation Report. Facility captains review and approve all rules violation reports and also monitor, review, and approve the logbooks. The institution reported that the warden and chief deputy warden conduct spot reviews of the logbooks during institution tours, classification committee hearings, and inmate appeals reviews. The institution also reported that the warden, chief deputy warden, and associate wardens are complying with the current mandates relative to disciplinary process.
A written explanation should be required of any official authorizing the voiding of a CDC-115 form. Furthermore, for proper monitoring and auditing purposes, copies of all voided CDC-115 forms must be forwarded to the chief disciplinary officer for the institution register and files.	FULLY IMPLEMENTED	California State Prison, Sacramento reported that a written explanation is required of any official who voids a rules violation report. All rules violation reports are forwarded to the appropriate chief disciplinary officer for the institution register files.

Copies of completed CDC-115 and 115-A forms should be delivered to inmates within five working days of the chief disciplinary officer's review.	FULLY IMPLEMENTED	California State Prison, Sacramento reported that copies of the completed rules violation reports are delivered to inmates within five working days of the chief disciplinary officer's review.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found that California State Prison, Sacramento incurred high costs in workers' compensation expenditures and related service fees paid to the State Compensation Insurance Fund.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections should increase the workers' compensation staff at California State Prison, Sacramento.	PARTIALLY IMPLEMENTED	The warden had submitted a budget concept statement to department headquarters requesting additional staff to manage the workers' compensation caseload. The California State Prison, Sacramento reported that the request was denied but that it continued to explore options to manage its workers' compensation caseload, including requesting additional staff through the budget process. The department indicated that its budget for fiscal year 2004-05 had been fully funded for workers' compensation costs. The institution also reported that, as a result of the department's reorganization and consequent departmental assumption of responsibility for workers' compensation cases, the need for additional institution staff to manage the caseload no longer exists. It reported that the workers' compensation costs for the institution were to have been $5.3 million in fiscal year 2002-03, $6.0 million in fiscal year 2003-04, and $5.2 million in fiscal year 2004-05. The Office of the Inspector General reviewed information obtained from the

		department's fiscal services unit and verified that the department had received a $115.8 million increase to its base budget in fiscal year 2003-04 to fund additional workers' compensation expenses unrelated to any employee population adjustments that might have altered the base budget's level of workers' compensation funding. The fiscal services unit reported that, although the institution is not allocated a specific increase in its base allotment, its annual needs are based initially on personnel year expenditures, which may be reassessed periodically and at year-end. It also reported that the department had redirected two positions to start addressing cost containment and that legislative action subsequently added six positions to implement the workers' compensation suspicious activity program. The fraud investigation program assists the department in managing claims through a fraud referral program. The department has also developed a workers' compensation cost containment strategy action plan to more effectively manage workers' compensation processes. While the specific recommendation to increase institution staff was not implemented, the department reported that it has increased staff at the department level to address workers' compensation expenditures issues. Although funding for workers' compensation costs has increased, it is not evident that the department has either decreased or stabilized workers' compensation expenditures. It is also not apparent that the changes made by the department have reduced service fees levied by the State Insurance Compensation Fund.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation and the warden implement measures to lower workers' compensation costs through enhanced case monitoring, thereby minimizing service fees paid to the State Compensation Insurance Fund.

ORIGINAL FINDING NUMBER 13

The Office of the Inspector General found that there were internal control weaknesses in accounting for the inmate trust funds.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that in the future, if vacancies occur in the trust accounting office and internal controls are compromised, the warden should take action to redirect resources to this area. If necessary, staff from other accounting units in the California Department of Corrections should be used to assist with the inmate trust accounting system.	FULLY IMPLEMENTED	California State Prison, Sacramento reported that, given its current staffing level, internal controls are not compromised. The institution reported that the warden would continue to redirect resources to comply with department mandates.

FOLLOW-UP RECOMMENDATIONS

None.