OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

ANNUAL REPORT

2005

STATE OF CALIFORNIA

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A MESSAGE FROM THE INSPECTOR GENERAL

Inspector General Matthew L. Cate

The year 2005 was pivotal for the Office of the Inspector General. During the year, the office assumed vastly expanded responsibilities for oversight of the state's correctional system and acquired powerful new tools with which to fulfill those duties.

Under new statutory requirements, the office took on an accelerated schedule of top-to-bottom audits of each of the state's 41 youth and adult correctional institutions and began evaluating the qualifications of every candidate for a state prison warden position.

In January, as a result of an agreement between the Governor's Office and the federal court, a new bureau—the Bureau of Independent Review— began operations inside the Office of the Inspector General to closely monitor internal affairs investigations within the state correctional system. Another new state law established an ombudsperson inside the office to oversee resolution of sexual abuse complaints by inmates and wards in state correctional institutions.

To enable the Office of the Inspector General to fulfill these new responsibilities, in addition to satisfying its existing mandates, the Governor and the Legislature restored staff and budget lost as a result of deep budget cuts in 2003.

At the same time, the Governor signed new legislation putting into place important safeguards to bolster the Inspector General's independence — a fixed six-year term for the Inspector General and an annually adjusted office budget tied to workload.

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>
> ***—Inspector General Matthew L. Cate***

Along with those changes, one additional critical reform was enacted: To make correctional agencies more accountable to the public and to bring transparency to the operation of the state's correctional system, the Legislature mandated that the Office of the Inspector General publicly release its findings.

Armed with these important tools, the Office of the Inspector General in 2005 began enforcing accountability on the part of the state's correctional entities from another direction— by instituting a policy of returning one year after the release of every audit and special review to assess the progress of the responsible entities in implementing the Inspector General's earlier recommendations.

Together, these changes mean that correctional entities must address deficiencies identified through the Inspector General's activities or be held accountable for failing to take action.

As a first step in implementing the new follow-up policy, in 2005 the Office of the Inspector General launched a comprehensive three-part "accountability audit" of 33 previous audits and special reviews of entities comprising the former Youth and Adult Correctional Agency. The first component of that project—a follow-up audit of the former California Youth Authority—was released in January, and the second—a follow-up audit of the former Board of Prison Terms—was released in July. Fieldwork for the third and final component—a follow-up audit of the former Department of Corrections—was completed by the end of the year. Future follow-up audits will be an integral part of the Inspector General's activities.

In conjunction with those projects, in 2005 the office continued to carry out a vigorous program of investigations and special reviews, examining among other issues the circumstances surrounding the stabbing death of a correctional officer, the shooting death of an inmate, and the suicide of a youth in state custody.

By year's end, the office had conducted 43 investigations into alleged misconduct by correctional agencies and employees and had issued a total of 233 new recommendations aimed at remedying deficiencies in the correctional system.

The Inspector General's oversight activities are taking place in a shifting correctional environment. Over the course of the year, the former Department of Corrections underwent reorganization and came under increased judicial scrutiny as the result of a series of class-action lawsuits. At the same time, the adult inmate population continues to challenge the capacity of the state's prisons to provide safe housing, let alone operate effective programs, while the juvenile ward population is both shrinking and becoming increasingly comprised of youths in need of ever-more intensive education and treatment.

The effect of the trends is a heightened urgency in finding solutions—to make the state's correctional system work in a way that best serves not only its fundamental public safety mission but also the broad public interest.

The Office of the Inspector General will continue to strenuously focus its oversight efforts in the furtherance of those goals.■

— Inspector General Matthew L. Cate.

OFFICE OF THE INSPECTOR GENERAL

HIGHLIGHTS OF 2005

- √ **Comprehensive three-part follow-up audit launched to assess implementation of the Inspector General's recommendations from 33 previous audits and special reviews.**
- √ **Budget and staffing of the Office of the Inspector General restored to $15.367 million and 95.8 positions after 2003 proposal to abolish the office.**
- √ **Follow-up audits of the former California Youth Authority and Board of Prison Terms completed and released.**
- √ **New laws establishing a fixed six-year term for the Inspector General and an annually adjusted workload-based budget go into effect to safeguard the Inspector General's independence.**
- √ **New law takes effect allowing the results of the Office of the Inspector General's audits, reviews, investigations, and monitoring activities to be made public.**
- √ **New law takes effect requiring the Office of the Inspector General to audit every warden one year after his or her appointment and every correctional institution at least once every four years.**
- √ **Fieldwork completed for comprehensive follow-up audit of the former California Department of Corrections.**
- √ **Bureau of Independent Review established inside the Office of the Inspector General.**
- √ **Bureau of Independent Review establishes offices throughout the state; hires and trains a staff of attorneys and investigators; and begins full-time monitoring of internal affairs investigations, opening 341 monitoring cases by the end of the year.**
- √ **Management review audit of the N. A. Chaderjian Youth Correctional Facility completed and released.**
- √ **Special review into the death of a correctional officer at the California Institution for Men completed and released.**
- √ **Office of the Sexual Abuse in Detention Elimination Ombudsperson established within the Office of the Inspector General to ensure impartial resolution of inmate and ward sexual abuse complaints.**
- √ **Office of the Inspector General assigned responsibility for evaluating the qualifications of all warden candidates and completes evaluations of six candidates.**
- √ **Special review of interpretive service procedures at the Board of Prison Terms completed and released.**
- √ **Office of the Inspector General given responsibility for monitoring Department of Corrections and Rehabilitation inmate death review process and quality of medical care.**
- √ **Special review into the death of an inmate at Wasco State Prison completed and released.**
- √ **Special review into the suicide of a ward at the N. A. Chaderjian Youth Correctional Facility completed and released.**
- √ **Special review of the former Commission on Correctional Peace Officer Standards and Training completed and released.**
- √ **Forty-three investigations into alleged misconduct by correctional agencies and employees completed by year's end.**
- √ **By the end of the year, the office issues 233 recommendations to address deficiencies in state correctional programs and institutions.**

ABOUT THE OFFICE OF THE INSPECTOR GENERAL

The Office of the Inspector General is responsible for independent oversight of the California Department of Corrections and Rehabilitation, which includes the Division of Adult Operations, the Division of Adult Programs, the Division of Juvenile Justice, the Corrections Standards Authority, the Board of Parole Hearings, the State Commission on Juvenile Justice, and the Prison Industry Authority. To fulfill its mission, the Office of the Inspector General rigorously conducts audits and investigations to uncover waste, fraud, abuse, criminal conduct, administrative wrongdoing, and poor management practices; monitors the department's internal affairs investigations; and reviews the qualifications of candidates for warden positions.

Since 1998, when it was established in its present form, the agency has identified millions of dollars in wasteful and inefficient practices in state correctional institutions and programs and has issued hundreds of specific recommendations to eliminate deficiencies in the correctional system. ■

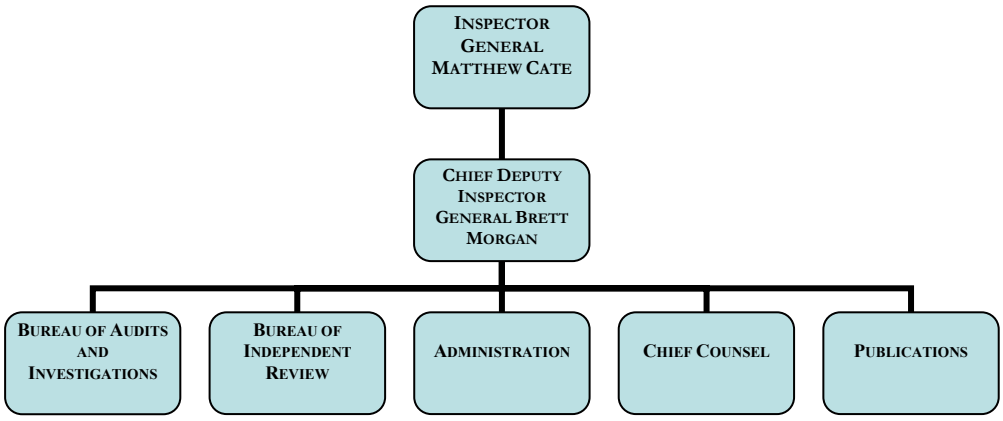
DUTIES OF THE OFFICE OF THE INSPECTOR GENERAL

- **Conduct investigations, audits, and special reviews of the state correctional system upon the initiative of the Inspector General and at the request of the Governor, members of the state Legislature, or the Secretary of the California Department of Corrections and Rehabilitation.**
- **Perform real-time oversight of internal affairs investigations into alleged misconduct by employees of the California Department of Corrections and Rehabilitation.**
- **Conduct audits of state correctional institutions at least once every four years and each warden one year after his or her appointment.**
- **Publicly report the results of audits, special reviews, and other oversight activity.**
- **Evaluate and report in confidence to the Governor on the qualifications of the Governor's candidates for state warden positions.**
- **Review the policies and procedures of the California Department of Corrections and Rehabilitation for conducting internal investigations and audits.**
- **Maintain a toll-free public telephone number to allow members of the public, families of wards and inmates, and employees of the California Department of Corrections and Rehabilitation to report administrative wrongdoing, poor management practices, and criminal conduct on the part of the department and its employees.**
- **Investigate complaints of retaliation against those who report misconduct by the California Department of Corrections and Rehabilitation and its employees.**
- **Refer matters involving criminal conduct to law enforcement authorities in the appropriate jurisdiction or to the California Attorney General.**

ORGANIZATIONAL STRUCTURE

The Office of the Inspector General, headed by Inspector General Matthew L. Cate, is comprised of a skilled team of professionals, including attorneys with expertise in public employment law, internal affairs investigations, criminal law, and civil rights law; auditors highly experienced in correctional policy and operations; seasoned investigators drawn from correctional agencies and a variety of other law enforcement settings; a chief counsel; a publications staff; and a capable administrative team. The office presently has 95.8 employee positions, including a staff of attorneys classified as special assistant inspectors general, who monitor internal affairs investigations, and a team of deputy inspectors general cross-trained in audits and investigations.

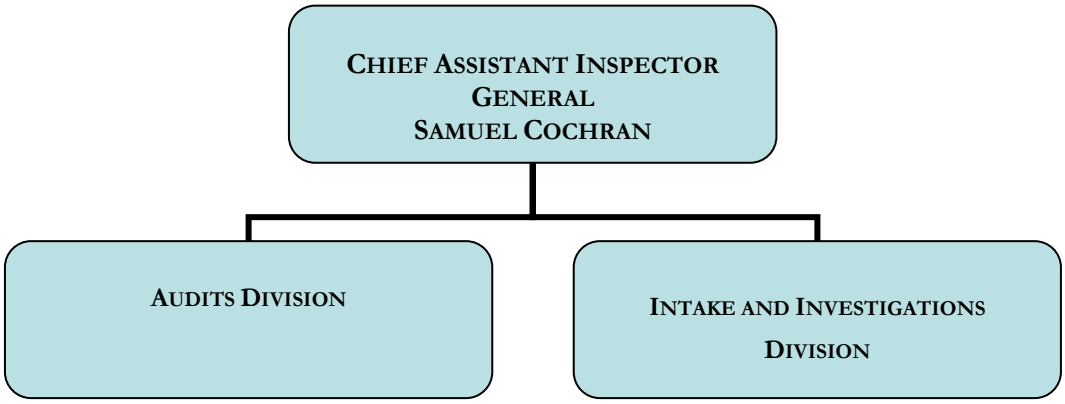
In addition to legal and administrative staff, the office is organized into two principal bureaus: the Bureau of Audits and Investigations, headed by Chief Assistant Inspector General Samuel Cochran and the Bureau of Independent Review, headed by Chief Assistant Inspector General David R. Shaw. Statutory authority for the establishment and operation of the Office of the Inspector General is provided in California Penal Code sections 6125 through 6133. ■



BUREAU OF AUDITS AND INVESTIGATIONS

Chief Assistant Inspector General Samuel Cochran

The Bureau of Audits and Investigations, under the direction of Chief Assistant Inspector General Samuel Cochran, conducts management review audits of the state's adult prisons and youth correctional facilities; special reviews and audits of correctional agencies and programs; and investigations into alleged misconduct by correctional agencies and employees. The bureau also evaluates the qualifications of all candidates for warden positions and reports the results in confidence to the Governor. The bureau is comprised of an audit division and an intake and investigations division.



Under a California Penal Code provision that took effect July 1, 2005, the bureau is responsible for performing audits of every state correctional institution once every four years and each warden one year after his or her appointment. Those requirements, which are being phased in, will be fully met by July 1, 2009. The audits evaluate the performance of the warden, identify areas of the institution's operations needing improvement, and examine compliance with laws, regulations, and policies. The bureau's other audits, special reviews, and investigations are conducted at the initiative of the Inspector General and at the request of the Governor, legislative members, or the secretary of the California Department of Corrections and Rehabilitation. The findings of every audit and special review are summarized in a public report, which is posted on the Office of the Inspector General's website at http://www.oig.ca.gov.

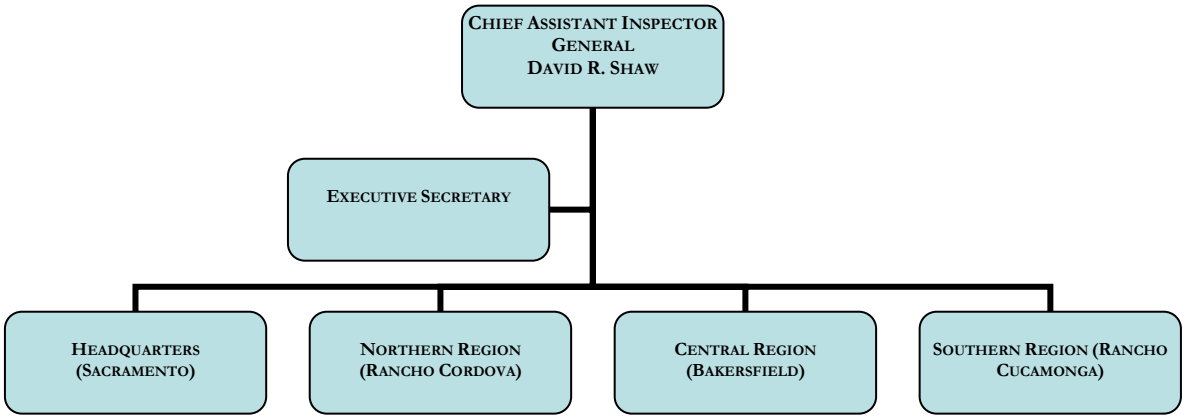
Through its intake staff, the Bureau of Audits and Investigations also receives and processes approximately 300 complaints a month concerning the state correctional system. Many of the complaints are resolved through discussions with institution staff or through correspondence with correctional administrators, while others result in investigations or special reviews. Those involving urgent health and safety issues receive priority attention. While the bureau's investigators handle many of the complaints, most cases involving allegations of serious administrative misconduct, criminal conduct, retaliation, fraud, and other wrongdoing by lower-level management and employees are referred to the Department of Corrections and Rehabilitation's Office of Internal Affairs, where the cases are monitored by the Office of the Inspector General's Bureau of Independent Review. Allegations of retaliation and other misconduct by higher-level department officials are investigated by the Office of the Inspector General's investigators. Most of the complaints received by the Office of the Inspector General arrive by mail or through the 24-hour toll-free telephone line, while others are brought to the attention of the Office of the Inspector General in the course of audits or other investigations. ■

BUREAU OF INDEPENDENT REVIEW

Chief Assistant Inspector General David R. Shaw

The mission of the Office of the Inspector General's Bureau of Independent Review is to safeguard the integrity of internal affairs investigations into allegations of serious misconduct inside the state's prisons and youth correctional facilities. The bureau was established effective January 1, 2005, with the support of the Governor as a central component in a court-ordered remedial plan resulting from a federal civil rights action against the former California Department of Corrections. That action, *Madrid v. Woodford*, identified severe deficiencies in the department's employee disciplinary process — including a "code of silence" among correctional officers that undermined internal affairs investigations and failed to address excessive use of force and other misconduct. As a means of remedying the problems, the bureau was assigned to provide real-time, on-the-scene oversight of investigations carried out by Department of Corrections and Rehabilitation internal affairs investigators to ensure the investigations are thorough and sound and that the discipline imposed is appropriate. Although bureau attorneys and investigators work cooperatively with Department of Corrections and Rehabilitation staff attorneys assigned to prosecute disciplinary cases, the bureau nonetheless retains the autonomy and the legal authority necessary to independently monitor internal affairs investigations and the employee disciplinary process.

Headed by Chief Assistant Inspector General David R. Shaw, the bureau is headquartered in Sacramento and staffed with teams of attorneys and investigators at regional offices in Rancho Cordova, Bakersfield, and Rancho Cucamonga.



Consistent with California Penal Code section 6133, and to promote accountability by making the internal affairs and employee disciplinary processes transparent to the public, the bureau issues semi-annual reports summarizing the monitoring activities. The reports include a synopsis of each monitored case, the bureau's actions, an assessment of the department's actions and the quality of the investigation and the disciplinary process, and any additional notes and observations. A summary of the bureau's monitoring and policy development activities is also presented in the Office of the Inspector General's annual reports. Together, the annual and semi-annual reports provide a comprehensive assessment of the department's internal affairs investigation and employee discipline processes. The reports are posted on the Office of the Inspector General's website at http://www.oig.ca.gov/reports/review_rpts.asp.■

THE YEAR IN REVIEW

2005 saw the Office of the Inspector General rapidly assuming new responsibilities and putting to use the enhanced tools and resources provided by the Legislature during the previous session. The new Bureau of Independent Review was staffed and fully operating by mid-year, while the Bureau of Audits and Investigations conducted seven audits and special reviews, began evaluating warden candidates, and implemented systematic follow-up work to monitor implementation of the Inspector General's previous recommendations. The office also helped bring pressure for reforms in the correctional system by publicly reporting the results of its audit, investigation, and monitoring activities. Following is a summary of the year's most important events and activities.

LEGISLATIVE ACTIONS

Important legislative actions during the year included the following:

- ***Fixed term for the Inspector General.*** Senate Bill 1342 (Speier and Romero), effective January 1, 2005, amended California Penal Code section 6125 to provide a fixed six-year term for the Inspector General, subject to Senate confirmation. Under that provision, the Inspector General may not be removed from office during that term except for good cause. The new law helps provide the Inspector General with the vital independence necessary for effective oversight of the state correctional system.

- ***Workload-based budget.*** Senate Bill 737 (Romero), effective May 10, 2005, amended California Penal Code section 6126(d) to provide for development of a workload-based budget to be used to annually adjust the Office of the Inspector General's budget beginning with the 2005-06 fiscal year. The measure further safeguards the Inspector General's independence by ensuring adequate funding.

- ***Public reporting requirements.*** Senate Bill 1352 (Romero and Speier), effective January 1, 2005, amended California Penal Code sections 6129(c)(2), 6131(a), and 6131(c) to provide for the Office of the Inspector General to publicly report the results of audits and investigations and to post the reports on its website. The bill repealed a previously existing law that made publicly revealing the results of the Inspector General's investigations a misdemeanor.

- ***Establishment of the Bureau of Independent Review.*** Senate Bill 1400 (Romero and Speier), effective January 1, 2005, added California Penal Code section 6133 to establish the Bureau of Independent Review within the Office of the Inspector General for the purpose of providing contemporaneous oversight of Department of Corrections and Rehabilitation internal affairs investigations. The bill also provides for the bureau to issue regular reports concerning its oversight of investigations into alleged misconduct and use

of force to the Governor and the Legislature and to post the reports on the Inspector General's website.

- ***Evaluation of warden candidates.*** Senate Bill 737 (Romero), effective July 1, 2005, amended California Penal Code section 6126(b) to provide for the Inspector General to evaluate the qualifications of candidates for warden positions and to report the results in confidence to the Governor.

- ***Mandated audits of wardens and institutions.*** Senate Bill 737 (Romero), effective July 1, 2005, also requires the Office of the Inspector General to audit every warden one year after his or her appointment and every institution at least once every four years.

- ***Sexual abuse ombudsperson.*** Assembly Bill 550 (Goldberg), signed into law on September 22, 2005, added California Penal Code section 2641, establishing the Office of the Sexual Abuse in Detention Elimination Ombudsperson within the Office of the Inspector General. The purpose of the ombudsperson is to investigate reports of mishandling of incidents of sexual abuse in correctional facilities and ensure the impartial resolution of inmate and ward sexual abuse complaints. The measure was scheduled to take effect January 1, 2006.

ADMINISTRATION

Staffing and budget. The fiscal year 2004-05 Budget Act restored 53 employee positions and $8.3 million in funding to the Office of the Inspector General, with the Legislature reversing a 2003 effort to abolish the office. The following fiscal year, the 2005-06 Budget Act increased funding to $15.4 million and a total of 95.8 employee positions. The funding increases resulted from a budget change proposal for 23.8 additional positions and $3.6 million in General Fund monies, less miscellaneous adjustments, to allow the Office of the Inspector General to continue independent oversight of the correctional system through audits and investigations and for an additional 19 positions and $3 million to fulfill the mandates of Senate Bill 737.

New facilities. To carry out its new mandates and to accommodate new staff hired as a result of those mandates, the Office of the Inspector General expanded its Sacramento headquarters office and opened three offices for the Bureau of Independent Review. The bureau's regional offices have been established in Rancho Cucamonga, Bakersfield, and Rancho Cordova, in close proximity to regional offices of the Department of Corrections and Rehabilitation's Office of Internal Affairs. ■

BUREAU OF AUDITS AND INVESTIGATIONS

The Office of the Inspector General's **Bureau of Audits and Investigations** carried out a vigorous program of audits, special reviews, and investigations during 2005. The year marked the beginning of the bureau's heightened emphasis on increasing accountability for needed reforms by systematically tracking the progress of the state's correctional entities in implementing the Inspector General's past recommendations. Toward that end, along with other audits and special reviews, the bureau launched a large-scale accountability audit in 2005 — a comprehensive follow-up review to assess the progress of the former Youth and Adult Correctional Agency and its subordinate entities in implementing 661 recommendations from 33 previous audits conducted by the Office of the Inspector General. The bureau also began preparing to meet a new legislative mandate calling for the office to conduct an audit of every correctional institution once every four years and one year after the appointment of a new warden. Altogether, the bureau completed seven audits and special reviews in 2005 and issued a total of 233 new recommendations to address deficiencies in the state's correctional system. During the year, the bureau also received and processed 3,824 complaints about correctional entities and employees and conducted 43 investigations into alleged misconduct. In fulfillment of a new legislative mandate, the bureau also began evaluating the qualifications of candidates for warden positions and by the end of the year had completed six such evaluations and provided the results to the Governor.

AUDITS AND SPECIAL REVIEWS

Following are the results of the audits and special reviews conducted by the Bureau of Audits and Investigations in 2005.

- ***Accountability Audit: The Board of Prison Terms, 2002-2003.*** In July 2005, the Bureau of Audits and Investigations completed an audit that assessed the progress made by the Board of Prison Terms in implementing 26 recommendations from two reviews conducted by the Office of the Inspector General in 2002 and 2003. The audit determined that the board had fully or substantially implemented fewer than half—46 percent—of the previous recommendations. The audit found that the board had made progress in tracking parole revocation cases to help ensure that suspected parole violators receive timely hearings, resulting in fewer delays. The audit also found, however, that the board continued to lack the

AUDIT HIGHLIGHTS

- √ The Board of Prison Terms had fully or substantially implemented fewer than half the previous recommendations.
- √ The board was doing a better job of tracking parole revocation cases to help ensure that suspected parole violators received timely hearings.
- √ The board was still unable to collectively identify statutory deadlines by which it must hold parole hearings for "lifer" inmates.
- √ The board's backlog of overdue parole consideration hearings had increased by more than 200 cases since December 2001 to a total of 1,607 as of March 31, 2005.

technological capability needed to identify statutory deadlines for conducting parole consideration hearings for inmates sentenced to indeterminate prison terms — so-called "lifer" inmates. Although it can make that determination for individual inmates, the board cannot collectively determine which inmates have deadlines approaching in order to schedule hearings in priority order. The audit determined that as of March 31, 2005, the board had amassed a backlog of 1,607 overdue parole consideration hearings — an increase of a more than 200 cases since December 2001. The audit also revealed that in official reports the board had misrepresented the number of indeterminate sentence hearings it had held from years 2002 through 2004 by including in the totals hearings that had been scheduled but not actually held. During those years, the board actually held nearly 4,000 fewer hearings than the 13,874 it reported holding. The Office of the Inspector General issued 12 new recommendations to address the findings of the 2005 audit. The full text of the report can be viewed by clicking on the following link to the Office of the Inspector General's website: Accountability Audit: Review of Audits of the Board of Prison Terms, 2002-2003 (July 2005). ■

- ***Accountability Audit: The California Youth Authority, 2000-2003.*** In January 2005, the Bureau of Audits and Investigations released the results of an audit assessing the progress of the California Youth Authority in implementing recommendations from nine audits and special reviews conducted by the Office of the Inspector General between 2000 and 2003. The audit determined that the department had made significant progress in some areas but that it failed to address numerous deficiencies central to its core mission of providing education and treatment to youths in custody. Overall, the department had fully implemented only 43 percent of the 241 previous recommendations, even though it had as long as four years to take action. Many of the problems identified earlier had either remained the same or had worsened, and some of the remaining deficiencies required prompt action for safety and security reasons. The Office of the Inspector General issued 93 new recommendations to address the audit findings. The full text of the report can be viewed by clicking on the following link to the Office of the Inspector General's website: Accountability Audit: Review of Audits of the California Youth Authority, 2000-2003 (January 2005). ■

AUDIT HIGHLIGHTS

- √ The California Youth Authority had fully implemented only 43 percent of 241 previous recommendations.
- √ Many of the remaining deficiencies were central to the department's mission of providing education and treatment to wards.
- √ Nine percent of wards at five facilities were still confined to cells 23 hours a day with little access to education, training, counseling, or other services.
- √ At one facility, an estimated 103 wards were on 23-hour-a-day confinement solely because the institution lacked enough teachers to hold education classes.
- √ The department was not consistently providing wards with mandated treatment services and was not providing diagnostic assessments within required time limits.
- √ The department was not providing wards with the four hours a day of education mandated by state law.
- √ At one facility, wards had received only 40 percent of required education time; at another, 30 percent. At still another, 30 percent of classes scheduled were not held because no teacher was available to teach the class.

- ***Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr.*** In March 2005, the Bureau of Audits and Investigations and the Bureau of Independent Review conducted a special review into the circumstances surrounding the January 10, 2005 stabbing death of Correctional Officer Manuel A. Gonzalez, Jr. at the California Institution for Men. The review identified a number of issues that played a role in the incident. In particular, the review determined that although the inmate who attacked Officer Gonzalez was a maximum custody inmate with a long history of in-prison violence, the institution had assigned him to a general population cell. The review also determined that correctional officers assigned to the inmate's living unit, including Officer Gonzalez, routinely violated standard security protocols as well as extra security restrictions imposed in response to violent incidents at the facility. The review found that the fatal stabbing might have been prevented if the officers had adhered to the security requirements. The review also found that the housing unit where the stabbing occurred was in disrepair and that tool controls were lax, allowing inmates to easily obtain and hide materials for making weapons. The review revealed in addition that the institution had delayed issuing protective vests to correctional officers, and had stored the vests in a warehouse until it received enough for all officers slated to receive them. The Office of the Inspector General issued 37 recommendations as a result of the review. The full text of the report can be viewed by clicking on the following link to the Office of the Inspector General's website: California Institution for Men, Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men (March 2005). ■

  REVIEW HIGHLIGHTS

  √ The California Institution for Men assigned the alleged assailant to a general population cell even though he was a maximum custody inmate with a long history of in-prison violence.

  √ Correctional officers assigned to the alleged assailant's living unit routinely violated standard security protocols and extra security restrictions imposed in response to other violent incidents.

  √ Immediately before the stabbing, Officer Gonzalez released the inmate from his cell onto the tier and then entered the tier alone, all in violation of security protocols.

  √ Inmates in the housing unit where the stabbing occurred were able to easily obtain weapons materials because the unit was in disrepair, and tool controls were lax.

  √ The institution had unduly delayed issuing protective vests to correctional officers and had instead stored the vests in a warehouse until it received enough for all officers who were to receive them.

- ***Special Review: Interpretation Services Procedures, Board of Prison Terms.*** In March 2005, the Bureau of Audits and Investigations issued a special review of the procedures used by the Board of Prison Terms to secure the services of foreign language interpreters. The review was prompted by an investigation by the Office of the Inspector General of a foreign language interpreter who was found to have submitted 261 false claims for services provided at parole revocation hearings, amounting to almost $12,000 over a three-year period. As a result of the review, the bureau

  REVIEW HIGHLIGHTS

  √ Lax controls at the Board of Prison Terms allowed a foreign language interpreter to be paid for 261 fraudulent claims over a three-year period.

  √ The board routinely paid invoices from interpreters without checking to make sure services had been provided or invoices had already been paid.

  √ The board did not specify terms of agreements in writing when it arranged for interpretation services.

identified several control deficiencies in the methods used by the Board of Prison Terms to retain and pay for foreign language interpretation services. In particular, the review determined that the board retained interpreters for parole hearings without fully specifying in writing the terms of the services to be provided; paid for the services without verifying that they had been rendered; and failed to ensure that invoices were not duplicates of invoices that had already been paid before approving payment. The Office of the Inspector General issued five recommendations as a result of the review. The full text of the report can be viewed by clicking on the following link to the Office of the Inspector General's website: Board of Prison Terms, Special Review of Interpretation Services Procedures (March 2005) ■

♦ ***Special Review: Commission on Correctional Peace Officer Standards and Training.*** In May 2005, the Bureau of Audits and Investigations issued a special review of the Commission on Correctional Peace Officer Standards and Training to assess whether the commission was fulfilling its mission of enhancing the training and professionalism of state correctional peace officers by developing and monitoring training and selection standards. The review determined that since its inception in 1998 the commission had made only minimal progress in developing correctional peace officer training standards, having completed standards for only seven of the 27 correctional peace officer classifications for which it was responsible. Moreover, the review determined that the commission had approved none of the standards it had developed. The review also determined that the correctional peace officer apprenticeship program, for which the commission was responsible, lacked key components and was threatened with decertification for non-compliance with state and federal standards. The Office of the Inspector General determined that the work of the commission had been hampered by budget cutbacks, lack of funding, and lack of personnel within the state's correctional departments for the development of training standards. A persistent stalemate on the executive board between management and labor representatives was a further impediment, and the commission had not met for nearly a year because it lacked a quorum. Under the Governor's reorganization plan, which was approved by the Legislature effective July 1, 2005, the commission was abolished, and its responsibilities were transferred to the new Corrections Standards Authority and to the Office of Training and Professional Development under the Department of Corrections and Rehabilitation. As a result of the review, the Office of the Inspector General issued 14 recommendations to the commission and its successor entities. The full text of the report can be viewed by clicking on the following link to the Office of the Inspector General's

AUDIT HIGHLIGHTS

- √ In the seven years of its existence, the commission had developed training standards for only seven of the 27 correctional peace officer classifications for which it was responsible.
- √ All of the standards developed had yet to be approved.
- √ The correctional peace officer apprenticeship program, for which the commission was responsible, was in danger of decertification for non-compliance with state and federal standards.
- √ The work of the commission had been hampered by budget cutbacks, lack of funding, and lack of personnel in the department to develop training standards.
- √ The commission's organizational structure caused persistent voting deadlocks between management and labor.
- √ The commission had not met for nearly a year because it lacked a quorum.

website: Commission on Correctional Peace Officer Standards and Training, Special Review (May 2005). ■

- ***Management Review Audit: N. A. Chaderjian Youth Correctional Facility.*** In May 2005, the Bureau of Audits and Investigations issued a management review audit of the N. A. Chaderjian Youth Correctional Facility to establish a baseline assessment of the facility's performance in carrying out essential functions and to provide recommendations to correct any deficiencies. The audit found that the institution was failing in its fundamental mission of providing wards with education, treatment, and counseling services and that the facility was not a safe environment for either staff or wards. The audit revealed that wards were not receiving the counseling and mental health care required under state law, in part because youth correctional counselors, who were designated to provide most of the counseling, had received almost no counseling training and were too busy with custody and security duties to counsel wards. Education services were similarly lacking. Wards at the facility were receiving only 40 percent of assigned educational programming, and more than a third of scheduled academic classes were being cancelled, mainly because teachers did not appear for class. Special education wards — 38 percent of the students at the facility's high school — were not receiving all of the special education service time they were mandated to receive. The institution was also endangering wards by failing to adequately monitor those receiving psychotropic medications and was not fully complying with mandated suicide prevention procedures. The institution was not complying with numerous security requirements and was plagued with dangerous structural and design defects. The Office of the Inspector General issued 56 specific recommendations to address the deficiencies. The full text of the report can be viewed by clicking on the following link to the Office of the Inspector General's website: N. A. Chaderjian Youth Correctional Facility, Management Review Audit (May 2005). ■

AUDIT HIGHLIGHTS

- √ The institution was failing in its mission of providing education, treatment, and counseling services.
- √ Wards were receiving only 40 percent of assigned educational programming.
- √ Special education wards—38 percent of the students at the high school — were not receiving mandated service time.
- √ Youth correctional counselors were too busy with custody and security duties to provide mandated counseling to wards.
- √ The institution was not adequately monitoring wards on psychotropic medications and was not fully complying with suicide prevention procedures.
- √ The facility was plagued with dangerous structural and design defects and was out of compliance with security requirements.

- ***Special Review: Ward Death at the N. A. Chaderjian Youth Correctional Facility.*** In December 2005, the Bureau of Audits and Investigations completed a special review into the circumstances surrounding the August 31, 2005 suicide death of a ward by hanging at the N. A. Chaderjian Youth Correctional Facility in Stockton. The review determined that at the time of his death, the ward had been locked in his room alone for eight weeks for nearly 24 hours a day because members of his gang had attacked three staff members. Although the ward was not involved in the attack, he was included in the lockdown because he refused to renounce his gang loyalties. The review determined that the ward had received virtually no mental health counseling, education, exercise, family

visits, or other services during the lockdown. The review also found that although the facility's lockdown was initially justified, the eight weeks of isolation and denial of mental health and other services were inconsistent with the mission of the Division of Juvenile Justice and may have contributed to the ward's suicide. The review found in addition that the Division of Juvenile Justice had failed to assess or act on the ward's mental health needs and had missed several signals, including four requests by the ward to see a mental health professional, that should have led it to provide him with mental health services. The review also determined that when the ward covered his windows and failed to respond, the staff did not follow required response procedures and waited 38 minutes before opening his door. The Office of the Inspector General issued 16 recommendations as a result of the review. The full text of the report can be viewed by clicking on the following link to the Office of the Inspector General's website: N. A. Chaderjian Youth Correctional Facility, Special Review into the Death of a Ward on August 31, 2005 (December 2005).■

REVIEW HIGHLIGHTS

√ At the time of the suicide, the ward had been locked alone in his room for 24 hours a day for eight weeks and had received no counseling, education, exercise, or family visits during that period.

√ The ward asked four times to see a mental health professional but did not receive such services.

√ The department failed to assess or act on the ward's need for mental health services despite clear signals that it should have done so.

√ The extended isolation and denial of mental health and other services were inconsistent with the mission of the Division of Juvenile Justice.

√ When the ward covered his windows and became unresponsive just before the suicide, the staff failed to follow required response procedures and waited 38 minutes before opening his

COMPLAINT STATISTICS

During calendar year 2005, the Office of the Inspector General received 3,824 complaints about correctional agencies and employees by mail and through the toll-free telephone line. Of that number, 2,951 came from inmates, 202 came from current or former correctional employees, and 671 came from other parties. The complaints included more than 4,800 allegations, with the most common allegations concerning staff misconduct; the inmate appeals/ward grievance process; and quality of or lack of access to medical care. In response to the complaints, the Office of the Inspector General reviews the information provided and takes one of the following actions:

- Closes the matter because of insufficient evidence to support further action.
- Refers the complainant to the appropriate entity in the Department of Corrections and Rehabilitation for response.
- Refers the complaint to the Department of Corrections and Rehabilitation's Office of Internal Affairs for an investigation.
- Investigates the allegations.
- Refers cases of criminal misconduct to the appropriate law enforcement authorities.

INVESTIGATIONS COMPLETED

In calendar year 2005, the Office of the Inspector General investigated 43 cases of alleged retaliation, criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses. Of the cases investigated, one was referred to the local district attorney's office for prosecution; four resulted in adverse action; four were referred to the Department of Corrections and Rehabilitation's Office of Internal Affairs for further investigation; six were referred to the department to revise or develop policies to resolve specific issues; and the remaining 28 cases were closed without further action. As required by California Penal Code sections 6129(c)(2) and 6131(c), the cases were summarized in the bureau's 2005 quarterly reports and are posted on the Office of the Inspector General's website.

WARDEN EVALUATIONS

Consistent with the provisions of Senate Bill 737, which became effective July 1, 2005, the Office of the Inspector General evaluated the qualifications of six candidates for warden positions during 2005 and reported the results in confidence to the Governor. Senate Bill 737 assigns the Inspector General responsibility for evaluating the qualifications of every candidate nominated by the Governor for appointment as a state prison warden and for advising the Governor within 90 days whether the candidate is "exceptionally well-qualified," "well-qualified," "qualified," or "not qualified" for the position. In making the evaluation, California Penal Code section 6126.6 requires the Inspector General to consider, among other factors, the candidate's experience in effectively managing correctional facilities and inmate populations; knowledge of correctional best practices; and the ability to deal with employees, the public, inmates, and other interested parties in a fair, effective, and professional manner. Under California Penal Code section 6126.6(e), all communications pertaining to the Inspector General's evaluation of warden candidates are confidential and absolutely privileged from disclosure. ■

BUREAU OF INDEPENDENT REVIEW

Officially established on January 1, 2005 under a bill signed into law the previous September, the Office of the Inspector General's **Bureau of Independent Review** underwent rapid development during the first half of the year. From January through June, the bureau established its headquarters and regional offices, recruited and hired staff, and carried out intensive training for new personnel. By July 1, it had begun full oversight of the Department of Corrections and Rehabilitation's internal affairs and employee disciplinary processes. As part of its oversight activities, the bureau actively participated in the development of departmental policies governing internal affairs and employee disciplinary procedures and conducted statewide training for the department's employee discipline and internal affairs employees. By year's end, with the cooperation of department administrators, wardens, staff attorneys, and internal affairs investigators, the bureau had become well-integrated into the internal affairs investigation and employee disciplinary procedures, and court-ordered reforms of those procedures were well underway. In addition to its internal affairs oversight, the Bureau of Independent Review served a leading role in the newly revived California District Attorneys Association's "Prison Crimes Committee," which addresses issues related to crimes committed in state prisons and juvenile facilities. During the course of the year, the bureau also conducted a special review into the shooting death of an inmate at Wasco State Prison and, with the Bureau of Audits and Investigations, participated in a special review into the circumstances surrounding the death of a correctional officer at the California Institution for Men. At the request of the federal court in the *Plata v. Schwarzenegger* lawsuit against the Department of Corrections and Rehabilitation, the bureau also evaluated the department's inmate death review process, which examines the quality of medical care provided. The bureau's review led to a re-evaluation of the inmate death review process and identified several cases needing further investigation. The bureau is monitoring those cases. ■

FACILITIES

As a critical component in the bureau's oversight role, bureau regional offices are located near each of the regional internal affairs offices of the Department of Corrections and Rehabilitation in Rancho Cucamonga, Bakersfield, and Rancho Cordova. The close proximity allows the Bureau of Independent Review ready access to the people, files, and evidence needed to monitor Office of Internal Affairs investigations. In the southern region, the Bureau of Independent Review is located in a building immediately adjacent to the Office of Internal Affairs in Rancho Cucamonga. In the central region, the bureau's office is situated in the same building in Bakersfield occupied by the Office of Internal Affairs. In the northern region, both the bureau's headquarters and regional office are located in the same building in Rancho Cordova as the Office of Internal Affairs. In a move that will enhance opportunities for the bureau to interact with Department of Corrections and Rehabilitation staff, the department has announced plans to relocate the legal staff of the Employment Law Unit into the same building. ■

RECRUITMENT AND HIRING

The bureau's headquarters and three regional offices in Rancho Cordova, Bakersfield, and Rancho Cucamonga were staffed by mid-January 2005 with 12 attorneys selected through a rigorous recruitment process for their expertise in criminal, civil rights, and public employment law. Classified as senior assistant inspectors general and special assistant inspectors general, the attorneys have significant experience working with law enforcement, labor organizations, and prosecutorial officials throughout the state. The bureau also recruited and hired deputy inspectors general with experience in correctional investigations and audits to work with the attorneys in oversight of internal affairs investigations.■

TRAINING

During the first six months of the bureau's operation, special assistant inspectors general and senior assistant inspectors general underwent intensive training on the protocols of the bureau and received a detailed introduction to all aspects of California's penal system from experts on the California Department of Corrections and the California Youth Authority (now consolidated as the California Department of Corrections and Rehabilitation), with an emphasis on internal affairs investigations. The training included a briefing from the U. S. District Court special master in *Madrid v. Woodford* on the history and role of the special master in relation to the state's correctional departments. Representatives from the Los Angeles Office of Independent Review addressed the mission of independent review. Mechanical issues, such as developing protocols, "cradle-to-grave" monitoring, case reporting, and promotion of reform were also covered. The bureau staff was also introduced to the Department of Corrections and Rehabilitation's "vertical advocates"— department employment law attorneys assigned to prosecute each disciplinary case from start to finish — and received a briefing on the vertical advocate function. Critical legal issues pertaining to internal affairs investigations and the disciplinary process were also covered, including how statutes of limitations are tolled, compelling subjects to give statements, and the Public Safety Officers Procedural Bill of Rights Act. In addition to the vertical advocate role, the bureau staff was informed of the role of employee relations officers and litigation coordinators at the institutions. Finally, an overview of the newly created central intake process, used to evaluate and assign internal affairs investigations, was discussed.

Later, more in-depth training included gang investigations, critical incident management, parole searches, search warrants, parolee-at-large investigations, and officer-involved shootings. The bureau staff also attended a seminar hosted by the California District Attorneys' Association that included crime scene preservation, evidence collection and documentation, electronic surveillance in correctional settings, administrative searches, *Miranda* rights and interrogation in prison, and the Public Safety Officers Procedural Bill of Rights Act. The seminar also provided an opportunity for the Bureau of Independent Review staff to be introduced to many of the deputy district attorneys who prosecute prison crimes.

A presentation was also made to the bureau staff on the Department of Corrections and Rehabilitation's use-of-force policy, the inmate complaint process, access to inmate records, responsibilities of employee relations officers and litigation coordinators, legal admonishments during employee interviews, and the civil service disciplinary process through the State Personnel Board. In addition, the Bureau of Independent Review was given an overview of the training curriculum for correctional staff and for special agents of the Office of Internal Affairs.

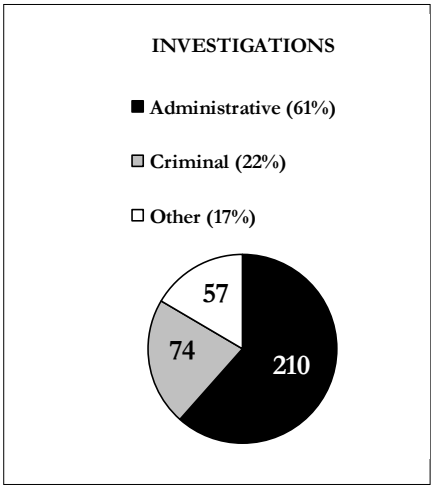
INTERNAL AFFAIRS MONITORING

As soon as professional staff was in place in the three regional offices in January 2005, the bureau began initial oversight activities, responding to critical incidents—prison events involving significant use of force or resulting in injuries or death—and monitoring the most serious investigations underway by the Department of Corrections and Rehabilitation's Office of Internal Affairs. Between January and June 2005, the bureau responded to 11 critical incidents and selected 28 cases for monitoring to familiarize bureau attorneys with the department's investigative and employee disciplinary procedures and to test the bureau's protocols. On July 1, 2005, full-time oversight activities began, with the bureau responding to 20 additional critical incidents and opening 341 cases for monitoring by the end of the year. The following table delineates by month the number of cases opened for monitoring by the bureau in 2005 after full-time monitoring began on July 1, 2005.

CASES OPENED FOR MONITORING

MONTH	OPENED FOR MONITORING
July	56
August	83
September	45
October	42
November	66
December	49
TOTAL	**341**

Of the 341 investigations monitored during that six-month period, 74 were criminal cases, 210 were administrative cases, and 57 were cases classified as "other"— those involving less serious allegations and requiring no further investigative actions. During the same six-month period, the Department of Corrections and Rehabilitation's Office of Internal Affairs opened 449 criminal and administrative internal affairs investigations, meaning that the bureau monitored 63 percent of the criminal and administrative cases opened by the Office of Internal Affairs during the last six months of 2005.

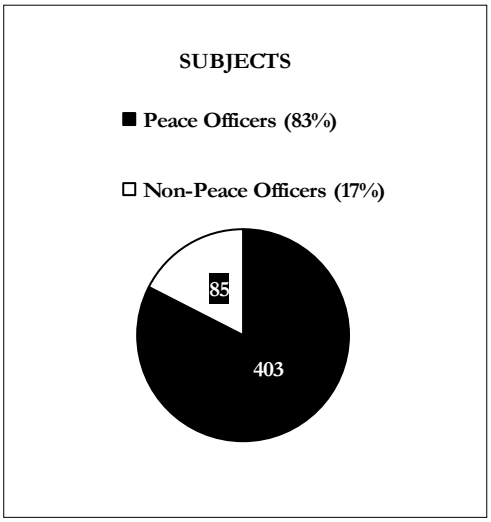


Most internal affairs cases involve allegations of administrative misconduct, ranging from misuse of state resources to dishonesty during a criminal investigation. If sustained, these

allegations may result in corrective or disciplinary action, including termination, depending on the severity of the misconduct. In some instances, the allegations may serve as the basis for a criminal case. In those situations, the administrative investigation proceeds independently of the criminal case and usually begins when the criminal case ends. During the latter half of 2005, 61 percent of internal affairs cases monitored by the bureau were administrative cases. Criminal cases are the most serious investigations and comprise the second-largest group of cases. During this period, 22 percent of the 341 cases monitored by the bureau were criminal cases. The remaining 17 percent of cases monitored consisted of other types of actions involving less serious allegations.

The cases monitored typically involve multiple allegations. The 341 cases monitored involved 708 allegations, averaging about two allegations per investigation.

Eighty-three percent of the cases monitored by the bureau involved peace officers. Owing to the inherent nature of the correctional environment, misuse of force is one of the most common allegations investigated by the department and monitored by the bureau. Because the case management system used by the Office of Internal Affairs defines each case by incident, with some incidents involving more than one subject, bureau-monitored cases may likewise reflect more than one subject. Illustrative of this, the number of employees investigated in the 341 cases monitored by the bureau totaled 488.■



POLICY AND LEGAL REFORMS

In addition to its monitoring activities during 2005, the Bureau of Independent Review actively participated in policy and legal reforms affecting the Department of Corrections and Rehabilitation's internal affairs and employee disciplinary processes.

Key among the reforms were the following.

- ***Central Intake Panel.*** Through the efforts of a strategic planning team made up of the major stakeholders in the department's disciplinary process, including the Bureau of Independent Review, a Central Intake Panel was established in May 2005 to review requests for internal affairs investigations from hiring authorities. The Central Intake Panel assesses each investigation request, determines whether an investigation should be conducted, and if so, assigns the case to the appropriate investigative unit. The Central Intake Panel is comprised primarily of special agents from the Office of Internal Affairs, with attorneys from the Bureau of Independent Review and employment law attorneys from the department's Employment Advocacy and Prosecution Team —vertical advocates — regularly participating in panel meetings. Experts from the Division of Correctional Health Care Services also occasionally participate to provide specialized

knowledge; other key department personnel, such as hiring authorities, other senior management staff members, employment relations officers, and institution investigators, are also encouraged to attend. The centralized, multi-disciplinary approach ensures that all requests for investigation and employee discipline submitted by hiring authorities to the Office of Internal Affairs are thoroughly reviewed by both the department and the bureau. The timely notice to the bureau and the Employment Advocacy and Prosecution Team afforded by the central intake process also serves to substantially increase the likelihood of a just outcome.

- ***Department Operations Manual.*** The bureau has played a significant role in reviewing and updating the Department of Corrections and Rehabilitation Operations Manual. Bureau staff and the chief counsel for the Office of the Inspector General reviewed the department's proposed revisions to Article 22, which governs the employee disciplinary process, for legal compliance, clarity, and appropriate bureau input and oversight. The bureau also has continued to assess policies governing internal affairs investigations, whistleblower retaliation, administrative immunity, subpoenaed witness notification, and incompatible activities. Major stakeholders have been given the opportunity to review and suggest changes to each proposal to ensure that policies are consistent and fair. In addition, the bureau has played an important role in an in-depth review and update of Article 14 of the manual, which covers internal affairs investigations, working closely with the Office of Internal Affairs and the Office of the Inspector General's chief counsel in that effort. ■

ASSESSMENT OF *MADRID* REFORMS

By the end of 2005, the reforms prescribed in the U. S. District Court-ordered *Madrid v. Woodford* remedial plan, and the bureau's role in those reforms, were substantially underway. The management of the Department of Corrections and Rehabilitation has readily accepted oversight of the internal affairs and employee disciplinary processes by the bureau and has integrated the bureau's activities into those processes. The management of the Office of Internal Affairs likewise has worked cooperatively with the bureau, and the professional relationship between that office and the bureau continues to mature at both headquarters and at the regional level. The executive manager of the department's Employment Advocacy and Prosecution Team also has provided the bureau with excellent support. Meanwhile, hiring authorities — prison wardens and youth correctional facility superintendents—have begun to routinely incorporate the bureau into employee disciplinary and investigation activities by contacting the bureau when significant incidents occur and including bureau staff in post-investigation disciplinary proceedings.

Although progress is being made daily, areas needing improvement include the following:

- The Employment Advocacy and Prosecution Team needs additional attorneys to effectively handle the high volume of disciplinary cases.

- Internal affairs investigators do not consistently use the interrogation techniques necessary to obtain complete and truthful responses. ■

SPECIAL REVIEW: SHOOTING OF AN INMATE AT WASCO STATE PRISON

In June 2005, the Bureau of Independent Review conducted a special review into the circumstances surrounding the death of inmate Daniel Provencio on January 16, 2005 at Wasco State Prison. The purpose of that review was to ensure that previous investigations by the Department of Corrections and Rehabilitation into the incident had been thorough, timely, and objective and to identify any systemic deficiencies or other factors that may have contributed to the inmate's death. Provencio was struck in the head by a direct-impact sponge projectile fired by a correctional officer from a 40-mm launcher after a fight erupted among inmates during an evening meal. Provencio lapsed into a coma and died on March 4, 2005. The Office of Internal Affairs of the Department of Corrections and Rehabilitation conducted a criminal investigation into the incident and found no criminal misconduct on the part of department employees. The department's Law Enforcement and Investigations Unit conducted a use-of-force investigation into the incident and concluded that the actions of the correctional officer who fired the direct-impact round were consistent with department policy. The comprehensive findings of the unit were presented to an independent Deadly Force Review Board, which determined that the officer's shooting of Provencio was reasonable under the circumstances and complied with department policy governing the use of less-than-lethal direct-impact weapons. As a result of its own review, the Bureau of Independent Review found that while the conclusions reached by the department's investigative entities were supported by the weight of the evidence, deficiencies within the institution and the department may have contributed to the inmate's death. The key findings and recommendations resulting from the bureau's special review are presented below. The department developed a corrective action plan to address the bureau's recommendations. The full text of the bureau's special review can be viewed by clicking on the following link to the Office of the Inspector General's website: Special Review into the Shooting of Inmate Daniel Provencio on January 16, 2005, at Wasco State Prison (June 2005). ■

KEY REVIEW FINDINGS

√ Investigations by the Department of Corrections and Rehabilitation into the incident were thorough, objective, and timely, and conclusions were supported by the evidence.

√ The actions of the officer who fired at the inmate were consistent with department policy.

√ Features of the 40-mm launcher used in the incident tend to cause projectiles to rise above the point of aim, which may have resulted in the projectile hitting the inmate in the head instead of in the legs where the officer said he was aiming.

√ The officer involved in the incident appeared to have had inadequate training on the 40-mm launcher.

√ The institution lacked a consistent policy covering qualification with the 40-mm launcher, and due to the high cost of rounds for the weapon, may not have allowed officers to fire live rounds in training.

√ The institution staff appears to have not conducted regular and thorough security checks of the housing unit that should have revealed that the inmates involved in the incident, including the victim, were manufacturing and consuming alcohol.

√ Emergency notification procedures for use-of-force incidents at the institution appeared to be deficient.

RECOMMENDATIONS

The Bureau of Independent Review recommended that the Department of Corrections and Rehabilitation take the following actions:

√ Develop a comprehensive training component on the use of direct-impact weapons from an elevated position.

√ Develop a comprehensive training component on how to effectively and safely employ the 40-mm launcher against a moving target. In the absence of such training, the department should discontinue use of the weapon.

√ Ensure that every officer armed with a department-issued weapon is regularly qualified with that weapon, including firing live rounds or using a realistic simulator.

√ Reassess the scope of work of each of the department's investigative entities to avoid unnecessary duplication and to ensure that administrative investigations are conducted into use-of-force incidents involving the death or serious injury of an inmate to identify potential staff misconduct.

The Bureau of Independent Review also recommended that Wasco State Prison do the following:

√ Develop clear written requirements governing security checks of housing units during shift changes, maintenance of housing unit logbooks, and timely cell searches following any significant incident at the institution.

√ Revise the prison's emergency notification procedures to clarify responsibility for ordering employees to remain at their posts following significant incidents at the institution.

√ Institute policies and procedures and training to ensure that evidence related to incidents resulting in injury to staff or inmates is preserved, pending instructions from investigating officials.

ADDITIONAL ACTIVITIES OF THE OFFICE OF THE INSPECTOR GENERAL

In addition to performing its primary functions, the Office of the Inspector General has been monitoring policy issues affecting the operations of the California Department of Corrections and Rehabilitation. In 2005, those efforts included addressing issues affecting the department's health care delivery system and its management, supervision, and treatment of sex offenders. Each of these efforts is described below:

- ***Medical Emergency Response Capabilities Focus Improvement Team.*** After the Office of the Inspector General published a special review into the death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men, the department adopted a corrective action plan that included appointing a Medical Emergency Response Capabilities Focus Improvement Team. The team was initiated in the fall of 2005, and the Office of the Inspector General has monitored its work from its inception.

  The Office of the Inspector General's oversight has included attending the team's meetings; reviewing medical charts, incident reports, and survey data; assessing medical research; visiting statewide custody facilities to evaluate emergency medical response capabilities; consulting with individuals involved in emergency medical services and related legal issues; performing legal research; and issuing periodic reports.

- ***Sex Offender Task Force.*** In late 2005, California received a grant from the U.S. Department of Justice's Center for Sex Offender Management to develop a statewide, comprehensive sex offender strategic plan and policy that will provide a blueprint for the management, supervision, and treatment of the state's sex offender population. This new model will include nationwide best practices, standards, and trends in the treatment, supervision, and management of sex offenders. A collaborative team (task force) consisting of representatives from the courts, the probation and corrections systems, law enforcement, the mental health community, victims organizations, and other entities is involved in the development of this strategic plan.

  The Office of the Inspector General attends the task force's meetings. ■

A LOOK AHEAD: PLANS FOR THE FUTURE

In the coming months, the Office of the Inspector General will continue to expand and deepen its oversight of California's correctional system. The office will not only continue to increase the number of audits performed each year but will also begin a regular schedule of unannounced inspections of every state correctional institution and will focus increased resources on the investigation of fraud inside the correctional system. Follow-up audits will continue to be conducted to assess the Department of Corrections and Rehabilitation's progress in implementing the Inspector General's past recommendations. The Inspector General will also take on a critical new role in the selection of superintendents of the state's juvenile correctional facilities and will audit every superintendent one year after his or her appointment.

- ***Audits of juvenile institutions.*** In addition to auditing every adult correctional institution one year after the appointment of a new warden and every correctional institution once every four years, the office will also audit every superintendent one year after his or her appointment. Subsequent follow-up audits — accountability audits — will evaluate the progress of the institution and the Department of Corrections and Rehabilitation in addressing deficiencies identified previously in the one-year and four-year audits.

- ***Unannounced inspections.*** To augment visits to correctional institutions by the Inspector General's staff in the course of audits and investigations and during evaluations of warden and superintendent candidates, deputy inspectors general will conduct unannounced inspections at every state correctional institution approximately twice per year. The purpose of the inspections will be to inquire into systemic issues and complaints that have been reported through the Inspector General's intake unit, establish new contacts at the institutions, and identify problem areas that may lead to formal audits and investigations.

- ***Fraud investigations.*** To uncover fraud in the correctional system, save taxpayer dollars, and hold wrongdoers accountable, the Inspector General will conduct complex, large-scale investigations in such areas as contracts and procurements, kickbacks, bribes, unjustified sole-source awards, and product diversion and substitutions. Investigations will be targeted to areas with potentially significant systemic problems, solutions, and dollar savings.

- ***Vetting of superintendent candidates.*** In addition to evaluating every candidate for a prison warden position, the Inspector General will now begin evaluating every candidate for a superintendent position at one of the state's juvenile correctional facilities. The results of the evaluations will be reported in confidence to the Governor.

- ***Critical incident roll-outs.*** In the future, when critical incidents occur at a correctional institution, deputy inspectors general from either the Bureau of Independent Review or the Bureau of Audits and Investigations will immediately respond to the institution on a call-out basis. Under protocols approved by the federal court, attorneys from the

Inspector General's Bureau of Independent Review have been responding to critical incidents since January 2005 — such as officer-involved shootings, suspicious inmate deaths, or the death of a correctional staff member —to assess the scene and monitor any internal affairs investigations. Now the Bureau of Audits and Investigations will roll out to incidents such as large-scale riots and escapes to assess whether systemic issues led to the incident, determine whether an audit is warranted, and determine whether the incident warrants an investigation of the warden or other members of the senior management staff.