OFFICE OF THE INSPECTOR GENERAL

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SPECIAL REVIEW INTO THE DEATH OF CORRECTIONAL OFFICER MANUEL A. GONZALEZ, JR. ON JANUARY 10, 2005 AT THE CALIFORNIA INSTITUTION FOR MEN

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STATE OF CALIFORNIA

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EXECUTIVE SUMMARY

This report presents the results of a special review conducted by the Office of the Inspector General into the circumstances surrounding the January 10, 2005 stabbing death of Correctional Officer Manuel A. Gonzalez, Jr. at the California Institution for Men. A criminal investigation into the incident was conducted by the San Bernardino County Sheriff's Department and resulted in criminal charges of murder against Jon Christopher Blaylock, an inmate at the California Institution for Men.

The purpose of the Office of the Inspector General's review was to identify systemic procedural and policy deficiencies, procedural violations, and other factors that may have contributed to Officer Gonzalez' death. In its review, the Office of the Inspector General examined the Department of Corrections incident report and attendant documents; reviewed policies and procedures governing safety and security, reception center housing placement and processing, inmate mental health diagnosis and placement, emergency incident response, medical response, and crime scene management. The Office of the Inspector General also examined the department's recent procurement and distribution of protective vests to correctional officers.

As a result of the review, the Office of the Inspector General identified a number of issues that played a critical role in the incident. The review determined that Blaylock had a long history of in-prison violence before he arrived at the California Institution for Men for reception center processing. He had most recently paroled from an indeterminate term in the security housing unit at California State Prison, Corcoran, where he had been placed in a single cell and on walk-alone yard status as a safety and security risk because of his numerous enemies and history of fighting with other inmates. At the time of his parole in 2002, he was classified as a Level IV maximum security inmate with 376 custody points, and he had been designated as requiring placement in a 180-design Level IV prison with internal and external armed coverage—the most secure configuration of the state's Level IV prisons. Less than four months after he paroled in 2002, Blaylock was arrested for shooting at a police officer. He remained in jail in Los Angeles County until his conviction in 2004 for attempted murder of a peace officer, whereupon he was sentenced to a 75-year state prison term. He arrived at the California Institution for Men for reception center processing on June 23, 2004 and remained there until the fatal stabbing on January 10, 2005.

The Office of the Inspector General found that despite Blaylock's history of in-prison violence, he was kept in a general population cell during nearly all of the seven months he spent at the California Institution for Men. Many of the state's other reception centers reported that — as a returning inmate who had most recently paroled from a security housing unit — he would have been automatically placed in an administrative segregation unit. After he allegedly assaulted another inmate at the reception center, he spent seven weeks in administrative segregation pending disciplinary action, but the assault charge was reduced to "mutual combat" and he was returned to the general population, where he remained until the stabbing of Officer Gonzalez.

The review also determined that correctional officers assigned to the living unit where Blaylock was housed, including Officer Gonzalez, routinely violated standard security protocols, as well as extra security restrictions that had been imposed in response to several other violent incidents at the facility. The Office of the Inspector General found that the fatal stabbing may have been prevented if Officer Gonzalez and other officers had adhered to those security requirements.

The Office of the Inspector General found in addition that the housing unit where the stabbing occurred is in such disrepair and tool controls so lax that inmates are able to easily obtain and hide materials for making weapons.

The Office of the Inspector General also found that the California Institution for Men unduly delayed issuing protective vests to correctional officers and instead stored them in a warehouse while updating its policies on vest distribution and waiting to receive enough vests for all officers designated to receive them in an effort to avoid complaints of unfairness. A vest assigned to Officer Gonzalez was in the warehouse when the stabbing occurred.

The following summarizes the Office of the Inspector General's findings:

FINDING 1

The Office of the Inspector General found that the California Institution for Men inappropriately housed Blaylock in a general population unit despite his recent parole from a security housing unit and his demonstrated violence toward other inmates.

As an inmate with a history of in-prison violence who had most recently paroled from an indeterminate term in a security housing unit, Blaylock should have been placed in administrative segregation when he arrived at the California Institution for Men. That action would have been consistent with California Code of Regulations, Title 15 and with the procedures followed at five other reception centers for males operated by the Department of Corrections. Yet, when Blaylock arrived at the California Institution for Men, he was assigned instead to a general population cell, where he remained throughout nearly all of his seven-month stay at the institution. The Office of the Inspector General found, in fact, that the California Institution for Men regularly places inmates who have paroled from administrative segregation and security housing units into general population housing.

Blaylock was involved in a violent altercation with another inmate six weeks after his arrival at the reception center and he was held in administrative segregation for seven weeks pending disciplinary action. He was then again released to the general population despite repeated notations in his files about his potential for violence and extensive information about his history of security housing and administrative segregation

confinement during earlier prison terms. On the day he allegedly stabbed Officer Gonzalez, he was still assigned to a general population cell.

FINDING 2

The Office of the Inspector General found that Blaylock's reception center processing was delayed due to complex case factors that severely limited his options for transfer to another institution.

Blaylock was housed at the California Institution for Men for seven months. The departmental guidelines state that reception centers will normally process inmates for transfer within 60 days. Blaylock's case, however, was far from normal. The complexities of his case, combined with his conduct, resulted in extending his confinement at the California Institution for Men. The Office of the Inspector General reviewed each aspect of Blaylock's reception center processing and found no delays resulting solely from staff inefficiency or misconduct.

FINDING 3

The Officer of the Inspector General found that the stabbing of Officer Gonzalez might have been prevented if officers on the second watch at Sycamore Hall, including the victim, had followed security protocols and additional security restrictions imposed in response to earlier incidents in the housing unit.

The Office of the Inspector General found that correctional officers on the second watch at Sycamore Hall, including Officer Gonzalez, in an attempt to calm racial tensions on the unit and return the tier to regular programming, consistently failed to follow post orders and standard security protocols. They also repeatedly violated additional security measures imposed after violent incidents between Black, Hispanic, and White inmates at the facility in December 2004. Tragically, the stabbing of Officer Gonzalez on January 10, 2005 was directly linked to the violation of those security requirements.

In interviews conducted by the Office of the Inspector General and the San Bernardino County Sheriff's Department, Sycamore Hall correctional staff and inmates consistently reported that policies and procedures designed to provide safety and security were not followed on second watch when Officer Gonzalez was on duty. The officers said, for instance, that in direct violation of security protocols, they frequently released inmates they believed were influential with other inmates out onto the tier to try to calm racial tensions. In particular, they reported that Gonzalez allowed Blaylock out of his cell on numerous occasions before the fatal stabbing, because he believed Blaylock to be a "shot caller," who could influence other Black inmates. On the day he was stabbed, Gonzalez not only directed that Blaylock be released from his cell, but also entered the tier alone to speak to Blaylock, in direct violation of established security protocols. Earlier that morning, a fellow officer warned Gonzalez that this conduct was dangerous and could result in a stabbing. By ignoring this warning, Gonzalez placed himself and other officers in harm's way.

In addition, the Office of the Inspector General found that second-watch correctional officers at Sycamore Hall did not perform required cell searches —as evidenced both by cell search logs and by approximately 35 weapons found during a comprehensive search of the housing unit conducted immediately after the fatal stabbing. Nor did they follow extra security measures imposed after racial violence in the unit that called for keeping inmate workers off the tier and racial groups separated during inmate movements. The correctional staff on a different watch also failed to report verbal threats made by inmates toward officers. Finally, the supervisory staff and management of the institution failed to adequately supervise the officers or hold them accountable for the lax security practices.

FINDING 4

The Office of the Inspector General found that Sycamore Hall inmates were able to obtain and hide weapons because of lax tool controls, poor building maintenance and the consistent failure of the correctional staff to conduct required cell searches.

The California Institution for Men was built in 1941. A lack of preventive maintenance at the aging facility has left Reception Center Central, and specifically Sycamore Hall and Madrone Hall, in a serious state of disrepair. The disrepair and structural defects provide inmates with a source of weapons stock and provides spaces for inmates to hide inmate-manufactured weapons. Compounding the disrepair and structural defects is the institution's failure to adhere to departmental policy requiring consistent and accurate inventory counts of tools legitimately used by inmates, thus hindering staff from detecting theft of tools and metal stock by inmates for use as weapons or in their manufacture.

FINDING 5

The Office of the Inspector General found that the California Department of Corrections procured and distributed protective vests to the institutions consistent with its budget change proposal and its agreement with the California Correctional Peace Officers Association; however, delays in issuing vests at the California Institution for Men were unwarranted.

In fiscal year 2001-02, the Department of Corrections received both one-time and ongoing funding to procure stab-resistant protective vests for its custody employees. The Office of the Inspector General determined that in the ensuing years, the department actually spent more than budgeted to procure these vests and distributed them to its institutions according to priorities outlined in the agreement with the California Correctional Peace Officers Association. At the time of the stabbing of Officer Gonzalez, however, the California Institution for Men had been holding in its warehouse 362 vests it had received on September 9, 2004. While the failure of the institution to distribute the vests immediately may not have violated the agreement with the union, depending upon the interpretation of the relevant sections of the Memorandum of Understanding, distributing the vests expeditiously would certainly have improved employee safety, including that of Officer Gonzalez, whose personally fitted vest was in the warehouse

when he was stabbed. Further, holding the vests in the warehouse for four months considerably shortens their useful life. The reasons the institution provided for not distributing the vests until the day following Gonzalez' death reflect a lack of urgency, and inadequate planning.

FINDING 6

The Office of the Inspector General found that the medical clinic at the California Institution for Men reception center where the victim was taken after the stabbing was poorly equipped and ill-prepared to handle the emergency.

The reception center clinic where Officer Gonzalez was first taken was not properly equipped, supplied or organized to deal with his medical emergency, nor was the clinic's medical staff prepared to cope with it. The deficiencies may not have contributed to the death of Officer Gonzalez, given the extreme severity of his wounds, but the evidence establishes that the care provided by the clinic staff was very deficient.

FINDING 7

The Office of the Inspector General found that the management of the California Institution for Men did not set up an Emergency Operations Center or institute an Emergency Operations Plan in the wake of Officer Gonzalez' stabbing due to ambiguous protocols. As a result, there was some confusion in the chain of command, emergency operations policies were not implemented, the crime scene was destroyed, and an incident log was never initiated.

The *California Department of Corrections Operations Manual* governs appropriate responses to disturbances at an institution, while individual institutions' own Emergency Operations Procedures address ancillary policies unique to each institution. However, these documents do not specifically address whether an Emergency Operations Center should be set up or an Emergency Operations Plan implemented following an assault on an officer resulting in serious injury or death. In the wake of the attack on Officer Gonzalez, the institution's management neither set up an Emergency Operations Center nor implemented an Emergency Operations Plan. As a result, there was some confusion in the chain of command that led to institutional staff's failure to follow critical emergency operations policies, destruction of the crime scene, and a failure to record events in an incident log. Despite these shortcomings, correctional officers were able to transport the wounded officer to a medical care facility quickly, effectively regain control of the housing unit, and take the suspect into custody without further serious injury to inmates or staff.

FINDING 8

The Office of the Inspector General found that the California Institution for Men did not implement important emergency procedures in response to the incident, leading to contamination of the crime scene and the loss of important evidence.

California Institution for Men staff failed to preserve the crime scene and physical evidence, including the clothing worn by Officer Gonzalez' alleged assailant. As a result, potentially important corroborative evidence, such as forensic evidence potentially linking the assailant and the victim was lost. As such, the State's case against inmate Blaylock must rely more heavily on eyewitness accounts than otherwise necessary. Institution staff did not follow established procedures for preserving crime scenes and physical evidence because some were traumatized by the assault and failed to do their duties, Investigative Services Unit officers lacked adequate training and experience, and there was inadequate command and control over the incident. Specifically, the warden did not implement the prison's Emergency Operations Procedures. Because these procedures provide detailed steps and checklists for myriad tasks including crime scene and evidence preservation, implementing them may have facilitated a more structured, systematic response by the institution.

FINDING 9

The Office of the Inspector General made confidential findings related to the adequacy of mental health care for particular inmates at the California Institution for Men.

The investigation of the Office of the Inspector General found that the California Institution for Men failed to adequately assess and address particular inmates mental health needs. However, due to state and federal medical privacy laws, those findings cannot be presented in a public document. Accordingly, pursuant to Penal Code section 6131 (b) the information in this section has been presented only to the Governor and the Youth and Adult Correctional Agency.

FINDING 10

The Office of the Inspector General found that Blaylock was permitted to conduct a telephone conference with an attorney before he was indicted for the murder of Officer Gonzalez and even though the attorney's request for the conference was not properly submitted in writing.

The Office of the Inspector General found that Corcoran State Prison, where Blaylock was transferred following the incident, allowed Blaylock to speak to an attorney by telephone before he was indicted for the murder of Officer Gonzalez and therefore before he had a right to counsel in the matter under the Sixth Amendment. The prison's litigation coordinator allowed the telephone conference even though the attorney's

request was not properly submitted in writing. The Office of the Inspector General found, however, that the litigation coordinator acted reasonably in granting the request.

INTRODUCTION

This report presents the results of a special review conducted by the Office of the Inspector General 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 was conducted pursuant to the Office of the Inspector General's responsibility under California Penal Code section 6126 for oversight of the Youth and Adult Correctional Agency and its subordinate entities. A criminal investigation of the incident was conducted by the San Bernardino County Sheriff's Department.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the review by the Office of the Inspector General was to identify systemic procedural and policy deficiencies, procedural violations, and other factors that may have contributed to the incident. The review examined whether the actions of the Department of Corrections and the California Institution for Men surrounding the incident were consistent with statutory and regulatory requirements and with the provisions of the collective bargaining agreement between the State of California and Bargaining Unit 6 of the California Correctional Peace Officers Association. In some instances, the Office of the Inspector General measured department and institution actions against the best or standard practices of other correctional and law enforcement entities. The review also considered whether the incident revealed the need for changes in statutory or regulatory requirements.

In conducting the review, the Office of the Inspector General examined the following:

- The mental health diagnostic, screening, and placement processes in place at the California Institution for Men at the time of the incident.

- Reception center policies and procedures in place at the California Institution for Men at the time of the incident, particularly those affecting the suspect's initial and continued placement in the reception center general population.

- Safety and security policies, procedures, and conditions at Sycamore Hall, the reception center general population living unit in which the suspect was incarcerated and to which Correctional Officer Gonzalez was assigned, as they existed at the time of the fatal stabbing.

- The history of the procurement by the Department of Corrections of stab-resistant protective vests; the department's negotiations with the California Correctional Peace Officers Association with regard to the vests; the policies and procedures governing the fitting and distribution of the vests; and the decision to not immediately distribute vests to the correctional staff at the California Institution for Men, including Correctional Officer Gonzalez.

- Incident and crime scene management policies, procedures, and practices before, during, and after the fatal stabbing, with emphasis on preparedness, response, medical care of the victim, crime scene preservation, and interaction with local law enforcement.

In reviewing these issues, the Office of the Inspector General conducted the following procedures:

- Assigned a team of 12 auditors, investigators and attorneys to conduct the inquiry.

- Toured Reception Center Central at the California Institution for Men on multiple occasions.

- Interviewed personnel of the Youth and Adult Correctional Agency, the Department of Corrections, and the California Institution for Men, including management staff, custody staff, medical personnel and other employees, as well as officials of Bargaining Unit 6 of the California Correctional Peace Officers Association and inmates.

- Interviewed investigators and other employees of the San Bernardino County Sheriff's Department, and attorneys and staff from the San Bernardino County District Attorney's Office.

- Reviewed investigative reports, incident reports, and other documents related to the stabbing provided by the entities listed above.

- Reviewed pertinent statutes and regulations; sections of *the California Department of Corrections Operations Manual*; and operational policies and procedures of the California Institution for Men.

- Reviewed post orders, living unit logs, inmate central files, classification committee notes, inmate medical and mental health records and evaluations, and other pertinent documents. Because of the inadequacy of documentation in many instances, the Office of the Inspector General supplemented this review with interviews of employees responsible for particular institution functions.

- Reviewed the collective bargaining agreement between the State of California and Bargaining Unit 6 of the California Correctional Peace Officers Association.

- Using information gathered from these procedures, analyzed and evaluated Department of Corrections and California Institution for Men policies, procedures, and practices with respect to the issues cited above, and formulated recommendations accordingly.

The Office of the Inspector General did not conduct a criminal investigation into the stabbing death of Correctional Officer Gonzalez and did not evaluate the quality of the investigation conducted by the San Bernardino County Sheriff's Department.

BACKGROUND

Department of Corrections Correctional Officer Manuel A. Gonzalez, Jr., 43, was fatally stabbed at 10:57 a.m. on January 10, 2005 on Tier 1 of Sycamore Hall at the California Institution for Men in Chino. The assailant was identified by law enforcement as Jon Christopher Blaylock, 35, an inmate who had been at the institution's reception center for more than six months awaiting permanent institution placement. The San Bernardino County Sheriff's Department investigated the incident and the San Bernardino County District Attorney's Office charged Blaylock with first-degree murder with special circumstances.

Blaylock has a history of violent behavior toward correctional employees and other inmates. Blaylock arrived at the California Institution for Men on June 23, 2004 to undergo reception center processing after receiving a 75-year prison sentence for the August 2002 attempted murder of a police officer, a crime committed shortly after he was released on parole from an earlier prison term. He had served two earlier state prison sentences in 1990 and 1993 for attempted burglary, and a ten-year prison term for robbery from which he paroled in 2002.

At the time of his 2002 parole, Blaylock was serving an indeterminate term in the security housing unit at Corcoran State Prison as a maximum security Level IV inmate with a classification score of 376 points.[1] He had been placed in a single cell and on walk-alone yard status as a safety and security risk because he had a history of fighting with other inmates and was believed to have numerous enemies.[2] He was therefore transferred from the security housing unit at Corcoran State Prison to a single cell in the administrative segregation unit at California State Prison, Los Angeles and paroled four days later, on April 23, 2002.

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[1] Classification scores are used to determine inmate custody level and institution placement. Scores are based on such factors as prison sentence; stability indicators such as age, employment history, and education level; and behavior in prison, including physical assaults, possession of deadly weapons, and serious rule violations. Under *California Code of Regulations,* Title 15, Section 3375.1, inmates are to be assigned to facilities with a classification level corresponding to the classification score, as follows:

0-18	Level I
19-27	Level II
28-51	Level III
52 and >	Level IV

[2] Because of acute overcrowding at Department of Corrections facilities, most inmates in secured housing and administrative segregation are double-celled. Single cells are reserved for inmates with a history of in-cell violence and predatory behavior. Administrative segregation is intended as a temporary placement pending a ruling or other action for inmates whose presence in the inmate general population poses a danger to themselves, others, or the security of the institution or could jeopardize the integrity of serious misconduct or criminal investigations. Secured housing may be assigned for either a determinate or indeterminate period and is designated for inmates whose conduct endangers the safety of others or the security of the institution. Inmates assigned to secured housing are designated either Maximum A or Maximum B security level. Inmates in both administrative segregation and secured housing are placed in full restraints when they come into contact with correctional staff and are allowed out of their cells only one hour a day.

On August 11, 2002, less than four months after he was released, Blaylock fired three shots at a police officer who had stopped him for riding a bicycle without a front headlight. The officer returned one shot. No injuries were reported. Blaylock was arrested and remained in county jail until his conviction in June 2004 for attempted murder of a police officer. He was sentenced to a 75-year term.

Blaylock was sent to the reception center at the California Institution for Men for processing on June 23, 2004 and was placed in a general population cell at Sycamore Hall. He remained in general population housing for nearly all of the seven months he spent at the reception center.

The California Institution for Men. The California Institution for Men, built in 1941, serves as a prison for Level I, II, and III inmates and as a reception center for male felons newly committed to the Department of Corrections from Los Angeles, San Bernardino, Riverside, San Diego, and Orange counties. With a design capacity of 2,778, the institution presently houses 6,298 inmates. Custody and support staff number 1,771.

The reception center at the California Institution for Men is one of seven reception centers for males operated by the Department of Corrections, along with High Desert State Prison, Wasco State Prison, Richard J. Donovan Correctional Facility, North Kern State Prison, Deuel Vocational Institution, and San Quentin State Prison. Known as Reception Center Central, the reception center is one of four facilities at the California Institution for Men. Arriving inmates consist of new commitments to state prison, parole violators being returned to custody, parolees-at-large extradited from other states, inmates enroute to other institutions, inmates returning to prison from court, and inmates scheduled for parole into the community from prisons throughout the state. The facility receives an average of 700 inmates a week and operates 24 hours a day, seven days a week.

Reception Center Central has a design capacity of 618 and a current inmate population of 1,465, seventy-eight of whom are designated as permanent work crew inmates. The rest of the inmate population consists of inmates undergoing reception center processing. The reception center is configured into two wings: Reception Center Central East, which consists of Birch Hall, Cypress Hall, and Palm Hall; and Reception Center Central West, which consists of Madrone Hall and Sycamore Hall. Reception Center Central Control is situated between Reception Center Central East and Reception Center Central West, adjacent on one side to the main entrance to the building and on the other side to the facility lieutenant's office.

Birch Hall, with 154 cells, including 49 single cells, houses inmates with sensitive needs who are not compatible with other general population inmates. Cypress Hall, with 102 cells, is used for administrative segregation overflow. Palm Hall, which is comprised of 102 cells (68 double cells and 34 single cells) is designated as the administrative segregation unit.

Sycamore Hall. Sycamore Hall and Madrone Hall, each with 102 cells, house general population inmates. Sycamore Hall is comprised of a west side and an east side, isolated from each other except through the guard spaces. Each side is made up of three tiers accessible by open staircases inside the tiers and by locked staircases inside the guard spaces.

On January 10, 2004, the day of the stabbing, 213 inmates were housed in Sycamore Hall, with four correctional officers responsible for inmate supervision and escort. The building was on modified lockdown because of earlier incidents in which an Hispanic inmate stabbed a Black inmate and a Black inmate stabbed an Hispanic inmate.

Following is a chronology of events leading up to the incident:

1990 to 1992	Blaylock serves a three-year term for robbery.
1993 to 2002	Blaylock serves a 10-year term for robbery with a firearm. At the California Men's Colony, he is found in possession of a weapon and is sent to California State Prison, Corcoran to serve a 10-month determinate sentence in the security housing unit. At the end of the 10-month term, he is given an indeterminate term in the security housing unit as a threat to the institution's safety and security. He is placed in a single cell on walk-alone yard status and is classified as a Level IV inmate with a custody point score of 376, indicating he requires confinement in a Level IV, 180-design prison. In April 2002 he is paroled.
April 23, 2002	Blaylock is transferred from the security housing unit at California State Prison, Corcoran to the administrative segregation unit at California State Prison, Los Angeles and released on parole.
August 11, 2002	Blaylock is stopped on a bicycle for riding without a front headlight and fires three shots at a police officer. There are no injuries. He is arrested.
August 2002 - June 2004	Blaylock remains in Los Angeles County jail until he is convicted of attempted murder of a peace officer, and sentenced to a 75-year prison term.
June 23, 2004	Blaylock arrives at the reception center at the California Institution for Men. The same day, Department of Corrections records printed at the California Institution for Men indicate that he paroled from the administrative segregation unit at California State Prison, Los Angeles County after transferring from the security housing unit at California State Prison, Corcoran. The California

	Institution for Men places him in a general population cell at Sycamore Hall.
June 24, 2004	More Department of Corrections records arrive, showing Blaylock had been classified as a Level IV inmate with 376 custody points and was designated as requiring "maximum custody" at the time of his parole. He remains in a general population cell at the reception center.
July 9, 2004	Blaylock's central file arrives at the reception center. The file contains information that he had been in and out of segregated housing and administrative segregation since 1990 because of more than 20 incidents of serious misconduct, including several incidents involving violence toward staff and other inmates and the possession and use of weapons. He remains in a general population cell at the reception center.
July 13, 2004	Blaylock's central file is audited and his earliest possible release date is calculated to be January 23, 2071.
July 27, 2004	The reception center medical department classifies Blaylock.
July 31, 2004	Blaylock was involved in a violent altercation with another inmate and is placed in administrative segregation. He is charged with assault.
August 2, 2004	A correctional captain reviews Blaylock's placement in administrative segregation and determines he is a threat to the safety and security of the institution and should remain in administrative segregation pending completion of the disciplinary process.
August 4, 2004	The Institutional Classification Committee meets with Blaylock and elects to retain him in administrative segregation pending completion of the disciplinary process. The committee changes his custody level to "MAX-S," meaning maximum security, single-cell, due to past violence.
September 9, 2004	A senior hearing officer adjudicates the rules violation resulting from the July 31, 2004 assault and reduces the charge to mutual combat.
September 22, 2004	The Institutional Classification Committee meets to consider whether Blaylock should continue in administrative segregation. The committee notes that Blaylock is serving a life term for attempted murder of a

	peace officer; notes that the rules violation was reduced to "mutual combat;" and releases him to the general population. The psychologist who assessed Blaylock is a member of the committee.
September 25, 2004	A reception center medical clearance chrono is completed for Blaylock's central file, clearing the way for classification personnel to complete the casework for transfer.
October 12, 2004	A correctional counselor I completes the reception center readmission summary, but the summary contains numerous errors and omissions. It reports that Blaylock paroled with "close B" custody, rather than the higher "MAX-S" custody. The section listing disciplinary history notes the 2000 weapons possession that result in a security housing unit term at California State Prison, Corcoran and omits the July 31, 2004 assault at the reception center.
October 14, 2004	The Institutional Staff Recommendation Summary, which must be completed before an inmate is transferred from the reception center, is completed. It omits the July 31, 2004 assault of the other inmate. The summary recommends that Blaylock be sent to California State Prison, Corcoran. The counselor notes that the interview with Blaylock had to be cut short because his behavior was "bizarre and confusing," and "he became very agitated, stating that staff were out to kill him."
November 17, 2004	The Institutional Classification Committee refers Blaylock's case to the chief deputy warden, recommending that the case be referred to the Departmental Review Board for placement guidance because of the difficulty of finding placement for Blaylock.
December 1, 2004	Blaylock appears before the Unit Classification Committee for a special review because of difficulty in placing him due to his medical and custody needs. The committee refers the case to the Departmental Review Board with a recommendation that he be endorsed for either the California Medical Facility-III or the California Men's Colony-E, both Level III facilities that allow only inmates with 51 custody points or fewer.
December 2, 2004	A staff psychologist submits a form to the senior supervising social worker requesting a referral to the Department of Mental Health for Blaylock.

December 6, 2004	The Departmental Review Board report dated November 19, 2004 is sent to the Department of Corrections headquarters. Sycamore Hall is placed on a modified program after a piece of metal is discovered missing from a light fixture, raising fears that it might be used as weapons material. The modified program calls for increased cell searches and caution during inmate movements.
December 19, 2004	A riot between Black and Hispanic inmates occurs in the Sycamore Hall culinary area in which several Hispanics sustain puncture wounds.
December 20, 2004	The modified program at Sycamore Hall is expanded to a modified lockdown with cell feeding, no recreational yard, escorted inmate movement, and a requirement that Black inmates be escorted separately from White and Hispanic inmates.
December 28, 2004	A Sycamore Hall correctional officer violates the modified program by opening the first-tier grill gate and allowing a Black inmate to enter while a White inmate porter is sweeping. The White inmate stabs the Black inmate from behind. The modified program is further expanded to prohibit inmate workers from entering Sycamore Hall. Blaylock tells a correctional officer and a correctional lieutenant that Black inmates blame the officer for the stabbing and want to "get him." The threat is not reported.
January 9, 2005	Blaylock becomes angry in a dispute with a correctional officer over his legal mail and reportedly shouts, "Then you wonder why motherfuckers get stabbed!" Again, the threat is not reported.
January 10, 2005	The fatal stabbing of Correctional Office Gonzalez occurs on the first tier of Sycamore Hall.

FINDINGS AND RECOMMENDATIONS

FINDING 1

The Office of the Inspector General found that the California Institution for Men inappropriately housed Blaylock in a general population unit despite his recent parole from a security housing unit and his demonstrated violence toward other inmates.

As an inmate with a history of in-prison violence who had most recently paroled from an indeterminate term in a security housing unit, Blaylock should have been placed in administrative segregation when he arrived at the California Institution for Men. That action would have been consistent with California Code of Regulations, Title 15 and with the procedures followed at five other reception centers for males operated by the Department of Corrections. Yet, when Blaylock arrived at the California Institution for Men, he was assigned instead to a general population cell, where he remained throughout nearly all of his seven-month stay at the institution. The Office of the Inspector General found, in fact, that the California Institution for Men regularly places inmates who have paroled from administrative segregation and security housing units into general population housing.

Blaylock was involved in a violent altercation with another inmate six weeks after his arrival at the reception center and he was held in administrative segregation for seven weeks pending disciplinary action. He was then again released to the general population despite repeated notations in his files about his potential for violence and extensive information about his history of security housing and administrative segregation confinement during earlier prison terms. On the day he allegedly stabbed Officer Gonzalez, he was still assigned to a general population cell.

Procedure for inmates who paroled from determinate terms in security housing. California Code of Regulations, Title 15, section 3341.5 requires that inmates returning to the Department of Corrections who paroled from a determinate sentence in security housing be evaluated by an Institutional Classification Committee to determine whether the determinate sentence should be reimposed. The section reads as follows:

> *When an inmate is paroled while serving a determinate term, the remaining time on the term is automatically suspended. When an inmate returns to prison, either as a parole violator or with a new prison commitment, ICC shall evaluate the case for reimposition of the suspended determinate term.*

That practice recognizes that inmates with a history of confinement in administrative segregation or security housing have exhibited conduct in the past that posed a threat to the safety of themselves or others or to the security of the institution. While Title 15 does not specify a similar procedure for inmates returning to custody who parole from indeterminate sentences in a segregated housing unit, it does provide that prison inmates

assigned to a security housing unit at an institution for either a determinate or indeterminate term may be released to the general population only upon review by a classification committee.

Department of Corrections inmate records provide security housing history. Information about whether an inmate was previously confined in specialized housing — including administrative segregation or a security housing unit — appears in various department records to which the reception center staff has access. The Offender-Based Information System, which reports the inmate's most recent prison housing before he paroled or discharged from custody is typically available to the reception center staff as soon as the inmate arrives at the institution. The Distributed Data Processing System, which gives the inmate's placement score and custody level before parole, is available the day after the inmate arrives at the institution. The inmate's central file, which contains detailed information about past in-custody conduct, identified enemies, and other classification information, including security housing history, typically arrives at the reception center between one and three weeks after the inmate's arrival.

Housing placement procedures at other reception centers. The Office of the Inspector General found that, consistent with Title 15, all of the other Department of Corrections reception centers for males automatically place into administrative segregation inmates who, according to the Offender-Based Information System, paroled from administrative segregation or security housing. The inmates are retained in administrative segregation pending review by an Institutional Classification Committee. Although the Offender-Based Information System does not specify whether a segregated housing term was for a determinate or an indeterminate sentence, the procedures assume a determinate term and therefore mandatory compliance with Title 15, section 3341.5. The procedures at those reception centers do not allow the staff discretion to place inmates who paroled from security housing into general population cells.

Reception center housing placement at the California Institution for Men. According to the receiving and release staff, at the time Blaylock arrived at the California Institution for Men, a check of the Offender-Based Information System to determine an inmate's most recent prison housing was typically performed within 48 hours of the inmate's arrival.[3] In a procedure still in effect, once the previous housing information is obtained from the Offender-Based Information System, the receiving and release supervisors at the California Institution for Men are allowed discretion about whether to place an inmate

[3] Until this review by the Office of the Inspector General, to obtain information from the Offender-Based Information System, the receiving and release staff was obliged to submit a list of incoming inmates to the institution's records office, where the Offender-Based Information System terminal was located. Because the records office is staffed only during business hours and because the reception center must accept parole violators 24 hours a day, seven days a week, the check of the Offender-Based Information System was often delayed for inmates arriving during non-business hours. Until the staff could obtain the previous housing information, inmates could be placed in general population housing. As a result of the review by the Office of the Inspector General, the California Institution for Men has remedied this problem by placing an Offender-Based Information System terminal in the receiving and records office, allowing the staff 24-hour access to the information.

who paroled from segregated housing or an administrative segregation unit into the general population. And in making that decision, the staff simply relies upon what the inmate says about why he was confined in segregated housing or administrative segregation. The process calls for a correctional sergeant to review the information from the Offender-Based Information System and to interview inmates who paroled from a segregated housing or administrative segregation unit to determine the reason for the specialized placement. If the inmate says the placement was for an offense that would usually carry a short term, such as participating in a riot or battery on an inmate, he is typically assigned to the general population, under the assumption that the time remaining on the term would likely be short. If the inmate reports that the specialized housing placement was for an offense carrying a longer term, the correctional lieutenant on duty interviews him to decide whether administrative segregation placement is necessary. The lieutenant has discretion to place the inmate in administrative segregation pending further review by the Institutional Classification Committee or to assign him to the general population.

Blaylock's general population placement at the California Institution for Men. The records show that the receiving and release staff at the California Institution for Men obtained the Offender-Based Information System information for Blaylock on the day he arrived at the institution, June 23, 2004, and that a correctional sergeant reviewed it. The Offender-Based Information System revealed that at the time Blaylock paroled in 2002, he had been in the security housing unit at California State Prison, Corcoran and had been transferred to the administrative segregation unit at California State Prison, Los Angeles County in Lancaster just before he was released. Yet, after the Offender-Based Information System review at the California Institution for Men, Blaylock was placed in the general population, which allowed him to leave his cell for meals and to come into closer contact with the staff and other inmates. Except for a one-page sheet documenting that the Offender-Based Information System process was carried out, the files include no information to explain why Blaylock was not placed into administrative segregation.

Blaylock remained in general population even after more information arrived. Because the reception center process does not provide for a routine re-evaluation of the initial housing decision after the Offender-Based Information System review, Blaylock remained in the general population even after more information about his background became available. On the day after his arrival, information from the Distributed Data Processing System arrived. That information showed that Blaylock had been a Level IV inmate with 376 custody points and was designated as requiring "maximum custody" at the time of his parole. On July 9, 2004, his central file, which contained more complete information about his background, also arrived. The central file revealed he had been in and out of security housing units and administrative segregation since 1990 because of an extensive pattern of serious misconduct. The file showed his disciplinary history included more than 20 incidents of serious misconduct, including several incidents involving violence. According to the file, during his then-most recent prison term, he had been sent from the California Men's Colony to California State Prison, Corcoran to serve a 10-month determinate sentence in the segregated housing unit for possession of a weapon. Classified as a maximum security inmate, he was on single-cell, walk-alone yard status as

a safety and security risk because of his history of violence toward other inmates and his numerous enemies — a designation that restricted him from physical contact with other inmates and required that he be placed in restraints whenever he left his cell or came into contact with correctional employees.

The central file reported that when he completed the 10-month determinate sentence in the security housing unit at California State Prison, Corcoran, the Institutional Classification Committee determined his high classification score and history required he be confined to one of the most secure of the state's Level IV institutions —a 180-design facility, rather than one of the less-secure 270-design Level IV facilities. The committee concluded he was therefore not eligible for placement in Corcoran's 270-design Level IV facility. The committee referred his case to a classification services representative with a recommendation that he be given an indeterminate sentence in the security housing unit. The classification services representative endorsed the security housing unit indeterminate sentence, noting:

> *Placement is necessary due to the high number of enemies and their placement which makes alternate housing not feasible. Indeterminate placement will address the inmate's safety needs as well as his health needs.*

The records show that the California Institution for Men audited Blaylock's central file on July 13, 2004 for the purpose of determining his earliest possible release date. The release date was calculated at January 23, 2071, but no action was taken to alter Blaylock's placement in a general population cell and no note appears to have been taken of his history of violence and security housing confinement.

The California Institution for Men lacks adequate administrative segregation space. Blaylock's placement in the general population may have been influenced by the shortage of administrative segregation beds at the California Institution for Men. With just 102 beds designated for administrative segregation, the institution lacks the capacity to provide security housing for all of the high-security inmates processing through the reception center. The classification staff reported that at the time of the Inspector General's review, Palm Hall, the administrative segregation unit at the institution, was completely full and all but four cells in Cypress Hall were being used as administrative segregation overflow. The staff told the Office of the Inspector General that the constantly revolving inmate population and the high number of inmates with safety requirements results in the constant need to move inmates into the general population beds to free up space in administrative segregation. Yet the general population housing units at the institution are poorly equipped to accommodate high-security inmates and control violence.

Sycamore Hall is inadequate for high-security inmates. The California Institution for Men uses Sycamore Hall as general population housing for its worst offenders, other than those in administrative segregation, but Sycamore Hall cannot provide the security required for inmates with high-security needs. The facility is a three-tiered housing unit of antiquated design with traditional bars on cells doors controlled by a recently installed

electronic bar box. It lacks gun coverage and has numerous blind spots that allow incidents to occur without detection. The facility is also in deteriorated physical condition, providing inmates with access to weapon-making materials and numerous locations for concealing weapons.

Blaylock was temporarily sent to administrative segregation after a serious altercation with another inmate. On July 31, 2004, six weeks after he arrived at the California Institution for Men, Blaylock was involved in a serious altercation with another inmate and was placed in administrative segregation pending disciplinary action. Following an investigation and a disciplinary hearing, the violation was reduced from assault on an inmate to mutual combat.

Blaylock was released from administrative segregation following the hearing. On September 22, 2004, about two weeks after disposition of the rules violation, the Institutional Classification Committee met to consider whether Blaylock should continue to be confined in administrative segregation. At that hearing, the committee took note of the fact that Blaylock was serving a life term for attempted murder of a peace officer; noted that he had been placed in administrative segregation because of the rules violation; and made the following ruling:

> *Committee notes the above RVR [rules violation] was heard and reduced to mutual combat, therefore Committee acts to release subject to general population*.

Blaylock remained in the general population for the rest of his stay at the California Institution for Men until the stabbing of Officer Gonzalez on January 10, 2005.

The institution failed repeatedly to put Blaylock in administrative segregation. In making the September 22, 2004 decision about whether to return Blaylock to the general population, the Institutional Classification Committee had the opportunity, as well as the obligation, to thoroughly review his central file**,** note his violent tendencies and previous segregated housing placement, and retain him in administrative segregation, regardless of the outcome of the rules violation. Blaylock's central file clearly documents his long history of in-prison violence, his maximum security classification, and the fact that he paroled from security housing unit.

Yet, the Institutional Classification elected to release Blaylock from administrative segregation on September 22, 2004 without mentioning his potential for violence. There is no documentation that in making the decision to return him to the general population the committee noted his previous security housing placement; examined the evidence and circumstances surrounding the altercation with the other inmate; or otherwise took into account the danger Blaylock represented to the staff and other inmates.

The California Institution for Men had numerous other opportunities to recognize and act upon Blaylock's violent history by putting him in administrative segregation, but each time failed to do so. The records show that the Institutional Classification Committee, chaired by the warden, has ultimate responsibility for ruling on administrative

segregation placement at the institution, reviewed Blaylock's case on at least four occasions between August 4, 2004 and November 17, 2004 without ever directing that he be placed in administrative segregation for the duration of his stay. Similarly, the Unit Classification Committee reviewed Blaylock's case on December 1, 2004 in connection with efforts to resolve difficulties in finding him a suitable institution placement, and also failed to question his placement in a general population cell.

It is also noteworthy that even though an August 21, 1998 memorandum from the deputy director of the Department of Corrections Institutions Division advised all wardens that it is mandatory for them to chair Institutional Classification Committee meetings on a "routine, rather than an exceptional basis," neither the warden nor the chief deputy warden at the California Institution for Men attended any of the classification committee meetings concerning Blaylock.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Institution for Men take the following actions:

- **Use the Offender-Based Information System to carefully screen all incoming inmates and assign them to administrative segregation if the offender paroled from an indeterminate security housing unit term or if the offender's history otherwise merits such placement.** [4]

- **Continue the newly adopted practice of using an Offender-Based Information System terminal 24 hours per day in lieu of placing unscreened inmates into the general population.**

- **Stress to line and supervisory staff the importance of carefully following prescribed classification regulations and procedures, including supervisory review of subordinates' work; use periodic audits by executive staff and progressive discipline to enforce compliance. Provide remedial training as necessary.**

- **Emphasize to all staff the need to charge inmates with the crimes the evidence demonstrates they committed while in custody, and use periodic audits by executive staff and progressive discipline to enforce compliance. Provide remedial training as necessary.**

In addition, the Office of the Inspector General recommends that the Department of Corrections take the following actions:

[4] During its investigation, the Office of the Inspector General recommended that the California Institute for Men install an Offender-Based Information System terminal within the Reception Center Central Receiving and Release area. The following week, the California Institute for Men installed the terminal and during the first week in operation staff discovered five maximum security inmates that would not have been discovered using the old screening method.

- **Consider establishing a pre-parole designation that would allow parole regions and county jails to route parole violators with specific custody designations to the reception centers most suitably designed to handle them.**

- **Work with the California Institution for Men to develop more administrative segregation beds. If this is impractical to do, evaluate modifying the prison's mission to preclude the need for more beds or prepare and submit a budget change proposal for the necessary funding.**

- **Work with the California Institution for Men to either phase out Sycamore Hall as a living unit for high-security inmates or to upgrade it to meet safety and security standards. If the latter, prepare and submit a budget change proposal for the necessary funding.**

- **Update the August 21, 1998 memorandum advising wardens that it is mandatory for them to chair Institutional Classification Committee meetings on a routine, rather than an exceptional, basis. Hold wardens accountable for doing so.**

- **Amend California Code of Regulation, Title 15, section 3341.5(8) to mandate that when an inmate returns to prison either as a parole violator or as a new commitment, having paroled from a security housing unit, the inmate be placed in administrative segregation pending an evaluation by the Institution Classification Committee.**

FINDING 2

The Office of the Inspector General found that Blaylock's reception center processing was delayed due to complex case factors that severely limited his options for transfer to another institution.

Blaylock was housed at the California Institution for Men for seven months. The departmental guidelines state that reception centers will normally process inmates for transfer within 60 days. Blaylock's case, however, was far from normal. The complexities of his case, combined with his conduct, resulted in extending his confinement at the California Institution for Men. The Office of the Inspector General reviewed each aspect of Blaylock's reception center processing and found no delays resulting solely from staff inefficiency or misconduct.

The Office of the Inspector General's review of Blaylock's central file disclosed several case factors that severely restricted the number of institutions capable of adequately addressing his housing needs. Blaylock was restricted based upon his custody, mental health, and medical needs. No single institution in the California Department of Corrections has the resources to accommodate Blaylock's cumulative case factors. Blaylock's extensive list of enemies precluded staff from housing him even at an institution that could accommodate most of those factors.

Blaylock's history of misconduct and the nature of his new commitment offense resulted in a placement score of 376 points. Blaylock would have been designated for placement in a 180-design housing unit because of his life sentence, prior security housing unit status, and gang affiliation. Based upon this combination of case factors, staff from both the Department of Corrections Classification Services Unit and the California Institution for Men were attempting to facilitate endorsement to an institution best suited to handle him.

Blaylock's central file arrived at the reception center within three weeks of his arrival. Blaylock arrived at the California Institution for Men on June 23, 2004 as a parole violator with a new term. His central file was received at the California Institution for Men within three weeks, and on July 13, 2004, the case records office conducted an audit of his file.

Blaylock's own actions resulted in a seven-week delay in processing. On July 31, 2004, Blaylock was placed in administrative segregation as a result of a serious rules violation report originally charging him for battery with a weapon on an inmate. Since this serious rules violation report could result in confinement in a security housing unit, the institution's classification staff was unable to refer Blaylock for transfer until the issue was resolved. Blaylock's disciplinary hearing was held on September 9, 2004, and on September 22, 2004, after the charges against him were reduced to "mutual combat," the Institutional Classification Committee released him from the administrative segregation unit.

The appropriateness of the decisions to reduce the charges against Blaylock and release him from administrative segregation unit are addressed elsewhere in this report. Setting these issues aside, the Office of the Inspector General found that the California Institution For Men staff processed these actions within reasonable time limits.

The institutional staff recommendation summary was completed three weeks later. An "institutional staff recommendation summary" is prepared by the inmate's correctional counselor to assist in determining the inmate's placement. This document contains a brief description of the case factors and an evaluation of the inmate's potential adjustment in prison. Based on these factors, the counselor recommended two institutions to the classification staff representative. This document was completed on October 14, 2004 in Blaylock's case. Although there is no specific documentation available from the classification staff representative, Blaylock's counselor documented that she received direction on or before October 20, 2004 from the department's Classification Services Unit concerning an enemy of Blaylock at the California Medical Facility. This aspect of Blaylock's processing took approximately six days, which is not an unreasonable amount of time.

Blaylock's transfer was further delayed by his extensive list of enemies. A review of Blaylock's form CDC-812, "Notice of Critical Case Information – Safety of Persons," reveals that inmate Blaylock had enemies documented at all of the institutions capable of accommodating most of his case factors. Beginning on October 14, 2004, institution staff documented several attempts to resolve enemy concerns at the identified institutions. These attempts included staff conducting interviews with the enemies to determine whether their issues could be set aside to allow Blaylock to transfer. In addition, staff considered whether they could transfer some of his enemies elsewhere to accommodate Blaylock.

On November 17, 2004 Blaylock's case was presented again to the classification staff representative, who instructed the California Institution for Men to forward the case to the Departmental Review Board[5] because of its complexity.

The Departmental Review Board referral process requires an institution to prepare additional classification reports citing the inmate's case factors and history and a description of the issues to be addressed by the Departmental Review Board. The department's Classification Services Unit is responsible for conducting research and facilitating Departmental Review Board committees. The Office of the Inspector General learned that the Classification Services Unit had been working with staff at the California Institution for Men to locate suitable housing for Blaylock, but were severely hampered by his numerous restrictive case factors and enemies.

In this case, the Departmental Review Board report dated November 19, 2004 was sent to the California Department of Corrections headquarters on December 6, 2004. Records

[5] The Departmental Review Board is the highest level of classification committee within the department, and is the final arbiter regarding classification issues.

there indicated that the Classification Services Unit received the institution's referral on December 7, 2004. The Classification Services Unit staff told the Office of the Inspector General that Departmental Review Board cases are normally reviewed within three to four months of receipt. Reception center cases are usually given priority due to the urgent need to transfer inmates to appropriate institutions. At the time of the incident on January 10, 2005, the Classification Services Unit had still not been able to find an institution suitable for Blaylock.

RECOMMENDATION

The Office of the Inspector General recommends that the California Department of Corrections initiate a peer review audit with subject matter experts to identify any discrepancies in the processing of reception center inmates at the California Institution For Men.

FINDING 3

The Office of the Inspector General found that the stabbing of Officer Gonzalez might have been prevented if officers on the second watch at Sycamore Hall, including the victim, had followed security protocols and additional security restrictions imposed in response to earlier incidents in the housing unit.

The Office of the Inspector General found that correctional officers on the second watch at Sycamore Hall, including Officer Gonzalez, in an attempt to calm racial tensions on the unit and return the tier to regular programming, consistently failed to follow post orders and standard security protocols. They also repeatedly violated additional security measures imposed after violent incidents between Black, Hispanic, and White inmates at the facility in December 2004. Tragically, the stabbing of Officer Gonzalez on January 10, 2005 was directly linked to the violation of those security requirements.

In interviews conducted by the Office of the Inspector General and the San Bernardino County Sheriff's Department, Sycamore Hall correctional staff and inmates consistently reported that policies and procedures designed to provide safety and security were not followed on second watch when Officer Gonzalez was on duty. The officers said, for instance, that in direct violation of security protocols, they frequently released inmates they believed were influential with other inmates out onto the tier to try to calm racial tensions. In particular, they reported that Gonzalez allowed Blaylock out of his cell on numerous occasions before the fatal stabbing, because he believed Blaylock to be a "shot caller," who could influence other Black inmates. On the day he was stabbed, Gonzalez not only directed that Blaylock be released from his cell, but also entered the tier alone to speak to Blaylock, in direct violation of established security protocols. Earlier that morning, a fellow officer warned Gonzalez that this conduct was dangerous and could result in a stabbing. By ignoring this warning, Gonzalez placed himself and other officers in harm's way.

In addition, the Office of the Inspector General found that second-watch correctional officers at Sycamore Hall did not perform required cell searches —as evidenced both by cell search logs and by approximately 35 weapons found during a comprehensive search of the housing unit conducted immediately after the fatal stabbing. Nor did they follow extra security measures imposed after racial violence in the unit that called for keeping inmate workers off the tier and racial groups separated during inmate movements. The correctional staff on a different watch also failed to report verbal threats made by inmates toward officers. Finally, the supervisory staff and management of the institution failed to adequately supervise the officers or hold them accountable for the lax security practices.

The Office of the Inspector General found that the serious security violations on the second watch were not corrected because the correctional sergeant and lieutenant responsible for supervising Sycamore Hall during second watch failed to consistently provide that supervision.

The Office of the Inspector General found in addition that the California Institution for Men's warden, the chief deputy warden, the associate warden responsible for the reception center, the facility captain and the unit's correctional lieutenants and sergeants all failed to monitor compliance with the directives specified in the modified program — the extra security measures imposed in response to violent incidents in the housing unit — between December 6, 2004 and January 9, 2005.

Modified program requirements. Sycamore Hall was placed on a modified program on December 6, 2004 after a piece of metal was discovered missing from a light fixture, raising fears that it might be used as weapons material. The modified program instructions directed the staff to increase cell searches and to "exercise caution" during inmate movements. On December 20, 2004, after a riot between Black and Hispanic inmates, the security restrictions were expanded to a modified lockdown, with cell feeding, no recreational yard, escorted inmate movement, and a requirement that Black inmates be escorted separately from White and Hispanic inmates. In a weekly program status report to the regional administrator dated December 20, 2004, the warden explained the reasons for the restrictions and said the incident would be investigated:

> *During the last modification period the White inmates were restricted to their cells during feeding and no recreational yard. On 12-19-04 a riot occurred in the Sycamore Culinary between Blacks and Hispanic inmates. Chemical agents were deployed. Several Hispanic inmates sustained puncture wounds. An investigation to determine the cause of the incident will be on going. Several weapons were discovered during the search of the culinary.*

The weekly modified program status report of December 27, 2004 reiterated the requirements, repeated that an investigation into the December 19, 2004 "will be ongoing," and emphasized the need for separated escort:

> *Escort all movement. White & Hispanics Together, Blacks Separately.*

Additional modified program requirements imposed. During the second watch at Sycamore Hall on December 28, 2004, a correctional officer violated the modified program by opening the first-tier grill gate and allowing a Black inmate returning from a medical visit to enter while a White inmate porter was sweeping. When the Black inmate entered his cell, the White inmate stabbed him from behind, inflicting two puncture wounds. In response to that incident, the modified program status report of January 3, 2005, which was in effect on January 10, 2005, and which was signed by the correctional captain and by the chief deputy warden for the warden, provided the additional directive that no inmate workers were to be allowed in Sycamore Hall. The report read in part:

> *On 12-28-04, a White porter stabbed a Black inmate returning from a ducat on the first tier. The Black inmate sustained two puncture wounds. This incident worsened the already increased racial tensions in Sycamore Hall.*

...Staff are to conduct increased searches of inmates living in common areas. Exercise caution during inmate movement. This procedure will not be changed without permission of the RCC Captain. Staff will separate White and Hispanic inmates from Black inmates.

...There will be no inmate workers in Sycamore Hall, the officers will cell feed and clean all areas within their housing unit. ... The workers will be confined to the culinary.

The modified program requirements came in addition to existing post orders governing cell searches, release of inmates from cells, and other security protocols. Post orders for Sycamore Hall correctional officers include the following requirements:

- ***Releasing inmates from cells.*** Post orders for all correctional officers and supervisory staff assigned to Sycamore Hall strictly limit the release of inmates from cells. The post orders read:

  Except for regular program activities which require the release of inmates from cells, such as meals, showers, clothing exchange and cell searches, cell doors will remain locked unless permission has been obtained from a Sergeant or Lieutenant. ***Inmates will only be released from their cells for authorized activities.*** *[Emphasis added]*

- ***Required cell searches.*** Post orders for Sycamore Hall housing unit correctional officers require officers on second and third watches to conduct a minimum of three cell or bed area searches for weapons and contraband on every shift. Officers are also required to search a cell after an inmate vacates the cell and to note any "discrepancies." The results of the searches to be entered in two places: on the unit cell search log and on the housing unit daily audit sheet, which is submitted to supervisors each day.

- ***Reporting threats and other information.*** Post orders require housing unit correctional officers to inform the next watch of any important occurrences. The post orders state:

  Record all unusual occurrences or noteworthy information in the unit log book and sign the log. Pass on any pertinent information to the relieving officer.

- ***Officers may not enter a tier alone or open a grill gate if front door is unlocked.*** Post orders for Sycamore Hall housing unit officers require the following:

  In the event there is a need to enter the tier, there will be no less than two (2) officers on the tier at a time. With the exception of inmate movement during yard release/recall, and an emergency evacuation of the unit, the front door to the housing unit will be locked before any unit grill gate is unlocked. A serious breach in security will exist if both the housing unit front door and any unit grill gate are unsecured at the same time. It is the responsibility of all housing unit staff to maintain the security of the unit at all times and to prevent any situation

which would allow uncontrolled inmate movement. All inmate movement will be strictly controlled by staff.

- ***General supervisory responsibilities.*** Post orders for the Sycamore Hall correctional sergeant and correctional lieutenant, under "general duties and responsibilities" specify the following:

  On a frequent and regular basis, you are to inspect all designated housing units. Inspect post orders.

- ***Supervisory responsibility for making post orders available.*** Post orders for the Sycamore Hall second and third watch housing unit sergeant specify as follows:

  Post orders must be available at the assigned positions and the current post order acknowledgement sheet will be signed by the assigned staff.

- ***Supervisory responsibility for incident investigations.*** Post orders for supervisors require them to review all incident reports and conduct investigations if necessary. The post orders provide:

  Review all incident reports, form CDC 837, for completeness and accuracy. Interview and conduct informal investigations when necessary. Conduct and prepare Investigative Reports.

- ***Supervisory responsibility for cell searches.*** Sergeants assigned to second and third watch at Sycamore Hall are required by post orders to sign the housing unit daily audit sheets after verifying that the information is accurate.

The Office of the Inspector General found that Officer Gonzalez, other correctional officers on second watch at Sycamore Hall, and Sycamore Hall supervisors consistently violated both post orders and modified program requirements. Specifically:

- ***Required cell searches were not performed.*** The Office of the Inspector General found that cell searches required by post orders were not properly conducted. Although Sycamore Hall officers on the second watch did regularly document the three required daily searches on the housing unit daily audit sheet, they did not document the searches in the unit cell search log. As a result, officers had no way of knowing each day which cells had already been searched, effectively nullifying any genuine search effort. In fact, the Office of the Inspector General found that unit cell search records at Sycamore Hall had not been maintained since February 2000.

  In addition, there is almost no evidence that the increased search efforts directed by the modified program requirements in effect between December 6, 2004 and January 10, 2005 were performed. A review by the Office of the Inspector General of unit search logs, housing unit logbooks, sergeant and lieutenant logbooks, housing unit

daily audit sheets and program status reports found only a single piece of documentation to suggest that searches of Sycamore Hall were increased. That notation, which appeared in the program status report signed on December 17, 2004 stated:

> *During the last modification period the housing unit has been searched at least once. Ongoing searches have produced only minor contraband.*

Yet after the stabbing of Officer Gonzalez on January 10, 2005, mass searches of Sycamore Hall yielded approximately 35 weapons.

- ***Investigations were not conducted.*** Even though modified program status reports in December 2004 and January 2005 indicated that recent incidents of violence would be investigated, the Office of the Inspector General found no evidence that investigations or inquiries were conducted. The program status report dated January 3, 2005 also failed to direct staff to investigate the cause of the December 28, 2004 incident, which clearly resulted from officers violating written directives to keep Black and White inmates separated. In violation of his post orders, the Sycamore Hall correctional captain failed to request an inquiry into the violation of written directives that directly contributed to the stabbing of the inmate on December 28, 2004, even though he signed off on the crime incident report. Asked about the policy violations surrounding the incident, the chief deputy warden said neither the warden nor the chief deputy warden reviewed the incident because if did not involve use of force by staff. The chief deputy warden said the reception center associate warden is normally the final reviewer on incidents that do not involve use of force. But when the Office of the Inspector General asked for the post orders or duty statement of the associate warden position, investigators were told that none exist. The chief deputy warden acknowledged that no investigation or inquiry into the incident was requested or conducted by anyone at the institution, although both the warden and the chief deputy warden acknowledged that an investigation or preliminary fact-finding inquiry should have been initiated.

- ***Inmate workers were allowed on the tiers during movement of other races.*** In violation of modified program restrictions, officers on second watch frequently allowed inmate porters to remain on the tiers during movement of inmates of other races. Instead of securing the porters during the movement, officers typically sent the porters to a different tier until the movement was completed.

- ***Permanent work crew inmates allowed on tier without supervision.*** Second-watch correctional officers allowed permanent work crew inmates to be on the tiers to carry out repairs without direct supervision so long as they had signed work orders. Officers also allowed them to be on the tiers during movement of inmates of other races, in direct violation of both modified program restrictions and post orders.

- ***Managers did not adequately communicate permanent work crew restrictions.*** The warden and chief deputy warden agreed that the modified program was intended to restrict all inmate workers from Sycamore Hall. Yet the directives in the modified program status report were ambiguous, leaving room for the interpretation that permanent work crew inmates were not included in the restrictions. The Sycamore Hall correctional captain, the second-watch correctional lieutenant, and the second-watch correctional sergeant told the Office of the Inspector General that permanent work crew inmates were routinely allowed into units to make necessary repairs during modified programs and lockdowns. Supervisors, staff, and inmates all noted that they believed permanent work crew inmates were not involved in the racial politics within the reception center.

- ***Inmates were released from cells without supervisory approval.*** Officer Gonzalez and other correctional officers on the second watch released inmates they believed to be influential with other inmates from their cells without authorization from supervisory or managerial staff, in violation of post orders and modified program restrictions. Blaylock was one of these inmates.

- ***Threats were not reported.*** The Office of the Inspector General found that on two occasions in the days preceding the fatal stabbing of Officer Gonzalez, Sycamore Hall officers on third watch did not report threats made by inmates against the staff. The first instance occurred during third watch on December 28, 2004. On that date, according to staff, Blaylock told a Sycamore Hall correctional lieutenant and a third-watch correctional officer that Black inmates blamed the officer for the stabbing that had occurred that day and wanted to "get him." On January 19, 2005, after the fatal stabbing of Officer Gonzalez, another third-watch officer told the San Bernardino County Sheriff's Department that on January 9, 2005, Blaylock became angry over a dispute with an officer about his legal mail, and had yelled, "Then you wonder why motherfuckers get stabbed!" Because in both instances the staff failed to notify institution management of the threats, Blaylock was not rehoused in Administrative Segregation Unit and no investigation was initiated to evaluate whether the threats were credible and to take appropriate action.

- ***Blaylock was repeatedly allowed out of his cell.*** Officer Gonzalez routinely allowed Blaylock, in particular, to move about unsupervised on the Sycamore Hall west-side tiers to calm other Black inmates and relieve racial tensions because he believed him to be a "shot caller." Witnesses made the following statements with respect to this practice:

  The guard would let him out when everyone else is in lock-down and treated him as a "shot caller."

  Gonzalez would let Blaylock out on the tier to talk to people. I did not know why the officers would let Blaylock out on the tier to talk to people….

I would see Blaylock out on the tier running the tier for his people doing favors and that it was a common practice. I was curious about why Officer Gonzalez was inside the tier area with Blaylock out because usually when the inmates were out on the tier the officers were always on the other side of the bars.

- ***Sycamore Hall supervisors failed to provide adequate supervision.*** Despite post orders requiring them to inspect all designated housing units "on a frequent and regular basis," it appears that the Sycamore Hall correctional sergeant and correctional lieutenant failed to provide required supervision. Although the unit logbook indicates that supervisory staff regularly toured the unit during first and third watches, it does not document similar inspections by the supervisory staff regularly assigned to second watch. Numerous statements by Sycamore Hall correctional officers also indicate that the second-watch correctional sergeant and correctional lieutenant remained in the dark about the serious violations of security protocols that regularly occurred during the second watch.

- ***Management did not monitor compliance with modified program requirements***. Management at the California Institution for Men allowed non-compliance with search requirements and did not monitor compliance with other modified program requirements. Management acknowledged they were aware that Sycamore Hall correctional officers were not conducting the cell searches required by post orders and modified program requirements. They told the Office of the Inspector General that the staff lacked the time to search cells being vacated and to keep up the unit logbook because of the high turnover of inmates at the institution and increased court mandates. The Office of the Inspector General also found no documented evidence that staff complied with modified program directives issued by management. The warden and chief deputy warden also said they had not documented staff compliance with the modified program requirements, but made a commitment to developing a chronological summary of actions taken during modified programs.

On January 10, 2005, a number of these security violations culminated in the fatal stabbing of Officer Gonzalez. On that day, Gonzalez directed another officer to unlock Blaylock's cell so he could have access to the tier and try to calm racial tensions. The officer refused, asking Gonzalez how they would explain it "if he stabs somebody." Gonzalez said no one would get stabbed and opened the cell himself. He subsequently returned Blaylock to his cell while other officers released White and Hispanic inmates for medical appointments. After the White and Hispanic inmates left, other officers working in the unit released eight Black inmates from their cells for medical appointments and had those eight inmates wait in the guard space. At that point, Gonzalez directed that Blaylock again be released from his cell and onto the tier. Shortly thereafter, two Hispanic permanent work crew inmates arrived unsupervised to make plumbing repairs at Sycamore Hall in a cell occupied by two Black inmates. Even though modified program restrictions were still in effect, and even though the front door of the housing unit was open, Gonzalez opened the grill gate to allow one of the two Hispanic permanent work crew inmates to enter the tier.

The two Black inmates who were occupying the cell needing the plumbing repair should have been moved to a secure area while the repairs were made, instead officers told them to come out of the cell and stand on the tier against the wall. An officer then opened the front door of the housing unit to release the eight Black inmates to medical appointments. At that moment, and while the door was open, a White inmate returned from a medical appointment unannounced and walked up the corridor toward the entrance to Sycamore Hall. One officer then left the guard space to control the White inmate, leaving three officers in the guard space, including Gonzalez, to watch the eight Black inmates, the Hispanic plumber, the two Black inmates who had been released from their cell because of the plumbing repair, and Blaylock. Meanwhile, Blaylock and the two Black inmates who had been released for the plumbing repair began roaming up and down the stairs to all three tiers of the living unit. At that point, one of the three officers was distracted by a telephone call and, simultaneously, Blaylock called to Gonzalez, asking him to enter the tier. In response, Gonzalez again opened the grill gate, with the front door to the housing unit still open, and went onto the tier alone to speak to Blaylock, all in direct violation of security protocols —risking not only his own safety, but also the safety of the other officers standing in the guard space and posted throughout the reception center. Immediately after Gonzalez entered the tier, the stabbing took place.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Institution for Men take the following actions:

- **Remind all custody staff of the importance of carefully reading and following post orders, including those requiring supervisory staff to monitor subordinates' work and to frequently inspect living units. Exercise progressive discipline to enforce compliance and provide remedial training as necessary.**

- **Management staff should monitor custody supervisors' adherence to important security-related directives and post orders, ensuring to hold supervisory staff accountable for compliance.**

- **Ensure that all security-related directives are as clear and specific as possible in order to avoid misinterpretation by staff.**

The Office of the Inspector General also recommends that the director of the Department of Corrections hold the warden and her executive staff accountable for ensuring that they comply with the above recommendations.

FINDING 4

The Office of the Inspector General found that Sycamore Hall inmates were able to obtain and hide weapons because of lax tool controls, poor building maintenance and the consistent failure of the correctional staff to conduct required cell searches.

The California Institution for Men was built in 1941. A lack of preventive maintenance at the aging facility has left Reception Center Central, and specifically Sycamore Hall and Madrone Hall, in a serious state of disrepair. The disrepair and structural defects provide inmates with a source of weapons stock and provides spaces for inmates to hide inmate-manufactured weapons. Compounding the disrepair and structural defects is the institution's failure to adhere to departmental policy requiring consistent and accurate inventory counts of tools legitimately used by inmates, thus hindering staff from detecting theft of tools and metal stock by inmates for use as weapons or in their manufacture.

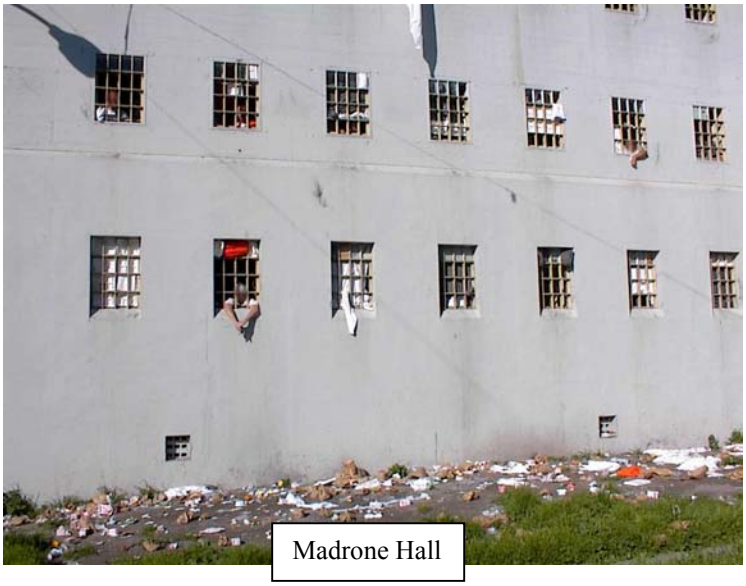
A lack of preventive maintenance has left Reception Center Central in a serious state of disrepair. During visits to the California Institution for Men between January 10, 2005 and February 9, 2005, the Office of the Inspector General noted numerous maintenance problems throughout Reception Center Central. During interviews with staff and inmates, the Office of the Inspector General repeatedly heard complaints about the lack of preventive maintenance, timely repairs, and insufficient maintenance staff necessary to maintain the aging physical plant.

Madrone Hall

The Office of the Inspector General found the lack of preventive maintenance at the California Institution for Men has left Sycamore Hall and Madrone Hall in a serious state of disrepair. This condition contributes to an increased availability of weapons stock, while structural defects allow weapons to be hidden within the cellblock or passed outside the building through broken cell windows. For example, at the time of the homicide Sycamore Hall had been on a modified program in which inmates were substantially restricted to their cells for five weeks due to missing metal from a light fixture. The metal can be cut and fashioned into a stabbing or slashing weapon. Illustrating the serious structural defects, a subsequent search for weapons found multiple weapons stored in the space between the toilets and the cell wall. Maintenance staff from

other institutions were eventually called in to assist in removing the toilets to check for other weapons and to reseal the toilets to prevent inmates from hiding contraband there again.

The state of disrepair at Madrone Hall also provides inmates with the ability to transport weapons or contraband from cell to cell. Many of the cell windows on the back side of Madrone Hall are broken, permitting inmates to "fish" an item from one cell to another by lowering or swinging the item on a string or other type of line. The Office of the Inspector General observed "wear marks" in an arcing pattern on the back side of Madrone Hall indicative of items having been repeatedly swung back and forth from cell to cell.



Madrone Hall

Maintenance storage areas were in disarray. In an effort to determine why such a large number of inmate manufactured weapons were present in Sycamore Hall on the date of the incident, the Office of the Inspector General toured the maintenance areas located in Reception Center Central at the California Institution for Men. The tour, conducted on February 9, 2005, included the boiler room, conex boxes (room-sized metal containers) and a storage area inside the secured perimeter directly behind the reception center. These areas were toured, in part, because of concern that inmate permanent work crews, such as the plumbing crew working in Sycamore Hall on the day Officer Gonzalez was murdered, were possibly providing inmates with weapons stock and tools to manufacture weapons.

The Office of the Inspector General found each area to be in total disarray. Within the boiler room area there were

unsecured tools in a five-gallon bucket, unsecured lockers containing welding rods and propane cylinders, and numerous unsecured bins containing non-inventoried replacement parts kept on hand for electrical and plumbing repairs. Many of these non-inventoried replacement parts could easily be used to manufacture weapons. The Office of the Inspector General asked maintenance staff if inmates had access to this area. Staff replied that one inmate was allowed into the boiler room area.

Tool inventories were non-existent or could not be located. The *California Department of Corrections Operations Manual* contains several provisions requiring staff to regularly inventory tools stored and used within the institutions. Because tools are used legitimately by some inmates, such as those assigned to permanent work crews, the most obvious purpose for tool inventory records is to allow for quick and accurate detection of missing or stolen tools. Section 52040.6 of the *Department of Corrections Operations Manual* provides that each institution shop, work area, or building where tools are used and stored shall have methods to account for issuance, storage, and key control of tools. Section 52040.6 also requires that each storage area include an inventory count permitting custody staff to conduct an immediate and accurate count of tools stored in that area.

In addition, section 52040.8 of the *Department of Corrections Operations Manual* provides that inventory listings of all tools shall be kept and checked prior to the beginning and ending of each work or class period. These checks must also be conducted before all breaks, including lunch. More specifically, section 52040.13.9 provides, in part, that all tools used by inmate work crews inside the security area shall be controlled and inventoried daily by the inmates' supervisor.

The Office of the Inspector General viewed the plumbing cart used by the permanent work crew inmates inside Reception Center Central and found that the cart contained numerous tools and replacement parts. Maintenance staff said the tools were inventoried daily, but were unable to locate the inventories on the day of the tour. None of the replacement parts had been inventoried. The cart did not contain a tool inventory card to allow for an immediate and accurate count of the tools as required by *Department of Corrections Operations Manual* section 52040.6. Staff explained that the institution's Investigative Services Unit confiscated the toolbox normally kept on top of the cart on January 10, 2005, following the homicide. The Office of the Inspector General contacted Investigative Services Unit staff to view the contents of the toolbox. Staff confirmed the toolbox had been secured in the Investigative Services Unit office since January 10, 2005. The Office of the Inspector General viewed the contents of the toolbox and found it contained the required listing of all its tools.

The Office of the Inspector General also viewed a yellow hazardous materials storage locker adjacent to the conex storage unit inside the secured perimeter directly behind the

reception center. The locker was unsecured and full of containers that had leaked their contents, causing corrosion on the shelves. There was also no inventory of the chemicals being stored as required by state mandate. The Office of the Inspector General advised management at the California Institution for Men of this safety hazard.

The Office of the Inspector General was informed that the maintenance shop within the corridor of the reception center was relocated to an area behind the minimum support facility on January 20, 2005 because the space was needed for the medical department to comply with court mandates.

Before leaving the California Institution for Men, the Office of the Inspector General requested copies of all Reception Center Central tool inventories for December 2004 and January 2005. On February 14, 2005, the Office of the Inspector General received from the utility shop supervisor a facsimile of some of the requested tool inventories. The facsimile contained a copy of a document entitled "Daily Inventory Tool Records" for January 2005 for "Toolbox #1," "Toolbox #2," and the "Staff Toolbox." The facsimile also contained the two-page inventory of the toolbox and cart used by the inmate plumbers inside the security area of the reception center. The sender noted that the December 2004 tool inventory had not been located.

On February 17, 2005, the utility shop supervisor sent the Office of the Inspector General the December 2004 Daily Tool Inventory Record; however, there is no indication on the form which tools corresponded with the inventory. On the facsimile cover sheet the sender wrote, "[W]e tore the place up and found the only inventory for 04 period. How lucky this was the one in question."

The Office of the Inspector General conducted a thorough review of the tool inventory records submitted as evidence that maintenance staff were conducting daily inventories as required by the *Department of Corrections Operations Manual*. In reviewing the documents received on February 14, 2005, the Office of the Inspector General found the following:

- The Daily Tool Inventory Record utilized by maintenance staff at the California Institution for Men reads, in part, that the staff member "counted and witnessed the listed items in this (tool locker/tool crib/tool boxes) on the date and time I have indicated."
- The three forms for January 2005 each contain 20 work days with three separate inventory counts per day for a total of 60 inventories per sheet and a cumulative total of 180 separate signature boxes. All 180 boxes contained the same individual's initials and handwriting apparently written with the same type of pen. The appearance of the forms suggests that one person signed off on all 180 separate spaces at the same time.
- The inventory documents record that three inventories were conducted per day between January 11, 2005 and January 31, 2005. However, the inmate plumber tool box used in Sycamore Hall on January 10, 2005 was seized as potential evidence that

day by Investigative Services Unit staff and held until it was released to a maintenance worker in the presence of the Office of the Inspector General on February 9, 2005. The maintenance worker who initialed the Daily Tool Inventory Record indicating that he inventoried the items in the tool box could not have had access to that tool box between January 11 and January 31, 2005, although his initials indicate that he did.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Institution for Men require staff to timely and accurately complete tool maintenance inventories.

In addition, the Office of the Inspector General recommends that the California Department of Corrections assemble an experienced team and conduct a thorough inspection of the California Institution for Men. This inspection should identify all maintenance problems and result in a corrective action plan. In addition, the team should identify staffing requirements and resources necessary to complete repairs and maintain the physical plant.

FINDING 5

The Office of the Inspector General found that the California Department of Corrections procured and distributed protective vests to the institutions consistent with its budget change proposal and its agreement with the California Correctional Peace Officers Association; however, delays in issuing vests at the California Institution for Men were unwarranted.

In fiscal year 2001-02, the Department of Corrections received both one-time and ongoing funding to procure stab-resistant protective vests for its custody employees. The Office of the Inspector General determined that in the ensuing years, the department actually spent more than budgeted to procure these vests and distributed them to its institutions according to priorities outlined in the agreement with the California Correctional Peace Officers Association. At the time of the stabbing of Officer Gonzalez, however, the California Institution for Men had been holding in its warehouse 362 vests it had received on September 9, 2004. While the failure of the institution to distribute the vests immediately may not have violated the agreement with the union, depending upon the interpretation of the relevant sections of the Memorandum of Understanding, distributing the vests expeditiously would certainly have improved employee safety, including that of Officer Gonzalez, whose personally fitted vest was in the warehouse when he was stabbed. Further, holding the vests in the warehouse for four months considerably shortens their useful life. The reasons the institution provided for not distributing the vests until the day following Gonzalez' death reflect a lack of urgency, and inadequate planning.

The California Department of Corrections introduced protective vests in the mid-1980s for custody staff working in its administrative segregation and security housing units, also referred to as lock-up units. The original vests were worn outside of the uniform and consisted of a cover with titanium plate inserts. Custody personnel working in lock-up units would retrieve a vest along with their other assigned security equipment prior to each shift and return the vest at the end of the shift. The vests came in limited sizes and over the years the technology for stab resistant vests greatly improved. According to the Department of Corrections, as vest technology progressed, the Department of General Services began testing protective vests and eventually developed standards for vendors to follow. Later, the National Institute of Justice began performing scientific tests on protective vests nationwide for law enforcement and certified vests that met certain standards of resistance to stabbing instruments. The Department of General Services eventually adopted the National Institute of Justice certification and now all protective vests purchased by the Department of Corrections must meet the National Institute of Justice certification.

In fiscal year 2001-02, the California Department of Corrections received $4.6 million in one-time funding to purchase protective vests for its high security-level facilities. The budget change proposal included $1.3 million in ongoing funding for vest maintenance and replacement.

The department spent more than budgeted to procure protective vests. In its review, the Office of the Inspector General compared the budgeted amounts with the expenditures for protective vests to ensure funds were expended as intended. The following table represents the amount budgeted and expended on protective vests from fiscal year 2001-02 to present:

Fiscal Year	Budgeted	Expended	Surplus/Deficit
2001-02	$4,625,000	$5,141,352	-$516,352
2002-03	1,308,000	481,536	826,464
2003-04	1,308,000	3,308,856	-2,000,856
2004-05*	1,308,000	33,579	1,274,421
Totals	$8,549,000	$8,965,323	-$416,323

*In the process of ordering for FY 2004-05.

The department adhered to its labor union agreement in issuing the vests to the institutions. The department followed the protective vest requirements outlined in its agreement with the California Correctional Peace Officers Association. Section 7.05 I of the labor agreement stipulates that as additional protective vests become available, they shall first be offered to employees working in Level IV facilities, then to employees in Level III facilities, then to employees in Level II facilities, and finally to employees in Level I facilities. Although the language is silent on reception centers, the California Department of Corrections determined in its fiscal year 2001-02 budget change proposal that reception centers fall between the Level III and Level II institutions for priority purposes. Inmates are technically unclassified during the reception center process but can have classification scores ranging from Level I through Level IV. The Office of the Inspector General determined that the department procured protective vests according to the following priorities:

1. Level IV-180 Design Facilities
2. Level IV-270 Design Facilities
3. Level III Facilities
4. Reception Centers
5. Administrative Segregation Units (replace expired vests)
6. Level II Facilities (future purchases)
7. Level I Facilities (future purchases)

The initial budget change proposal approved for fiscal year 2001-02 estimated funding for providing protective vests to Level IV facilities, Level III facilities, and reception centers, but erroneously excluded the California Institution for Men from its schedule. The error was caught later, but it was too late to add funding to the budget. The department, however, ran into additional problems that prevented the procurement of protective vests as originally planned. First, the price of protective vests had increased by more than 25 percent since the preparation of the budget change proposal. Second, the original estimate assumed custody staff would share vests in a fashion similar to the existing practice in its lock-up units. Last, the type of vest used to formulate the original

estimate was no longer available for purchase and the department was required to purchase specific vests meeting standards set by the Department of General Services, which required vests that are individually fitted for staff. As a result, the department was limited to purchasing protective vests for its Level IV and Level III facilities during fiscal year 2001-02 and fiscal year 2002-03. The department continued ordering vests for the remaining Level III facilities and its reception centers, including the California Institution for Men, during fiscal year 2003-04.

Due to the changes cited above, the original omission of the California Institution for Men does not appear to have delayed the prison from receiving the vests beyond the time other reception centers received them.

Protective vests could have been provided to employees earlier. The California Institution for Men could have provided protective vests to correctional employees in September 2004. Notwithstanding that the Department of Corrections was in compliance with the budget change proposal, correctional employees could have benefited if the protective vests had been distributed upon their arrival at the institution. Although the Office of the Inspector General found no specific requirement for protective vests to be issued immediately upon their arrival, distributing the vests in a reasonable time period would have enhanced employee safety, including that of Officer Gonzalez, whose personally fitted vest remained in the warehouse at the time of his death.[6] There is no guarantee that Officer Gonzalez would have survived the stabbing had he been wearing a protective vest, since the inmate could have chosen to attack other vital areas of the body. However, providing protective vests to staff shortly after arrival would at least provide additional safety for those employees. Further, the fact that the institution began issuing vests to officers within a few days of the incident demonstrates that the prison was capable of distributing the vests.

In addition to the safety aspects, there are economic benefits to distributing the vests upon their arrival. According to the California Department of Corrections, the protective vests have a useful life of approximately five years regardless of whether they are worn or stored in a warehouse. As a result, the 362 protective vests delivered to the California Institution for Men on September 9, 2004 had expended nearly 7 percent, or $8,188, of their useful life sitting in the warehouse awaiting distribution.

The institution cited several reasons for not distributing the vests. The reasons the institution provided for not distributing the vests until a few days following Gonzalez' death reflect a lack of urgency, inadequate planning, and a concern for not jeopardizing employee relations. According to the California Institution for Men, management had meetings to discuss whether to issue protective vests to its employees but failed to take action for the following reasons:

[6] The associate warden for business services said he removed Officer Gonzalez' protective vest from the warehouse on January 11, 2005 in order to not further traumatize the staff. At the request of the Office of the Inspector General, the institution placed the vest in the custody of its Investigative Services Unit. The Office of the Inspector General subsequently examined the vest and verified that the manufacturer's label identified it as being assigned to Officer Gonzalez.

- California Institution for Men Operational Supplement 33020.16 for protective vests needed to be updated. The current policy was based on the lock-up units only and did not address some of the issues unique to the new, individually fitted vests. The existing policy was based on the staff exchanging pooled vests rather than having individually assigned vests. The California Institution for Men reported it is still in the process of updating this operational supplement.

- The California Institution for Men had only 362 vests on hand, but needed more than 900 to cover all staff. Prison management was concerned that there could be issues of fairness with officers who had vests working alongside officers who did not. In addition, the institution had a second purchase order for 578 additional vests, only 100 of which had arrived by December 29, 2004, and was in the process of scheduling additional fittings.

- Management was concerned about the impact of "post and bid." Like all institutions, the California Institution for Men has continuous post and bid that allows staff with seniority to bid for vacant post assignments as they occur. Therefore, an officer who may require a vest one day could end up working a post the next day that no longer requires a vest.

Distribution of vests at the institution lagged behind other reception centers. The timeliness of vest delivery to the California Institution for Men was average compared to that of other reception centers, but distribution to officers lagged behind. For comparison purposes, the Office of the Inspector General reviewed the protective vest orders of five reception centers, including the California Institution for Men. The following table compares the number of vests required, number of vests received, percentage of vests received, and number of days elapsed to initiate distribution of vests as of January 11, 2005:

Reception Center	Vests Required	Vests Received	% Received	Days to Distribute
California Institution for Men	940	462	49.2%	124
Deuel Vocational Institution	657	480	73.1%	6
North Kern State Prison	813	733	90.2%	14
R.J. Donovan Correctional Facility[7]	727	0	0	NA
Wasco State Prison[8]	833	0	0	NA

As shown above, the California Institution for Men had received only about half its vests — far behind North Kern State Prison and the Deuel Vocational Institution. However,

[7] R.J. Donovan ordered 515 vests on November 24, 2004. The vests were delivered to the institution on February 18, 2005. According to the Department, these vests have been distributed.
[8] Wasco State Prison ordered 496 vests on November 10, 2004. The vests were delivered to the institution on January 21, 2005. According to the Department, these vests have been distributed.

neither the R. J. Donovan Correctional Facility nor the Wasco State Prison had received any vests. In distributing to its employees, the California Institution for Men lagged behind the reception centers that had received their vests. Both the Deuel Vocational Institution and North Kern State Prison distributed the majority of its vests to employees within 14 days of receipt, whereas the California Institution for Men took four months. These facilities informed the Office of the Inspector General that neither of them had updated their local policies concerning protective vests. Further, since issuing the vests to employees, the institutions have not received a grievance concerning the vests.

According to records provided by the protective vest supplier, 588 employees from the California Institution for Men had been fitted prior to January 10, 2005. After employees are fitted, the contractor provides a list to the institution's contact person for final approval of the order. The contractor's records showed the ordering process varied from institution to institution, with some taking only a few days and others, such as the California Institution for Men, taking more than two months for final approval. Once the contractor receives final approval, the vests are shipped within about 60 days according to the contract. In reviewing the records, it appears the California Institution for Men has not approached issuing protective vests with a sense of urgency. If the California Institution for Men had waited until all vests arrived, the vests would still be in the warehouse because additional fittings were still in process at the time of this review.

The department's protective vest policy has not been updated. The Department of Corrections has not updated its protective vest policy since adopting the new fitted vests in September 2002. According to the Department of Corrections, neither its central office nor the institutions had finalized the policies and procedures for distribution of new protective vests at the time of this review. Lack of a new policy was cited as one of the main reasons for delaying vest distribution to staff at the California Institution for Men. The Office of the Inspector General was informed that the Emergency Operation Unit in Sacramento was in the process of revising *California Department of Corrections Operations Manual* section 33020.16 to address the new protective vest policies and procedures. The California Institution for Men was also in the process of updating its local policies and procedures. Generally, the local policies are required to only address institution-specific issues that are not addressed in the broader departmental policy. Because institution-specific policies follow departmental policies, the California Institution for Men and other institutions might have been more efficient in updating their policies had the Department of Corrections been more proactive in updating the *California Department of Corrections Operations Manual*.

Potential employee relations problems should not have delayed issuing the vests. The California Institution for Men's concerns about post and bid and potential employee issues should not have prevented the issuance of protective vests. As cited previously, the California Institution for Men expressed concerns that providing protective vests to some officers and not to others would create inequities among its staff. In addition, post and bid was an ongoing concern because staff who may require a vest today may not require one tomorrow. However, the institution could have addressed some of these concerns by prioritizing vest distribution to employees working in certain housing units. For example,

staff working in a housing unit with the highest number of incidents the past twelve months could have received priority over those in another housing unit. The California Institution for Men and the contractor told the Office of the Inspector General that initial vest fittings completed from May 11 through May 14, 2004 were not based on the employee's job assignment but rather on who happened to be working that day and decided to stop by for a fitting. The California Institution for Men could easily have justified its distribution to officers if it had developed priority-based distribution criteria. The California Institution for Men told the Office of the Inspector General that it was not in the process of negotiating with the union concerning these issues, but was trying to address these concerns through a new policy.

The Office of the Inspector General met with the local CCPOA chapter president to get his perspective on the issuance of protective vests. According to the chapter president, he has had no formal discussions with the California Institution for Men concerning the issuance of protective vests. He said he "heard through the grapevine" over the summer of 2004 that more than 300 vests had arrived at the institution, but he was never officially informed by the prison administration. The chapter president said he had a few informal conversations with the employee relations officer and a facility captain about how many vests had arrived, what type they were, and who was going to receive them, but he was not provided with specifics about the institution's plan for distribution. He said he was told that the prison administrators were working on a new protective vest policy that would address the new procedures. The chapter president informed the Office of the Inspector General that he was concerned about inequities in distribution, training on proper use, vest maintenance, and lack of vest policies. The chapter president said he planned to address these issues through the grievance process once the vests were issued. To date, the chapter president said he has not received a copy of the new policy or even discussed the protective vest issue with the management of the California Institution for Men. The chapter president said that, "at no time did the union suggest the California Institution for Men delay issuing vests to its officers."

The department must improve accountability for protective vests. *California Department of Corrections Operations Manual,* section 33020.16.4 requires each institution to prepare quarterly protective vest inventory reports utilizing CDC Form 1405 (Protective Vest Quarterly Inventory Summary). As part of its review, the Office of the Inspector General requested copies of these reports for the California Institution for Men, but found the prison does not prepare such reports. In fact, the unit responsible for coordinating the reports was unaware of the requirement and had never seen a CDC Form 1405.

As noted earlier, the protective vests have a useful life of only about five years. Therefore, the California Department of Corrections needs an inventory system to track protective vests to ensure they are replaced once their useful life has expired. The CDC Form 1405, if utilized, is a start toward such a system. The Department of Corrections said it is working on an automated system that will track all safety equipment, including protective vests.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Department of Corrections do the following:

- **Issue protective vests to correctional employees expeditiously upon arrival of the vests at the institution.**

- **Update *California Department of Corrections Operations Manual* section 33020.16 to address new policies and procedures for protective vests.**

- **Require facilities to report quarterly vest inventory using CDC Form 1405, and develop and implement an inventory tracking system to ensure all protective vests are adequately accounted for and replaced according to manufacturer's standards.**

FINDING 6

The Office of the Inspector General found that the medical clinic at the California Institution for Men reception center where the victim was taken after the stabbing was poorly equipped and ill-prepared to handle the emergency.

The reception center clinic where Officer Gonzalez was first taken was not properly equipped, supplied or organized to deal with his medical emergency, nor was the clinic's medical staff prepared to cope with it. The deficiencies may not have contributed to the death of Officer Gonzalez, given the extreme severity of his wounds, but the evidence establishes that the care provided by the clinic staff was very deficient.

Relationship of reception center clinic to the institution hospital. Reception Center Central is a large building located several hundred yards south of the institution's hospital. The institution's hospital is a general acute care hospital licensed by the State of California, and its primary purpose is to meet the health and emergency medical needs of inmates. Despite its physical distance from the hospital, the clinic located at the reception center is considered an out-patient facility of the hospital, and has a pharmacy from which medications are dispensed to inmates housed at the reception center. The clinic's primary purpose is to provide medical, psychiatric, and psychological screenings of reception center inmates. Although it typically provides certain health care services not requiring hospital attention, the clinic's staff is sometimes called upon to respond to medical emergencies at the clinic and in other areas of the institution's reception center.

Medical summary of the stabbing incident. Officer Gonzalez was stabbed just before 10:57 a.m. in Sycamore Hall. Four correctional officers carried him to the reception center medical clinic and laid him on the floor of the clinic's interview room where medical personnel, including licensed vocational nurses, registered nurses and physicians were present. All of their reports were consistent in describing multiple stab wounds to Officer Gonzalez, accompanied by profuse bleeding.

Clinic staff initially applied direct pressure to the wounds, attached an automated external defibrillator to Officer Gonzalez, began cardiopulmonary resuscitation (CPR), and attempted to establish an airway to begin ventilation. The clinic staff did not defibrillate because the automated external defibrillator initially indicated that CPR should be initiated. Staff did not establish an intravenous line, nor did they administer cardiac medications. A member of the clinic staff called 911 at 11:02 a.m.

At 11:03 a.m., a medic engine from the fire district began its response from approximately 2.5 miles away. At the same time, an ambulance from American Medical Response also initiated its response. The medic engine was first on scene and initiated treatment at 11:10 a.m. by providing ventilation with a bag valve mask. The fire paramedics established an intravenous line at 11:12 a.m. and re-intubated Officer Gonzalez at 11:15 a.m. Paramedics performed defibrillation and at 11:15 a.m., administered medications, including epinephrine, atropine, and lidocaine. At 11:20 a.m.,

a needle thoracostomy[9] was performed, Officer Gonzalez was defibrillated again and additional epinephrine administered. Additional atropine was administered at 11:26 a.m.

The ambulance transporting Officer Gonzalez departed the prison at 11:20 a.m., arriving at Chino Valley Medical Center at 11:30 a.m. Doctors pronounced Officer Gonzalez dead at 11:52 a.m. The San Bernardino County Sheriff's Department homicide investigator's report says that the medical examiner who performed the autopsy determined that the first stab wound penetrated the chest cavity and the heart, causing major bleeding inside the chest cavity.

The clinic's emergency equipment and supplies are not kept together. The clinic's equipment and supplies for use in respiratory, cardiac and other medical emergencies includes airway equipment, oxygen, some intravenous access supplies, an automatic external defibrillator, medications, dressings and related material. These items are not kept together for immediate access in an emergency. For example, the advanced airway equipment and drugs are kept in a case in a locked closet down the hall in a different room from the oxygen, an automated external defibrillator, and other emergency first-aid supplies.

While the oxygen, an automated external defibrillator, and first-aid box are available in the same room of the clinic where Officer Gonzalez was initially taken, these items are not kept together. The oxygen tanks are routinely stored behind the main door of the clinic's interview room, while the other equipment is located a short distance away in that room. During its review, the Office of the Inspector General visited the clinic at various times on five different days. On two of those days, the automated external defibrillator, the box of first-aid supplies and an additional container of items were kept together, while on the other days they were sometimes separated and moved to other locations to accommodate other work in cramped quarters. The Office of the Inspector General noted that at times some of this emergency equipment was partially hidden from view by sweaters, snack food, and other items.

The manner in which the equipment and supplies were located and stored in the clinic at the time of the incident involving Officer Gonzalez required clinic personnel to go to different locations to obtain or search for necessary equipment and supplies, wasting valuable time.

Clinic staff suggested to the Office of the Inspector General that the clinic needs a crash cart for providing emergency medical care. The cart would keep all necessary equipment together and could be easily taken to the location of any emergency in the large facility

[9] Thoracostomy is done to drain fluid, blood, or air from the space around the lungs. Severe injuries to the chest wall can cause bleeding around the lungs. A punctured lung allows air to gather outside the lung, causing its collapse (called a pneumothorax). Chest tube thoracostomy (commonly referred to as "putting in a chest tube") involves placing a hollow plastic tube between the ribs and into the chest to drain fluid or air from around the lungs.

served by the clinic. It would also assure that all necessary equipment would be immediately available should a patient be brought to the clinic.

The institution's *Hospital Policy & Procedure No. C-14,* which provides guidance for assuring crash cart availability in the hospital's emergency room, requires that crash carts be fully equipped with emergency medical equipment, and that they be operational at all times. The policy sets forth an inventory list of equipment and supplies and provides for their security. The clinic does not comply with the policy and there is no alternative policy applicable to the clinic.

Some equipment and supplies were not in ready-to-use condition. Two oxygen tanks are kept in the clinic room where Officer Gonzalez was taken. Both tanks have the required regulators, but only one has attached to it the handle or key necessary to activate the flow of oxygen. There was a delay in providing Officer Gonzalez with oxygen at the time of the incident because the only tank with the required key did not have the necessary "tree" attached to the regulator to allow oxygen tubing to be attached. A member of the clinic staff had to remove the tree from the tank that did not have a key, and attach it to the tank that did have a key before oxygen could be provided to Officer Gonzalez, costing valuable time in a critical situation. Clinic staff told the Office of the Inspector General that an additional delay occurred when staff could not immediately locate a face mask.

Missing equipment and supplies hampered treatment. Clinic medical staff had to abandon efforts to establish intravenous access on Officer Gonzalez when they discovered they did not have the required tubing with which to connect fluid to a catheter. Establishing intravenous access in a trauma victim permits medical staff to infuse a bleeding patient with replacement fluid and to establish a means of delivering medications to that patient. Typical equipment needed to establish intravenous access includes a catheter, an IV start kit, tubing, and fluid solution.

When the Office of the Inspector General inspected equipment and supplies almost a month after the incident, endotracheal tubes were found in a case containing medications. There was no stylet to assist in the intubation of a patient, or a syringe that could be used to inflate the balloon cuff of the endotracheal tube following intubation. Clinic staff told the Office of the Inspector General that a stylet and syringe were not available at the time of Officer Gonzalez' emergency.

At the time of the Office of the Inspector General's inspection there was no device present in the clinic that could be used to prevent an endotracheal tube from being dislodged accidentally following intubation. The Office of the Inspector General's post-incident interviews with clinic staff have determined that the tube used on Officer Gonzalez became dislodged at some point. The Office of the Inspector General did not observe an esophageal detector device, suction device, or suction catheter with the airway equipment during its inspections. Clinic staff told the Office of the Inspector General that such equipment was not available at the time of the incident. The continued absence of these supplies leaves the clinic unprepared should a similar medical emergency occur.

Other equipment and supplies, though available, are inadequate. The emergency supplies set aside in the clinic include a single 20-gauge catheter. A larger supply of catheters is required to enable the clinic staff to establish IV access in patients during medical emergencies. Catheters with a larger bore are also needed for trauma victims. Medical professionals expecting to encounter emergency situations typically equip themselves with a plentiful supply of fluids in large-volume bags, yet only a single 500-ml bag (approximately 16 fluid ounces) of normal saline was in the clinic's emergency supplies at the time of the Office of the Inspector General's tour.

The institution's ambulance stationed at the institution hospital has large-volume bags of normal saline, tubing and start kits, but is not stocked with catheters. Under these circumstances, establishing IV access in a patient at the clinic will be delayed by the necessity of waiting for an ambulance to deliver the additional supplies.

Some available equipment and supplies were not used. The Office of the Inspector General's interviews of clinic staff revealed that an end-tidal CO_2 detector or measuring device was available to provide capnometry or capnography[10] during endotracheal intubation, but was not used on Officer Gonzalez. Such a device assists in confirming that the endotracheal tube has been properly placed and is being maintained while the patient is being ventilated.

Though a pulse oximetry device to measure the level of oxygen in a patient's blood was available, it does not appear to have been utilized to determine that Officer Gonzalez was being properly ventilated. A pulse oximeter can be used whether or not an artificial airway is used and can be used regardless of the type of airway utilized.

Oropharyngeal airways[11] were available to assist in maintaining a patient airway, in the absence of an endotracheal intubation. The Office of the Inspector General's interviews of clinic staff found a substantial probability that staff did not successfully intubate Officer Gonzalez with an endotracheal tube, and did not resort to use of an oropharangeal airway after encountering problems with achieving proper intubation. Although available, clinic staff did not administer cardiac medications to Officer Gonzalez because of their inability to establish IV access and because they did not know such medications could be administered through a properly placed endotracheal tube.

The very presence of such supplies at the clinic reflects the institution's recognition that their use can be reasonably anticipated. However, the fact that these supplies were not

[10] Capnography is the continuous analysis and recording of carbon dioxide concentrations in air expelled from the lungs. Although the terms capnography and capnometry are sometimes used synonymously, capnometry suggests measurement or analysis alone without a continuous written record or graph.

[11] Oropharangeal airways are used to maintain the airway in the unconscious patient during assisted breathing, and do not extend deeply into the trachea ("windpipe") as do endotracheal tubes.

used suggests that staff is not properly trained in their use, which was confirmed through the Office of the Inspector General's interviews with clinic staff.

The clinic lacks standardized inventory control for emergency supplies and equipment. Although such procedures exist for medications, there are no established inventory control procedures for other emergency equipment and supplies at the clinic. The clinic staff is not provided with a written list of supplies that must be included in the first-aid, airway, and IV supplies cases. The Office of the Inspector General learned that even a month after the incident, some of the supplies used on Officer Gonzalez still had not been replaced, and during inspections conducted at that time, no bag valve mask or AMBU bag were included with the emergency medical supplies. Clinic staff were confused as to what supplies were used in treating Officer Gonzalez and just as confused about what should typically be included among the clinic's emergency medical equipment and supplies.

The Office of the Inspector General's inspections noted that the case containing airways, intubation equipment, medications, and many other items was quite disorganized, with most equipment and supplies placed haphazardly in the case, making it difficult for staff to find a particular item rapidly during an emergency.

During the Office of the Inspector General's first inspection of the airway equipment case, there was no security seal on the outside of the case. On the following day, there was a seal on the case, requiring someone from the pharmacy staff to break the seal for a second inspection and reseal it afterwards. During a third inspection, this process was repeated. None of these precautions were exhibited the first time the equipment case was inspected.

Unless improved, the clinic's current practices with respect to inventories will leave it unprepared to address future emergencies. One of the clinic's staff informed the Office of the Inspector General that the clinic treats as many as 20 to 30 stab wounds per month.

The institution's *Hospital Policy & Procedure No. C-14* provides that crash carts be available and operational in the hospital's emergency room, fully equipped with emergency medical equipment and supplies. The policy prescribes an inventory list of equipment and supplies and provides for their security. While this policy does not explicitly apply to the clinic, it can still serve as a valuable guideline until clinic-specific policies are developed.

Regular inspections of supplies and equipment are not performed. The clinic's medical staff has no procedure requiring regular inspections of emergency equipment to ensure that all necessary equipment is available and ready to use when needed. There is no policy requiring re-stocking and replacement of missing and consumed materials when an emergency is over.

While the institution's *Hospital Policy & Procedure No. C-14* requires that emergency equipment and supplies in the hospital's crash cart be audited at the beginning of each

shift, no such requirement exists for the clinic. As a result, missing or inoperable equipment and supplies may not be discovered until needed during an actual emergency.

The absence of policies, training, and supervision in this area is demonstrated by the fact that, at the time of the Office of the Inspector General's review, items consumed in the effort to save Officer Gonzalez had not been replaced, and items unavailable when critically needed had not been added to the emergency supplies. Unless corrected, the absence of a policy requiring regular inspections will contribute to the clinic being unprepared for future emergencies.

Orientation of new clinic staff is inadequate. The Office of the Inspector General's interviews with clinic staff revealed that staff members are not adequately briefed on the location of emergency equipment when first assigned to the clinic. Some staff members believed the only key available to turn on the flow of oxygen is attached to one of the tanks, while others thought the key is kept in a desk drawer. During interviews, a number of staff members were unable to locate basic equipment, such as a bag valve mask, AMBU bag, and airway adjuncts.

In addition to a lack of initial orientation, the institution does not conduct drills or offer periodic in-service training in responding to emergency medical situations to clinic staff. There is evidence that such training existed at one time — a written examination administered to medical staff at the institution in May 2000 tested staff on their knowledge of emergency drills at the institution. The Office of the Inspector General's interviews of clinic staff disclosed confusion and a lack of uniform understanding as to the extent and type of emergency medical services that clinic staff should provide. For example, some of the clinic staff believe it appropriate for them to administer medications to a patient experiencing cardiac arrest, while others believe such medications should be administered at the institution's hospital or by paramedics responding from outside the facility. The clinic staff members are unaware of any guidelines providing clarity or guidance on this issue. Without proper training, the clinic's staff cannot be expected to perform adequately during an emergency.

Lack of specialized training in emergency medicine. The institution does not conduct or otherwise provide sufficient specialized training in emergency medicine for its medical staff. All medical staff who assisted in the attempt to save Officer Gonzalez' life held the appropriate professional licenses. Those requiring certification in cardiopulmonary resuscitation (CPR) were currently certified.[12]

The institution does not currently require that any of its clinic personnel maintain certification in advanced cardiovascular life support. Medical staff interviewed by the Office of the Inspector General stated that advanced cardiovascular life support certification was required for emergency room employees in the past, but that the institution no longer imposes such a requirement. One member of the clinic staff told the

[12] Physicians are not required to be certified in CPR.

Office of the Inspector General that he had not received any "code blue" training in eight years.

Both physicians present when Officer Gonzalez was brought to the clinic knew that epinephrine, atropine, and lidocaine could benefit a patient experiencing cardiac arrest. But the lack of advanced cardiovascular life support training and certification may explain why one physician did not know, while the other would not state, that epinephrine, atropine, and lidocaine could all be administered through a properly placed endotracheal tube after intubation. These medications and others are included in the case containing the endotracheal tubes and IV fluid. One of these physicians also works shifts in the institution hospital's emergency room where the protocols refer to the use of such medications. The Office of the Inspector General determined during interviews with these physicians that neither has received any specialized training or certification in emergency medicine, although one has continuing education credits in heart failure and coronary syndromes as recently as December 2002. One of the physicians advised the Office of the Inspector General that he had not worked in an emergency room in approximately 25 years, and the other said that the only emergency medical experience he has comes from working shifts in the institution's emergency room.

As an example of the confusion among clinic staff members as to procedures, a nurse with significant administrative responsibilities initially told the Office of the Inspector General that there were no cardiac medications in the clinic's supplies. This nurse later said the medications were intended for use in responding to emergencies involving inmates, but 911 is to be called for medical emergencies involving employees. Still later, this nurse said that use of these medications is to be directed by the physicians.

Clinic staff do not routinely perform some of the skills associated with providing emergency medical services. Intubation is one example. One of the physicians told the Office of the Inspector General that staff members are required to train or demonstrate ability to perform oral intubations on a mannequin every six months, but the institution could not produce evidence of such a practice, nor could other clinic staff members recall such a practice. The nurse who claims to have intubated Officer Gonzalez told the Office of the Inspector General that such periodic training is not required.

The lack of specific training in emergency procedures, supplemented by periodic refresher courses, can result in the delivery of inadequate care during future emergency situations.

Insufficient direction and leadership during the emergency. Several of the Office of the Inspector General's interviews with clinic staff revealed that at least two physicians were present when Officer Gonzalez arrived in the clinic. Some clinic staff stated that physicians failed to provide substantial assistance, direction, and leadership during the attempts to save the officer's life. Interviews of the two physicians reveal they have little, if any, significant training and no substantial experience in dealing with significant medical emergencies.

Without at least one medical staff member providing directions acknowledged by the rest of the staff, there can be a lack of focus and coordination in delivering emergency medical services.

The institution's *Hospital Policy & Procedure C-11* states that the Medical Officer of the Day or other physicians working in the hospital are to direct the medical care team when a "code blue" is called in response to a patient who is not breathing or has no pulse. The fact that this policy statement is directed to hospital operations does not diminish its value in providing guidance to clinic procedures in the absence of policies specific to that area.

Inadequate documentation of events during the emergency. Clinic staff members involved in treating Officer Gonzalez prepared incident reports on California Department of Corrections Form 837 as required. These reports are the only written documentation of emergency medical care that clinic staff prepared, and are inadequate in describing the assessment, care and treatment of Officer Gonzalez.

Based on interviews with the Office of the Inspector General, some clinic staff indicated the belief that standard medical charting is not required for emergency medical treatment provided at the clinic, while others believe that such charting is required only if emergency treatment is provided to inmates.

The institution's *Hospital Policy & Procedure No. C-11* includes by reference a "Cardiopulmonary Resuscitation Form" that must be completed during treatment of a patient experiencing cessation of breathing or pulse. The form requires that hospital staff record pertinent information concerning medical assessment and care, as well as the patient's response to treatment. The clinic staff created no such record concerning Officer Gonzalez.

Additional policies and procedures directly requiring, or indirectly referring to, charting or other documentation of medical care provided in the hospital include *Hospital Policy and Procedures A-10, C-5, C-6, C-15*, and *E-10*. These policies and procedures require charting as a means of avoiding errors and to aid in diagnosis, treatment, and care of both inmates and employees. Clinic staff complied with none of these policies and procedures in connection with Officer Gonzalez.

Proper documentation minimizes or eliminates ambiguity about what occurred, and who performed particular procedures. Proper charting has the added advantage of providing evidence that appropriate medical care was provided and further assists by improving future medical care and in managing risk.

In contrast with the documentation produced by the institution's clinic staff, the fire and ambulance paramedics did a much more thorough job of providing medical documentation on their standardized patient care reports.

As a result of the clinic staff's failure to document the incident adequately, there remain discrepancies in critical details of Officer Gonzalez' treatment:

- The fire paramedics defibrillated Officer Gonzalez shortly after their arrival because he was experiencing ventricular fibrillation. If clinic staff had pressed the "analyze" control on the automated external defibrillator that they attached earlier to Officer Gonzalez, the device would have recognized such a heart rhythm and recommended defibrillation. However, because clinic staff did not maintain charts of the incident there is no way to tell precisely how long Officer Gonzalez was attached to the clinic's automated external defibrillator or how frequently someone activated the "analyze" control. Further, there is no way to tell how long Officer Gonzalez had a heart rhythm in need of defibrillation prior to the fire paramedics' arrival.

- Though the 837 reports record clinic staff's attempt to establish an intravenous line, there is no mention as to whether the attempt was successful. The Office of the Inspector General learned only during subsequent interviews with clinic staff that the attempt to establish an intravenous line was unsuccessful because supplies to accomplish the task were inadequate. The critical missing item was the tubing for connecting the catheter to fluids. None of the clinic staff's 837 reports mention the reason an intravenous line could not be established. The necessary intravenous line tubing had still not been added to the intravenous line supplies and other emergency equipment at the clinic a month after the problem was first encountered.

- The Office of the Inspector General's examination of the 837 reports revealed significant discrepancies in identifying the type of airway used in attempting to ventilate Officer Gonzalez. One registered nurse wrote in his 837 report that he "was able to insert the trach tube." His oral statement indicated the tube had a balloon cuff. Another nurse wrote in her 837 report that she advised fire paramedics that Officer Gonzalez needed to be re-intubated, suggesting that the clinic staff's attempts at this procedure were unsuccessful or that the tube had been dislodged while the patient was being moved. The same nurse was clear in stating that she handed a packaged endotracheal tube, equipped with a balloon cuff, to the physicians.

  One of these physicians told the Office of the Inspector General he intubated the patient with an endotracheal tube about six inches long having no balloon cuff, and that he does not know what an oropharyngeal airway is.[13]

  Two of the medical technical assistants (MTA's) directly involved in providing care to Officer Gonzalez stated during their interviews that an endotracheal tube was not used, but that an oropharyngeal airway was. When shown an oropharyngeal airway the same MTA told the Office of the Inspector General that it did not look like the airway used on Officer Gonzalez. Another of the MTA's described an airway to

[13] The difference between an oropharyngeal airway and an endotracheal tube is significant. The oropharyngeal airway, when properly sized, does not extend past the pharynx when inserted and is rather easily inserted in an unresponsive patient with an absent gag reflex. In contrast, the endotracheal tube is actually inserted in the trachea with great care given to avoid placing it in the esophagus.

which the AMBU bag was attached after insertion. However, there is nothing on an oropharyngeal airway to which an AMBU bag can be attached**.**

- Only one of the 837 reports suggests any sort of problem with the airway, recording that paramedics were advised of a need to re-intubate Officer Gonzalez. Interviews of clinic staff by the Office of the Inspector General a month later disclosed the airway used on Officer Gonzalez became dislodged at some point. There is no written record as to when or how the airway became dislodged, how long staff took to recognize the airway was dislodged, or how long, if at all, effective ventilation was provided.[14] In fact, there is insufficient evidence to conclude the airway was properly placed.

- There is no documentation discussing the adequacy of the ventilation provided at any time. Interviews of some clinic staff indicate that Officer Gonzalez' chest was observed to rise and fall after intubation and ventilation, which if true suggests tracheal and not esophageal placement of the endotracheal tube. However, the nurse who claims to have performed the intubation said there was no rise and fall of the chest following intubation. There is no written documentation describing Officer Gonzalez' response to ventilation. In addition, clinic staff have offered no testimony, oral or written, regarding any definitive primary or secondary assessments verifying that the endotracheal tube was properly placed in the trachea as opposed to the esophagus. The "Cardiopulmonary Resuscitation Form" used in the California Institution for Men Hospital, but apparently not used at the clinic, calls for such information.

The clinic staff's collective omission of these critical details from official written reports deprives management and staff alike of the ability to conduct an objective critique of the handling of Officer Gonzalez' emergency.

No staff debriefing or incident critique conducted. The medical staff was appropriately offered stress debriefing for psychological benefit following the incident. However, there was no attempt to evaluate or debrief the handling of the medical emergency or the adequacy of available equipment and supplies. Some clinic staff indicated in interviews with the Office of the Inspector General that they desired to speak with someone about what had actually happened, because they felt there had been problems and they wanted to contribute to better preparation in the future. Specific incident debriefing is an essential part of quality improvement.

The institution's *Hospital Policy & Procedure No. C-11* requires that a hospital nursing supervisor or lead nurse prepare a written critique after medical services have been provided to a patient experiencing a cessation of breathing or pulse. Several items on that

[14] If an endotracheal tube was actually used, there are no incident reports mentioning whether someone attempted to secure it, even with nothing more than tape, to guard against dislodging. Subsequent interviews, however, revealed there was no attempt to secure the endotracheal tube before lifting the officer to a gurney and wheeling him out of the building.

critique form would apply in this case. For example, one of the questions addresses whether the crash cart was adequately stocked. It appears, however, that clinic staff believe this policy was never intended to apply outside of the hospital.

Hospital Policy & Procedure No. Q-1 describes a quality assurance program.[15] Its purpose is to systematically monitor and evaluate the quality and appropriateness of nursing care, pursue opportunities to improve nursing care and clinical performance and resolve problems. No such policy and procedure is in place for the clinic, however. One of the questions on a test administered by the institution in May 2000 indicates that all emergency medical responses involving an ambulance shall be reviewed monthly to identify procedural or training issues requiring correction. The institution made no apparent attempt to review the quality of the care provided to Officer Gonzalez until the Office of the Inspector General's inquiry was initiated.

Key members of the clinic staff provided conflicting information about critical details. One of the nurses reported in his 837 report that he personally intubated Officer Gonzalez, and further confirmed this during an interview with the Office of the Inspector General. The nurse's written 837 report that he inserted a "trach tube" into the patient is corroborated by testimony of the other medical staff present during the event, except for one of the physicians who claims that he, and not the nurse, intubated Officer Gonzalez.

This physician who claims to have intubated Officer Gonzalez told the Office of the Inspector General he personally listened to Officer Gonzalez' heart and lung sounds when the officer was first brought to the clinic and that both were absent. However, one of the MTA's in the clinic during the incident reports that Officer Gonzalez' carotid pulse was initially palpable and the chest was seen rising and falling before clinic staff initiated ventilation. At least one member of the clinic staff told the Office of the Inspector General that the physician who claims to have attempted to listen to heart and lung sounds simply opened the officer's uniform and walked away.

The physician claiming to have intubated Officer Gonzalez told the Office of the Inspector General the following:

- He was unable to identify by name the instrument normally used to assist in the intubation of patients.

- He performed a blind intubation without the assistance of a light source. The Office of the Inspector General observed two fully functional disposable laryngoscopes[16] inside the case containing a small supply of endotracheal tubes.

- He could not and did not confirm that the endotracheal tube was in the trachea.

[15] Many health care providers have moved to a quality improvement program instead of a quality assurance program.

[16] This instrument permits visual confirmation that the endotracheal tube been inserted through the vocal cords and into the trachea and not into the esophagus.

- A pulse oximeter was not used and that he does not know what an end-tidal CO_2 monitor is. This physician was not familiar with the terms capnometry or capnography.

- The only way to secure an endotracheal tube after intubation is to either hold the tube in place with the fingers or to inflate the balloon cuff at the distal end of the tube to hold the tube against the interior wall of the trachea. Neither is an adequately reliable method of securing a tracheal tube. The physician confirmed that the endotracheal tube he used did not have a balloon cuff. All of the other endotracheal tubes seen by the Office of the Inspector General on subsequent inspections at the clinic have inflatable balloon cuffs. Typically, only endotracheal tubes for infants and small children have no inflatable balloon cuffs.

- He held the tracheal tube in place with his fingers but could not explain how or when the endotracheal tube became dislodged.

- There was no stylet present among the supplies, or if there was, that he did not see it. He also said there is no suction device available at the clinic and further stated that he did not know how suction might be needed during an intubation procedure.[17]

- He did not know what an oropharyngeal airway was, insisted that the carina[18] was the portion of the anatomy separating the esophagus from the trachea, and was unfamiliar with the Glasgow Coma Scale; terms commonly known to those familiar with performing intubations.

- He personally saw on the small screen of the automated external defibrillator/cardiac monitor four or five ECG waves that changed to a straight line, indicating Officer Gonzalez' heart rhythm was asystole (cardiac standstill). The physician said he administered no cardiac medications, and that the four or five ECG waves he observed were insufficient for him to determine the exact type of heart rhythm before he recognized Officer Gonzalez was asystole.

Nonetheless, this same physician wrote an 837 report failing to mention his having intubated the patient, the method used to provide an airway, how placement of the endotracheal tube was confirmed, and that he read and assessed ECG waves on a cardiac monitor while Officer Gonzalez was in the clinic. This physician's 837 report further describes that he issued various orders to other medical personnel.

The policies and protocols governing emergency medical procedures lack coordination. The policies and protocols governing emergency medical procedures create confusion among staff because they lack coordination. The California Institution for Men has three

[17] Suction is necessary to remove blood and other liquids that can block visual inspection of endotracheal tube placement, or that may be aspirated into the patient's lungs.

[18] The carina trachaea is a projection of the lowest tracheal cartilage, forming a prominent semi lunar ridge running antero posteriously between the openings of the two bronchi. The carina trachaea is below the portion of the anatomy separating the esophagus from the trachaea.

separate sets of health care protocols. The first are policies and procedures for the medical/surgical unit of its hospital. The second are the hospital's emergency medical policies and procedures. The third are policies and procedures intended only for the clinic and are outpatient protocols concerning the care to be provided inmates.

While the institution's emergency operations plan contains a resource supplement[19] concerning emergency medical treatment, it applies only in the event of a major disturbance and provides guidance for transporting those injured in such disturbances without providing specific treatment protocols. The institution has no written policies and procedures for providing emergency medical care to its employees outside of its hospital.

There are no emergency medical care protocols available to the staff in the clinic. While there are medical protocols located in the institution's hospital, these do not specifically and comprehensively address emergency care to be provided by clinic staff. Some clinic staff believe the hospital protocols do not apply to the clinic, while others do not know whether they apply.

The institution's general practice is to call a private ambulance company to transport seriously ill or injured employees to an outside medical facility. This is the written policy to be applied during a major disturbance. In contrast, inmates experiencing a medical emergency are usually transported by the facility ambulance to the institution's hospital. These policies do not preclude employees from being taken to the institution's hospital or inmates from being transported to outside hospitals.

The same equipment and staff assigned to provide first-response emergency medical services to inmates at the clinic are the same that would be used for employees experiencing an emergency. Neither inmates nor employees will be well served by the state of emergency-preparedness that the Office of the Inspector General observed at the institution's clinic.

Information in the institution's emergency operations procedures is incorrect. The institution's emergency operations procedures list a phone number to an ambulance substation in Chino to contact for emergency medical transportation off institution grounds, but that phone number is no longer in service. The 800 central dispatch number for the ambulance company, however, is valid. Fortunately the clinic staff simply called 911 when seeking assistance for Officer Gonzalez, activating a response by not only American Medical Response, but Chino Valley Fire whose number is not listed in the procedures.

The emergency procedures identify a list of hospitals as providers of emergency medical services, but Loma Linda University Medical Center, the only Level I trauma center in the region, is not listed.

[19] Resource Supplement Number 17, *Providing Emergency Medical Treatment for All Staff and Inmates.*

Employees and inmates at the institution's central unit are isolated from the traditional 911 community for obvious safety and security reasons. They are also isolated, to some extent, from the services of the facility's ambulance and hospital emergency room, further underscoring the need to plan and prepare clinic staff for medical emergencies in the clinic or at other locations. That planning and preparation is inadequate at this time.

RECOMMENDATIONS

While the primary function of the reception center's clinic is to perform inmate medical evaluations, it is also common for clinic staff to provide emergency medical care, and specialized equipment and supplies have been provided to it for that purpose. Indeed, the very environment of the institution provides strong reason for it to be properly prepared to respond to medical emergencies since other alternatives may be delayed or inaccessible due to security concerns.

Accordingly, the Office of the Inspector General recommends that the California Institution for Men take the following actions with respect to its central reception center clinic:

- **Develop comprehensive procedures specific to the clinic that focus on delivery of emergency medical services.**

- **Assess the clinic's needs with respect to emergency medical supplies and equipment and assure that the clinic is adequately stocked with them. The chief medical officer should institute a practice of conducting regular inventories and inspections of these supplies and restock those that have been consumed or lost to spoilage or obsolescence.**

- **Ensure that the emergency supplies are ready to use and are immediately accessible. A crash cart would address this purpose within the clinic, and could also be easily taken to any emergency in the facility served by the clinic.**

- **Provide specialized training in emergency medical procedures for clinic staff and other employees as appropriate. This may include courses leading to advanced cardiovascular life support certification. Further, management should conduct regular emergency drills for clinic staff. Management should provide additional training in medical charting and proper documentation of emergency medical incidents.**

- **The insitution's medical staff should engage in thorough debriefing following incidents of medical emergencies. California Evidence Code, section 1157 encourages a frank evaluation of quality of care issues by prohibiting discovery of such information. The California Institution for Men should take full advantage of this statute by engaging in candid and**

complete self-assessments after significant medical events, whether involving inmates or employees.

- **The institution should consider retaining the services of a consultant in emergency medicine to provide a comprehensive review of its policies, protocols, procedures, staffing, training, quality assurance/improvement program, supply and equipment requirements and to provide guidance on implementing improvements. The consultant should be knowledgeable and experienced in establishing and maintaining emergency medical clinics outside of a traditional hospital setting.**

In addition, the Department of Corrections should review the emergency preparedness of its other institutions to ensure that the deficiencies found at the California Institution for Men do not exist elsewhere.

FINDING 7

The Office of the Inspector General found that the management of the California Institution for Men did not set up an Emergency Operations Center or institute an Emergency Operations Plan in the wake of Officer Gonzalez' stabbing due to ambiguous protocols. As a result, there was some confusion in the chain of command, emergency operations policies were not implemented, the crime scene was destroyed, and an incident log was not initiated.

The *California Department of Corrections Operations Manual* governs appropriate responses to disturbances at an institution, while individual institutions' own Emergency Operations Procedures address ancillary policies unique to each institution. However, these documents do not specifically address whether an Emergency Operations Center should be set up or an Emergency Operations Plan implemented following an assault on an officer resulting in serious injury or death. In the wake of the attack on Officer Gonzalez, the institution's management neither set up an Emergency Operations Center nor implemented an Emergency Operations Plan. As a result, there was some confusion in the chain of command that led to institutional staff's failure to follow critical emergency operations policies, destruction of the crime scene, and a failure to record events in an incident log. Despite these shortcomings, correctional officers were able to transport the wounded officer to a medical care facility quickly, effectively regain control of the housing unit, and take the suspect into custody without further serious injury to inmates or staff.

Emergency response procedures in Sycamore Hall. Sycamore Hall is located in Reception Center Central, one of four facilities at the institution. While all correctional officers with radios use the same frequency there, Reception Center Central Control personnel scan all institutional radio frequencies for emergency situations. Reception Center Central Control also maintains and dispenses personal alarms for officers on duty, as well as protective equipment and less-than-lethal weapons for Code 2 emergency responders. Alarm response drills are conducted monthly. There are an estimated 20 to 25 Code 1 alarms weekly on Sycamore Hall, 15 of which are potentially dangerous situations to staff or inmates. There are approximately five Code 2 alarms weekly (requiring the need for additional officers or ballistic impact weapons) and one Code 3 alarm every two months (requiring officers to respond from all parts of the institution).

When a correctional officer activates a personal alarm, an audible and visible emergency signal activates in the main corridor outside that officer's unit. The activation of either a personal alarm or a telephonic alarm triggers an automatic entry on the computer log at Reception Center Central Control. No log entries of other communications are made and radio traffic is not recorded.

Response to attack on Officer Gonzalez. Four correctional officers were responsible for supervision and escort of the 213 inmates housed in Sycamore Hall on January 10, 2005, the date of the incident. Two officers were in the first tier guard space of Sycamore Hall at the time, while a third was just outside the tier. The assault occurred on the west side

of Sycamore Hall's first tier, approximately 15 feet from the grill gate separating the guard space from the tier.

Immediately after the assault, Officer Gonzalez made his way into the guard space with the aid of a fellow officer and collapsed. The gate to the tier was then closed and one officer activated his personal alarm while another gained control of several inmates who were in the guard space awaiting medical appointments.

Code 1 responders from Madrone Hall were the first to arrive. One of those officers broadcast an "officer down" call, and with the assistance of three other officers, carried Officer Gonzalez to the medical clinic. Additional Code 1 responders from Reception Center Central East moved down the central corridor and were directed to Sycamore Hall by Reception Center Central Control, where they formed a skirmish line in the guard space at the gate.

The facility lieutenant at Reception Center Central assumed responsibility as incident commander and immediately radioed for a Code 2 response. The designated Code 2 responders proceeded to Sycamore Hall equipped with 37 mm and 40 mm launchers. Reports estimate that as many as 25 correctional officers assembled in the tier 1 guard space and that five or six officers assembled in the tier 2 guard space in front of the gate.

Before senior command staff arrived, the situation in the tier 1 guard space was described by witnesses as "pandemonium." Eventually, two facility captains arrived and took control. A lieutenant (not the incident commander) then returned to Reception Center Central Control and called for a Code 3 response, which was transmitted to all other facilities in the institution. In another building adjacent to the front gate, the security administration building lieutenant heard the initial radio traffic. Under the Emergency Operations Plan, that lieutenant would have been the interim emergency commander. Acting independently and without contact from the incident commander on scene, that lieutenant had already initiated a Code 3 response by telephone. By the time Code 3 responders arrived at Sycamore Hall, the three inmates who had been at large were in custody, so the Code 3 responders were assigned various search and coverage tasks until ordered to stand down.

At the time of the stabbing, the warden and her executive staff were meeting in another building in the institution. After being notified, the warden and her staff moved quickly to Reception Center Central, arriving as Officer Gonzalez was being carried into the medical clinic. The warden never declared herself the emergency commander, nor did she receive a debriefing from the acting emergency commander. The warden did assign facility captains to supervise the apprehension of inmates still at large on the tier. The warden then remained on site at Reception Center Central to deal with issues arising from the assault on Officer Gonzalez, sent her chief deputy warden to follow the ambulance to the hospital, and assigned an associate warden to run the routine affairs of the institution.

Once the inmates were restrained and escorted out of Sycamore Hall, the incident commander conducted a briefing for all responders and ordered a search of the inmates

and formation of teams to search all the cells on the west side of Sycamore Hall. After the search was complete, the incident commander declared the incident over.

Emergency Operations Center and Emergency Operations Plan are not specifically required. Following an inmate attack on an officer, establishing an Emergency Operations Center and implementing the Emergency Operations Procedures is not specifically required by the California Department of Corrections Operations Manual. The language of the *California Department of Corrections Operations Manual* establishes the conditions under which the Emergency Operations Plan is to be applied. The *Department of Corrections Operations Manual* states that the Emergency Operations Plan is to be implemented "in the event of an **inmate initiated disturbance which significantly disrupts routine institutional operations or programs** [section 55010.3, emphasis added]."

Department training materials distinguish between an "incident," defined as an isolated event, and a "disturbance," defined as an event that disrupts normal institutional operations. While an "incident" will not trigger the application of the Emergency Operations Plan, a "disturbance" will.

Unquestionably, institutional operations were disrupted when Officer Gonzalez was stabbed. As a result of events on Sycamore Hall's west side, responders throughout the institution were called to the scene, and the whole institution was placed on lock down. The command staff, however, told the Office of the Inspector General that they regarded the events of January 10, 2005 as an "incident," rather than a "disturbance." In various interviews, they pointed out that the disruption of institutional operations following the stabbing arose strictly as a result of the administration's response to the incident, rather than from the incident itself.

Institutional staff interviewed by the Office of the Inspector General further suggested the Emergency Operations Procedures were never intended to apply to a one-on-one assault because the disturbances mentioned in the introductory language of the *California Department of Corrections Operations Manual* "include, but are not limited to, general riots, sit-down or hunger strikes, large scale demonstrations, taking of hostages, multiple attacks on persons, or attempts by inmates to incite others to participate in any of the aforementioned actions" *(California Department of Corrections Operations Manual*, section 55010.3). Staff further noted that the resource supplements likewise address concerns of a more global or large-scale nature, such as widespread rioting, a major escape, or a natural disaster. A third reason staff gave for not applying the Emergency Operations Procedures is that the stabbing was a unique, critical situation demanding a rapid response that would have been impeded by establishment of centralized authority in the form of a command center.

In sum, the *California Department of Corrections Operations Manual* does not provide clear-cut guidance defining an attack on an officer resulting in serious injury or death as an occasion triggering implementation of the Emergency Operations Procedures.

Emergency Operations Procedures could have improved the response. If the institution had implemented Emergency Operations Procedures, its response to the assault on Officer Gonzalez would have been improved. The principal advantages of following the procedures are: (1) it establishes a clear chain of command in situations where the usual chain of command may become confused; (2) it facilitates communication with outside agencies by requiring activation of an Emergency Operations Center; (3) it clearly establishes procedures to be followed, including evidence and crime scene preservation, and provides checklists; and (4) it requires the creation of an incident log, which is valuable in recreating events and as a training tool.

If the Emergency Operations Procedures are triggered, they provide the chain-of-command for handling the emergency. The EOP provide that the lieutenant who is the on-duty watch commander at the security administration building is the interim emergency commander and that the warden is the emergency commander.

Following the stabbing of Officer Gonzalez, the facility lieutenant at Sycamore Hall assumed control of the scene as the incident commander. Perhaps as many as 25 correctional officers crowded into the guard space on the first tier of Sycamore Hall, where eight inmates were on the floor and the air was contaminated with pepper spray.[20] The area was also a crime scene. Numerous impact munitions were fired down the tier without result. The incident commander attempted to transmit cease-fire orders to the upper tiers by messenger, rather than by radio. As noted above, before senior command staff arrived, the situation in the tier 1 guard space was described as "pandemonium.[21]" The situation calmed down after senior officers arrived, effective cease-fire orders were given, and inmates who were at large soon submitted to custody.

In the course of the Office of the Inspector General's inquiry, executive staff frequently responded that the nature of the command response was justified by the uniqueness of the incident and its unforeseen nature. An EOP's purpose is to prepare in advance for, and to provide structure and guidance during, unpredictable incidents. Sections of the Emergency Operations Procedures addressing a number of concerns arising following the stabbing of Officer Gonzalez should have been consulted. For example, the Emergency Operations Procedures sets forth a notification grid (Resource Supplement Number 1); the emergency chain of command (Resource Supplement Number 2); procedures for securing an emergency area (Resource Supplement Number 8); procedures for

[20] Pepper spray is authorized for use inside CIM housing units. (*Resource Supplement 9*, at 9-16.)

[21] The breakdown of the chain of command was exacerbated because on-site responders and control elements were all monitoring the same open radio frequency and undertook to operate independently. As many as 25 responders gathered in the first tier guard space. This disorder likely contributed to the IC's decision to relay cease-fire orders to Code 2 responders on the upper tiers by sending a messenger through the locked staircase. Not only does the institution not have facility-targeted communications, it does not have the means of recording radio traffic in emergencies, or at any time. Today, even relatively small organizations have found it economical to acquire "trunking" radio systems. Such systems provide for a master radio channel, but still allow users to be assigned to one or more "talk groups," providing targeted communications. All radio traffic can be recorded on such a system. Some system vendors offer methods of indexing, time-stamping, and archiving communications.

establishing an Emergency Operation Center (Resource Supplement Number 15 of the Emergency Operation Procedures, which states that "effective control of a major disturbance/emergency situation requires the activation of an Emergency Operation Center (EOC)"); procedures for conducting mass searches (Resource Supplement Number 24); procedures for crime scene preservation and preservation of evidence (Resource Supplement Number 28); and procedures for incident reporting (Resource Supplement Number 30).

When command staff arrived on scene, according to one senior officer, a cease-fire was ordered, control was established, and the developing situation was "slowed down." Instructions to surrender were communicated to the three inmates at large on the tier and they complied. Had procedures provided in the EOP been followed, fewer Code 1 responders would have gathered in the Sycamore Hall tier 1 guard space, communication with Code 2 responders in the upper tiers would likely have been more effective, senior staff could have promptly exerted control, and the situation may have been brought under control sooner and more effectively.

The Emergency Operation Procedures further provide specific instructions regarding summoning and coordinating mutual aid (Resource Supplement Numbers 5, 6 and 19). The plan provides that the Emergency Operations Center shall have a mutual aid liaison and an institution operations administrator, whose duties include summoning local law enforcement and summoning emergency medical services and coordinating transportation of injured staff to outside medical facilities. The Emergency Operations Center and the mutual aid liaison would have provided clear points of contact for outside agencies. The procedures require that outside agencies be contacted, even if they are not summoned. Had senior staff, operating through an EOC, elected to become involved in evidence collection and crime scene preservation, or if the required notifications had been made, the San Bernardino County Sheriff's Department could have been notified immediately, the crime scene preserved to the extent possible and evidence collected in a systematic manner.

In this instance, the warden assigned senior officers to assemble an extraction team. After the situation on Sycamore Hall was contained, those officers focused on the security and transportation of the three inmates involved. On Sycamore Hall, the incident commander ordered comprehensive inmate body and cell searches. As described fully in Finding 8 of this report, those searches destroyed the immediate crime scene and disrupted the chain of evidence.

Implementation of the Emergency Operations Procedures concerning crime scene and evidence preservation would have made a dramatic difference. The scene could have been subjected to less contamination and destruction; the evidence recovered could have been collected in an efficient and systematic manner; and evidence of any forensic value could have been clearly identified. Following those procedures could have made it more likely that the murder weapon, Blaylock's clothing, and the clothing of the other inmates on the tier would have been identified and recovered.

These problems would have been minimized had staff consulted Resource Supplement Number 28, which makes it a priority for first responders "to preserve evidence and to protect the crime scene from destruction or contamination" (subsection A). Among other things, Resource Supplement 28 also requires the first custody supervisor on scene to remove all but essential and authorized persons from the scene and to designate a staff member to note and record all persons entering the scene (subsection A.2.c.); record the crime scene by photographing the entire area, including any and all evidence, using distance and close up photos of each item to show spatial relationships within the crime scene (subsection A.2.e.); measure the placement of all evidence from fixed standard points (subsection A.2.f.); and to designate no more than two officers to collect all evidence systematically (subsection A.3.b.1.). Resource Supplement 28 is so specific as to instruct evidence collectors to enter the scene from the left side and collect all evidence by moving clockwise around the area (subsection A.3.a.).

A type of log was created at the incident commander's direction. However, that log recorded only minimal information. The Security Administration Building watch commander also regularly keeps a log. Literally dozens of reports were written by officers and non-sworn staff within a day of the incident. Yet even after analyzing those logs and the reports of various investigators who followed, the Office of the Inspector General discovered it difficult to determine definitively what information was gathered or broadcast, who responded, when they arrived on scene, what orders were given and when, and who was notified of the incident. All such information should have been recorded in an incident log, a form for which is provided in the resource supplements. Neither that form, nor any of the accompanying checklists, was used.

Incidents such as the one involving Officer Gonzalez are rare and unpredictable. The information that should have been collected in an incident log would have been valuable in developing policies and training curricula to address future situations.

To their credit, emergency responders efficiently accomplished their primary mission. The situation on Sycamore Hall was contained and controlled safely for both officers and inmates. Notwithstanding the highly emotional circumstances, officers did not enter the tiers, use of force was within policy and legal limits, and Officer Gonzalez was promptly evacuated. However, because centralized control was never effectively established, actions were taken that had the potential to adversely affect the criminal prosecution or the liability of the institution.

RECOMMENDATIONS

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

- **Reinforce with institutional executive staff the intent, objective, and purpose of implementing the Emergency Operations Plan when an inmate initiated disturbance significantly disrupts routine institutional operations or programs.**

- **Update section 55010 of the *California Department of Corrections Operations Manual* so that it (1) clarifies ambiguities such as the circumstances under which the Emergency Operations Plan should be implemented, and (2) incorporates changes in technology that have occurred since the manual's last revision in 1989.**

In addition, the Office of the Inspector General recommends that the California Institution for Men reinforce, through training, the responsibility of supervisors and management to direct employees to provide leadership and direction in the face of emotionally devastating situations such as a staff murder to ensure that all objectives specified under the Emergency Operations Procedures are met. These objectives include, but are not limited to, consideration of crime scene preservation and evidence collection to enhance potential criminal prosecutions.

FINDING 8

The Office of the Inspector General found that the California Institution for Men did not implement important emergency procedures in response to the incident, leading to contamination of the crime scene and the loss of important evidence.

As referenced in Finding 7, California Institution for Men staff failed to preserve the crime scene and physical evidence, including the clothing worn by Officer Gonzalez' alleged assailant. As a result, potentially important corroborative evidence, such as forensic evidence potentially linking the assailant and the victim was lost. As such, the State's case against inmate Blaylock must rely more heavily on eyewitness accounts than otherwise necessary. Institution staff did not follow established procedures for preserving crime scenes and physical evidence because some were traumatized by the assault and failed to do their duties, Investigative Services Unit officers lacked adequate training and experience, and there was inadequate command and control over the incident. Specifically, the warden did not implement the prison's Emergency Operations Procedures. Because these procedures provide detailed steps and checklists for myriad tasks including crime scene and evidence preservation, implementing them may have facilitated a more structured, systematic response by the institution.

Responsibility for crime scene preservation begins with the first responding officer who arrives at a scene where a crime may have been committed. Once the first responder identifies that the severity of the crime and/or the need for a crime scene investigation exists, that officer must preserve the scene so that physical evidence at the scene is not moved, destroyed, or otherwise contaminated by the subsequent intrusion of other parties. This can be accomplished by numerous means, including using crime scene tape, barriers, or other means to isolate the area. Physical evidence is any and all physical objects or recorded observations and measurements of events, which may aid investigators or a court in reaching a conclusion about the crime. In a stabbing, the crime scene may contain physical evidence such as blood on the floor or elsewhere that can be used in forensic testing to link the DNA of the victim to the assailant. This is especially significant when both the victim and suspect are bleeding. Other physical evidence may include the stabbing instrument or the clothing of a suspect or the victim, which may yield fingerprints, the blood of the victim and/or the assailant, transferred clothing fibers, and other items capable of being analyzed forensically.

The Department of Corrections recognizes the importance of crime scene preservation by making it a four-hour component of its basic correctional officer academy training program. In addition, the Office of the Inspector General found that the California Institution for Men provided three hours of correctional officer training in crime scene preservation and evidence preservation between February 19, 2001 and November 23, 2003. This training was part of the in-service training curriculum required by the now-defunct section 7K of the State's collective bargaining agreement with the California Correctional Peace Officers Association. (Following the death of Officer Gonzalez, the prison conducted two one-hour sessions on crime scene preservation.) Crime scene preservation and evidence preservation are also part of the post orders for the prison's

five-member Investigative Services Unit, and are an integral part of the institution's Emergency Operations Procedures.

Last revised in 1989, section 55010 of the *California Department of Corrections Operations Manual* requires that each warden have in effect at all times an Emergency Operations Plan for meeting emergencies and disturbances which may significantly disrupt routine institutional operations or programs. The purpose of the plan, a confidential document located in specific secure areas of the prison, is to specify institutional procedures in the event of an emergency or inmate-initiated disturbance. The California Institution for Men's plan is entitled Emergency Operations Procedures, and it contains 50 resource supplements that identify policies and procedures for a variety of possible events ranging from riots and escapes through natural disasters. Included in these resource supplements are checklists for command and control, duties of the incident commander, the interim emergency commander, the emergency commander, and other key staff, and specific procedures to be followed for mass searches and crime scene preservation and evidence preservation. Resource Supplement Numbers 4, 5, and 6 task the incident commander, the interim emergency commander, and the emergency commander with crime scene preservation and evidence preservation, among other duties. Resource Supplement Number 24 provides procedures for mass searches and evidence preservation, while Resource Supplement Number 28 specifies detailed procedures for crime scene preservation and evidence preservation. As shown in Finding 7, section 55010 of the *California Department of Corrections Operations Manual* and the California Institution for Men's Emergency Operations Procedures can facilitate an orderly response to a surprising, stressful event. However, neither document specifies all circumstances under which the emergency procedures should be implemented.

The California Institution for Men failed to preserve the crime scene and physical evidence. Notwithstanding the requirements for and the importance of crime scene preservation and evidence preservation, the Office of the Inspector General found significant failures on the part of institution staff to carry out their duties in the aftermath of the stabbing. Specifically, the Office of the Inspector General found:

- ***Failure by Investigative Services Unit staff to seal off the crime scene at the south stairwell.*** Within minutes of the 10:57 a.m. assault on Officer Gonzalez at the south staircase of the first tier in Sycamore Hall-West, numerous correctional staff responded to the Code I and Code II alarms. Among the early responders to Sycamore Hall-West and Reception Center Central were four of the five members of the Investigative Services Unit. The responders remained outside the tier area until inmate Blaylock and the two other inmates were restrained about 43 minutes after the assault. Although this represented the first opportunity to seal off the reported scene of the stabbing at the south staircase and begin the criminal investigation, no one, including Investigative Services Unit staff did so. In fact, at that time, most of the Investigative Services Unit's staff was monitoring inmate Blaylock, who had been moved to Palm Hall. During the cell extractions and the mass search for weapons that followed, foot traffic contaminated the crime scene making subsequent forensic analysis difficult, if not impossible. The Office of the Inspector General's review of

the physical configuration of Sycamore Hall-West determined that the crime scene at the south staircase could have been sealed off without hindering the mass search and cell extractions. This is because there are alternative access and egress points the search team and escort officers could have used. The only effort to preserve any portion of Sycamore Hall-West occurred at 12:25 p.m. when an Investigative Services Unit sergeant ordered the cordoning off of three cells with crime scene tape, including Blaylock's, at 12:25 p.m.

- ***Failure to treat Sycamore Hall-West as a crime scene.*** Once staff had searched and removed the inmates from Sycamore Hall, they had established control over the area of the crime scene. However, instead of preserving the scene to the extent possible, staff began their cell-by-cell search of Sycamore Hall. As they searched, staff heaped linen, inmate jumpsuits, and other laundry items in huge piles in the main corridor. Despite the fact that Sycamore Hall-West was now in the institution's control, the staff failed to consider cordoning off the housing unit as a crime scene. Had this occurred the homicide investigators could have ordered a forensic examination of key areas such as the guard space where Officer Gonzalez collapsed, the main corridor, and the medical unit where he was taken for critical corroborative evidence.

- ***Clean up of blood evidence.*** Rather than wait for the arrival of a forensics team, staff cleaned up blood evidence around Sycamore Hall-West and Reception Center Central, thus eliminating the possibility of locating and identifying blood from a reported cut on the assailant's hand. This cleanup effort was evidently an emotional response to Officer Gonzalez' death. One correctional sergeant reported that he initiated a decontamination of Officer Gonzalez' blood by spraying the affected floor area with cleaner and wiping the floor area with towels. The sergeant reportedly acted out of concern that inmates would defile, disrespect, and dishonor the blood of Officer Gonzalez if it remained on the floor. Although the Office of the Inspector General sympathizes with the feelings of institution staff, disturbing or destroying potential evidence that could aid in the criminal prosecution of the assailant cannot be allowed.

- ***Failure to preserve the alleged assailant's clothing as physical evidence.*** Based on the probable close quarters in which inmate Blaylock allegedly attacked and stabbed Officer Gonzalez, Blaylock's clothing may have had trace blood, fiber or DNA evidence to support a criminal prosecution. When inmate Blaylock surrendered to institution staff, they ordered him to strip down to his underwear before being taken into custody. However, correctional officers did not recover his clothing. As staff searched and secured the remaining inmates and searched Sycamore Hall for the murder weapon, they tossed trash, debris and the contents of the cells onto the tier floor. Linen and jumpsuits removed from the cells were piled in the main corridor of Reception Center Central. When staff realized several hours later that Blaylock's clothing had not been recovered, what should have been a simple recovery of potential evidence became impossible, and Blaylock's clothing was never located. Even if staff could have identified his clothing in the piles of linen and clothing in the main corridor, the integrity of that evidence would have been compromised because

of the commingling of the clothing with other items and the resulting contamination of possible trace evidence.

- ***Failure to examine and preserve blood on the alleged assailant's hands.*** On January 10, 2005 at 12:45 p.m. after inmate Blaylock was taken into custody, a medical technical assistant examined inmate Blaylock because force had been used in his apprehension. The medical technical assistant documented the examination on a Form C7219 (Medical Report of Injury or Unusual Occurrence). On the form, the medical technical assistant reported that Blaylock had an abrasion or a scratch and blood on one of his hands. Although staff photographed and videotaped Blaylock following his capture, it is unclear whether those images captured the blood evidence on the hand. Further, it appears that samples of the blood were not obtained prior to Blaylock's being transferred to Corcoran State Prison. The presence of blood on the suspect's hand in a stabbing case is clearly of evidentiary value.

- ***Poor evidence collection, storage, and chain of custody practices.*** Collecting, storing, and establishing the chain of custody of physical evidence is foundational to presenting evidence in court and is critical in defeating defense challenges of bias, evidence altering, evidence contamination, and other issues. The Office of the Inspector General reviewed department and institution policies and procedures for collecting, storing, and transferring evidence and found them generally consistent with accepted policies and procedures within the law enforcement profession. Further, review of the staff's collection of approximately 35 stabbing and slashing instruments during the mass search indicated that most officers appropriately maintained sole custody of the evidence until booking the item into the Security Administration Building evidence locker room. However, in addition to the evidence collection problems previously discussed, the Office of the Inspector General found that the actual practices of custody staff within the Security Administration Building and in the Investigative Services Unit were not always compliant. Specifically, the Office of the Inspector General found:

    - In collecting stabbing and slashing instruments, staff did not attempt to preserve the weapon for forensic examination, including latent and blood trace evidence. Such evidence is directly relevant in establishing possession when inmates are double-bunked, as is the case with most inmates in Sycamore Hall-West. Moreover, rather than placing the instruments into paper bags, some staff temporarily stored the recovered weapons in their vests and cargo pants, without considering the presence of trace evidence.

    - The Evidence Locker Register, used to record evidence in the Security Administration Building, is not formatted to keep a complete record when there are multiple movements of the evidence. Instead, there is space for only one entry without having to resort to ad hoc recording. Additionally, the Evidence Locker Register consists of loose-leaf pages in a binder. As such, the possibility of adding or eliminating pages exists, threatening the integrity of the document. Further, the Investigative Services Unit has two additional sites in the

Administration building used to store evidence without logs, registers or any other tracking system for the evidence stored there.

- Entries in the Evidence Locker Register pertaining to the mass search for weapons cited above contained numerous irregularities. Some did not record the quantities of weapons found, and the dates of the entries for fourteen weapons are not chronological, suggesting that some weapons were turned in before the contemporaneous recording of entries required by sound chain of custody procedures. At least seven entries were made in the handwriting of someone other than that of the officer who secured the evidence despite a requirement that the booking officer complete the entry. The date of the transfer, and the identity of the San Bernardino County Sheriff's Department employee who received the weapons are not recorded in the register as required by sound chain of custody practices.

- Investigative Services Unit staff does not consider forensic examination of evidence in its criminal investigations. When the Office of the Inspector General inquired how evidence requiring further forensic examination is handled at the institution, Investigative Services Unit staff stated that correctional officers rarely, if ever, request forensic examination of evidence. The Investigative Services Unit officer responsible for the evidence function stated that he could not remember when a request for forensic examination was made on an item of evidence booked by staff. The Investigative Services Unit officer stated that because the vast majority of criminal prosecutions involved crimes that were witnessed by staff, there was no need for examination of evidence for latent prints or blood evidence except when requested by a prosecutor.

- Correctional staff who recover evidence such as weapons take the evidence to the Security Administration Building's evidence locker room, where the Office of the Inspector General observed numerous unsecured paper bags of evidence stacked on top of the locked evidence lockers. Although these bags appeared to be closed and sealed, any person in the evidence room would have access to the evidence.

- Although Security Administration Building personnel monitor access to the evidence locker room, it is possible for an officer inside the room to work unobserved. Failing to limit access to booked evidence to specified property custodians could bring into question the chain of custody. Further, the locker door cards describing the booking of the evidence indicated that their contents had been booked up to two years before. The fact that evidence has remained in lockers for up to two years while other evidence was stored on top of those lockers suggests that evidence initially booked into the Security Administration Building's evidence room is not moved to more secured locations for long-term storage.

Inadequate command and control over the incident. When the Office of the Inspector general asked the warden and her executive staff why crime scene preservation and evidence protection and collection procedures were ignored or poorly implemented, the response was direct and to-the-point: the assault on Officer Gonzalez was a one-on-one act that was unique and horrific. The nature of the incident completely overwhelmed staff. Consequently, the warden and her staff gave priority to issues that immediately became apparent and ignored those issues that did not immediately become apparent. One executive staff member explained that, "The main priority was to save the officer's life. Everything was emotion-based. All bets were off."

Despite the shift in priorities brought on by Officer Gonzalez' death less than an hour after the stabbing, the warden and her staff still did not implement the Emergency Operations Procedures. By not doing so, they lost the value of the checklists and the myriad policies and procedures for command and control, crime scene preservation and evidence preservation, and other functions addressed by the procedures. To their credit, the warden and her staff responded immediately to provide medical aid to Officer Gonzalez. They also moved swiftly to isolate and take into custody three inmates whom they reasonably believed were involved in the assault. They also provided for the safety of the suspected assailant by placing him in Palm Hall, with staff guarding him, and arranging to transport him to another institution within hours of the incident. Simultaneously, staff moved to prevent destruction of the unaccounted for murder weapon by searching and removing the inmates from Sycamore Hall-West and conducting mass searches of the tiers and cells.

However, prison management did not consider coordinating the staff's efforts to find the murder weapon with an effort to preserve the crime scene, with the result that the crime scene was irreparably altered and contaminated, and critical evidence was destroyed or lost.

Moreover, institution management did not use the considerable outside investigative expertise available or consider forensic crime scene analysis until 2:05 p.m., more than three hours after the assault, when detectives from the Chino Police Department arrived at the request of Investigative Services Unit staff to provide investigative advice. Prior to their arrival, three investigators from the department's Law Enforcement Investigations Unit had shown up within one and one-half hours of the assault. However, because investigative responsibility remained with the Investigative Services Unit, the Law Enforcement Investigations Unit staff provided only investigative support. With the arrival of a deputy director from the Department of Corrections the status of the criminal investigation was revisited in the early evening. After an assessment of the state of the investigation, investigative responsibility was transferred to Law Enforcement Investigations Unit.

The following day, after further discussion regarding the investigative expertise and resources available to the department, including Law Enforcement Investigations Unit,

investigative responsibility was ultimately transferred to the San Bernardino County Sheriff's Department.

As a result of the preceding conditions identified by the Office of the Inspector General, important forensic and other physical evidence was lost. Further, the admissibility of other evidence such as stabbing instruments may be challenged in future legal proceedings. Lack of this evidence may make it more difficult to successfully prosecute inmate Blaylock or to obtain a conviction.

Staff at the crime scene failed to preserve the crime scene and preserve evidence for the following reasons:

- ***Traumatized staff.*** Some correctional staff assigned to Sycamore Hall-West and Reception Center Central, as well as other institution staff, were traumatized by the incident, and their academy training and institutional training were inadequate for them to respond automatically.

- ***Investigative Services Unit shortcomings.*** The investigation of criminal acts by inmates at the California Institution for Men is the responsibility of the Investigative Services Unit. However, staff in the Investigative Services Unit had neither the training nor the experience to respond adequately to a staff homicide. Of two lieutenants, one sergeant, and two correctional officers in the unit, only the two correctional officers had had training in homicide investigations and none had ever investigated a staff homicide. Moreover, the two lieutenants had not attended the basic investigation course. None of the five was familiar with forensic examination techniques, there was no crime laboratory support, and the Investigative Services Unit did not practice sound evidence collection, storage, and transfer techniques.

- ***No memorandum of understanding for lead agency in staff homicide investigations.*** Although the institution has various memoranda of understanding with local law enforcement and the district attorney for deadly force investigations and prosecution of certain types of inmate offenses, there is no memorandum of understanding with a competent local law enforcement agency by which that agency would assume the lead role in investigating the murder or attempted murder of a staff member. Given the limitations of the prison's Investigative Services Unit cited in this report, such an agreement would be appropriate.

- ***Failure to learn from a 2003 incident.*** During its review, the Office of the Inspector General learned of an officer-involved shooting in 2003 in the Palm Hall exercise yard. In that incident, a correctional officer used deadly force to stop an inmate-on-inmate attack. Both the department's Office of Investigative Services and the department's Law Enforcement Investigation Unit reviewed the incident; both entities criticized the lack of crime scene preservation and evidence collection. The two investigative organizations found little coordination between Palm Hall correctional staff and the Investigative Services Unit staff responding to the incident. As a result, the crime scene was disturbed to the point where the two organizations personally

contacted the institution and recommended that the institution establish a "squad" of trained correctional staff to respond to crime scenes and either cordon them off or collect evidence as necessary.

RECOMMENDATIONS

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

- **Evaluate the need for a memorandum of understanding or protocols governing when an outside agency should take primary responsibility for the criminal investigation of a crime against a staff member. In doing so, consider the limited resources of institutional investigative units and the emotional impact that a crime against staff may have on the institution's ability to react properly.**

- **Reevaluate and assess the scope and responsibility of institutions' Investigative Services Units as the primary criminal investigative entity given their manpower, training, and resource limitations.**

- **Clearly define the role and expectations of Investigative Services Units in identifying and securing potential crime scenes, identifying and preserving evidence and, if they remain the primary investigative entity, proper collection and processing of the crime scene and evidence.**

- **Evaluate the need for training at the correctional officer, sergeant, and Investigative Services Unit levels regarding the identification and collection of physical evidence with potential forensic examination in mind, including but not limited to the manner of collection, processing and documentation.**

- **Develop a "lessons learned" instructional curriculum by which all institutions can learn what went right and what went wrong in the events leading up to and following the death of Officer Gonzalez.**

In addition, the Office of the Inspector General recommends that the California Institution for Men take the following actions:

- **Evaluate whether the "squad" concept of correctional officers specially trained in crime scene investigation and crime scene and evidence preservation is appropriate for the California Institution for Men under existing conditions.**

- **Using departmental policies and procedures, as well as the best practices of the law enforcement profession, develop better methods for processing, booking, and transferring evidence. These methods should include a**

"chain of custody" that will satisfy legal and operational requirements of both the transferring and receiving entities.

FINDING 9

The Office of the Inspector General made confidential findings related to the adequacy of mental health care for particular inmates at the California Institution for Men.

The investigation of the Office of the Inspector General found that the California Institution for Men failed to adequately assess and address particular inmates mental health needs. However, due to state and federal medical privacy laws, those findings cannot be presented in a public document. Accordingly, pursuant to Penal Code section 6131 (b) the information in this section has been presented only to the Governor and the Youth and Adult Correctional Agency.

FINDING 10

The Office of the Inspector General found that Blaylock was permitted to conduct a telephone conference with an attorney before he was indicted for the murder of Officer Gonzalez even though the attorney's request for the conference was not properly submitted in writing.

The Office of the Inspector General found that Corcoran State Prison, where Blaylock was transferred following the incident, allowed Blaylock to speak to an attorney by telephone before he was indicted for the murder of Officer Gonzalez and therefore before he had a right to counsel in the matter under the Sixth Amendment. The prison's litigation coordinator allowed the telephone conference even though the attorney's request was not properly submitted in writing. The Office of the Inspector General found, however, that the litigation coordinator acted reasonably in granting the request.

The Office of the Inspector General found that after Blaylock was transferred from the California Institution for Men to California State Prison, Corcoran, an attorney called Corcoran State Prison's litigation coordinator and requested to speak with Blaylock. The attorney told the litigation coordinator that she currently represented Blaylock in an appellate case and that she wanted to speak to him to advise him not to speak with police. The litigation coordinator obtained the attorney's name and contact information, terminated the call, and then confirmed the attorney's name and contact information through the California State Bar's web site. The litigation coordinator called the attorney back at the phone number listed on the California State Bar's web site and informed her that a teleconference would be arranged. With the litigation coordinator's approval, the teleconference between Blaylock and the attorney was completed within the next hour. The litigation coordinator said that at the time the attorney contacted her, she was unaware of Blaylock's alleged involvement in the murder of Officer Gonzalez.

Under the Sixth Amendment of the United States Constitution, Blaylock had no right to counsel regarding the murder of Officer Gonzalez because that right attaches only "at the time adversary judicial proceedings are initiated against the accused, such as when the defendant is indicted or arraigned" [*People v. Frye* (1998) 18 Cal. 4th 894, 897]. Thus, Blaylock had no Sixth Amendment right to counsel regarding the murder of Officer Gonzalez because he had not yet been indicted or arraigned on that charge. Accordingly, criminal investigators were free to approach Blaylock, provide his Miranda warnings and attempt to interrogate him regarding that crime, at which time Blaylock could invoke his Fifth Amendment right to remain silent and request the presence of an attorney.

The litigation coordinator informed the Office of the Inspector General that requests from attorneys to conduct confidential telephone calls are a routine part of her duties and that she can authorize such calls once she is satisfied that the caller is a bona fide attorney. The litigation coordinator further stated that approving such calls is within her authority and that she does not need to obtain approval from her superiors or the warden. In this case, she told the Office of the Inspector General that this attorney's request was handled in the same fashion as all other such requests, that granting the request was entirely her

decision, and that she did not request approval from the warden or others before granting the request.

The Office of the Inspector General confirmed through the California Appellate Court web site that the attorney in question is, in fact, the attorney of record in *People v. Blaylock,* California Appellate Court Case No. B176178 (a matter unrelated to the murder of Officer Gonzalez).

Telephone calls between an attorney and an inmate-client are governed by Title 15 of the California Code of Regulations, section 3282(g). Under Title 15, section 3282(a)(2), a telephone call between an inmate and an attorney is considered a "confidential call."

According to Title 15, section 3282 (g)(1):

> *[C]onfidential calls may be approved on a case-by-case basis by the institution head or designee **only** upon written request from an inmate's attorney on the attorney's office letterhead stationery. The date, time duration, and place where the inmate will make or receive the call, and manner of the call are within the discretion of the institution head. A confidential call from an inmate shall be made from a prison telephone or, with appropriate authentication of the call, may be received from the attorney. [Emphasis added.]*

Section 3282(g)(2) of Title 15 states as follows:

> *[I]t is within the discretion of the institution head or designee to approve or deny a confidential call, provided that the attorney/client communication privilege is not violated. Thus, an institution head or designee may deny a confidential call based on a determination that normal legal mail or attorney visits were the appropriate means of communications and were not utilized by the inmate or attorney. If the demand for confidential calls seriously burdens institutional operations, the institution head or designee may prioritize confidential calls.*

The Department of Corrections Correctional Law Unit told the Office of the Inspector General that although these sections may be somewhat confusing, they probably allow individual institutions a degree of flexibility on how to handle requests for "confidential calls" from attorneys. The Correctional Law Unit said that many institutions were never set up for accepting and coordinating confidential calls, noting that where some attorneys may request telephone conferences with inmate-clients weekly, such requests would be burdensome on the institution.

Based on its interview of the litigation coordinator at Corcoran State Prison, the Office of the Inspector General found that the attorney's request for a confidential call with Blaylock was not based on a written request on the attorney's office letterhead stationery as required by Title 15, section 3282(g)(1). Further, the Office of the Inspector General found that the requesting attorney advised the litigation coordinator that she intended to tell Blaylock not to speak with the police. As Blaylock's Sixth Amendment right to counsel attached only as to the offense for which he was being represented (and not to any and all future crimes), there is an argument that the attorney's telephone conference

with Blaylock was granted prematurely. However, the Office of the Inspector General questions whether it is appropriate for the litigation coordinator to inquire about the purpose or substance of any attorney's confidential call to a client.

A representative of the Department of Corrections Correctional Law Unit told the Office of the Inspector General that the Title 15 provisions controlling confidential calls is somewhat confusing and appears to allow individual institutions leeway in its implementation. Although the litigation coordinator did not adhere strictly to the Title 15, section 3282 (g)(1) requirement that attorneys' requests to confer by telephone with clients be written on the attorney's letterhead, she made reasonable efforts to establish that the caller was, in fact, a licensed attorney.

RECOMMENDATIONS

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

- **Evaluate and, if necessary, modify regulations governing "confidential calls" between inmates and their attorneys. Such modifications may address (1) permitting verification through independent sources that the requesting attorney is licensed to practice, (2) verifying that the attorney actually represents the inmate in question and (3) balancing inmates' right to counsel with the institution's need to validate such calls and its resources available to facilitate them.**

- **Develop procedures for wardens and chief deputy wardens to communicate with key institutional staff members (such as the litigation coordinator and the public information officer) when inmates requiring special handling enter their institutions. Such communications should include instructions to staff that all external inquiries concerning these inmates be referred to the attention of the warden or warden's designee.**