



2006 ANNUAL REPORT

OFFICE OF THE INSPECTOR GENERAL

**MATTHEW L. CATE
INSPECTOR GENERAL**

STATE OF CALIFORNIA

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2006 Annual Report

EXCELLENCE IN CORRECTIONS THROUGH MODEL OVERSIGHT

A MESSAGE FROM THE INSPECTOR GENERAL

I am pleased to present the Office of the Inspector General's 2006 Annual Report. This report highlights our efforts last year to identify the main challenges of the California Department of Corrections and Rehabilitation. The annual report also shows how our work can effect positive change in California's correctional system.

The OIG's vision is to fully use our oversight power to help transform the department into a model correctional agency. We are passionate about prison reform, and my office will continue to hold the department accountable to its mission of improving public safety and reducing recidivism.

The Office of the Inspector General's mission is to provide oversight and public accountability of the correctional system through independent monitoring, audits, and investigations.

In 2006, the OIG's Bureau of Audits and Investigations released several reports highlighting issues of concern for the department and the public. The most critical issues included:

- **Officer safety.** Our follow-up review into the death of Officer Manuel A. Gonzalez, Jr., showed that the California Institution for Men made excellent progress fixing the safety concerns we identified in our initial report. However, the department neglected to address some important recommendations. Thus, the department missed an opportunity to improve the safety of correctional officers statewide.
- **Community safety.** Our investigation of paroled high-risk sex offenders placed near schools alerted the public and the department to the full impact of this dangerous violation of the law. Our investigation also resulted in the removal of an administrator.

- **Fiscal integrity.** Our review into the department's substance abuse treatment contractors identified nearly \$5 million in overpayments to the contractors that the state can recover.
- **Accountability.** Our accountability audit of the department's adult operations and adult programs gave legislators and the public a detailed review of the department's progress in addressing previous recommendations.

Another major accomplishment was the implementation of the warden vetting process. The OIG now evaluates the qualifications of each warden candidate the Governor wishes to appoint. The warden vetting process ensures only the most capable candidates take on this life-and-death responsibility.

Also in 2006, the OIG's Bureau of Independent Review began to show real dividends in its oversight of internal affairs investigations. According to the OIG's 2006 accountability audit, the percentage of the department's internal affairs investigations failing to meet the one-year statute of limitations dropped from 43 percent in 2002 to 2 percent in 2006.

As we look to the future, my office will focus on the department's management of an overcrowded system and the related problems—high recidivism and lack of adequate medical care. The OIG will conduct rigorous audits, investigations, and inspections to root out the causes of these ongoing problems and recommend practical solutions. My office will also make recidivism reduction one of *our* strategic objectives, and we will use the newly created California Rehabilitation Oversight Board to hold the department accountable for its rehabilitation efforts.

In addition, we plan to complete the first one-year evaluations of new wardens to ensure the effective management of the state's correctional institutions. And we are determined to help the department fully comply with federal court requirements for the officer discipline process, thus ending the longstanding *Madrid* lawsuit.

The OIG accomplished a great deal in 2006, but much work remains if we are to help the department attain excellence in corrections while serving the broad public interest. As my office strives to meet these objectives, we will never stray from our values—the Office of the Inspector General's FIRST priorities: Fairness, Integrity, Respect, Service, and Transparency.



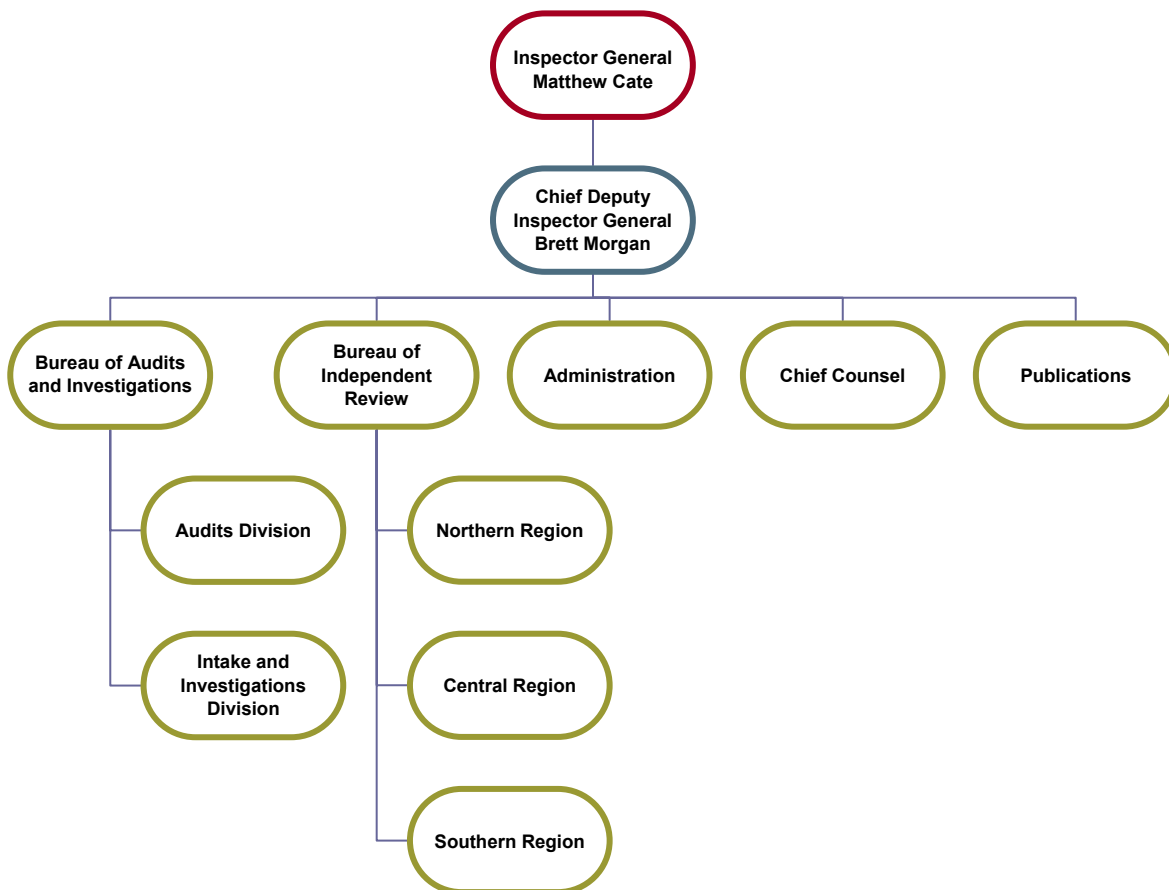
Matthew L. Cate
Inspector General

DUTIES OF THE OFFICE OF THE INSPECTOR GENERAL

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

ORGANIZATIONAL OVERVIEW

- The Office of the Inspector General (OIG) comprises a skilled team of professionals that includes attorneys with expertise in internal affairs investigations and criminal law, auditors experienced in correctional policy and operations, and investigators drawn from correctional and law enforcement agencies.
- At the end of 2006, the OIG maintained 95 employee positions, including a staff of attorneys classified as special assistant inspectors general and a team of deputy inspectors general cross-trained in audits and investigations.
- In addition to legal, administrative, and publications staff members, the OIG is organized into two principal bureaus: the Bureau of Audits and Investigations (BAI) and the Bureau of Independent Review (BIR).
- California Penal Code sections 6125 through 6133 provide the statutory authority for the OIG's establishment and operation.



KEY ISSUES

SAFETY AND SECURITY

Safety and security have always been the top operational priorities for correctional administrators, government policymakers, and the public. Since its inception, the OIG has identified various safety and security deficiencies in California's correctional system. In 2006, we continued to identify opportunities for the CDCR to address weaknesses in safety and security.

Review of Correctional Officer's Death

In the December 2006 report titled *Follow-up Review of the Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men*, the OIG followed up on previous



recommendations on the circumstances surrounding the fatal stabbing of a correctional officer. Our inspectors found that although the institution made significant progress in implementing recommendations, the department's progress in addressing the recommendations for which it was responsible was limited. As a result, the department may be missing an opportunity to address circumstances at other

institutions that are similar to circumstances we observed at the California Institution for Men. The OIG made 11 recommendations to address the ongoing issues.

Paroled Sex Offenders Placed Near Schools

In November 2006, the OIG published a summary report that focused on community safety. The report, titled *Investigation into the Improper Placement of Parolees Designated as High-Risk Sex Offenders Within a Half-Mile of a School*, found that paroled high-risk sex offenders in Los Angeles County had been moved repeatedly. The evidence suggested parole administrators were "either attempting to deliberately conceal the presence of high-risk sex offenders inside the half-mile limit until appropriate housing could be located or they misinterpreted an existing law affecting sex offender registration." No matter what the parole administrators' intent was, our report revealed flawed reasoning and mismanagement on the part of the department.

Improper Inmate Housing

In March 2006, the OIG reported that potentially dangerous maximum custody inmates returning to department custody still slipped through the screening process at reception centers and ended up in the general

population. In the report titled *Special Review: Improper Housing of Maximum Custody Inmates at California State Prison Reception Centers*, our inspectors identified 66 maximum custody inmates at reception centers statewide who should have been assigned to administrative segregation. Instead, the reception centers housed these inmates with general population inmates.

This inmate housing review stemmed from an earlier review of a correctional officer's fatal stabbing at the California Institution for Men reception center in 2005. Officer Manuel A. Gonzalez, Jr., was killed by an inmate who, despite a history of in-prison violence, was placed in a general population cell instead of segregated housing. In the March 2006 special review, we reported that placing violent maximum custody inmates in general population housing endangers institution safety. "Given...the danger posed by even one improperly placed maximum custody inmate," the report stated, "the large number of maximum custody inmates found in general population housing in this snapshot-in-time review suggests a significant problem." As a result of this special review, the OIG issued 13 recommendations to the department.



In addition, following an investigation in June 2006, we issued a management letter to the department describing an untenable temporary housing situation at the California Institution for Men (*Evaluation of the Use of Holding Cells at the California Institution for Men*). We found that the institution assigned reception center inmates for up to 72 hours in holding cells designed for temporary use, such as to confine inmates waiting for transportation to court appearances or other prisons. These holding cells contain neither beds nor toilets, creating potentially inhumane conditions. The institution told us it housed the inmates in the holding cells because it lacked bed space. The institution attributed the lack of bed space to an increase in the number of new inmates the institution receives in its reception center and to temporary reductions in the number of beds due to retrofitting. While we found that the institution adapted well to this situation and the staff performed professionally, we concluded that the institution should avoid this housing situation in the future. We made five recommendations to address the issues in the management letter.

Ward's Suicide Attempt

The OIG reported concerns to the department in July 2006 related to the conditions of a transfer that appeared to precipitate a ward's attempted suicide. In the management letter *Evaluation of Circumstances Surrounding a Ward's Suicide Attempt*, we found that the Division of Juvenile Justice failed

to follow required safety protocols concerning wards who have a significant mental health history, including suicide attempts. The OIG made no recommendations as a result of this evaluation, but we did advise the division to review its transfer policy.

Life-saving Efforts for Inmates

Also in July 2006, the OIG reported to the department eight recommendations the department should consider as it revised its policies related to advance directives and do-not-resuscitate orders for inmate patients. In the management letter *Evaluation of Draft Policies for Advance Directives and Do-Not-Resuscitate Orders*, we identified several improvements the department could make to its proposed policies to maximize the policies' effectiveness.

Critical Incident Roll-outs

The OIG's Bureau of Independent Review monitors the department's handling of critical incidents at adult and juvenile correctional institutions. When a critical incident—usually involving excessive use of force—occurs at an institution, bureau attorneys and investigators roll out to the scene to ensure that the department's investigation is thorough and fair. This real-time oversight frequently identifies systemic issues that affect the safety and security of both staff members and inmates.

In 2006, the Bureau of Independent Review reported on 101 “critical incidents”—incidents at adult and juvenile correctional institutions often involving serious injury or death.

Investigations and Complaints

In 2006, the intake and investigations arm of the OIG's Bureau of Audits and Investigations examined several safety and security concerns. These concerns included allegations of medical negligence, gang threats, criminal conduct, and improper housing conditions.

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

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

KEY ISSUES

WASTE, FRAUD, AND ABUSE

In a time of mounting prison costs and taxpayer scrutiny, promoting economy and efficiency within the state's correctional system is a crucial responsibility. Part of the OIG's mission is to thoroughly investigate allegations of financial waste, fraud, and abuse by CDCR staff members, supervisors, and management. In 2006, the OIG demonstrated its worth in providing independent oversight by holding the department publicly accountable for its financial mismanagement.

Overpaid Substance Abuse Treatment Contractors

In October 2006, the OIG identified nearly \$5 million that the department had overpaid substance abuse treatment contractors over a four-year period. "The department's oversight of the substance abuse treatment contractors is lacking," the report stated. "The review determined that the department



overpaid three drug treatment service coordinators...because it did not require the contractors to reconcile revenues to actual costs as required under the contracts."

The report, *Special Review into Concerns Related to Substance Abuse Treatment Contractors*, also revealed that the department had violated the California Constitution and state policy by allowing contractors to retain ownership of potentially millions of dollars worth of equipment that the contractors purchased with state funds but had a unit cost of less than \$5,000. We made 12 recommendations to address the issues included in this report.

Mismanaged Union Leave Time

The OIG reported in July 2006 that the department failed to adequately manage approximately \$12 million in public resources. The department's mismanagement created an operational burden both on itself and on its institutions because it did not accurately control and account for union leave time.

The report, *Special Review into Management of Union Leave Time by the California Department of Corrections and Rehabilitation*, revealed that the department failed to provide adequate oversight of union leave time in accordance with state law, wasting potentially millions of dollars in public resources. During our review, we estimated the fiscal impact of specific union leave accounting errors. However, the department's failure to maintain accurate records prevented our inspectors from calculating "the total fiscal impact of the department's mismanagement of union leave or identifying monies that may be owed to the state as a result." The OIG included nine recommendations to the department to address these issues.

Inappropriate Use of State Resources

The OIG investigated and monitored several cases that involved inappropriate use of state resources within the department. As part of its work, the Bureau of Audits and Investigations examines alleged misconduct by correctional employees; these allegations usually stem from complaints or are uncovered during audits or other investigations. In 2006, these cases ranged from misuse of state property, such as viewing pornography on a state computer, to time sheet irregularities.

Monitoring of Administrative and Criminal Cases

In 2006, the OIG's Bureau of Independent Review significantly increased its monitoring caseload. With the primary responsibility of ensuring the department's internal affairs investigations are fair and adequate, the bureau reported on 399 cases in 2006. Many of these cases involved dishonesty, sexual misconduct, improper use of force, or failure to report the improper use of force.

Detailed assessments of the Bureau of Independent Review's case monitoring activities are found in the bureau's semi-annual reports posted on the OIG's Web site: www.oig.ca.gov.

KEY ISSUES

ACCOUNTABILITY

Public accountability of the state's correctional system is crucial to enacting reforms and bringing transparency to the CDCR's operations. Therefore, the Legislature has mandated that the OIG publicly release its audit findings. We also investigate retaliation and favoritism complaints, evaluate the Governor's warden candidates, and assess the department's progress in implementing

recommendations. The OIG's efforts ensure that legislators and the public can hold department institutions and employees accountable.

2006 Accountability Audit

In April 2006, the OIG issued an audit of the department's progress in implementing past recommendations we made in 22 separate reports that affect the department's adult operations and programs. This "accountability audit," *Review of Audits of the California Department of Corrections and Rehabilitation Adult Operations and Adult Programs, 2000–2004*, included 91 new recommendations and revealed two broad findings:

- The staff members and management of individual institutions had been highly responsive to recommendations resulting from past audits and had taken numerous steps to improve operations.
- The department itself, however, had been less responsive to past recommendations. In fact, the department had yet to address its three most troubling and long-standing problems—the need to overhaul its antiquated information technology system, the need to provide inmates with adequate medical care in a fiscally sound manner, and the need to fulfill its broader public safety mission by better preparing inmates for release.

Correctional Peace Officer Standards and Training

The OIG reported in October 2006 on the department's efforts to implement recommendations related to the former Commission on Correctional Peace Officer Standards and Training. In the report titled *Follow-up Review of Recommendations Pertaining to the Former Commission on Correctional Peace Officer Standards and Training*, we found that the department failed to implement most of the recommendations from the 2005 special review.

Specifically, progress toward developing correctional peace officers' selection and training standards was limited, and the department had not implemented recommendations pertaining to the correctional peace officer apprenticeship program. We made six additional recommendations to address these concerns raised in the initial report.



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Parole Suitability Hearing Process

In September 2006, the OIG, in response to concerns raised by a state senator, found that the Board of Parole Hearings did not provide mandatory

parole rescission hearings to five prisoners serving life sentences, although the board did perform other inmate hearings appropriately. In the management letter titled *Evaluation of the Parole Suitability Hearing Process for Prisoners Serving Life Sentences*, the OIG found, however, that on August 22, 2006, the board reconsidered each case and affirmed parole for one inmate and scheduled parole rescission hearings for the remaining four inmates. We also determined that parole suitability hearings do incorporate direction to the inmate about requirements for achieving parole suitability. The OIG did not make any recommendations as a result of this evaluation.

Assessment of Madrid Reforms

The OIG's Bureau of Independent Review measures the department's compliance with reforms set forth in the *Madrid* Remedial Plan. The *Madrid* Remedial Plan stemmed from a civil rights lawsuit filed by a group of Pelican Bay State Prison inmates. The federal district court decision held that state



officials had "permitted and condoned" the use of excessive force against inmates in violation of the Eighth Amendment and that internal affairs investigations into alleged misconduct "were pursued to avoid finding officer misconduct as often as possible."

In 2006, the *Madrid* reforms continued to have a positive impact. With the bureau's assistance, the department's internal affairs investigations were more timely and thorough, and disciplinary outcomes showed greater consistency and fairness as more department employees were held accountable.

Warden Evaluations

Consistent with the provisions of Senate Bill 737, during 2006 the OIG evaluated the qualifications of 13 candidates for warden positions and reported the results in confidence to the Governor.

Senate Bill 737 assigns the Inspector General responsibility for evaluating the qualifications of every candidate the Governor nominates for appointment as a state prison warden. The Inspector General advises the Governor within 90 days whether the candidate is "exceptionally well-qualified," "well-qualified," "qualified," or "not qualified" for the position. To make the evaluation, California Penal Code section 6126.6 requires the Inspector General to consider the candidate's experience in effectively managing correctional facilities and inmate or ward populations; knowledge of correctional best practices; and ability to deal with employees, the public, inmates, and other interested parties in a fair, effective, and professional manner.

CONCLUSION

CDCR PROGRESS IN 2006

In the face of increased oversight and sweeping reform legislation, the OIG noted that the CDCR made progress in some areas in 2006:

- In the 2006 accountability audit, we reported that, in response to prior recommendations, the department's adult institutions improved in a wide range of operations, including security requirements, employee disciplinary actions, staff training, and the inmate appeals process.
- In the follow-up of the March 2005 special review into a correctional officer's stabbing death, we reported that the California Institution for Men implemented a department directive requiring the institution to place any newly received inmate in administrative segregation if that inmate's previous housing assignment or violent history warrants such placement.
- The Bureau of Independent Review reported that the department reached a reasonable outcome in an overwhelming number of internal affairs cases—96 percent during the July to December 2006 reporting period. In light of the department's numerous reforms, it is commendable that the department arrived at a fair disposition in the vast majority of monitored cases.

We appreciate the department's efforts to advance California's correctional system. However, this annual report clearly shows that some issues stay unresolved, and many recommendations still slipped through the cracks. Addressing the OIG's outstanding recommendations—while complying with new reform legislation—remains a key challenge in the coming year.

A LOOK AHEAD

PLANS FOR THE FUTURE

In 2007, the OIG will continue to transform as an organization to better provide model oversight of California's evolving correctional system. Federal judicial and state legislative actions have changed the landscape of California's prisons, and we are poised to provide independent oversight of the CDCR—during this period of change and beyond.

Fraud Investigations

To uncover fraud in the correctional system, save taxpayer dollars, and hold wrongdoers accountable, the OIG will conduct complex, large-scale investigations of contracts and procurements, kickbacks, bribes, unjustified sole-source awards, and product diversion and substitutions. We will target investigations to areas with potentially significant systemic problems.

Vetting of Superintendent Candidates

In addition to evaluating every prison warden candidate, the OIG will evaluate every candidate for a superintendent position at the state's juvenile correctional facilities. We will report the evaluation results in confidence to the Governor.



Audits of Adult and Juvenile Institutions

The OIG will audit every warden or superintendent one year after his or her appointment, and we will begin to perform a comprehensive audit at each correctional institution at least once every four years. To shine a light on areas where the department has not implemented the OIG's recommendations, we will publish a report to identify these issues and to describe the potential impact of the department's unresponsiveness.

Unannounced Inspections

Besides visits to correctional institutions during audits, investigations, and warden and superintendent evaluations, the OIG's deputy inspectors general will conduct unannounced inspections at every state correctional institution—including privately operated facilities—at least twice a year. The purpose of the inspections will be to assess the institutions' operations and to increase the OIG's presence.

Critical Incident Roll-outs

When critical incidents occur at a correctional institution, sworn staff from the Bureau of Independent Review (BIR) or both the BIR and the Bureau of Audits and Investigations (BAI) will respond immediately to the institution on a call-out basis. Under protocols approved by the federal court, since January 2005 the BIR's special assistant inspectors general have responded to critical incidents to assess the scene and monitor internal affairs investigations. These critical incidents include officer-involved shootings, suspicious inmate deaths, or a correctional staff member's death. Now the BAI will also roll out to incidents, such as escapes and large-scale riots, to assess whether systemic issues led to the incident and to determine whether the incident warrants an audit and whether the incident calls for an investigation.



Federal Court Mandated Responsibilities

In two separate class action lawsuits, the federal court assigned the OIG ongoing responsibilities as part of a state settlement agreement. In *Plata v. Schwarzenegger*, the federal court assigned a receiver to oversee the development of a sustainable system that provides the minimum level of medical care to fulfill the department's obligation to inmates under the U.S. Constitution. The court required the OIG to review the receiver's operations to ensure transparency and accountability. In *Armstrong v. Schwarzenegger*, the court required the OIG to help the department develop an accountability system. This system will ensure wardens and prison medical administrators comply with the remedial plan that resulted from the court's findings.

AB 900 Responsibilities

In May 2007, the Governor signed Assembly Bill 900, the Public Safety and Offender Rehabilitation Services Act of 2007, which assigned the OIG two important additional responsibilities. The legislation creates the California Rehabilitation Oversight Board (C-ROB) within the OIG to examine the department's mental health, substance abuse, educational, and employment programs for inmates and parolees. The legislation also requires the Inspector General to serve on a three-member panel with the State Auditor and a Judicial Council appointee. The panel will verify that the department met certain conditions before the State Public Works Board releases new construction funds.

APPENDIX

2006 REPORTS

Bureau of Audits and Investigations

- Special Review: Improper Housing of Maximum Custody Inmates at California State Prison Reception Centers (March 2006)
http://www.oig.ca.gov/reports/pdf/Improper_Housing.pdf
- Quarterly Report, January–March 2006
<http://www.oig.ca.gov/reports/pdf/Q1rept2006.pdf>
- Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation Adult Operations and Adult Programs, 2000–2004, Volumes I and II (April 2006)
<http://www.oig.ca.gov/reports/pdf/Accountability-Audit-CORR-Volume%20I.pdf>
<http://www.oig.ca.gov/reports/pdf/Accountability-Audit-CORR-Volume%20II.pdf>
- Evaluation of the Use of Holding Cells at the California Institution for Men (management letter, June 2006)
- Quarterly Report, April–June 2006
<http://www.oig.ca.gov/reports/pdf/BAI%20Quarterly%20April-June%202006.pdf>
- Special Review into Management of Union Leave Time by the California Department of Corrections and Rehabilitation (July 2006)
http://www.oig.ca.gov/pdf/071406_UnionLeave.pdf
- Evaluation of Circumstances Surrounding a Ward's Suicide Attempt (management letter, July 2006)
- Evaluation of Draft Policies for Advance Directives and Do-Not-Resuscitate Orders (management letter, July 2006)
- Evaluation of the Parole Suitability Hearing Process for Prisoners Serving Life Sentences (management letter, September 2006)
- Quarterly Report, July–September 2006
<http://www.oig.ca.gov/reports/pdf/BAI%20Quarterly%20July-Sept%202006.pdf>

- Follow-up Review of Recommendations Pertaining to the Former Commission on Correctional Peace Officer Standards and Training (October 2006)
http://www.oig.ca.gov/reports/pdf/follow-up_final_092706.pdf
- Special Review into Concerns Related to Substance Abuse Treatment Contractors (October 2006)
<http://www.oig.ca.gov/reports/pdf/FinalRptMasterDoc103106.pdf>
- Summary Report: Investigation into the Improper Placement of Parolees Designated as High-Risk Sex Offenders Within a Half-Mile of a School (November 2006)
<http://www.oig.ca.gov/reports/pdf/Summary%20Report%20nov%2028,%202006.pdf>
- Follow-up Review of the Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men (December 2006)
http://www.oig.ca.gov/reports/pdf/CIM_Public_%20REPORT_121206.pdf
- Quarterly Report, October–December 2006
http://www.oig.ca.gov/reports/pdf/2006_4thQrter.pdf

Bureau of Independent Review

- Semi-annual Report, January–June 2006
http://www.oig.ca.gov/reports/pdf/Semi-Annual_0606.pdf
- Semi-annual Report, July–December 2006
http://www.oig.ca.gov/reports/pdf/BIR_SAR_07-12_2006.pdf



OFFICE OF THE INSPECTOR GENERAL

**P.O. BOX 348780
SACRAMENTO, CA 95834-8780**

(916) 830-3600

WWW.OIG.CA.GOV