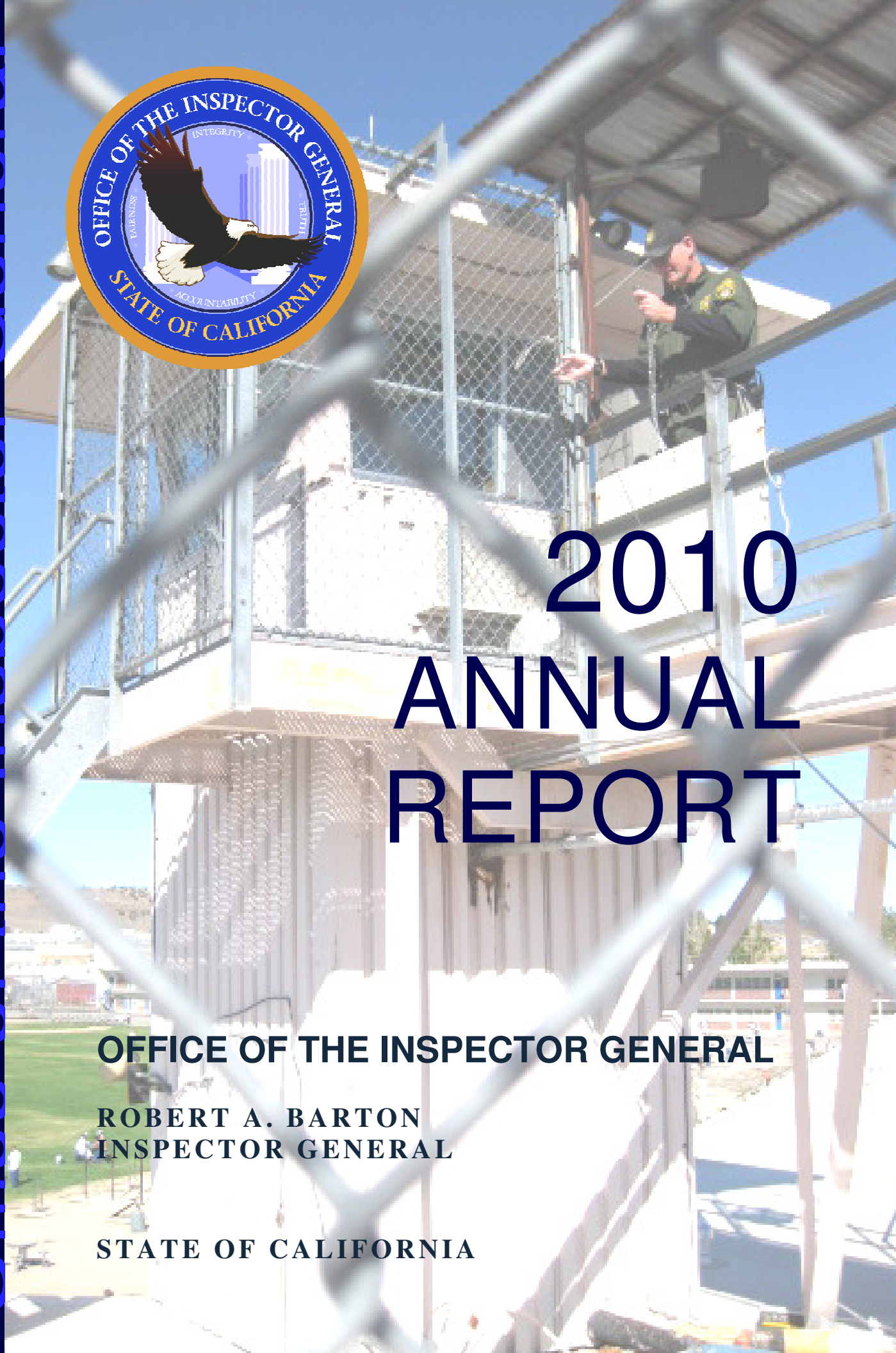
Office of the Inspector General



2010 ANNUAL REPORT

OFFICE OF THE INSPECTOR GENERAL

ROBERT A. BARTON
INSPECTOR GENERAL

STATE OF CALIFORNIA

Contents

2010 Annual Report

A MESSAGE FROM THE INSPECTOR GENERAL

I am honored to have been sworn in as the new Inspector General on August 29, 2011. While I must apologize for delay, I am proud to report on the hard work and dedication of the Office of the Inspector General (OIG) staff in 2010. The OIG shared the same challenges faced by all other state agencies, including: budget cuts from the continuing fiscal crisis, employee furloughs, and staff reductions. Nevertheless, the OIG remained dedicated to the mission of bringing transparency and improvement to the California Department of Corrections and Rehabilitation (CDCR), and saving taxpayer dollars.

The Office released 42 public reports in 2010 – six more than were released in 2009; more than double the number published in 2008. As a result, recommendations were made to improve CDCR practices and policies, improve public safety, and save taxpayer dollars.

For example, in 2010, the OIG made recommendations in parolee supervision, helping CDCR focus attention on areas that could be improved to make California safer. In addition, we identified at least $13.2 million that could be saved related to prescription medication practices.

The OIG played a pivotal role in ending court involvement in the federal class action lawsuit, *Madrid v. Schwarzenegger*, dealing with the internal affairs and employee discipline process of CDCR. In 2010, we monitored 534 internal affairs investigations and the resulting employee discipline process. We also monitored 229 critical incidents such as riots or homicides, and published our semi-annual reports with our assessments of these incidents. Our independent oversight and contemporaneous monitoring of the CDCR, along with their willingness to work collaboratively, resulted in the federal court finding no further need for court involvement in the CDCR discipline process. We continue to provide oversight in this area to ensure fairness, consistency, and transparency of internal affairs and the employee discipline system.

The OIG also reviewed over 350 use-of-force incidents in 2010. In August 2010, the CDCR implemented a new use-of-force policy, with input from the OIG. We will soon publish our periodic report assessing the use-of-force incidents that have occurred following implementation of the new policy.

In 2010, the OIG completed the first round of medical inspections of all 33 adult institutions. The first cycle of our inspections established a baseline to evaluate improvement in medical care as required by the federal court in *Plata v. Brown*. The federal court and federal receiver rely in large part on our reports to evaluate CDCR's progress in providing a constitutional level of medical care in the prison system. The OIG will continue to work with CDCR and the federal receiver to achieve CDCR compliance and eliminate the need for federal intervention.

Although there has been great progress in the past year, there is much more to be accomplished. Like everyone, we will do more with fewer resources. Despite a 45 percent budget reduction and significant layoffs, we are taking steps to maintain our

responsiveness to issues within the CDCR. We are making more efficient use of our personnel in regional teams, cross training our employees in many facets of our monitoring responsibilities, and consolidating resources wherever possible. I look forward to the challenge of serving our great state in this capacity.

Robert A. Barton
Inspector General

DUTIES OF THE OFFICE OF THE INSPECTOR GENERAL

Below were the duties of the OIG in 2010.[1]

- Conduct investigations, audits, and special reviews of the state correctional system at the request of the governor, members of the Legislature, the secretary of the CDCR and upon the initiative of the Inspector General.
- Perform real-time oversight of internal affairs investigations into alleged misconduct by CDCR employees.
- Assess the quality of representation provided by CDCR legal staff in disciplinary matters.
- Conduct audits of correctional institutions and baseline audits of each warden or superintendent one year after appointment.
- Provide recommendations to CDCR regarding its policies and procedures to ensure they meet or exceed industry standards.
- Maintain a toll-free public telephone number and intake unit to allow reporting of administrative wrongdoing, poor management practices, criminal conduct, fraud, or other abuses in CDCR.
- Investigate complaints of retaliation against those who report misconduct by CDCR and its employees.
- Evaluate and report to the governor the qualifications of the governor's candidates for warden and superintendent positions for the state's adult and juvenile correctional institutions.
- Refer matters involving criminal conduct to law enforcement authorities in the appropriate jurisdiction or to the California attorney general.
- Investigate the mishandling of sexual abuse incidents within correctional institutions, maintain the confidentiality of sexual abuse victims, and ensure impartial resolution of inmate and ward sexual abuse complaints through the Sexual Abuse in Detention Elimination Ombudsperson.
- Examine CDCR's various mental health, substance abuse, educational, and employment programs for inmates and parolees through the California Rehabilitation Oversight Board (C-ROB).

[1] As a result of legislation enacted in 2011, the duties of the OIG were modified. Senate Bill (SB) 78, SB 87, and SB 92 significantly reduced the OIG's budget; removed the peace officer status of OIG employees; removed the mandate that the OIG conduct audits and investigations of the CDCR and replaced it with the requirement that the OIG instead conduct policy and performance reviews of the CDCR (at the request of the Governor, the Senate Rules Committee, or the Speaker of the Assembly); removed the requirement that the OIG conduct quadrennial facility operation reviews and one-year warden follow-up audits; and codified the OIG's medical inspection program.

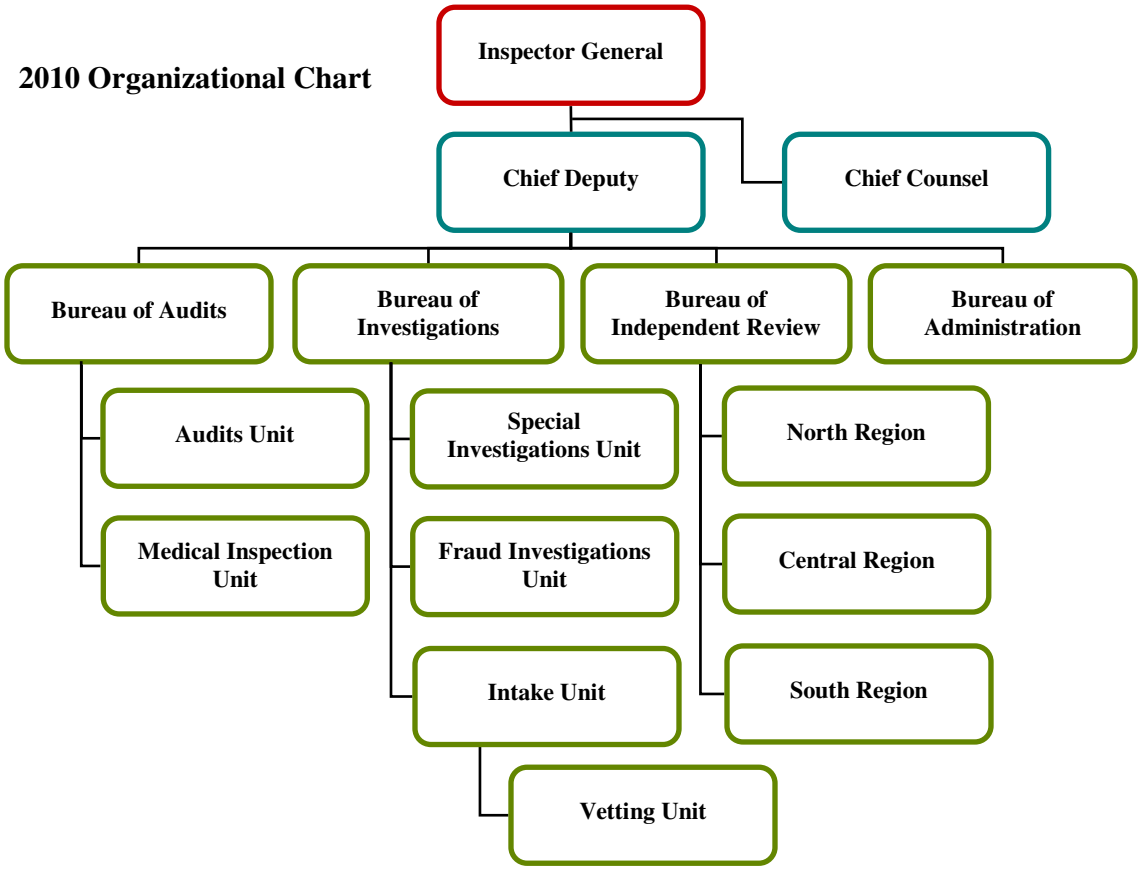
- Conduct semiannual inspections of adult and juvenile correctional institutions to examine systemic issues, identify problem areas that may lead to investigations or audits, and follow up on prior complaints.
- Report on the California Prison Health Care Receivership Corporation's expenditures to ensure transparency and accountability.
- Respond 24/7 to critical incidents, including officer-involved shootings, large-scale riots, suicides, and staff member deaths caused by inmates.
- Perform medical inspections to provide independent and objective information regarding the delivery of medical care to inmates at adult correctional institutions.
- Monitor CDCR's use-of-force committee meetings conducted by wardens, superintendents, and parole administrators across the state.

ORGANIZATIONAL OVERVIEW

In 2011 the OIG instituted a significant re-organization.[2] The following represents the organization of the OIG in 2010.

- The OIG is comprised of a skilled team of professionals that includes attorneys with expertise in internal affairs investigations and criminal and employment law, auditors experienced in correctional policy and operations, and investigators drawn from correctional and law enforcement agencies.
- At the end of 2010, the OIG had 151 employee positions, including a staff of attorneys classified as special assistant inspectors general and a team of deputy inspectors general trained in audits and investigations.
- In addition to legal, administrative, and publications staff members, the OIG was organized into three operational bureaus: the Bureau of Independent Review (BIR), the Bureau of Audits (BOA), and the Bureau of Investigations (BOI).
- California Penal Code sections 6125 et seq. provide the statutory authority for the OIG's establishment and operation.

2010 Organizational Chart



[2] In 2011, the OIG will reduce its workforce from 151 positions to 87 positions, and eliminate the separate bureau designations.

SAFETY AND SECURITY

Safety and security have always been the top operational priorities for correctional administrators, government policy makers, and the public. Since its inception, the OIG has identified safety and security deficiencies in California's correctional system. In 2010, OIG inspectors continued to identify opportunities for CDCR to address weaknesses in safety and security.

The California Department of Corrections and Rehabilitation's Supervision of John Gardner

In June of 2010, the BOI released a special report on parolee supervision. This special report identified systemic problems that transcended the John Gardner case and jeopardized public safety. The investigation resulted in seven recommendations pertaining to parolee supervision.

Special Report: August 2009 Riot at the California Institution for Men

On April 22, 2010, the BOA released a special report concerning the August 2009 riot at the California Institution for Men (CIM) in Chino, California. The purpose of the special report was to identify the conditions and circumstances leading up to the riot and to evaluate the institution and CDCR's actions in addressing the riot and re-establishing normal operations in the riot's aftermath.

The report identified security risks at CIM Reception Center West. We made nine recommendations to correct the problems and deficiencies found during the review.

One-Year Warden Audits

In 2010, the BOA issued one-year reviews on the performance of the wardens at six California prisons: California State Prison, Los Angeles County; California State Prison, Sacramento; Avenal State Prison; Central California Women's Facility; California Correctional Center; and Valley State Prison for Women. These reviews assessed the wardens' performance one year after his or her appointment to the

position. During these reviews, the OIG performed the following tasks: surveyed employees, key stakeholders, and CDCR executives; analyzed operational data compiled and maintained by CDCR; interviewed employees, including the wardens; and completed onsite inspections of the prisons. The performance reviews gathered information and focused on four key areas, one of which was safety and security.

During these six audits, we found that the new wardens were all seen by their staff as strong leaders in the area of safety and security. When surveyed, the majority of staff members of all six prisons indicated positive opinions about their prisons' safety and security. On average, 80 percent of employees across the six prisons shared this sentiment. When employees made negative comments about safety and security, they often balanced their criticism with praise for their wardens' efforts to remedy existing problems.

Investigations and Complaints

In 2010, the OIG's Bureau of Investigations completed nine criminal, ten administrative, one retaliatory, and seventy-four preliminary investigations. Many of these investigations had direct impact on safety and security within the CDCR.

The OIG received an average of 243 complaints each month by mail and through a toll-free telephone line. Most complaints concerned allegations of staff misconduct, the appeals and grievance process, and the quality or lack of access to medical care. We gave priority attention to complaints that involved urgent safety and security issues.

As mandated by California Penal Code sections 6129(c)(2) and 6131(c), the OIG published quarterly reports that summarized investigations completed in the previous quarter. These reports are available on the OIG's website at: http://www.oig.ca.gov/pages/reports/quarterly.php

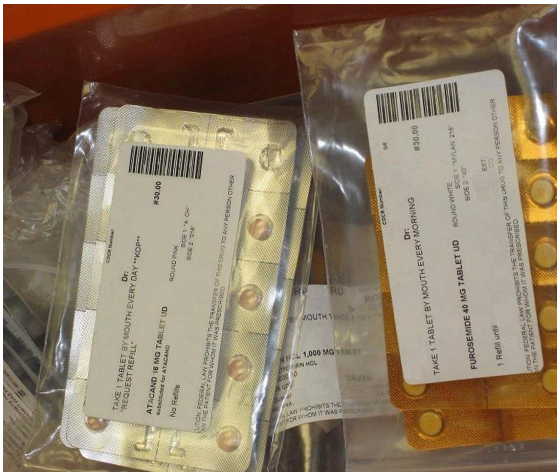
Community Involvement

In 2010, the OIG's Bureau of Independent Review twice hosted the Prison Crimes Council, which is a voluntary organization comprised of state and local corrections officials, prosecutors, and law enforcement officials working as equal partners to promote public safety throughout the state correctional system.

The council tackled multiple issues impacting the correctional community. The council not only diligently managed District Attorney agreements with CDCR,

but also embarked upon many challenging discussions such as officer involved shootings, the impact of contraband cell phone legislation, and the prosecution of marijuana use in a correctional setting.

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 was to thoroughly investigate allegations of financial waste, fraud, and abuse made against CDCR staff members, supervisors, and management.

Special Report: Lost Opportunities for Savings Within California Prison Pharmacies

In April 2010, the OIG released a special report identifying that CDCR's pharmacy operations lacked oversight and accountability, which cost the state at least $13.2 million. We determined one cause of the operational failure was that pharmacy managers reported to an outside consultant rather than the court-appointed medical receiver[3], who was more familiar with the challenges and complexities of state government. Our in-depth review revealed waste in four operational areas.

We first reported that prison pharmacies failed to restock unused medications. There were almost no procedures for identifying and restocking medications, which costs taxpayers at least $7.7 million every year. We also identified that due to a lack of oversight, clinicians routinely prescribed non-formulary[4], or unauthorized, medications. This practice alone cost taxpayers at least $5.5 million in 2009. To address the deficiencies identified in this report, we provided 12 recommendations to the California Prison Health Care Receivership Corporation.

California Prison Health Care Receivership Corporation's Use of State Funds for Fiscal Year 2008-09

In June 2010, we issued our third annual report concerning how the California Prison Health Care Receivership Corporation spent state funds to carry out its federal court mandate to oversee California's prison medical system during fiscal 2008-09. The review highlighted how the receivership spent $91.2 million in state funds for its operating costs and long-term capital assets. As a result of our recommendations, the

[3] In October 2005, the U.S. Northern District Court of California imposed a receivership on CDCR to raise the delivery of medical care to constitutional standards.

[4] Formulary is a term used to describe a list of approved medications.

receivership initiated the transfer of some capital assets to CDCR. It is important to note that the OIG reviews did not, and were not intended to, include a review of expenditures for direct inmate medical care delivery.

Letter: CDCR Statewide Electronic Law Library

As requested by the Governor's Office, we performed a review as to whether potential savings could be realized if CDCR implemented a statewide electronic law library system. Our research indicated potential savings by replacing the paper based law libraries with an electronic format. In a letter to CDCR Secretary Matthew L. Cate, we recommended that CDCR conduct further research on the cost effectiveness of switching to an electronic law library system and develop solutions that will reduce its costs in this area.

Letter: Monitoring of Redirected Health Care Employees who are Subjects of Administrative or Criminal Investigations

In November 2010, the OIG sent a letter to Federal Receiver J. Clark Kelso and CDCR Secretary Matthew L. Cate that reported the results of an OIG review to determine the salary costs associated with health care staff redirected from their clinical duties while earning professional salaries. The estimated cost to backfill redirected health care employees was over $8.6 million as of July 31, 2009. Another survey as of March 31, 2010, showed the cost had decreased to $3.3 million.

We included a list of recommendations to help establish a more standardized procedure for identifying an accurate account of redirected health care employees.

Use-of-Force Monitoring and Review

The OIG monitored the use-of-force review process. In 2010, CDCR reported 7,458 use-of-force incidents in the adult program and 1,605 in the juvenile program. The OIG attended 244 use-of-force review meetings at the department, and performed an additional 350 use-of-force reviews. In addition, the OIG sat as a non-voting member of CDCR's Deadly Force Review Board.

In August 2010, the CDCR implemented a new use-of-force policy, with input from the OIG. We will soon publish our periodic report assessing the use-of-force incidents that have occurred following implementation of the new policy.

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

ACCOUNTABILITY

Public accountability of the state's correctional system is crucial to enacting reforms and bringing transparency to CDCR's operations. Therefore, the Legislature mandated that the OIG publicly release its audit findings. We also investigated retaliation and favoritism complaints, evaluated the governor's warden and superintendent candidates both before and after appointment, and assessed CDCR's progress in implementing our recommendations.

Special Report: The Board of Parole Hearings Psychological Evaluations and Mandatory Training Requirements

In July 2010, the OIG released a special report concerning the Board of Parole Hearings' (parole board) process for preparing psychological evaluations used for parole suitability hearings and the parole board's commissioner training program. The purpose of the special report was to review concerns expressed by the Senate Rules Committee for two particular issues: (1) that factual errors may exist in psychological evaluations, and (2) that certain psychologists may give elevated risk assessment conclusions when compared to conclusions made in prior psychological evaluations. In addition, the report addressed the parole board's executive officer's request to examine its new commissioner training program. The OIG issued eight recommendations to the parole board to address these issues.

2010 Accountability Audit

In July 2010, the OIG issued the 2010 Accountability Audit of CDCR. This two-chapter audit analyzed 87 open recommendations from nine prior reports and special reviews. The accountability audit provided follow-up results on previous audits and special reviews, and it noted whether CDCR and the California Prison Health Care Services had implemented prior recommendations. CDCR fully or substantially implemented 62 percent of the recommendations we made.

The Bureau of Independent Review's Monitoring Activities

Since its inception in 2004, the OIG's Bureau of Independent Review has responded onsite to critical incidents at the state's correctional institutions and monitored selected CDCR internal affairs investigations. Critical incidents included those serious events such as riots or homicides, which required CDCR's immediate response.

In 2010, the Bureau of Independent Review responded to 229 critical incidents and monitored 534 disciplinary cases. The Bureau of Independent Review continued to document a positive trend in which CDCR demonstrated improvement in overall handling of internal affairs investigations and employee disciplinary matters. Detailed assessments can be found in the semi-annual reports posted on the OIG's website.

One-Year Warden Audits

As mentioned in our Safety and Security section, the BOA issued one-year reviews on the performance of the wardens at six California prisons in 2010. These reviews assessed the warden's performance one year after his or her appointment to the position. In addition to evaluating safety and security issues, these audits also examined inmate programming, business operations, and employee-management relations.

Letter: Inspection of Out-of-State Facilities

In December 2010, the OIG issued a letter to the Secretary of CDCR informing him of concerns noted during our inspections of five privately run out-of-state facilities that house California inmates.

The OIG's inspection revealed concerns about denial of inmate rights or privileges; safety and security weaknesses; and unenforced rules, policies, practices or contract provisions. We urged the CDCR Secretary to immediately address the issues regarding the denial of inmate rights and safety and security weaknesses. CDCR fully or substantially implemented corrective action for 18 of our concerns, took partial corrective action for 13 concerns, and did not address 2 concerns.

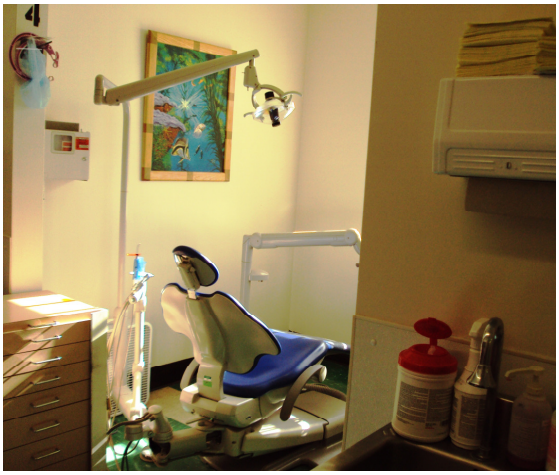
Inspections

The OIG conducted inspections of all adult correctional institutions, youth correctional facilities, and community correctional facilities to identify unsafe conditions and assess facility maintenance. These inspections resulted in informal recommendations for improvement.

Warden and Superintendent Evaluations

Penal Code section 6126.6 requires the OIG evaluate the qualifications of every candidate whom the governor nominates for appointment as a state prison warden or a youth correctional facility superintendent and report in confidence to the governor. Eleven warden and superintendent evaluations were opened in 2010. Including those opened in 2009, nine warden candidates had evaluations completed in 2010.

CIVIL RIGHTS



It is incumbent upon CDCR to ensure that inmate civil rights, such as adequate medical care, are protected. In 2008, under the authority of the California Penal Code and at the request of the federal receiver, the OIG developed a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 33 adult prisons. In 2010, we continued our evaluation of inmate medical care.

Medical Inspection Unit

The remedial efforts that began as the result of the class action lawsuit *Plata v. Brown* continued in 2010. The OIG's Medical Inspection Unit (MIU) issued reports for medical inspections at 17 prisons during 2010. The MIU also performed medical inspections at seven additional prisons, but the results from those inspections were not published in the 2010 calendar year.

In June 2010, the MIU completed the first full cycle of 33 inspections at all prisons, which provided a baseline measurement for the stakeholders in the *Plata* litigation. The reports analyzed and summarized the prisons' overall scores and their scores in up to 20 components of prison medical care. The reports also included analysis of the scores in five general medical categories: medication management, access to medical providers and services, continuity of care, primary care provider responsibilities, and nurse responsibilities.

REHABILITATION

National research has revealed that for every $1.00 invested in rehabilitation programs for offenders, at least $2.50 is saved in correctional costs.[5] *In 2010, the California Rehabilitation Oversight Board within the OIG continued to examine CDCR's progress in implementing and providing rehabilitation programs.*

The California Rehabilitation Oversight Board

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

The legislation established the California Rehabilitation Oversight Board (C-ROB) within the OIG. Chaired by the Inspector General, C-ROB is a statewide board of 11 members who have expertise in state and local law enforcement, and in the education, treatment, and rehabilitation of criminal offenders.

C-ROB regularly examined and reported to the governor and the Legislature on the rehabilitative programming that CDCR provided to the adult inmates and parolees under its supervision. By statute, these reports included findings in the following areas:

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

In 2010, C-ROB published two reports, one in March and the other in September 2010. CDCR has frequently changed its programs over the last few years to comply with drastic budget cuts, making comparable rehabilitation program data unavailable

[5] "California Rehabilitation Oversight Board Amended Biannual Report, March 15, 2011," Office of the Inspector General, Sacramento, Ca., March 15, 2011, p. 1.

for analysis. In the two 2010 reports, C-ROB described the new rehabilitation program models and discussed its concerns with the models. The board expressed an overall concern that the drastic reductions in programming funds may impair California's ability to improve offender rehabilitation and reduce recidivism.

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

REPORTS RELEASED IN 2010

Bureau of Audits

- Warden James Walker One-Year Audit California State Prison Sacramento (January 2010)
- California Correctional Center Medical Inspection Results (January 2010)
- Folsom State Prison Medical Inspection Results (March 2010)
- Kern Valley State Prison Medical Inspection Results (March 2010)
- North Kern State Prison Medical Inspection Results (March 2010)
- Special Report: August 2009 Riot at the California Institution for Men (April 2010)
- Warden Brian Haws One-Year Audit California State Prison Los Angeles County (April 2010)
- California State Prison, Solano, Medical Inspection Results (April 2010)
- California Substance Abuse Treatment Facility and State Prison, Corcoran, Medical Inspection Results (May 2010)
- Valley State Prison for Women Medical Inspection Results (May 2010)
- California Prison Health Care Receivership Corporation Use of State Funds (June 2010)
- Ironwood State Prison Medical Inspection Results (June 2010)
- Special Report on the Board of Parole Hearings: Psychological Evaluations and Mandatory Training Requirements (July 2010)
- Warden Mary Lattimore One-Year Audit Central California Women's Facility (July 2010)
- Accountability Audit 2000-2008 Review of Audits of the CDCR (July 2010)
- California State Prison, Corcoran, Medical Inspection Results (July 2010)
- Calipatria State Prison Medical Inspection Results (July 2010)
- Chuckawalla Valley State Prison Medical Inspection Results (July 2010)
- Letter: CDCR Statewide Electronic Law Library (August 2010)

- Summary and Analysis of the First 17 Medical Inspections of California Prisons (August 2010)
- Correctional Training Facility Medical Inspection Results (August 2010)
- Warden Tina Hornbeak One-Year Audit Valley State Prison for Women (September 2010)
- Warden Ron Barnes One-Year Audit California Correctional Center (September 2010)
- Mule Creek State Prison Medical Inspection Results (September 2010)
- Warden James Hartley One-Year Audit Avenal State Prison (October 2010)
- California Institution for Men Medical Inspection Results (October 2010)
- Salinas Valley State Prison Medical Inspection Results (October 2010)
- CDCR's Legal Costs Associated With 12 Significant Class Action Lawsuits (November 2010)
- Pelican Bay State Prison Medical Inspection Results (November 2010)
- Wasco State Prison Medical Inspection Results (November 2010)
- Letter: Inspection of Out-of-State Facilities (December 2010)

Bureau of Investigations

- Quarterly Report, July - September 2009 (March 2010)
- Special Report on Lost Opportunities for Savings Within California Prison Pharmacies (April 2010)
- Special Report on CDCR's Supervision of John Gardner (June 2010)
- Quarterly Report, October - December 2009 (June 2010)
- Letter to Federal Receiver J. Clark Kelso and CDCR Secretary Matthew L. Cate regarding the Monitoring of Redirected Health Care Employees who are Subjects of Administrative or Criminal Investigations (November 2010)
- Quarterly Report January - March 2010 (November 2010)
- Quarterly Report April - June 2010 (November 2010)

Bureau of Independent Review

- Semi-Annual Report July - December 2009 (April 2010)
- Semi-Annual Report January - June 2010 (September 2010)

California Rehabilitation Oversight Board

- C-ROB Biannual Report (March 2010)
- C-ROB Biannual Report (September 2010)

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

ANNUAL REPORT

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STATE OF CALIFORNIA
OCTOBER 2011