

**Robert A. Barton**  
Inspector General

# Office of the Inspector General

## 2012 ANNUAL REPORT



**January 2013**

**Fairness ♦ Integrity ♦ Respect ♦  
Service ♦ Transparency**

# Office of the Inspector General 2012 ANNUAL REPORT



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# Table of Contents

<b>FOREWORD</b>	<b>1</b>
<b>OIG OUTREACH</b>	<b>3</b>
<b>ORGANIZATIONAL OVERVIEW</b>	<b>5</b>
<b>FUNCTIONS OF THE OFFICE OF THE INSPECTOR GENERAL</b>	<b>6</b>
<b>Statewide General Intake</b>	<b>6</b>
<b>Discipline Monitoring</b>	<b>7</b>
<b>Medical Inspections</b>	<b>9</b>
<b>Warden/Superintendent Vetting</b>	<b>9</b>
<b>Blueprint Monitoring</b>	<b>10</b>
<b>The California Rehabilitation Oversight Board (C-ROB)</b>	<b>11</b>
<b>Authorized Reviews</b>	<b>11</b>
<b>CDCR CORRECTIVE ACTION PLAN UPDATE</b>	<b>12</b>
<b>Status of Recommendations Made to CDCR During 2012</b>	<b>12</b>
<b>Status of Recommendations Made to CDCR During 2011</b>	<b>12</b>
<b>APPENDIX: REPORTS RELEASED IN 2012</b>	<b>13</b>

# FOREWORD

The Office of the Inspector General (OIG) has moved steadily forward over the last year. This progress was recognized when the agency was presented with the *Excellence in Innovative Leadership in State Government* award from the Asian Pacific State Employees Association



(APSEA) in November 2012. After being appointed Inspector General (IG) by Governor Brown on August 29, 2011, I was recommended for confirmation by the Senate Committee on Rules on February 22, 2012, and was unanimously confirmed by the full Senate on March 5, 2012.

The staff and operational reorganization of the OIG was completed in February 2012, wherein our office did away with bureau designations and began operating on a regional basis, achieving our statutory mandates more efficiently.

*APSEA Presentation: Excellence in Innovative Leadership*

In July 2012, our California Department of Corrections and Rehabilitation (CDCR or department) oversight role was expanded by the Legislature when they tasked the OIG with monitoring CDCR's adherence to its *Future of California Corrections Blueprint*. This mandate was added to our existing statutory duties. Our statewide intake function continues to respond to the concerns of persons both inside and outside the department. Our Discipline Monitoring Unit (DMU) continues to build on the improvements gained from the now-terminated *Madrid* injunction and provide transparency to critical areas within the department such as use of force (UOF), contraband surveillance watch (CSW), internal affairs investigations, and the employee discipline process. Our staff maintain a daily presence within the State's prisons and juvenile facilities, providing real-time monitoring and recommendations to improve correctional operations, while protecting the interests of the taxpayers.

The OIG completed 20 warden/superintendent evaluations and made recommendations to the Governor on their qualifications, to assist in providing stability and quality leadership to the department. The OIG's role in the California Rehabilitation Oversight Board (C-ROB) continues to be an invaluable avenue of transparency for the rehabilitative efforts of CDCR and a conduit for the public's interest in that arena. The OIG's Medical Inspection Unit (MIU) completed 27 medical inspections and published 30 medical inspection reports, and it is hoped the progress demonstrated by the department in improving the delivery of medical care to inmates will soon accomplish the goals of the Federal Court in the *Plata* lawsuit. If the Court's receivership ends, the OIG will continue with ongoing inspection and oversight in accordance with statutory mandates.

2011 was a major transitional year for the OIG, and our staff admirably responded and made 2012 a year of progress. We continue to use the real-time monitoring model to assist CDCR in achieving their goal of being the best correctional system in the nation. The department has

implemented many of the recommendations from our formal reports, and as this report documents, implementation progress continues.

The OIG will continue to be value added to the administration of corrections in California, and our dedicated staff is committed to fulfilling our mission in the most efficient and responsive manner possible. We look forward to additional opportunities to serve our great State and the taxpayers that rely on our agency to provide transparency to the correctional system.

Robert A. Barton  
Inspector General

## OIG OUTREACH

As a part of the OIG's mission to act as the eyes and ears of the public into the State correctional system, Inspector General Barton has made 58 institution visits. Since his appointment, the IG has visited every institution and youth correctional facility at least once. The IG has also visited the out-of-state facilities that house California inmates, including North Fork Correctional Facility in Oklahoma, Tallahatchie County Correctional Facility in Mississippi, and La Palma Correctional Center and Red Rock Correctional Center in Arizona.

The IG visited the Trinity River Fire Conservation Camp and attended parole consideration hearings held by the Board of Parole Hearings and participated in legislative budget hearings. The IG participated in the statewide wardens' meeting and supervisory academy, and also attended the CDCR Rehabilitation Summit. Additionally, the IG continues to meet monthly with CDCR executive staff to address issues and concerns.

The OIG held an annual all-staff meeting to allow employees from each region the opportunity to meet and work together in one location. The OIG is fostering cooperation across agency, hierarchical, and functional boundaries and creating a team environment. During the meeting, OIG staff worked within their teams to create strategic plans for their units and presented them to the agency. This afforded every employee the opportunity to gain a deeper understanding of each unit's mission and collaborate on how to achieve their goals. Employees were also tasked with working within their units to revise the OIG administrative policies and create desk manuals for their various job functions.

The OIG continues to network with non-governmental entities by attending the Association of Inspectors General (AIG)

annual conference, coordinating meetings regarding the Prison Rape Elimination Act (PREA), and maintaining an open dialogue with the Prison Law Office. Additionally, the IG attended the 18th Annual National Association for Civilian Oversight of Law Enforcement Conference; the Responsibility, Rehabilitation, and Restoration Symposium; and the Los Angeles County Criminal Justice Group meeting. The IG also attended APSEA's Navigating Leadership Challenges and Equal Employment Opportunity in a Changed World conference and served on the panel discussing leadership tools, approaches, and skills for thriving in a changed world.

### Asian Pacific State Employees Association Award



*APSEA Award – Excellence in Innovative Leadership in State Government. Received by IG Robert Barton and Chief Deputy IG Roy Wesley*

In 2012 the OIG was awarded the APSEA *Excellence in Innovative Leadership in State Government* award. The OIG was recognized as a government agency exemplifying outstanding leadership in implementing transformational strategies, customer service, collaborative partnerships, and dedication to championing innovation and creativity in the workplace. The OIG was honored to receive this award and be recognized for its hard work and innovation during our transition.

## Prison Crimes Council

The Prison Crimes Council (PCC) of the California District Attorneys Association (CDAA) has met twice yearly since 1999 to promote better relations and training between District Attorney (DA) offices and CDCR institutions statewide, with the goal of more successfully prosecuting prison crimes. The PCC has representatives from CDAA, CDCR, OIG, DAs from counties with prisons, the Attorney General's Correctional Law Unit, and local law enforcement agencies.

Up until May 2012, the OIG hosted the PCC meetings and partnered with the Sacramento County DA's Office to create agendas relevant to all stakeholders. CDAA now hosts the PCC meetings, but the OIG remains an active partner and participant.

Over the past few years, collaboration among the attendees at these semi-annual meetings

has produced many significant accomplishments, including:

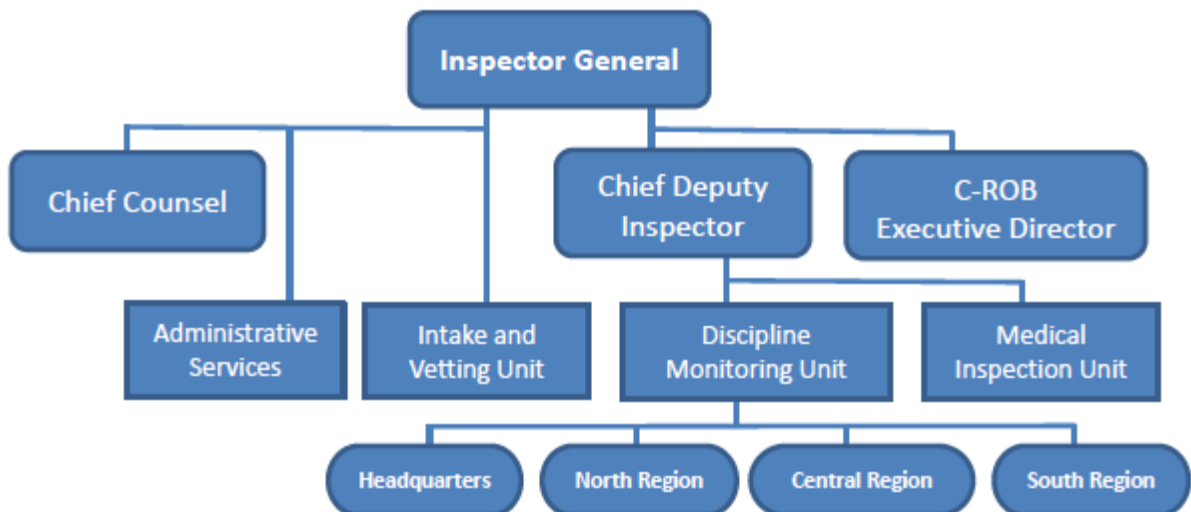
- Clarified each county's elected DA's roles in successfully prosecuting prison crimes for all 33 institutions;
- Minimized inmate movement by passing legislation to administer a video appearance court calendar;
- Delivered live (and subsequently videotaped) training sessions by trial attorneys in DA Prison Crime Units;
- Increased the prosecution of civilians and staff caught introducing cell phones into institutions through the passage of the cell phone interdiction law and the increased use of the felony bribery and conspiracy statutes; and
- Assisted CDCR with its implementation of *Pitchess* and *Brady* protocols.

# ORGANIZATIONAL OVERVIEW

Because statutory revisions in July 2011 refocused the OIG’s responsibilities, the office implemented a significant reorganization of its operational structure. Specifically, the OIG significantly reduced its workforce, eliminated bureau designations, redistributed duties, and regionalized workforce according to need. The following represents the organization of the OIG at the close of 2012:

- California Penal Code sections 2641, 6125 et seq., and 6141 provide the statutory authority for the OIG’s establishment and operations.
- The OIG is comprised of a skilled team of professionals, including attorneys with expertise in internal affairs investigations and criminal and employment law and inspectors experienced in correctional policy, operations, and investigations.
- In addition to executive and administrative operations in Sacramento (Natomas), the OIG is regionally organized into three areas: North, Central, and South. The North Region is in Rancho Cordova, the Central Region is in Bakersfield, and the South Region is in Rancho Cucamonga, all co-located with CDCR’s OIA staff.

2012 Organizational Chart





# FUNCTIONS OF THE OFFICE OF THE INSPECTOR GENERAL

California Penal Code section 6125 establishes the Office of the Inspector General as an independent agency and provides for the Inspector General to be appointed to a six-year term by the Governor, subject to Senate confirmation.

In 2011, the Legislature focused the OIG's duties and the office was restructured. The following sets forth the current statutory duties and functions of the OIG and its work in 2012.

## Statewide General Intake



*Intake Staff Reviewing a File*

The OIG maintains a statewide intake process to receive communications from any individual regarding allegations of improper activity within the CDCR. Every complaint is logged and reviewed, and receives a follow-up response. Any complaints requiring a higher level of review and interaction with CDCR are referred to our regional operations teams who make direct contact with the involved institution.

In 2012, the OIG's Intake Unit received 3,490 general complaints filed by inmates, families, CDCR employees,

and advocacy groups. Similar to prior years, most complaints concerned allegations of staff misconduct, access to the inmate appeal process, and the quality or lack of access to medical care. Based on the OIG screening criteria, Intake staff conducted additional research into matters and requested clarifying documentation from the institutions for 392 complaints.

Intake staff referred 43 complaints to the OIG's regional operations teams to bring the matters to the attention of the institution and monitor departmental response at the local level. Intake staff referred 65 complaints to OIG nursing staff who conducted additional analysis for medical, dental, and mental health complaints received in 2012 related to the quality or lack of access to health care for inmates. Where violations of policies or procedures were determined, the OIG referred the complaints to CDCR's Division of Correctional Health Care Services for remedy.

## Retaliation Claims

California Penal Code section 6129 requires the OIG to receive and respond to retaliation complaints. The OIG's Chief Counsel conducts assessments of retaliation complaints submitted by CDCR employees against members of CDCR management. If the complaint states a prima facie case, the complaint is investigated by an OIG inspector and a merit determination is made. Any finding is communicated to CDCR for corrective action. In 2012, the OIG received ten complaints relating to allegations of retaliation. Nine of the ten complaints did not meet the legal requirement for an investigation. One complaint is currently being investigated by the OIG.

## **Sexual Abuse in Detention Elimination Act Ombudsperson Claims**

California Penal Code section 2641 directs the OIG to act as the ombudsman for complaints related to sexual abuse in detention. The OIG is tasked with reviewing allegations of mishandling sexual abuse investigations within correctional institutions, maintaining the confidentiality of sexual abuse victims, and ensuring impartial resolution of inmate and ward sexual abuse complaints. The OIG monitors CDCR's handling of all sexual abuse allegations and all subsequent investigations of staff involvement.

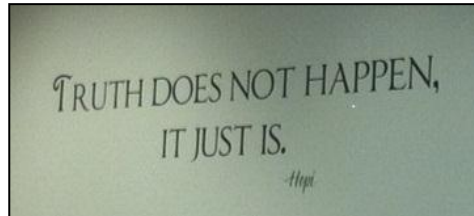
The OIG received and reviewed 13 complaints relating to inadequate investigations of sexual abuse in detention. When necessary, these matters were addressed directly with CDCR.

## **Discipline Monitoring**

California Penal Code section 6133(c)(1) mandates the OIG publish a Semi-Annual Report of its oversight of CDCR internal affairs investigations, employee discipline, and use of force. Prior to July 2011, the OIG monitored these areas through its Bureau of Independent Review (BIR). Following the reorganization of the OIG, these activities are now monitored regionally by the OIG's Discipline Monitoring Unit.

The OIG's DMU provides contemporaneous oversight of CDCR's internal affairs investigations and employee discipline process. Use-of-force reviews conducted by CDCR and CDCR's response to critical incidents within the institutions are also monitored. Since its inception, the OIG has maintained a notification process with CDCR for critical incidents within

the department, including, but not limited to, use of deadly force, unexplained deaths in custody, homicides, suicides, large-scale riots, escapes, and other serious or newsworthy incidents. Each incident is evaluated and reported in the OIG's Semi-Annual Report.



*CDCR's Central Intake Motto*

## **Internal Affairs and Employee Discipline Monitoring**

The OIG monitoring of CDCR's internal affairs and employee discipline cases includes monitoring of the allegation intake process, the investigation phase by CDCR's Office of Internal Affairs, the decision-making process by the hiring authorities, and the handling of the matter by the CDCR Employee Advocate Prosecution Team (EAPT) attorneys (referred to as vertical advocates). Monitoring includes all case activity up to and including State Personnel Board proceedings, if necessary. During 2012, the OIG published two Semi-Annual Reports, one in April and one in October. The time period of these reports covered July through December 2011 and January through June 2012. These reports covered 520 monitored cases and documented the performance by the department.

## **Critical Incident Monitoring**

The OIG maintains regional on-call monitors who can respond on-site 24 hours per day to critical incidents reported to our office from any of the

State's correctional institutions. The OIG monitors the incident and any subsequent investigation with special emphasis on determining what led up to the incident, whether it was handled appropriately, and what, if any, action should be taken afterward. If neglect or misconduct is suspected, the OIG will recommend and subsequently monitor a secondary investigation. The OIG may recommend policy changes to prevent future occurrences and conform to best practices. In some instances, the OIG has identified systemic issues that should be addressed statewide. During the July through December 2011 and January through June 2012 time periods, the OIG monitored 223 critical incidents.

### **Contraband Surveillance Watch**

In 2012, citing concerns that CDCR's contraband surveillance watch process was being applied improperly and inconsistently, the Legislature requested the OIG to develop a CSW monitoring program. In March 2012, the OIG began a four-month pilot program to develop a method to monitor CDCR's contraband surveillance watch process. Beginning on July 1, 2012, the OIG began its formal monitoring of the department's CSW process.

The OIG is now notified any time an inmate is placed on contraband surveillance watch. The OIG collects all relevant data, including the name of the inmate, the reason the inmate is placed on CSW, what contraband is suspected, what contraband is actually found, and the times the inmate was placed on and taken off CSW. Additionally, whenever an inmate is kept on CSW longer than 72 hours, the OIG goes on scene to inspect the condition of the inmate and ensure the department is following its policies. The OIG inspects all logs and reviews the evidence used to place the inmate on

CSW. This on-scene process continues every 72 hours until the inmate is removed from CSW. Serious breaches of policy are immediately discussed with institution managers.

The results of our monitoring program will be reported every six months as part of the OIG's Semi-Annual Report. The first report of CSW activities will cover the period July 1, 2012, through December 31, 2012.

### **Use-of-Force Reviews**

The OIG monitors CDCR's use-of-force review process. During 2012, the OIG published two UOF reports, one in June and one in October. The first UOF report summarized UOF reviews from July through December 2011, and the second UOF report summarized UOF reviews from January through June 2012.

In 2012, CDCR reported 7,194 use-of-force incidents in the adult system. The OIG reviewed 1,296 incidents involving force while attending 215 use-of-force review meetings. The OIG also performed an additional 1,566 reviews of incidents involving force. In addition, the OIG participated as a non-voting member of CDCR's Deadly Force Review Board.

In our June 2012 UOF report, the OIG made seven recommendations to CDCR to improve its use-of-force practices and policies, and in our October 2012 UOF report, we made one additional recommendation. All eight recommendations are being implemented by the department.

While the OIG is still monitoring CDCR's use-of-force review process, we have temporarily discontinued our UOF reporting to give the department time to implement a new use-of-force process.

The new process was designed by CDCR following a recommendation by the OIG to streamline the use-of-force incidents allowing greater scrutiny of the more serious incidents. We continue to attend use-of-force meetings and made recommendations in 99 of the department's decisions in 2012. The OIG's next UOF report will cover the six-month period of January through June 2013, and will be published semi-annually thereafter.

**Detailed assessments of the OIG's case monitoring activities and use-of-force reviews are available on the OIG's website at:**

**[www.oig.ca.gov/](http://www.oig.ca.gov/)**

## Medical Inspections



*OIG's Medical Inspection Team at Work*

The OIG conducts an objective, clinically appropriate, and metric-oriented medical inspection program to review delivery of medical care at each of the adult institutions in California. Every institution is inspected annually.

During the 2012 calendar year, the OIG's Medical Inspection Unit conducted 27 medical inspections and published 30 medical inspection reports. The OIG also published a report comparing the Cycle 1 and Cycle 2 medical inspection results of the 33 adult institutions.

In February 2012, the OIG began its Cycle 3 medical inspections and will complete Cycle 3 inspections by March 2013. The OIG's Cycle 4 medical inspections will begin in April 2013, and all inspections will likely be completed within a 12-month time period.

## Comparative Summary and Analysis of the First and Second Medical Inspection Cycles of California's 33 Adult Institutions

On July 13, 2012, the OIG published a Comparative Summary and Analysis of the First and Second Medical Inspection Cycles of all 33 adult institutions. The report summarized trends from the first and second reporting cycles and highlighted areas with significant medical score increases or decreases among the 33 institutions. Medical inspection scores were compared across five general medical categories based on each institution's overall score from 20 distinct medical components.

The inspection results demonstrated that all but one of the 33 institutions improved their overall medical care scores from Cycle 1 to Cycle 2.

**Individual and summary medical inspection reports are available on the OIG's website at: [www.oig.ca.gov](http://www.oig.ca.gov)**

## Warden/Superintendent Vetting

Penal Code section 6126.6 requires that 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 the recommendation in confidence to the governor within 90 days of the request to evaluate the candidate.

In recognition of CDCR's need for stable leadership in the institutions, the OIG increased the efficiency of completing vettings to assist in quickly reducing a backlog of acting warden and superintendent candidates, while maintaining an effective and thorough evaluation process.

The OIG implemented a three-phase vetting process, streamlining the process with the goal of completion by the OIG in 60 days. In addition to conducting a background investigation of the candidate and surveying designated stakeholders, the first phase consists of a site visit conducted by a team of inspectors, which provides the OIG with an overview of the institution's operations. During the second phase, the IG himself consults with outside stakeholders, conducts a management review, and tours the facility while observing the candidate interact with inmates and staff. During the final phase, the IG evaluates all of the information gathered during the vetting process and evaluates the candidate's suitability for the position of warden or superintendent after a one-on-one interview with the candidate. The IG then submits a confidential recommendation to the Governor.

During 2012, the OIG began 24 warden and superintendent evaluations,

completing 20 of those evaluations in 2012. The OIG completed those evaluations in an average of 58 days. This is a 30 percent improvement in timeliness of reviews.

## Blueprint Monitoring

To monitor implementation of the *Future of California Corrections Blueprint*, the Legislature passed and the Governor signed legislation in 2012 mandating the OIG periodically review delivery of the reforms identified in the *Blueprint*, including, but not limited to, the following specific goals and reforms described by the *Blueprint*:

- Whether the department has increased the percentage of inmates served in rehabilitative programs to 70 percent of the department's target population prior to their release;
- The establishment of and adherence to the standardized staffing model at each institution;
- The establishment of an adherence to the new inmate classification score system;
- The establishment of and adherence to the new prison gang management system, including changes to the department's current policies for identifying prison-based gang members and associates and the use and conditions associated with the department's secured housing units; and
- The implementation of and adherence to the Comprehensive Housing Plan described in the *Blueprint*.

The OIG anticipates publishing its first Blueprint Monitoring report in Spring 2013.



## The California Rehabilitation Oversight Board (C-ROB)



*C-ROB Meeting in Progress*

The enactment of the Public Safety and Offender Rehabilitation Services Act of 2007 (AB 900) established the 11-member California Rehabilitation Oversight Board. Chaired by the Inspector General, C-ROB meetings are conducted quarterly to examine CDCR's various mental health, substance abuse, educational, and employment programs for inmates and parolees.

In 2012, C-ROB's Executive Director Renee Hansen conducted program reviews and met with education staff at all 33 adult institutions and the 4 out-of-state facilities that house California inmates. Director Hansen reported back to the board the best practices she observed and the challenges of delivering rehabilitation programs in an institution setting, ascertained during her program reviews.

Pursuant to statute, C-ROB published two reports in 2012. The reports highlighted that CDCR continued to be challenged with a hiring and spending freeze during the first half of 2012; however, the department continued to make positive strides in implementing improvements in the delivery of rehabilitation programming. Additionally, the inclusion in the *Future of California Corrections Blueprint* of a strategy for program expansion sent a positive signal reiterating the support of rehabilitative programming by the department.

C-ROB reports are available on the OIG's website at:

<http://www.oig.ca.gov/pages/c-rob/reports.php>

### Authorized Reviews

In 2011, the Legislature created an authorized review process codified in Penal Code section 6126. Upon request of the Governor, Speaker of the Assembly, or Senate Committee on Rules, the OIG will conduct a review of CDCR policies, practices, or procedures set forth in the review request. Upon completion of the review, the OIG will report its findings and recommendations to the authorizing entity. In 2012, the following authorized review was conducted:

#### High Desert State Prison

In May 2012, the OIG reported back to the Senate Committee on Rules regarding an authorized review of alleged staff misconduct at High Desert State Prison to determine if staff were subjecting sex offender inmates to potential harm by intentionally or negligently identifying them to other inmates. The OIG interviewed over 52 inmates and 23 officers and reviewed multiple reports and complaints. Three potential misconduct cases were referred to CDCR's Office of Internal Affairs and subsequently monitored by the OIG. This review illustrates the ability of the OIG to work in a true monitoring role while CDCR itself addresses a problem. Authorized reviews will continue to be a vital tool in the overall role of the OIG to provide true independent oversight.

# **CDCR CORRECTIVE ACTION PLAN UPDATE**

In 2012, the OIG completed 1 authorized review and published 31 formal reports containing 8 recommendations. The recommendations in these reports result in greater transparency, taxpayer savings, process improvements, increased accountability, and higher adherence to policies and constitutional standards.

## **Status of Recommendations Made to CDCR During 2012**

CDCR has fully implemented six of the eight OIG recommendations, and has partially implemented the remaining two recommendations, with full implementation expected in 2013.

## **Status of Recommendations Made to CDCR During 2011**

The OIG noted in its 2011 Annual Report the department planned to implement 18 recommendations made by the OIG during 2011. To date, the department has fully or partially implemented 11 of those recommendations and 2 recommendations are no longer applicable. Additionally, the department reports it has formed a workgroup to plan implementation of three recommendations, pursued a policy change to address one recommendation, and is considering labor negotiations on the final recommendation.

**The 2011 Annual Report is available on the  
OIG's website at:  
<http://www.oig.ca.gov>**

# APPENDIX: REPORTS RELEASED IN 2012



## Annual Report

-  2011 OIG Annual Report (March 26, 2012)


## Semi-Annual Reports

-  Use-of-Force within CDCR January-June 2012 (October 17, 2012)
-  OIG Semi-Annual Report January-June 2012 (October 2, 2012)
-  Use-of-Force within CDCR July-December 2011 (June 21, 2012)
-  OIG Semi-Annual Report July-Dec.2011 (April 13, 2012)


## California Rehabilitation Oversight Board (C-ROB)

-  C-ROB Biannual Report September 15 2012 (September 14, 2012)
-  C-ROB Biannual Report March 1 5 2012 (March 15, 2012)

## Authorized Review Letter Reports








-  Special Review - May 2012 High Desert State Prison (June 14, 2012)

## Medical Inspection Comparative Report














-  Comparative Summary and Analysis of the First and Second Medical Inspection Cycles of California's 33 Adult Institutions (July 30, 2012)

## Medical Inspection Reports











### Cycle 3

-  California Substance Abuse Treatment Facility and State Prison at Corcoran Medical Inspection Results Cycle 3 (December 21, 2012)
-  Pelican Bay State Prison Medical Inspection Results Cycle 3 (December 20, 2012)
-  California State Prison Corcoran Medical Inspection Results Cycle 3 (December 6, 2012)
-  California Correctional Center Medical Inspection Results Cycle 3 (November 29, 2012)
-  California Institution for Women Medical Inspection Results Cycle 3 (November 28, 2012)
-  Valley State Prison for Women Medical Inspection Results Cycle 3 (November 28, 2012)
-  California State Prison Los Angeles County Medical Inspection Results Cycle 3 (November 15, 2012)



-  Kern Valley State Prison Medical Inspection Results Cycle 3. (November 8, 2012)
-  Central California Women's Facility Medical Inspection Report Cycle 3 (November 8, 2012)
-  North Kern State Prison Medical Inspection Results Cycle 3 (November 8, 2012)
-  High Desert State Prison Medical Inspection Results Cycle 3 (November 7, 2012)
-  California Correctional Institution Medical Inspection Results Cycle 3 (November 1, 2012)
-  Sierra Conservation Center Medical Inspection Results Cycle 3 (September 18, 2012)
-  Pleasant Valley State Prison Medical Inspection Results Cycle 3 (August 29, 2012)
-  California Rehabilitation Center Medical Inspection Results Cycle 3 (August 29, 2012)
-  San Quentin State Prison Medical Inspection Results Cycle 3 (August 23, 2012)
-  Richard J. Donovan Correctional Facility Medical Inspection Results Cycle 3 (July 12, 2012)
-  California Men's Colony Medical Inspection Results Cycle 3 (July 12, 2012)
-  California Medical Facility Medical Inspection Results Cycle 3 (June 21, 2012)
-  California State Prison Sacramento Medical Inspection Results Cycle 3 (June 19, 2012)

## Cycle 2

-  Calipatria State Prison Medical Inspection Results Cycle 2 (April 23, 2012)
-  California Institution for Men Medical Inspection Results Cycle 2 (April 19, 2012)
-  Wasco State Prison Medical Inspection Results Cycle 2 (March 15, 2012)
-  Chuckawalla Valley State Prison Medical Inspection Cycle 2 (March 8, 2012)
-  Avenal State Prison Medical Inspection Results Cycle 2 (February 23, 2012)
-  Mule Creek State Prison Medical Inspection Results Cycle 2 (February 9, 2012)
-  California State Prison Solano Medical Inspection Results Cycle 2 (January 19, 2012)
-  Salinas Valley State Prison Medical Inspection Results Cycle 2 (January 19, 2012)
-  Pelican Bay State Prison Medical Inspection Results Cycle 2 (January 12, 2012)
-  Ironwood State Prison Medical Inspection Results Cycle 2 (January 12, 2012)



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CHIEF DEPUTY INSPECTOR GENERAL

**STATE OF CALIFORNIA**  
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