Robert A. Barton
Inspector General

Office of the Inspector General

2013 ANNUAL REPORT

January 2014

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
2013 ANNUAL REPORT

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FOREWORD

I am pleased to present the Office of the Inspector General's 2013 Annual Report. After two full years of evolving changes in the scope and mission of the office, the Office of the Inspector General (OIG) is confidently on course to achieve its mission while continuing to safeguard the interests of the taxpayers. It is my goal to continuously evaluate and adapt the functions of the office to achieve its statutory mandates. Through various monitoring functions, the OIG continues to be value added to the State and provide transparency to the functioning of the California Department of Corrections and Rehabilitation (CDCR or the department).

In 2013, the OIG headquarters and administrative staff merged physical locations with the northern operations unit staff. The move resulted in a more efficient and cost-effective agency. In 2013 the OIG also began the monitoring of CDCR's adherence to its *Future of California Corrections Blueprint* (the *Blueprint*). This monitoring is essential to ensure the department moves forward with its *Blueprint* goals in a timely and transparent fashion and achieves the fiscal and rehabilitative goals promised to the State.

The Discipline Monitoring Unit, comprising attorneys and inspectors, continues to monitor and report on use of force, critical incidents, contraband surveillance watch, internal affairs investigations, and the employee discipline process within CDCR. It is important that staff of the OIG 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 also consults with the department on proposed changes to its programs and facilities. The new California Health Care Facility, Stockton, where I attended the ribbon cutting ceremony on July 25, 2013, is an example of the continual expansion and improvement of correctional care occurring in the department. Office of the Inspector General staff visited the facility on multiple occasions and monitored the activation process.

I remain committed to personally visiting and interacting with staff and inmates at every institution in the State on an annual basis, and have successfully reached that target in 2013.

Inspector General Robert Barton and Larry Fong, Chief Executive Officer, at the Ribbon Cutting Ceremony at the California Health Care Facility, Stockton

In 2013, the OIG completed ten warden/superintendent evaluations and made recommendations to the Governor on each of them within 60 days of initiation. The OIG's Medical Inspection Unit completed 11 medical inspections and published 13 medical inspection reports. The OIG continues to staff and chair the quarterly California Rehabilitation Oversight Board meetings and report on the state of rehabilitative programs in the department as well as provide a public forum for discussion of those efforts.

The Office of the Inspector General's statewide intake function continues to respond to the concerns of persons both inside and outside the department. The OIG expanded its intake function to utilize its regional staff and their working relationships with the institutions to follow up on and resolve complaints.

In a continuous effort to abide by California's initiatives to reduce the State Government's environmental impact, the OIG is transitioning to a paperless office. The OIG Intake Unit was the first unit to convert all of its paper case files into an electronic paperless case management system. This new system saves money and staff hours, thus increasing the OIG's effectiveness in processing complaints. The OIG is committed to reducing waste, decreasing costs, and improving efficiency by converting as many processes as possible to a paperless system.

The OIG strives to be responsive to the concerns of the Legislature and the public, and in addition to its mandated oversight duties, the office was requested to review CDCR's use of security housing units for its female inmate population. The OIG's review made recommendations to the department related to security housing unit terms, and the OIG made eight additional recommendations to CDCR this year in its other reviews and monitoring activities.

We at the Office of the Inspector General 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

The OIG provides public transparency for the State's correctional system. One of the ways to have an impact and become aware of issues within corrections is to have a personal presence within the institutions. In addition to OIG staff monitoring and providing on-scene response to incidents, the Inspector General visits every adult institution and youth correctional facility at least once annually. In 2013, the Inspector General conducted 46 institution visits in person. In addition, the Chief Deputy Inspector General visited all four out-of-state correctional facilities that house California inmates—Tallahatchie County Correctional Facility in Mississippi, North Fork Correctional Facility in Oklahoma, and La Palma Correctional Center and Florence Correctional Center in Arizona. The visits include inspection of the physical grounds, inspection of the medical facilities, review of the educational programs, and impromptu interviews with inmates and staff. The OIG also has staff visiting each prison to assess the rehabilitation and education operations on an annual basis as part of its review for the California Rehabilitation Oversight Board.

In addition to conducting institution visits, the Inspector General maintains a presence by attending noteworthy events throughout the state. During 2013, Inspector General Barton attended the Enhanced Outpatient Program Dedication Ceremony at the California Medical Facility. The Inspector General also attended the California Prison Industry Authority and the CDCR Office of Correctional Safety Emergency Operations Training Center Grand Opening and Ribbon Cutting Ceremony in May. In June, the Inspector General spoke at the graduation ceremony for the California Association of Alcoholism and Drug Abuse Counselors' Offender Mentor Certification Program at California State Prison, Solano. In October, OIG staff attended the high school graduation ceremony at the O.H. Close Youth Correctional Facility in Stockton.

The Inspector General also attended parole consideration hearings held by the Board of Parole Hearings and participated in legislative hearings regarding CDCR. Additionally, the Inspector General continues to meet with CDCR executive staff, members of the Legislature and their staff, and staff from the Office of the Governor to address ongoing issues and concerns.

The OIG held an annual All-Staff Meeting to allow for cross-training and cooperation across agency, hierarchical, and functional boundaries to better foster a team environment. During the meeting, OIG staff heard from the Health Care Receiver and critical stakeholders within CDCR. Staff also received training from a nationally renowned speaker and author on police ethics and the importance of peer interventions.

Office of the Inspector General staff attended the California State Association of Counties' Innovation Summit addressing corrections and health care in November 2013. The Innovation Summit was chaired by former CDCR Secretary Matthew L. Cate and addressed the Public Safety Realignment, its impact on counties and the offender population, and making long-term impacts to recidivism.

Staff of the OIG also attend briefings on public safety realignment, parole populations, crime trends, and prison capacity challenges held at the Public Policy Institute in Sacramento.

National Association for Civilian Oversight of Law Enforcement

In April 2013, the Inspector General attended a conference in Los Angeles and worked with the National Association for Civilian Oversight of Law Enforcement on a partnership between the U.S. and Russia to study civilian oversight. The representatives of two Russian nongovernmental organizations and the U.S. participants discussed different models of oversight structure and the strengths and weaknesses of different approaches. In addition, the Inspector General attended the 19th Annual National Association for Civilian Oversight of Law Enforcement Conference, where he gave a presentation entitled *Basic Skills of Effective Oversight Reporting*, in which he examined elements such as the purpose of reporting, the method behind producing quality reports, and the expected outcomes of oversight reports. The conference was attended by law enforcement and oversight professionals from across the nation as well as several international representatives. The Inspector General met with the U.S. Inspector General, Michael Horowitz, and discussed future communications regarding the treatment of federal prisoners and shared issues with California's prison system, such as overcrowding, mental health care, solitary confinement, and rehabilitation.

Patriotic Employer Award for support of the Guard and Reserves, received by Inspector General Robert Barton and Deputy Inspector General Matt Young (Major, U.S. Army Ret.)

Patriotic Employer Award

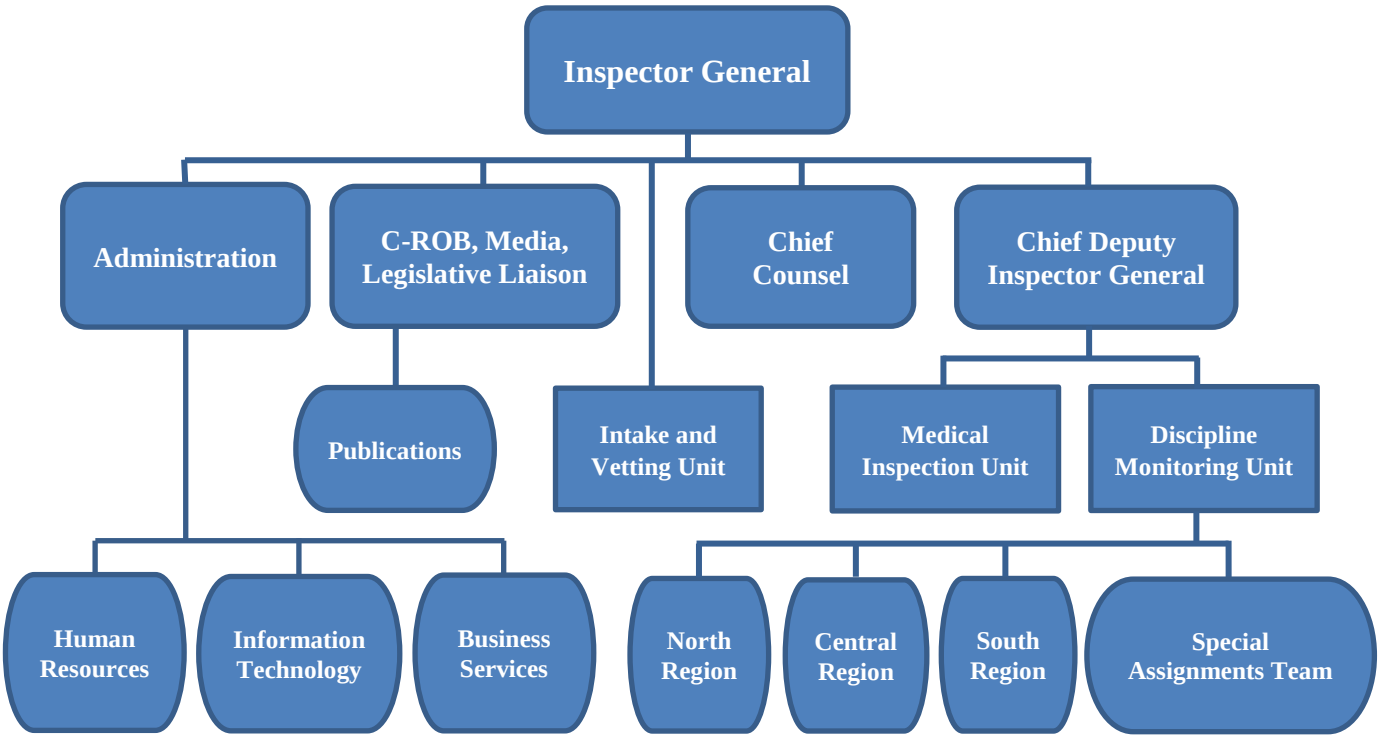
In 2013, the Inspector General was awarded the Employer Support of the Guard and Reserve Patriotic Employer Award. The Inspector General was recognized for demonstrating his appreciation and value for the military service of OIG staff who serve their country in more than one way—as civil servants and military reservists. In 2013, three OIG staff served as reservists in the military: Ian Marty, Suzann Gostovich, and Tim Rieger. The Inspector General was honored to receive this award acknowledging support of OIG employees who are active members of the Guard and Reserve as well as the numerous veterans and staff with immediate family who serve or have served in the military.

ORGANIZATIONAL OVERVIEW

In 2013, the headquarters and administrative staff of the OIG merged physical locations with the northern operations unit staff in order to increase efficiency and cost-effectiveness. All three OIG offices are now co-located with CDCR's three Offices of Internal Affairs. As a result of moves and consolidation from five offices to three, the OIG reduced its office space by 10,905 square feet, resulting in a savings of over $277,000 annually.

- California Penal Code Sections 2641 and 6125 et seq. provide the statutory authority for the OIG's establishment and operations.
- The OIG comprises a skilled team of professionals, including attorneys with expertise in internal affairs investigations, criminal law, and employment law and inspectors experienced in correctional policy, operations, and investigations.
- In addition to executive and administrative operations in Sacramento (Rancho Cordova), 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.

2013 OIG Organizational Chart

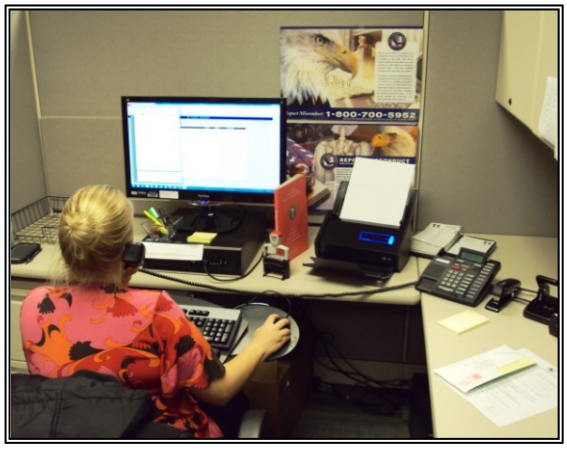


FUNCTIONS OF THE OFFICE OF THE INSPECTOR GENERAL

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. Robert A. Barton was appointed on August 29, 2011, and his term will expire in 2017.

In 2011, the Legislature focused the OIG's duties and the office was restructured. This section sets forth the current statutory duties and functions of the OIG and its work in 2013.

Statewide General Intake



OIG Intake Unit Staff

The OIG maintains a statewide intake process to receive communications from any individual regarding allegations of improper activity within CDCR. While the OIG intake process is not detailed in any of the OIG's regular reports, it is an important function of the agency.

The OIG Intake Unit logs, reviews, analyzes, and responds to every non-duplicative complaint it receives. Intake Unit staff screen all complaints within 24 hours of receipt to identify potential safety concerns. Staff directly contact institutional personnel in order to remedy issues that may be addressed informally, such as failure to accept an appeal, failure to schedule a classification hearing, or failure to schedule medical appointments. In addition, during 2013, Intake Unit staff contacted institutions 24 times based on letters indicating potentially unsafe conditions, such as enemy concerns, or, more commonly, an inmate displaying bizarre or threatening behavior. Intake Unit staff require CDCR to provide a status of the situation to ensure the department rectifies any safety concerns and provides appropriate intervention to mental health inmates.

The Intake Unit focuses OIG staff resources on the most serious complaints by using a matrix of common prison issues that receive priority attention. Lack of access to grievance processes or to health care, serious due process violations, unnecessary extended stays in segregation units, sexual abuse, serious staff misconduct, and inappropriate uses of force are included in the matrix. However, if a trend of lesser policy violations is identified, the Intake Unit makes efforts to remedy any potentially systemic problem. In most instances, the Intake Unit encourages complainants to utilize CDCR's grievance processes to resolve their issues before contacting the OIG; therefore, lack of access to the grievance process or unjustified rejection of appeals by CDCR staff often receive the most attention from Intake Unit staff.

In 2013, the Intake Unit staff gained access to CDCR's Electronic Records Management System. This access has improved the timely acquisition of pertinent documents for review, which enhances the Intake Unit's ability to analyze situations and determine if a policy violation or misconduct may have occurred.

When Intake Unit staff find potential misconduct or policy violations after reviewing complaints and corresponding CDCR documents, the cases are presented at a twice monthly meeting with the Inspector General for consideration of referral to OIG regional field staff. In the field, OIG staff work directly with corrections administrators to remedy identified issues, which may result in simple, informal fixes, such as the training of staff, or the initiation of inquiries, investigations, or use-of-force reviews to determine whether potential misconduct may have occurred. When CDCR initiates an investigation, OIG regional staff monitor it in accordance with the OIG's normal discipline monitoring activities and report their findings in the Semi-Annual Report.

In 2013, the OIG's Intake Unit received 2,766 general complaints filed by inmates, families, CDCR employees, and advocacy groups. In addition, the Office of the Governor assigned the OIG to review and respond to 60 complaints in 2013. Similar to prior years, most complaints concerned allegations of staff misconduct, access to the inmate appeal process, and the quality of or lack of access to medical care. Based on the OIG screening criteria, Intake Unit staff conducted additional research into matters and requested clarifying documentation from the institutions for 626 complaints.

Regional Operations Team

Intake staff referred 82 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 166 complaints to OIG nursing staff, who conducted additional analysis of medical, dental, and mental health complaints related to the quality of or lack of access to health care for inmates. Where the OIG determined potential violations of medical policies or procedures occurred, the OIG referred the complaints to CDCR's Division of Correctional Health Care Services for remedy.

CDCR Oversight Activities

As a result of the OIG's move to Rancho Cordova, the OIG distributed more than 2,000 inmate and 750 staff posters redesigned to reflect its new address and provide more clarification on the OIG's role and how to submit a complaint to the OIG. The posters also encourage inmates to submit copies of official documentation relating to their claims. The Inspector General and OIG staff visiting the institutions verify the posters are visible.

Beginning July 8, 2013, inmates in CDCR's security housing units staged a hunger strike to protest, among other issues, California's use of solitary confinement. As part of the OIG's monitoring duties, the agency dispatched inspectors and attorneys to the involved institutions to ensure CDCR staff were following policies and procedures, and to monitor conditions of confinement, medical and mental health checks, and the medical and dietary procedures for food consumption. The hunger strike ended on September 5, 2013. With the end of the hunger strike, the Chairpersons of both the Assembly and Senate Committees on Public Safety convened a joint public hearing on issues related to segregated housing in California's prisons. The hearing was held

on October 9, 2013, and the Inspector General gave testimony on the current policies and procedures as well as conditions within CDCR's security housing units. Subsequent to the hearing, the Senate Rules Committee requested the OIG further examine the conditions specifically related to female inmates serving security housing unit terms (see Special Review: Female Inmates Serving Security Housing Unit Terms in CDCR).

Retaliation Claims

California Penal Code Sections 6128 and 6129 require the OIG to receive and review complaints of retaliation levied against members of CDCR management by CDCR employees. The OIG's Legal Unit analyzes the allegations of each complaint to determine whether the complaint states a prima facie case of retaliation. If the complaint meets this initial legal threshold, the OIG initiates an investigation into the allegations and determines whether retaliation has occurred. If the OIG determines a CDCR employee has been subjected to unlawful retaliation, the OIG's Intake Unit provides a report of its findings to CDCR along with a recommendation of the appropriate corrective action to be taken.

In 2013, the OIG received seven complaints of retaliation. Of these seven complaints, the Legal Unit determined five did not state a prima facie case of retaliation. The Legal Unit is currently in the process of completing its review of the two remaining complaints received in 2013 to determine whether either states a prima facie case. The OIG also completed an investigation it began in response to a retaliation complaint received in late 2012.

Sexual Abuse in Detention Elimination Act Ombudsperson Claims

California Penal Code Section 2641 directs the OIG to act as the ombudsperson 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. CDCR notified the OIG of 73 sexual abuse allegations during 2013, including 52 with an inmate as the alleged perpetrator and 21 with a staff member as the alleged perpetrator. In recent months, the OIG has observed an increasing trend in inmate complaints alleging sexual harassment by prison staff. However, the Intake Unit discovered that some institutions have not been reporting allegations of sexual harassment per the Prison Rape Elimination Act, and in accordance with CDCR policy. Therefore, the OIG has recently begun referring sexual harassment allegations to OIG regional staff, who meet with wardens to ensure institutions are properly investigating and reporting these types of incidents to the OIG. Regional staff also request wardens provide additional training to their staff concerning the notification process for sexual harassment claims. The OIG will address this issue, including the lack of notification by institutions to the OIG, in the Semi-Annual Report.

The OIG received and reviewed 60 complaints relating to inadequate investigations of sexual abuse in detention and sexual harassment by staff. The Intake Unit referred six of those allegations to OIG regional staff for remedy.

Monitoring Activities

California Penal Code Section 6133(b)(1) mandates the OIG publish a Semi-Annual Report of its oversight of CDCR internal affairs investigations, employee discipline, and use of force.

The OIG's Discipline Monitoring Unit provides contemporaneous oversight of CDCR's internal affairs investigations and employee discipline process. The OIG also monitors use-of-force reviews conducted by CDCR and CDCR's response to critical incidents within the institutions. The OIG maintains a notification process with CDCR for critical incidents within the department, including, but not limited to, use of deadly force, deaths in custody, homicides, suicides, large-scale riots, escapes, and other serious or newsworthy incidents. In 2013, the Discipline Monitoring Unit monitored and reported on 932 incidents in the OIG's Semi-Annual Reports.

Internal Affairs and Employee Discipline Monitoring

The OIG's monitoring of CDCR's internal affairs and employee discipline cases includes the allegation intake process, the investigative 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 attorneys (referred to as vertical advocates). Monitoring includes all case activity, up to and including State Personnel Board proceedings, if necessary. The Semi-Annual Reports document the department's adherence to its operating rules and procedures regarding employee discipline.

Critical Incident Monitoring

The OIG maintains regional on-call inspectors general who can respond on site 24 hours per day to critical incidents reported to the OIG from any of the State's correctional institutions. During the July through December 2012 and January through June 2013 time periods, the OIG monitored 133 critical incidents. 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 the OIG suspects neglect or misconduct, the staff 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.

For example, the OIG recommended the Office of Internal Affairs expand its use of Deadly Force Investigation Teams beyond uses of force involving firearms. As a result, the Office of Internal Affairs Deadly Force Investigation Teams will now respond to use-of-force incidents involving strikes to the head with batons and impact munitions. It has always been the OIG's practice to monitor such incidents.

Contraband Surveillance Watch

The OIG began its formal monitoring of the department's contraband surveillance watch process July 1, 2012, to ensure the process is conducted within departmental policy and not used for punitive purposes.

Department staff notify the OIG any time an inmate is placed on contraband surveillance watch. The OIG reviews all relevant data regarding the use of contraband surveillance watch. Additionally, whenever the department keeps an inmate on contraband

surveillance watch longer than 72 hours, the OIG goes on scene to inspect the condition of the inmate and ensure the department is following its policies. This on-scene process continues every 72 hours until the department removes the inmate from contraband surveillance watch. The OIG immediately discusses serious breaches of policy with institution managers.

Use-of-Force Monitoring

In 2013, CDCR reported 8,930 use-of-force incidents in the adult system. The OIG reviewed 3,192 incidents involving force while attending 564 use-of-force review meetings. The OIG also performed an additional 49 use-of-force reviews outside of the review meetings. The OIG also participated as a non-voting member of CDCR's Deadly Force Review Board.

The OIG's monitoring activities are detailed in its Semi-Annual Reports, available on the OIG's website at: www.oig.ca.gov/pages/reports.php

Medical Inspections

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.

During 2013, the OIG's Medical Inspection Unit conducted 11 medical inspections and published 13 medical inspection reports and one comparative report of the first three medical inspection cycles of the 33 adult institutions.

In February 2012, the OIG began its Cycle 3 medical inspections, completing them in May 2013. After the completion of the Cycle 3 inspections and publication of the end-of-cycle Comparative Report, the OIG placed the medical inspection program on hiatus to update the inspection tool and consult with the stakeholders and the federal court. The result is an updated medical inspection tool that will now not only address compliance with policy, but also examine quality of care. One result of this change is that the OIG no longer "borrows" doctors from CDCR to conduct the inspections, but instead employs its own doctors and nurses for the inspection process. Cycle 4 medical inspections began in December 2013 with pilot inspections to finalize the new inspection tool. Formal inspections will begin in 2014 and will likely be completed within 18 months.

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

OIG's Medical Inspection Team

On July 15, 2013, the OIG published the Comparative Summary and Analysis of the First Three Medical Inspection Cycles of all 33 adult institutions. The report summarized trends from the first, second, and third 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 with one exception, each of the institutions improved its overall medical care score from Cycle 2 to Cycle 3.

Medical inspection reports are available on the OIG's website at: www.oig.ca.gov/pages/reports.php

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.

The OIG uses a three-phase vetting process with a completion goal of 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 Inspector General personally consults with outside stakeholders, conducts a management review, and tours the facility while observing the candidate interact with inmates and staff. In the final phase, the Inspector General reviews 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 Inspector General then submits a confidential recommendation to the Governor.

During 2013, the OIG completed ten warden and superintendent evaluations. The OIG completed each of those evaluations in an average of 57 days. Due to the high rate of attrition within CDCR management, the OIG anticipates a continual demand for warden vetting in 2014. Currently, there are at least ten institutions without permanent wardens.

Blueprint Monitoring

In 2012, the Legislature passed and the Governor signed legislation mandating the OIG periodically review delivery of the reforms identified in *The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight and Improve the Prison System* (the *Blueprint*).

The department showed good initial progress in implementing the goals of the *Blueprint* in 2013. With regard to the standardized staffing model, the department is meeting the *Blueprint* goals at every institution. In addition, the department has established and is adhering to the new inmate classification score system, showing a trend toward overall reduction in higher-level inmate placements. Also, the comprehensive housing plan outlined in the *Blueprint* is generally on schedule, and the department is housing inmates at *Blueprint*-prescribed levels. The department still needs to show considerable progress in the categories of rehabilitative programs and gang management, and the OIG is committed to monitoring and making recommendations to the department in its pursuit of these goals.

The OIG published its first *Blueprint* Monitoring report in April 2013 and its second report in October 2013.

Blueprint monitoring reports are available on the OIG's website at: www.oig.ca.gov/pages/reports.php

California Rehabilitation Oversight Board

California Rehabilitation Oversight Board Meeting in Progress

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

In 2013, C-ROB's Executive Director, Renée Hansen, and her staff visited 27 institutions to observe rehabilitation programs and to ensure programs are being delivered to CDCR's target population. C-ROB staff review a variety of rehabilitative programming, including substance abuse treatment, academic education programs, and career technical education programs.

Pursuant to statute, C-ROB published two reports in 2013. These reports commended the department for its dedication and progress in implementing rehabilitative programming and made several recommendations for improvement.

The March 15, 2013, report outlined the many changes the department was making as a result of the *Blueprint*. C-ROB focused on the department's plan to improve access to rehabilitative programs and to create sufficient capacity for approximately 70 percent of the department's target population. Additionally, C-ROB underscored the importance of implementing proper assessment and case management programs, which are essential components of the California Logic Model.

In the September 15, 2013, report, C-ROB focused on how the department administers programs to female offenders and encouraged the department to continue improving gender-responsive treatment for female offenders. In this report, C-ROB recommended the department continue to work toward developing an Arts in Corrections program to be administered statewide. C-ROB would like to see the department work collaboratively with the California Prison Industry Authority, which provides excellent opportunities for offenders and has proven to be effective at reducing recidivism. Lastly, C-ROB emphasized the importance of the pre-release benefit application process to provide continuity of care for offenders released into the community. The members of C-ROB look forward to further improvements to the department's rehabilitative programming. C-ROB will review the status of its recommendations and report the findings in the biannual reports published in March and September.

California Rehabilitation Oversight Board reports are available on the OIG's website at: http://www.oig.ca.gov/pages/c-rob.php

Special Reviews

In 2011, the Legislature created a special review process codified in Penal Code Section 6126. Upon request of the Governor, the Speaker of the Assembly, or the Senate Rules Committee, 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 and publish a public report.

Special Review: Female Inmates Serving Security Housing Unit Terms in CDCR

On October 31, 2013, the Senate Rules Committee requested the OIG examine the conditions specifically related to female inmates serving security housing unit terms. During this review, the OIG conducted site inspections of the California Institution for Women and the Central California Women's Facility, interviewing staff and inmates and reviewing applicable laws, policies, departmental rules and regulations, central files for 160 inmates, disciplinary rules violation reports, segregation logs, and other pertinent documents. In December 2013, the OIG published its report, which contained nine findings and recommendations, the most significant being the need for the department to develop housing options for female inmates who refuse to accept their assigned housing due to enemy or safety concerns.

Special Reviews are available on the OIG's website at:
www.oig.ca.gov/pages/reports.php

CDCR CORRECTIVE ACTION PLAN UPDATE

In 2013, the OIG completed one special review and published 22 formal reports containing 17 recommendations. The recommendations in these reports promote greater transparency, taxpayer savings, process improvements, increased accountability, and higher adherence to policies and constitutional standards.

Status of Recommendations Made to CDCR During 2013

The OIG made eight recommendations to CDCR in the October 2013 Semi-Annual Report, and nine more recommendations in the December 2013 Special Review: Female Inmates Serving Security Housing Unit Terms in the California Department of Corrections and Rehabilitation. The department has partially or substantially implemented three of the eight Semi-Annual Report recommendations; three more are under consideration but potentially barred due to inadequate funding. Regarding the final two Semi-Annual Report recommendations, the department contends its existing policies are within the guidelines established by statute or regulation, but they will be reviewed. In response to the recommendations made in the special review, the department has requested a 60-day Corrective Action Plan update, so the OIG expects to learn the status of these recommendations in early 2014.

Status of Recommendations Made to CDCR During 2012

The OIG made eight recommendations to the department in 2012, of which six have been fully implemented and two remain partially implemented, both having to do with ongoing policy revisions and review.

Annual Reports are available on the OIG's website at:
www.oig.ca.gov/pages/reports.php

APPENDIX: REPORTS RELEASED IN 2013

Annual Report

- 2012 OIG Annual Report (January 31, 2013)

Semi-Annual Reports

- OIG Semi-Annual Report July–December 2012 Volume I (April 2, 2013)
- OIG Semi-Annual Report July–December 2012 Volume II (April 2, 2013)
- OIG Semi-Annual Report January–June 2013 Volume I (October 15, 2013)
- OIG Semi-Annual Report January–June 2013 Volume II (October 15, 2013)

California Rehabilitation Oversight Board (C-ROB)

- C-ROB March 15, 2013 Biannual Report (March 15, 2013)
- C-ROB September 15, 2013 Biannual Report (September 15, 2013)

Blueprint Monitoring Reports

- Initial Report on CDCR's Progress Implementing its Future of California Corrections *Blueprint* (April 2, 2013)
- Second Report on CDCR's Progress Implementing its Future of California Corrections *Blueprint* (October 29, 2013)

Special Review Reports

- Special Review: Female Inmates Serving Security Housing Unit Terms in the California Department of Corrections and Rehabilitation (December 31, 2013)

Medical Inspection Comparative Report

- Comparative Summary and Analysis of the First Three Medical Inspection Cycles of California's 33 Adult Institutions (July 15, 2013)

Medical Inspection Reports, Cycle 3

- Deuel Vocational Institution Medical Inspection Results Cycle 3 (January 9, 2013)
- Centinela State Prison Medical Inspection Results Cycle 3 (January 30, 2013)
- Calipatria State Prison Medical Inspection Results Cycle 3 (February 14, 2013)

- Folsom State Prison Medical Inspection Results Cycle 3 (March 6, 2013)
- Avenal State Prison Medical Inspection Results Cycle 3 (March 21, 2013)
- Wasco State Prison Medical Inspection Results Cycle 3 (March 28, 2013)
- Correctional Training Facility Medical Inspection Results Cycle 3 (March 28, 2013)
- Salinas Valley State Prison Medical Inspection Results Cycle 3 (March 28, 2013)
- Chuckawalla Valley State Prison Medical Inspection Results Cycle 3 (April 4, 2013)
- Mule Creek State Prison Medical Inspection Results Cycle 3 (April 18, 2013)
- Ironwood State Prison Medical Inspection Results Cycle 3 (April 18, 2013)
- California Institution for Men Medical Inspection Report Cycle 3 (May 17, 2013)
- California State Prison Solano Medical Inspection Results Cycle 3 (May 30, 2013)

2013 ANNUAL REPORT

OFFICE OF THE INSPECTOR GENERAL

Robert A. Barton
INSPECTOR GENERAL

Roy W. Wesley
CHIEF DEPUTY INSPECTOR GENERAL

STATE OF CALIFORNIA
January 2014