Robert A. Barton
Inspector General

Office of the Inspector General

2015 ANNUAL REPORT

January 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
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FOREWORD

OIG Mission
To safeguard the integrity of the State's correctional system by providing oversight and transparency through monitoring, reporting, and recommending improvements on policy and practices of the California Department of Corrections and Rehabilitation.

OIG Vision
To transform the State's correctional system into a model for inmate rehabilitation, employee conduct, health care delivery, and transparency in correctional programs.

This year, more than ever before, saw an increased national discussion regarding issues of incarceration, including input from the President of the United States. Issues of over-incarceration, restorative justice, re-examination of sentencing, meaningful rehabilitation opportunities, mindfulness and resiliency training for staff, and limiting solitary confinement have been brought to the forefront of public consciousness. Now more than ever, is an opportunity for California to be a leader in smart and effective corrections policy that enhances public safety. It is my goal to aid CDCR in fulfilling that role.

2015 was a year of notable events within the Office of the Inspector General (OIG). After several months of collaboration with the various involved entities, the OIG embarked on a new and expanded medical inspection cycle. Reports are now provided assessing not only compliance with medical policies, but also the quality of clinical care provided. The Medical Inspection Unit doubled in size to enable the agency to conduct more inspections in a shorter time period. It is hoped that the feedback provided in the reports will be valuable in all parties' efforts to improve the state of prison healthcare. The OIG also expanded its process for follow up and reporting on intake complaints. More details will be included in future Semi-Annual reports on the efforts between the OIG and the CDCR to resolve issues brought to our attention. There continues to be an emphasis within OIG to positively impact the rehabilitation efforts of CDCR and to assist in adding to the department's progress in this area.

The OIG is also assisting the California Health and Human Services agency in its effort to create a disciplinary process with added transparency and oversight. In December, the OIG completed a special report regarding High Desert State Prison that will hopefully result in permanent positive changes at that institution. In addition, the OIG has maintained a constant presence in the prisons via our monitoring activities and outreach.

There are continued challenges faced by the department, especially in the turnover of key staff, including, but not limited to wardens. It is the goal of the OIG to aid in regaining stability by expeditiously completing our recommendations regarding wardens, and in working with new administrators in achieving the common goal of making the California correctional system a model agency. There is now a new Secretary and Chief Counsel for the Department, as well as a vacancy for the very important post of Director of Rehabilitative Programs. The OIG looks forward to working with these new partners, along with the legislature, and the administration, to improve the California criminal justice system and make it a leader in this rejuvenated environment of national discussion.

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OIG OUTREACH

The OIG consistently seeks opportunities to better assess and recommend improvements within CDCR. This requires communication with departmental staff, the institutions, and outside stakeholders. The OIG also educates these entities about the OIG mission and solicits input from them. Finally, the OIG searches for ways to learn about best practices to be implemented within the State's system. All of this requires constant outreach by the agency.

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 daily presence through OIG staff monitoring and providing on-scene response to incidents, the Inspector General or Chief Deputy Inspector General visits every adult institution and youth correctional facility at least once annually. In 2015, the Inspector General conducted 34 institution visits. The Chief Deputy Inspector General conducted 16 institution visits and visited O.H. Close Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, and Baseline Fire Camp. The Inspector General and Chief Deputy Inspector General also visited the 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. In total, the Inspector General and Chief Deputy conducted 50 institution visits in 2015.

Above and beyond the staff who monitor systems within the prisons on a daily basis, OIG staff are specifically tasked to assess the rehabilitation and education operations as part of a review for the California Rehabilitation Oversight Board and *Blueprint* monitoring function at least twice per year. The California Rehabilitation Oversight Board, where the OIG and staff interact with the department and other stakeholders at regular meetings, provides another avenue for input.

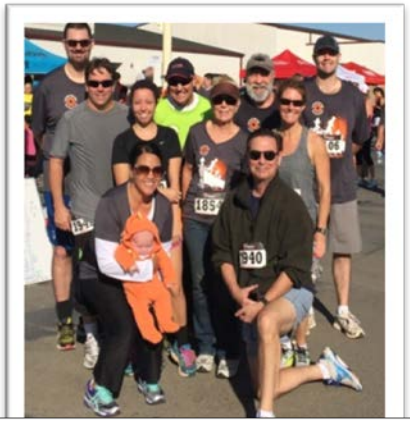
The Office of the Inspector General staff make presentations to the CDCR Office of Internal Affairs academy regarding the role and function of the OIG. Presentations are also made by the OIG to correctional officer candidates in the Galt academy, and at CDCR leadership conferences. Additional presentations on the OIG's role and function were provided to various entities when requested such as the Division of Adult Parole Operations, Life Support Alliance, the American Civil Liberties Union (ACLU), Statewide Inmate Family Council, etc.

The OIG continues to maintain a close liaison with senior management at the department. The Chief Deputy Inspector General holds monthly meetings with the Director of Adult Institutions, the Director of Adult Parole Operations, the Director of Internal Oversight and Research, and the Deputy Director for the Office of Internal Affairs. The Inspector General also meets monthly with the Secretary of CDCR. These meetings allow for a high-level discussion of issues and problems and their timely resolution. In addition, the Assistant Chief Deputy Inspector General has monthly meetings with the Chief Counsel for the Employment Advocacy and Prosecution Team, the Chief of Field Operations, the Office of Internal Affairs, the regional Assistant Chief Counsels for the Employment Advocacy and Prosecution Team, and regional Special Agents in Charge for the Office of Internal Affairs. These meetings delve into more day-to-day operational issues and have been extremely helpful in resolving issues at the field level. The Inspector General and OIG staff also attend noteworthy events throughout the State to maintain contact with the department and the public in order to educate and establish working relationships with stakeholders.

The Inspector General personally:

- Participated in the Executive Development Orientation Program
- Presented at the Volunteer Advisory Task Force
- Presented at the Life Support Alliance first lifer annual seminar
- Attended the Service Employees International Union's annual legislative reception
- Attended the California Leadership Forum
- Attended the Community Justice 2014 International Summit hosted by the Administrative Office of the Courts
- Participated in the California State Employees with Disabilities training symposium "Advancing Disability Employment in State Government"
- Presented a training seminar at CDCR's Correctional Training Center regarding Employee Investigation and the Disciplinary Process
- Participated as a guest speaker at the annual National Association for Civilian Oversight of Law Enforcement (NACOLE) conference
- Participated in the Smart on Safety Summit in Los Angeles
- Presented at the Division of Adult Parole Operations leadership conference
- Attended the Californians for Safety and Justice conference
- Attended events sponsored by the Anti-Recidivism Coalition (ARC)
- Attended the Actor's Gang Prison Project rehabilitative program graduation at the California Institution for Men
- Participated in the Mindful Justice working conference at the Fetzer Institute in Michigan
- Supported the Caring for Kids charity event with staff members of the OIG to raise funds and awareness for adoption and foster care
- Attended the California Prison Industry inmate graduation at the Folsom Women's Facility
- Attended and addressed a Pain of the Prison System (POPS) club meeting at Venice High School
- Attended and presented at the Asian Pacific State Employee Association's leadership conference
- Attended the Survivor's Speak Conference as part of National Crime Victims' Rights Week
- Presented at the Inmate Family Council
- Attended a workshop titled Burning Down the House, the End of Juvenile Prison
- Attended the 70th year anniversary of Pine Grove Youth Conservation Camp

Inspector General Bob Barton participating in the Life Support Alliance seminar with Jennifer Shaffer, Executive Officer of the Board of Parole Hearings.



Inspector General Bob Barton and OIG staff supporting the Caring for Kids charity run.

Staff of the OIG from the C-ROB, Publications, and Rehabilitation unit:

- Attended CDCR's Medal of Valor Ceremony
- Attended Defy Ventures inmate rehabilitative programming group
- Participated in CDCR's Gender Responsive Training Conference
- Participated in CDCR's Internet Protocol Television Integration Content Selection Committee
- Attended Insight Prison Project's Victim Offender Education Group
- Attended briefings on public safety realignment, parole populations, crime trends, and prison capacity challenges held at the Public Policy Institute in Sacramento.
- Visited DAPO's Lifer Peer Reentry Navigation Network pilot program
- Attended the One Family rehabilitative program graduation
- Participated in the California Coalition on Sexual Offending training conference

Other staff of the OIG:

- Attended the 70th year anniversary of Pine Grove Youth Conservation Camp
- Coordinated an agency-wide clothing drive to support a local Female Offender Treatment and Employment Program
- Observed annual firecrew training at Ishi fire camp

The OIG invited outside stakeholders to address and interact with OIG Staff at the annual OIG All-Staff meeting to provide feedback, training, and cooperation across agency, hierarchical, and functional boundaries.

The Inspector General, Chief Deputy Roy Wesley, and Senior Assistant Inspector General, Suzann Gostovich at Ishi fire camp.

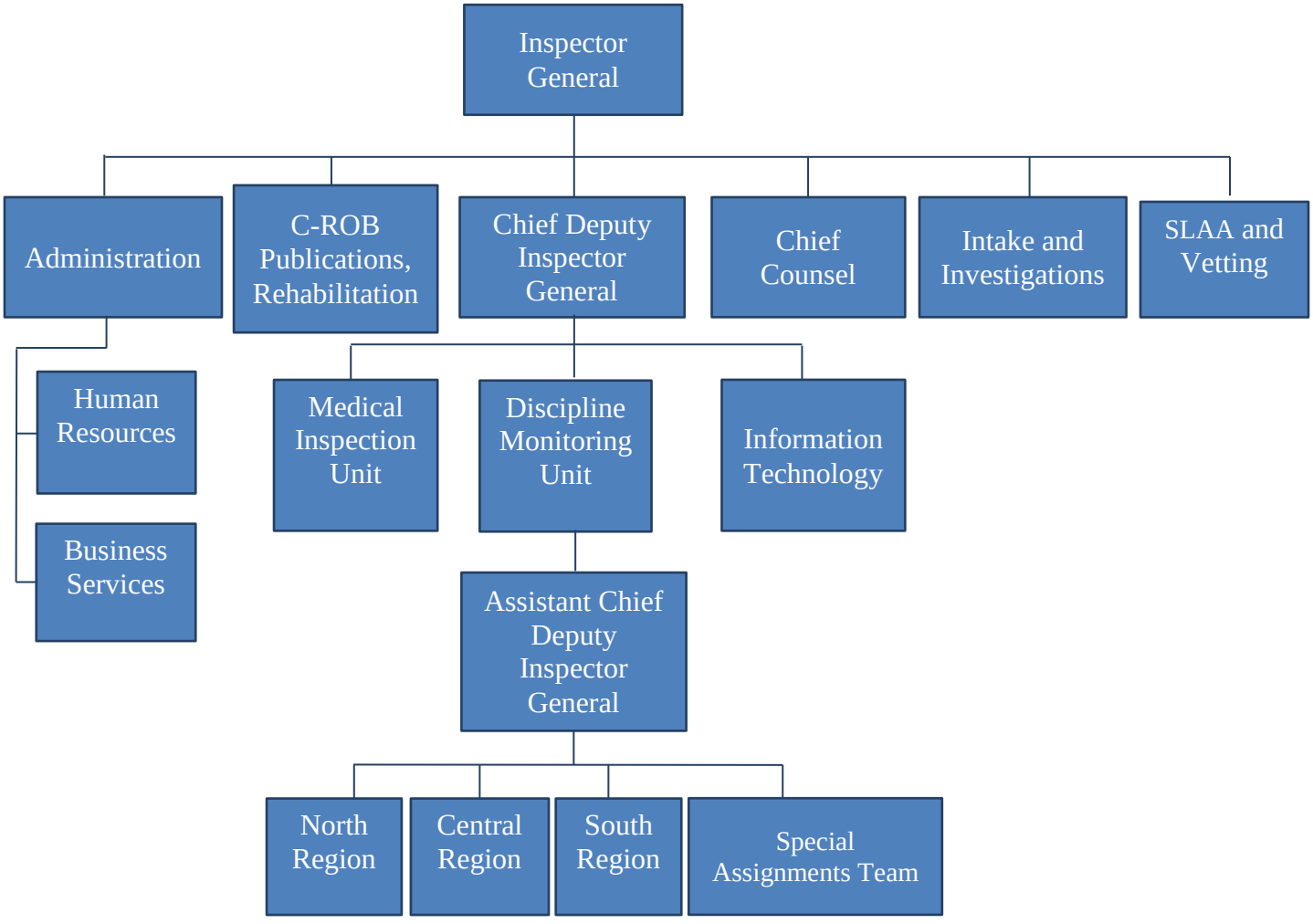
Expert Assistance Provided to the California Health and Human Services Agency

At the request of the Secretary of California Health and Human Services Agency, the OIG has entered into an interagency agreement to provide expertise for the creation of a system of transparent oversight of the disciplinary processes for the Department of State Hospitals and the California Department of Developmental Services. The goal of the joint venture is to create a robust internal affairs process with public reporting. The OIG worked closely with the Secretary's office and provided detailed reviews of the various strategies and proposals developed. The OIG continues its collaboration with the California Health and Human Services Agency as that agency activates its plan for transparent oversight of the employee disciplinary system.

ORGANIZATIONAL OVERVIEW

- California Penal Code Sections 2641 and 6125 et seq. provide the statutory authority for the OIG's establishment and operations.
- The OIG staff is a skilled team of professionals, including attorneys with expertise in internal affairs investigations, criminal law, and employment law, as well as inspectors experienced in correctional policy, operations, and investigations. The OIG has a cadre of medical professionals in the Medical Inspection Unit. There are also analysts and various support staff within the OIG, all of whom are integral in achieving the OIG mission.
- The OIG is organized into three regions: North, Central, and South. The North Region is co-located with executive and administrative operations in Sacramento (Rancho Cordova), the Central Region is in Bakersfield, and the South Region is in Rancho Cucamonga.

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.

California Penal Code Sections 2641 and 6125 et seq. set forth the functions of the Office of the Inspector General.

Statewide General Intake

The OIG maintains a statewide intake process to receive communications from any individual regarding allegations of improper activity within CDCR. The OIG does not independently conduct investigations. However, complaints of misconduct are brought to the department's attention.

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. During 2015, Intake Unit staff contacted institutions 34 times indicating potential safety concerns based on letters and messages left on the toll-free public phone line, calls received on the main OIG telephone number, and complaints submitted electronically. These complaints expressed potentially unsafe conditions, such as enemy concerns, threatening behavior, or other indicators that there may be a safety or security risk for staff or inmates. 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.

In non-urgent matters, 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. 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 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.

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

Complaints alleging theft, fraud, or waste of State resources concerning CDCR are also presented to the Inspector General for consideration of referral to the California State Auditor.

In 2015, the OIG's Intake Unit received 2,266 general complaints submitted by inmates, parolees, families, CDCR employees, and advocacy groups, including 36 complaints the Office of the Governor assigned the OIG to review. Based on the OIG screening criteria, Intake Unit staff conducted additional research into matters or requested clarifying documentation from CDCR institutions for 844 of these complaints.

The OIG's Intake Unit received 136 complaints alleging inappropriate healthcare, a lack of access to healthcare, or both. OIG Intake or medical staff conducted additional analysis of these medical, dental, and mental health complaints. The OIG referred these complaints to CDCR's Division of Correctional Health Care Services for remedy where the OIG determined potential violations of medical policies or procedures occurred.

Field Inquiries

Since its inception, the OIG has provided a process by which inmates, CDCR staff, and the public can report misconduct. The OIG examines complaints received and assigns staff to conduct field inquiries regarding the complaints at the institutions. On July 1, 2015, the OIG began to collect data regarding CDCR's response to OIG's inquiries to be included in our semi-annual report. In 2015, the OIG referred 70 field inquiries to the OIG's regional operations teams to bring the matters to the attention of the specific institutions and to monitor departmental response at the local level.

CDCR Oversight Activities

Retaliation Claims

California Penal Code Sections 6128 and 6129 provides an avenue for 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 provides a report of its findings to CDCR along with a recommendation of the appropriate corrective action.

In 2015, the OIG received 16 retaliation complaints. The Legal Unit determined 2 stated a prima facie case of retaliation and opened investigations into each complaint. One of those investigations has been completed; the other is still pending. Of the 14 other complaints, the Legal Unit determined 12 did not state a prima facie case of retaliation and is still in the process of evaluating the other two.

The OIG also concluded its investigation into a complaint it received in 2013 and determined neither of the two remaining complaints it received in 2014 stated a prima facie case of retaliation.

Sexual Abuse in Detention Elimination Act Ombudsperson Claims (also referred to as Prison Rape Elimination Act 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 Inspector General met with both Just Detention International and ACLU to explain the agency's role in this area.

CDCR notified the OIG of 264 sexual abuse allegations during 2015, including 127 with an inmate as the alleged perpetrator, 136 with a staff member as the alleged perpetrator; and 1 with an inmate and staff as alleged perpetrators. The OIG monitors CDCR's handling of all sexual abuse allegations and all subsequent investigations of alleged staff involvement.

The OIG received and reviewed 127 complaints alleging inadequate investigations of sexual abuse in detention and sexual harassment by staff. The Inspector General referred fourteen of those allegations to OIG regional staff for follow up.

Monitoring Activities

California Penal Code Section 6133(b)(1) mandates the OIG publish a Semi-Annual Report of its oversight of CDCR.

The OIG's Discipline Monitoring Unit provides contemporaneous oversight of CDCR's internal affairs investigations and employee discipline process. The OIG also oversees CDCR's response to critical incidents within the institutions and monitors the department's contraband surveillance watch process and use-of-force reviews. In addition, the OIG conducts field inquiries based on complaints received from inmates, CDCR staff, and the public.

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 Employment Advocacy and 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. In 2015, the OIG opened 514 employee discipline cases for monitoring.

Closed discipline cases are reported in Volume I of the OIG's Semi-Annual Report: www.oig.ca.gov/pages/reports.php

Critical Incident Monitoring

The OIG maintains regional on-call staff who can respond on site 24 hours per day to critical incidents reported to the OIG from any of the State's correctional institutions. In 2015, the OIG monitored 195 critical incidents.

The OIG monitors a critical 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, OIG staff will recommend and subsequently monitor any 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 and made recommendations statewide or at a specific institution.

Critical incident case summaries are reported in Volume II of the OIG's Semi-Annual Report, available at: www.oig.ca.gov/pages/reports.php

Contraband Surveillance Watch

The OIG monitors the department's contraband surveillance watch process to ensure it 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 opens a case, goes on scene to inspect the inmate's condition, and ensures 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.

In 2015, the OIG was notified of 308 contraband surveillance watch cases, 175 fewer than in 2014. Of the 308 notifications in 2015, the OIG monitored the 101 cases that extended beyond 72 hours, as compared to 123 cases extending beyond 72 hours in 2014. The continued decrease in the need and length of contraband surveillance watch is a positive trend.

Contraband surveillance watch reports are found in Volume II of the OIG's Semi-Annual Report, at: www.oig.ca.gov/pages/reports.php

Use-of-Force Monitoring

The OIG continues to monitor the department's use-of-force review process. The OIG attended 891 Executive Review Committee meetings and reviewed nearly 3,500 of the almost 6,000 use of force incidents. For the past year, OIG has been developing a new use-of-force monitoring tool to allow more in-depth analysis of each use of force incident and allow collection of data identifying those officers who use force most often and those inmates against whom force is used most often. The new tool will also allow identification of "hotspots" where force is used within a prison. The new tool was deployed on January 1, 2016 and is undergoing field beta testing. The OIG also participates as a non-voting member of the CDCR Deadly Force Review Board.

Use-of-Force reports are found in Volume II of the OIG's Semi-Annual Report, at: www.oig.ca.gov/pages/reports.php

Medical Inspections

Pursuant to California Penal Code, Section 6126(f), 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.

After completing pilot medical inspections at seven institutions, the OIG began its fourth cycle of medical inspections on January 26, 2015. During 2015, the OIG completed 12 of its Cycle 4 medical inspections. Related to those inspections, the OIG issued eight final public reports; as of December 31, 2015, the OIG had also issued one additional draft report to external stakeholders.

The Cycle 4 medical inspection methodology includes qualitative reviews and compliance testing conducted by teams staffed with OIG clinicians and deputy inspectors general, who use 16 quality indicators of health care to assess each institution. During the second half of 2015, the OIG more than doubled its Medical Inspection Unit staff to complete the inspection cycle faster. Once all of the new teams are fully staffed and trained, the OIG should be able to conduct a full cycle of

inspections over a period of approximately 12 months.

OIG Cycle 4 Medical Inspections Conducted During 2015

Institution Inspected	Final Report Issued	Rating
FSP	April 2015	Adequate
CTF	June 2015	Adequate
CRC	July 2015	Adequate
CCC	August 2015	Inadequate
CVSP	September 2015	Adequate
NKSP	October 2015	Inadequate
SOL	December 2015	Inadequate
KVSP	December 2015	Adequate
CCI	January 2016	Adequate
PBSP	*(pending)*	*TBA*
VSP	*(pending)*	*TBA*
CEN	*(pending)*	*TBA*

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. Candidates have typically been acting wardens for at least three months before the OIG process begins. The OIG is keenly aware of the need for stability in management and, therefore, strives to complete its part of the vetting process as expeditiously as possible.

The OIG uses a three-phase vetting process with an internal completion goal of 60 days, and this year 10 vettings were completed, with an average completion time of 56 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 with the candidate. 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. The Inspector General then submits a confidential recommendation to the Governor.

Due to the high rate of attrition from retirement within CDCR management, the OIG anticipates a continual demand for warden vetting in 2016. Currently, the following 13 institutions are without permanent wardens:

- Avenal State Prison
- California Correctional Center
- California Health Care Facility
- California Institution for Men
- California Men's Colony
- California State Prison, Los Angeles County
- Centinela State Prison
- Correctional Training Facility
- High Desert State Prison
- Kern Valley State Prison
- North Kern State Prison
- Sierra Conservation Center
- Wasco State Prison.

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 continued to show progress in implementing the goals of the *Blueprint* in 2015. 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 made progress in implementing some of its rehabilitative program goals, but it was unable to attain its goal of reaching 70 percent of its target population by June 30, 2015, as only 56 percent of its target was served.

On August 31, 2015, the department entered into a settlement agreement for Todd Ashker, et al., v. Governor of the State of California, et al., Settlement Agreement, C 09-05796 CW. The agreement involves changes to policies and practices for placing, housing, managing, and retaining inmates who have been validated as prison gang members and associates, along with conditions in each of its four Security Housing Unit (SHU) institutions. This agreement is to be implemented over a 24-month pilot period, placing an emphasis on completing all remaining case reviews for all SHU inmates on a definitive timeline—within 12 months of the court's preliminary approval of the settlement agreement—by August 31, 2016. These reviews are to be conducted by Institution Classification Committees, and inmates who have served the longest SHU terms will be prioritized. The OIG will continue to monitor and report on the revised agreement.

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

California Rehabilitation Oversight Board

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 three times per year to examine CDCR's various mental health, substance abuse, education, and employment programs for inmates and parolees. The C-ROB report is published annually, on September 15.

In 2015, C-ROB staff, in collaboration with the OIG's *Blueprint* monitoring team, visited all 35 adult institutions to observe rehabilitation programs and identify successes and challenges in programming.

C-ROB staff review a broad range of rehabilitative programs, services, and activity groups, including substance abuse treatment, academic education programs, career technical education programs, and volunteer rehabilitative programming.

Institution site visits revealed many positive changes occurring within the department,

especially its efforts to expand reentry services and substance abuse treatment. The department successfully increased its rehabilitative program capacity by nearly 30 percent in less than two years, has developed a case management plan, and has addressed all four of the recommendations from the 2014 C-ROB report. The 2015 C-ROB report also provides four recommendations.

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

Special Reviews

A special review process is 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: High Desert State Prison Susanville, CA

The Office of the Inspector General completed one Special Review in 2015. The Senate Committee on Rules requested a review of the practices at High Desert State Prison regarding various aspects of interaction between staff and inmates. The report was published December 16, 2015[1]. The report makes several findings and recommendations. The review lasted several months and involved interviews with dozens of former staff and former and current inmates, and active monitoring of 20 potential misconduct investigations involving HDSP staff. In addition, OIG staff conducted reviews of prior inmate appeals, disciplinary actions, confidential files, and complaints against staff; reviews of misconduct allegation inquiry reports, internal affairs investigation reports, and heath review reports; and research into current policy and practices plus past reviews done at the institution.

As a result of this statutorily authorized review process, the OIG was sued by the California Correctional Peace Officers Association in an attempt to curtail the legitimate oversight efforts of the OIG. The pending litigation threatens the ability of this oversight agency to conduct lawful reviews and provide public transparency to the conditions and practices within CDCR.

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

CDCR CORRECTIVE ACTION PLAN UPDATE

In 2015, the OIG completed one special review and published 17 formal reports containing 62 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 in 2014

The OIG made five recommendations to CDCR in the March 2014 Semi-Annual Report, and four more recommendations in the October 2014 Semi-Annual Report. The department has fully or substantially implemented five of the nine Semi-Annual Report recommendations and partially implemented one of the recommendations. Two of the recommendations have not been implemented, and the remaining one is currently being reviewed.

The OIG made three recommendations in the November 2014 *Special Review: Electronic Monitoring of Sex Offenders on Parole and the Impact of Residency Restrictions*. Of the three recommendations made in that special review, two have been fully implemented and one has been partially implemented.

There were also six recommendations made in the C-ROB March 2014 Biannual Report and four made in the C-ROB September 2014 Biannual Report. The California Rehabilitation Oversight Board is an independent board, and, unlike the OIG, does not have authority to request specific responses to recommendations; however, the department has fully or substantially implemented four of the six recommendations from the March 2014 C-ROB report, and partially implemented the remaining two recommendations. In addition, the department has partially implemented the four recommendations from the September 2014 C-ROB report.

Status of Recommendations Made to CDCR in 2015

The OIG made eight recommendations to CDCR in the March 2015 Semi-Annual Report, and three more recommendations in the October 2015 Semi-Annual Report. The department has fully or substantially implemented four of the eleven Semi-Annual Report recommendations and partially implemented four of the recommendations. One of the recommendations has not been implemented, and the two remaining recommendations are currently being reviewed.

The OIG made 45 recommendations to the department in the December 2015 *Special Review: High Desert State Prison Susanville, CA.* These recommendations are all currently being reviewed.

There were also four recommendations made in the September 2015 C-ROB report. Three of the recommendations have been partially implemented and one is currently being reviewed.

The Medical Inspection Reports also contain institution-specific recommendations that are provided to the Receiver and the department, but due to the authority of the Receiver to implement corrections, the department does not submit a corrective action plan for the recommendations in the MIU reports.

APPENDIX: REPORTS RELEASED IN 2015

Annual Report

- 2014 OIG Annual Report (January 2015)

Semi-Annual Reports

- OIG Semi-Annual Report July–December 2014 Volume I (March 20, 2015)
- OIG Semi-Annual Report July–December 2014 Volume II (March 20, 2015)
- OIG Semi-Annual Report January–June 2015 Volume I (September 16, 2015)
- OIG Semi-Annual Report January–June 2015 Volume II (September 16, 2015)

Medical Inspection Reports

- California Training Facility Medical Inspection Results Cycle 4 (June 18, 2015)
- California Rehabilitation Center Medical Inspection Results Cycle 4 (July 3, 2015)
- California Correctional Center Medical Inspection Results Cycle 4 (August 25, 2015)
- California State Prison, Solano Medical Inspection Results Cycle 4 (December 22, 2015)
- Chuckawalla Valley State Prison Medical Inspection Results Cycle 4 (September 29, 2015)
- Folsom State Prison Medical Inspection Results Cycle 4 (April 22, 2015)
- Kern Valley State Prison Medical Inspection Results Cycle 4 (December 31, 2015)
- North Kern State Prison Medical Inspection Results Cycle 4 (October 23, 2015)

California Rehabilitation Oversight Board (C-ROB) Report

- C-ROB September 15, 2015 Biannual Report (September 15, 2015)

Blueprint Monitoring Reports

- Fifth Report on CDCR's Progress Implementing its Future of California Corrections *Blueprint* (March 16, 2015)
- Sixth Report on CDCR's Progress Implementing its Future of California Corrections *Blueprint* (September 30, 2015)

Special Review Reports

- 2015 Special Review: High Desert State Prison Susanville, CA (December 16, 2015)

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

2015 ANNUAL REPORT

OFFICE OF THE INSPECTOR GENERAL

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STATE OF CALIFORNIA
January 2016