OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

HIGH DESERT STATE PRISON, SUSANVILLE

ACTING WARDEN DAVID RUNNELS

NOVEMBER 2001

STATE OF CALIFORNIA

GRAY DAVIS, GOVERNOR

State of California

Office of the Inspector General
801 K Street, Suite 1900
Sacramento, CA 95814

Memorandum

Date: November 1, 2001

To: EDWARD S. ALAMEIDA, JR.
Director, California Department of Corrections

From: STEVE WHITE
Inspector General

Subject: HIGH DESERT STATE PRISON MANAGEMENT REVIEW AUDIT

I am pleased to forward to you the enclosed report of the management review audit of High Desert State Prison recently conducted by the Office of the Inspector General. The audit was conducted pursuant to California Penal Code Section 6051.

The Office of the Inspector General audit found that the institution is generally well run, but we identified a number of significant medical issues that require the attention of management. In addition, the audit revealed several issues having department-wide implications. Although these matters are beyond the control of the institution management, we are presenting them in this report for your review and disposition.

A draft version of the report was provided to Acting Warden David Runnels and Chief Medical Officer M. Bargon. The joint response to the draft report by Warden Runnels and Dr. Bargon is included in the report as Attachment A.

Throughout the course of the management review audit, the Office of the Inspector General staff received excellent cooperation from management and staff at High Desert State Prison. I wish to acknowledge and express my appreciation for the courtesy extended to my staff.

Please call me if you have questions concerning the report.

SW:dj

Enclosure

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency
David Runnels, Warden (A), High Desert State Prison
M. Bargon, Chief Medical Officer, High Desert State Prison

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REPORT

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NOVEMBER 2001

STATE OF CALIFORNIA **GRAY DAVIS, GOVERNOR**

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EXECUTIVE SUMMARY

This report presents the results of a management review audit of High Desert State Prison conducted by the Office of the Inspector General from April 2001 through August 2001. The purpose of the audit was to provide a baseline review in accordance with *California Penal Code* Section 6051. The audit focused on institutional processes relating to communications, investigations, security, personnel, training, medical services, dental services, and financial matters.

High Desert State Prison has had a series of wardens since it opened in August 1995. The current acting warden, David Runnels, assumed the position in November 2000 when Warden Roy Castro transferred to the California Correctional Center. Runnels previously served as chief deputy warden at High Desert State Prison from June 1998 to November 2000. As acting warden, he is responsible for overseeing all institution operations except for medical, dental and psychiatric programs; which are under the direction of the recently hired chief medical officer/health care manager, Norman Baron, M.D.

In assessing the institution's operations, the Office of the Inspector General staff toured the facilities and observed operations, conducted interviews and surveys of employees, met with inmate advisory committees, and reviewed pertinent documents related to key systems, functions, and processes. Overall, the Office of the Inspector General found that the institution has performed satisfactorily, considering that: the custody operation is responsible for housing and programming some of California's most dangerous inmates, the prison has difficulty hiring staff because of its remote location, the prison is continually overcrowded, and it is under severe budget constraints.

Acting Warden Runnels is confronted with the challenges of having to manage a high-security, overcrowded institution with the potential for violence on a daily basis. More than 60% of the inmate population is classified as Level IV, and there are constant concerns about inmate and staff safety. Prison gangs have been responsible for numerous incidents since the institution opened, and recently a correctional officer at the facility was critically injured during an assault on staff members. The inmates, many serving life terms with no possibility of parole, are uncooperative and difficult to program. As a result, a large proportion of the inmate population is constantly on modified programming. During a modified program or lockdown situation, inmates are locked in their cells for extended periods of time, with limited opportunities to exercise or to interact with staff and other inmates, and custody personnel are generally required to escort all inmate movement.

High Desert State Prison experiences recruitment and retention problems because of its rural location. Also, it must compete for staff resources with its neighboring institution, the California Correctional Center. Staff retention issues affect not only vacancies but also operational policies. The staff and the inmates commented on the lack of stability within the facility's management structure in recent years, which has created an uncertain environment. Changes in management can affect inmate programming and operational practices because each new manager has a particular approach. Several staff members stated that the institution's operations have been improving, but that management must be given the opportunity to establish greater stability in order for recent efforts to be sustained.

In addition, like almost all California prisons, the institution is operating at nearly twice the capacity for which it was designed. The institution was designed to house 2,200 inmates but is currently housing about 4,300. The majority of the inmates must be doubled celled, which can create a security problem if the inmates are not appropriately matched: Classification and custody personnel must be cognizant of each inmate's background to ensure that they do not place inmates or staff members at risk. The institution appears to be in good physical condition, but overcrowding causes undue wear and tear on the facility and equipment and the plant operations staff must ensure proper maintenance for facilities and systems that are working in excess of the design capacity.

Another issue is the institution's projected $1.4-million budget shortfall. The deficit is the result of a number of factors, including increased workers' compensation costs, overtime, and department-mandated budget reductions. To help mitigate the deficit, headquarters instructed the institution to leave non-critical positions vacant as well as to reduce inventories and supplies to minimum operating levels. Only purchases directly related to critical health, safety, and security issues are being allowed.

Overall, the management review audit revealed no major issues of concern regarding non-medical areas under the direction of the warden. The majority of the notable deficiencies were in the health care program, which is under the direction of the health care manager. Following is a list of notable deficiencies, by program area.

FINDINGS—INSTITUTION PROGRAM

- The inmate appeals system contains deficiencies that undermine the integrity of the appeals process and subject inmates to possible safety risks.
- Inmate services during lockdown are inadequately documented.
- Inmate appeals are not processed within the prescribed time limits.
- Inmates paroled from the Susanville institutions pay an extra $55 transportation cost compared to inmates paroled from the Folsom institutions.

FINDINGS—HEALTH CARE PROGRAM

- Inmate medical records are inadequately documented.
- Inmate medications could be tampered with before they are administered.
- Inmates on psychotropic medication are not included in the mental health delivery system.
- Inmates are not receiving dental services required by state regulations.
- Inmates are not provided with the medical, psychiatric, and dental chrono forms (CDC Form 128 C) in a timely manner.

- Inmate medications are not adequately accounted for and controlled.

- Inmate medical appeals are not processed within the prescribed time limits.

Some of the recommendations of the Office of the Inspector General regarding these situations will require the involvement and support of California Department of Corrections headquarters management, because they require changes to departmental policies and procedures.

Throughout the review process, the staff of the Office of the Inspector General received excellent cooperation and assistance from the staff of High Desert State Prison.

INTRODUCTION

The Office of the Inspector General conducted its management review audit of High Desert State Prison pursuant to its authority under *California Penal Code* Section 6051. This statute provides that the Office of the Inspector General is required to perform a baseline audit of any California Department of Corrections institution whenever the warden position becomes vacant and a new warden is appointed. The purpose of the baseline audit is to inform the new warden about program deficiencies and to provide recommendations for improvement. The baseline review includes, but is not limited to, issues relating to communications, investigations, security, personnel, training, medical services, dental services, and financial matters.

BACKGROUND

David Runnels was assigned as interim warden at High Desert State Prison in November 2000 when Warden Roy Castro was appointed warden at the California Correctional Center. Warden Runnels was the chief deputy warden at High Desert State Prison from June 1998 through November 2000. He began his state career in 1982 as a correctional officer with the Deuel Vocational Institution in Tracy and was later promoted to correctional sergeant at California State Prison, Solano. He held various positions at Solano, including employee relations officer, business manager, correctional captain, and correctional administrator.

High Desert State Prison opened in August 1995 and became one of nine institutions in the state to house Level IV male inmates. The prison's design is considered the most secure within the California correctional system: it has two 180-design facilities, which give the custody staff a 180-degree view from the control booth. The prison is located on 325 acres in Susanville, adjacent to the California Correctional Center. It houses approximately 4,300 minimum- to high-maximum-custody inmates. More than 60% of the inmate population is designated Level IV. The institution also operates a 190-bed reception center for inmates being remanded to the care of the California Department of Corrections from Northern California counties.

The 4,300 inmates are divided among five facilities. Facilities A and B are of the 270-design and house both Level III and Level IV inmates. (Building 5, located in Facility A, houses the majority of the reception-center inmates.) Facilities C and D are of the 180-design and house Level IV inmates as well as inmates assigned to administrative segregation. Facility E is the minimum-support facility, located just outside the secure perimeter, and houses only Level I inmates.

The institution's mission is to provide for the confinement of general population Level I, Level 3, and Level 4 inmates who are willing to participate in vocational, academic, or support services programs.

High Desert State Prison is one of the largest employers in Lassen County. It has an annual operating budget of more than $100 million and currently employs more than 1,200 full-time staff members.

OBJECTIVES, SCOPE AND METHODOLOGY

The objectives of the management review audit were to evaluate the institution management's performance in:

1. Planning, organizing, directing, and coordinating all correctional, business management, work-training incentive, and related programs; and
2. Formulating and executing a progressive program for the care, treatment, training, discipline, custody, and employment of inmates.

In order to accomplish these objectives, the audit team performed various procedures in the general areas of communications, investigations, institution safety and security, inmate programming, health services, dental services, personnel, training, and financial management. Those procedures included:

1. Performing analytical reviews of financial information and data trends;
2. Conducting interviews with the warden, the administrative staff, custody and non-custody employees, and inmates;
3. Gathering input from randomly selected employees via questionnaire regarding the warden's and the chief deputy warden's effectiveness in communication;
4. Touring the facilities and observing their operations; and
5. Gathering, reviewing, and analyzing pertinent documents related to key systems, functions, and processes, to substantiate the observations made through on-site visits and interviews.

PROBLEMS OF MANAGING A LEVEL IV PRISON IN A REMOTE LOCATION

The remote location of High Desert State Prison, coupled with its large population of Level IV inmates, presents particular management challenges.

- ***Lockdowns.*** High Desert State Prison has had numerous lockdowns since opening in August 1995. This is not uncommon for Level IV institutions, which incarcerate a large number of inmates who have violent backgrounds and gang affiliations and are serving life terms. The prison's lockdowns affect inmate access to medical care, access to education and work programs, and other inmate privileges such as canteen and visiting. Therefore, it is not surprising that the institution experiences an increase in the number of appeals filed by inmates during lockdowns. These appeals create additional workload for correctional staff members who must address the issues and respond to the inmates in a timely manner. Lockdowns also mean that academic and vocational instructors are not able to provide instruction to students, which has a major impact on inmate education and training. During lockdowns, teachers are redirected to assist with mail processing, with documenting property obtained during cell searches, and with community events.

The following chart displays the average number of inmates affected by a lockdown or modified program during the period of February 4, 2001 through July 1, 2001.

Inmate Population*	Inmates on Modified Program (average)	Inmates on Lockdown Status (average)	Percentage on Modified/Lockdown
3,940	1,042	1,427	62.7%

* Excludes administrative segregation and reception center inmates.

From June 10, 2001 to August 2, 2001, the entire institution except the minimum-custody facility was on lockdown status.

- ***Recruitment and Retention.*** The remote location of High Desert State Prison has a major impact on recruitment and retention of staff. This is especially true in the area of medical services. The prison has a high vacancy rate for both medical technical assistants and registered nurses. California in general is experiencing a nursing shortage, and the institution is currently competing with hospitals as far away as the Sacramento area to retain the existing staff, with some hospitals even offering hiring incentives to potential employees.

  The prison also has difficulty recruiting correctional officers. Over the last three years, the institution has received only 30% of what it requested from the academy. The shortage of correctional officers is currently a statewide problem, but it is even greater in hard-to-recruit areas such as Susanville. The high number of vacancies at the prison means that its correctional officers are often required to work a significant amount of overtime to cover shifts.

- ***Lack of Stability in Leadership Positions.*** It is critically important for a prison, especially a Level IV institution, to have a strong and stable leadership to provide focus and direction for both staff and inmates. Yet High Desert State Prison has continually experienced a great deal of turnover at the management level. Since opening in August 1995, the prison has had seven wardens or acting wardens, as shown below.

  - David Runnels (acting) - November 2000 to present
  - Roy Castro - July 1998 to November 2000
  - Denise Mayle (acting) - July 1998
  - Susan Yearwood - July 1997 to June 1998
  - Robert Ayers (acting) - April 1997 to June 1997
  - Richard Gile (acting) - January 1997 to April 1997
  - William Merkle - September 1994 to December 1996 (member of the activation team from September 1994 through August 1995)

There also have been numerous rotations at the positions of chief deputy warden, associate warden, and facility captain. High Desert State Prison records show that from January 1998 to June 2001, the institution has had seven chief deputy wardens. During the same period, there have been 10 associate wardens at Complex 1, six at Complex 2, six at Central Operations, and five at Business Services. Facility captains have had a similar turnover pattern. In just the last two years, each of the four facilities has had five different captains in charge of facility operations.

The turnover in leadership positions has made it difficult for management to build relationships with the staff and to provide consistent policy direction in the operation of the institution.

FINDINGS AND RECOMMENDATIONS

INSTITUTION PROGRAM

FINDING 1

The Office of the Inspector General found deficiencies in the inmate appeals system at High Desert State Prison that undermine the integrity of the appeals process and subject the inmates to possible safety risks.

High Desert State Prison inmates complained to the Office of the Inspector General that their appeals are often lost or ignored. Some of the inmates said they suspect the custody staff reads the complaints, especially those concerning staff members, thereby jeopardizing the inmates' safety. Although those assertions cannot be validated, the Office of the Inspector General found deficiencies in the inmate appeals system at the institution that compromise the integrity of the process. In particular, the present procedures do not adequately ensure that appeals submitted by the inmates reach the appeals office and that they are not intercepted or reviewed by those with a direct interest in the complaint.

How appeals are submitted. During normal institution operations, inmates can file appeals either by sending them to the appeals office through the prison's internal mail system or by placing them in the appeals lock-box located in each housing unit. Appeals sent by mail are picked up from the inmates by members of the housing staff, collected by the first-watch inside patrol officer, and taken to the institution mail-room. Appeals dropped into lock-boxes are collected every night by the first-watch inside patrol officer, who delivers the appeals to the program office. At the program office, the facility captain or designee reviews the appeals, decides which are to be handled at the formal level and which at the informal level, and forwards those to be handled at the formal level to the appeals office. The appeals office logs the formal-level appeals and coordinates and prepares responses.

Procedures during lockdowns. When the institution is in lockdown, as is frequently the case, inmates are confined to their cells and therefore are denied access to the lock-boxes. As a result, the inmates must rely on the housing staff to gather appeals and give them to the first-watch inside patrol officer. The inmate places the appeal in the cell door and a member of the housing staff picks it up to be collected by the first-watch inside patrol officer.

Inadequate separation of duties. Whether under normal operations or during lockdowns, the present system allows the appeals to pass through the hands of those who might have an interest in the complaint. Under normal operations, members of the housing staff who might be subjects of an appeal have access to any appeals submitted by mail when they pick up the appeals from the inmates. During lockdowns inmates lose the option of bypassing the housing staff by dropping appeals into the lock-box. As a result, the staff members who pick up the appeals are the same employees who provide inmates with day-to-day oversight and who may be the subjects of complaints.

Similar problems in the inmate appeals system statewide. Inmates from throughout the state have written to the Office of the Inspector General alleging similar problems at other

institutions and expressing general mistrust of the prison appeals process. Through audits of the inmate appeals systems and processes of other institutions and of the Department of Corrections Inmate Appeals Branch, the Office of the Inspector General has identified significant systemic deficiencies.

RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections undertake a thorough revamping of the inmate appeals system statewide to address the deficiencies in the inmate appeals system.

FINDING 2

The Office of the Inspector General found that the institution cannot document that the inmates received hot meals and showers during lockdowns.

According to *California Department of Corrections Operations Manual,* Section 54080.5, "A minimum of two hot meals shall be served every 24 hours with three meals provided at regular hours during each 24-hour period."

In addition, *California Code of Regulations*, Title 15, Article 5, Section 3060, requires the institution to provide the means for all inmates to keep themselves and their living quarters clean and to practice good health habits. Section 54080.21.6 of the *Department of Corrections Operations Manual* specifically states:

> *Inmates undergoing disciplinary detention shall be provided the means to keep themselves clean and well groomed. Haircuts shall be provided as needed. Showering and shaving shall be permitted at least three times per week.*

The Office of the Inspector General reviewed documents for the period of June 10, 2001 through July 31, 2001 to determine whether inmates received hot meals and showers during a recent lockdown. The institution was unable to produce evidence that hot meals were served for five out of a possible 52 days (9.6%). The documentation on showers did not specify which inmates received the showers. In many cases, the housing unit log simply stated that lockdown showers started, with no indication of which cells were completed. In other cases, the documentation noted that showers were completed in section A, B, or C but with only one section completed each day. Under this schedule, only one section would actually receive three showers during a seven-day period; the remaining two sections would not be in compliance with the three-shower-per-week requirement.

If the institution cannot provide documentation of services such as hot meals and showers during lockdowns, the California Department of Corrections opens itself to possible litigation with potentially high cost to the State. In addition, inmates may become hostile when denied these rights and, as a result, may cause harm to the staff or to other inmates.

RECOMMENDATION

The Office of the Inspector General recommends that the warden ensure that staff members document services provided to each inmate during lockdowns to ensure that inmates are provided with mandated services and to avoid potential litigation.

FINDING 3

The Office of the Inspector General found that inmate appeals, especially appeals related to medical issues and to the Americans with Disabilities Act, were not processed within the prescribed time limits. Furthermore, modification orders resulting from medical appeals were not implemented.

California Code of Regulations, Title 15*,* Section 3084.6 provides: "First level appeals shall be completed within 30 working days, second level responses within 20 working days, or 30 working days if first level is waived."

The Office of the Inspector General found that these requirements are not being met at High Desert State Prison. Of 78 appeals sampled for the period of July 2000 through March 2001, 36 (46%) were not processed in a timely manner either at the first or the second formal level review, or at both levels. The sample included 13 appeals related to medical issues and three related to the Americans with Disabilities Act.

Appeals were overdue by between one day and 106 days, as described below.

- Of 42 appeals reviewed at the first level only, 18 (43%) were overdue. Of these 18 overdue appeals, six related to medical issues and one related to the Americans with Disabilities Act. Of the 18 overdue appeals:
    - Twelve were overdue by 1-30 days.
    - Four were overdue by 31-60 days.
    - One was overdue by 62 days.
    - One was overdue by 106 days.
- Of 16 appeals reviewed at the second level only, six (38%) were overdue by 1-30 days.
- Of 20 appeals reviewed at both the first and the second levels, 12 (60%) were overdue. Of the 12 late appeals, one related to a medical issue, and two related to the Americans with Disabilities Act. Of the 12 overdue appeals:
    - Six were overdue at both the first and the second level reviews. At the first level review, four appeals were overdue by 1-30 days, one was overdue by 34 days, and one was overdue by 35 days. At the second level review, five appeals were overdue by 1-30 days, and one appeal was overdue by 58 days.

- Three appeals were overdue at the first level review by 8-26 days.
- Three appeals were overdue at the second level review by 1-20 days.

Further evidence that health care appeals are not being processed on time can be found in the reports submitted by the appeals office to the chief deputy warden. The July 2001 report of overdue appeals shows 50 medical appeals at the first level, including five overdue from 2000, and 18 medical appeals at the second level. The report also shows 14 appeals at the first level and two appeals at the second level relating to the Americans with Disabilities Act.

High Desert State Prison has also failed to follow through on several modification orders. Modification orders are actions to be taken by the appropriate division head in response to an appeal that has been partially or fully granted at the formal level of review.

The July 2001 report of overdue appeals included six late-appeal modification orders to the health care manager. Of the six modification orders, two should have been completed during 2000, but neither had been completed as of July 2001. One of these modification orders directed the health care manager to issue a chrono of the appellant's physical limitations and directed a classification committee to determine his health care status. The other modification order directed the health care manager to replace an inmate's prescription eyeglasses and to have the inmate sign the CDC 813, Board of Control Release Claim Form.

RECOMMENDATION

The Office of the Inspector General recommends that the warden continue overseeing the inmate appeals process and that the health care manager hold his staff accountable for processing appeals and implementing modification orders in a timely manner.

FINDING 4

The Office of the Inspector General found that inmates paroled from the Susanville prisons pay an extra $55 transportation charge compared to inmates paroled from the Folsom institutions.

The difference in the transportation charge to High Desert State Prison parolees represents an equity issue over which the Susanville inmates have no control, unless they can arrange another method of transportation acceptable to the institution.

In compliance with *California Code of Regulations*, Title 15, Sections 3075.2(d) and (e), High Desert State Prison and the California Correctional Center arranged with a private company to transport inmates paroled from the institutions to the Sacramento Greyhound bus station. The cab company charges the parolees $55 for this service. In July 2001, 191 parolees from the California Correctional Center and 60 parolees from High Desert State Prison used the shuttle service to Sacramento.

The $55 and the bus ticket from Sacramento are paid from the $200 release allowance each inmate receives when paroled after serving at least six months. For example, an inmate paroled to Los Angeles County would spend $55 for the shuttle to Sacramento and $45 for a bus ticket from Sacramento to Los Angeles, leaving the parolee with $100. A similar inmate paroled from California State Prison, Sacramento would be transported to the Sacramento Greyhound bus station by the institution staff at no cost to the inmate, giving the inmate an additional $55 to spend.

RECOMMENDATION

The Office of the Inspector General recommends that the wardens of the two Susanville institutions work with the California Department of Corrections headquarters staff to have additional funds allocated to remotely located institutions, to make parolee transportation costs more equitable among institutions.

If the number of parolees using the shuttle service in July 2001 is reflective of the year, the combined cost for the two institutions would be approximately $166,000 per year.

An alternative may be for the California Department of Corrections to transport the parolees to a Greyhound bus station closer to Susanville, such as Red Bluff or Redding. A bus ticket to Los Angeles from either of those locations would cost $59.

FINDING 5

The Office of the Inspector General found numerous safety problems and documentation deficiencies in the administrative segregation housing units and control rooms.

While touring and inspecting the administrative segregation housing units and the control rooms, investigators noted the following problems.

- ***Exterior windows covered.*** The exterior windows of several cells in the administrative segregation housing units in Facility D, Buildings 7 and 8 were covered by paper. According to the institution's Operational Procedure #101, covering the windows is prohibited. This infraction severely limits the amount of light and effectively prevents the staff from visually monitoring the interior. This situation was brought to the attention of the building sergeant, who responded that the problem is common and is rectified when the staff conducts routine cell searches. Given that cell searches are conducted randomly when the inmates exit for yard time, interviews, and other reasons, it appears that cell windows can be blocked for varying periods of time, leading to security and safety problems.

- ***String found linking cells.*** The investigators saw string of the type used by inmates to surreptiously move items from one cell to another stretched on the ground between two cells. Although investigators pointed out the string to the sergeant, the officer did not correct the problem.

- ***Operating procedure binders not updated.*** Several binders in Facility D, Building 8, contained local operating procedures and *California Department of Corrections Operations Manual* supplements. One of the binders contained operating procedures that were dated from 1995-96. A second binder contained operating procedures dated between July 1998 and February 2000. Having outdated and multiple copies of operational procedures may confuse the staff as to the proper procedures to follow.

- ***Post orders not updated annually or acknowledged by staff.*** Several of the post orders for Facility D, Buildings 7 and 8, and for the main entrance gate have not been updated annually, as required by *Department of Corrections Operations Manual*, Section 51040.4. In some instances the correctional officers had not acknowledged that they had read the post orders and understood the duties and responsibilities of the post, as required by *California Department of Corrections Operations Manual*, Section 51040.6. In addition, the supervisor for the entrance gate did not inspect and sign the post order each month, as required by *California Department of Corrections Operations Manual*, Section 51040.6.

- ***Custody staff shifts not adequately documented in isolation log.*** Members of the custody staff did not consistently sign the CDC-114 isolation log for Facility D, Building 7 when arriving for and departing from their shifts. Based on a 10-day sample, selected from the June and July 2001 time period, the Office of the Inspector General staff found instances in which some posts had no documented coverage or only partial coverage. In other instances, staff members signed in but failed to sign out.

- ***Medical staff rounds not adequately documented in isolation log.*** Medical personnel often failed to indicate on the CDC-114 isolation log their respective classifications. It was impossible for the investigators to determine from the review whether a medical person signing in was a medical technical assistant, a registered nurse, a psychiatric technician, or a doctor. For the dates reviewed, there was no notation that identified whether a psychiatric technician toured the building or was on duty. On several dates, the log contained the signature of only one medical person. The isolation log did not indicate whether medical staff members had made rounds during the third watch, which contradicted the custody staff's assertion that a medical technical assistant makes at least one round inside the administrative segregation unit on the second and third watch. The investigators assumed that the rounds were being made, but at least one of the medical technical assistants was negligent in signing in. This lack of supporting signatures could have legal repercussions if the prison were faced with litigation and the need to show proof that the medical staff had in fact provided a routine and required medical presence.

- ***Cell searches not documented.*** Cell searches were not always recorded in the administration segregation cell search log when there was an inmate change. This is not in compliance with Operational Procedure #101, which requires a thorough cell search after an inmate departs from his assigned cell and before another inmate is assigned. One important reason for these searches is to hold the inmates accountable for contraband found in the cells.

- ***Hazardous metal steps.*** Metal steps leading from the ground floor to the control booth in Facility C, Building 5, become slippery when wet, constituting a safety issue that could result in employee injuries and workers' compensation cases. The institution control room staff pointed out the problem and recommended that a non-slip surface be painted on or otherwise applied to the steps.

  RECOMMENDATION

  The Office of the Inspector General recommends that the warden ensure that the staff and the inmates comply with the institution's existing policies and procedures. The Office of the Inspector General also recommends that a non-slip surface be applied to the metal steps leading from the ground floor to the control room in Facility C, Building 5.

FINDING 6

The Office of the Inspector General found that the design of the cells in the administrative segregation unit does not allow the custody staff to control the lights inside the cells.

While touring the administrative segregation unit, investigators noted that the inmates have sole control over the interior electric lights because the light switches are located inside the cells. There are no override switches outside the cells or in the control rooms. At night, if an inmate is taken from or placed in a cell, correctional staff members cannot see into the cell without a flashlight, creating a safety and security hazard.

RECOMMENDATION

The Office of the Inspector General recommends that in future construction projects the Department of Corrections design buildings to provide the custody staff with the capability of overriding and controlling the cell lights from the outside. According to Warden Runnels, the new 100-bed administrative segregation unit currently under construction at the prison incorporates this feature, but the department should also review the possibility of retrofitting the existing housing to allow the custody staff to control the lighting inside the cells.

FINDING 7

The Office of the Inspector General found that security cameras are not available to monitor activity on the main yards.

Cameras with videotapes could:

- Enable the staff to observe daily activities;
- Enable the staff to identify and document gang affiliations; and
- Document incidents that occur in the main yards.

During incidents, the videotapes could help identify the inmates involved, serve as documentation for disciplinary actions, and be used to evaluate the staff's response to the incident. The tapes also could be useful in training sessions.

RECOMMENDATION

The Office of the Inspector General recommends that the prison install video cameras on the main yards.

FINDING 8

The Office of the Inspector General found that improvements are needed in documenting the preparation and maintenance of category one investigations.

The following deficiencies were noted during review of the documentation for 12 category-one investigations. The investigations were judgmentally sampled from the institution's investigative files.

- The Internal Affairs investigation report, CDC Form 989 A/B, did not include a signature block for the supervisor's review or the warden's approval, as required by the Office of Investigative Services *Investigative Services Guide*, Section 4340.
- Certain investigative documents—the advisement-of-rights form and the witness interview worksheet—were not identified with the case reference number. Furthermore, these documents, along with other correspondence, were not stamped or marked "confidential." Such markings are required by *California Department of Corrections Operations Manual*, Sections 31140.7.6 and 31140.13.
- The Internal Affairs Investigation Request, CDC Form 989, was not signed and dated by the hiring authority, which would provide a record of appropriate authorization.
- The advisement-of-rights form did not contain a signature attesting to its review.
- Pertinent documents, such as closure letters, were noted in the chronology and status sheets, but copies were not placed in the case files.
- There were unsigned memoranda in the case files. Items of evidence should be reviewed to determine their authenticity.
- Multiple witness interviews were included on the same tape. This practice could cause confidentiality problems in the event of discovery requests. Furthermore, lost or damaged tapes would result in the loss of multiple interviews.

RECOMMENDATION

The Office of the Inspector General recommends that the warden ensure that the Investigative Services Unit captain (1) reviews the documentation used to support category-one investigations, and (2) implements a policy of storing witness interviews on separate tapes.

FINDING 9

The Office of the Inspector General found several procedural errors in the inmate disciplinary process.

Investigators reviewed a non-statistical sample of inmate rule violation reports from the institutional register and noted the following problems.

- ***Rule violation reports signed by someone other than the reporting employee.*** Investigators found that the final copy of the rule violation reports were not always signed by the reporting employee. *California Department of Corrections Operations Manual,* Section 52080.3.1, requires that the reporting employee submit the rules violation report to the employee's immediate supervisor for review and approval.

- ***Rule violation reports voided after supervisors' approval.*** Reporting employees voided the rule violation report after the first- and second-line supervisors had approved and classified the report and copies were given to the inmates. Under *California Department of Corrections Operations Manual,* Section 52080.3.8, only the staff member who initially classified the rules violation or a staff member at a higher level may change the classification of the rules violation before the hearing is held.

- ***Rule violation reports time limits not met.*** A copy of the completed rule violation report was not provided to the inmate within five working days after the chief disciplinary officer's review, as required by *California Code of Regulations*, Title 15, Section 3320(l).

- ***Rule violation reports missing from register.*** Rule violation reports were missing from the register of institution violations, although they were logged in the institutional register as having been heard. *California Department of Corrections Operations Manual,* Section 52080.15.1, requires that one completed copy of each rule violation report issued be maintained in chronological order in the register of institution violations for five calendar years.

RECOMMENDATIONS

The Office of the Inspector General recommends that the warden implement the following policies and procedures to remedy the procedural deficiencies in the inmate disciplinary system.

- The reporting employee must sign the rule violation report to authenticate it. In the rare instance in which the employee is not available, the signed draft report should be attached to the completed rule violation report for verification of authenticity.

- When the rule violation report has been approved and classified, the disciplinary hearing should be conducted. Only the staff member who classifies the rule violation report or a staff member at a higher level, preferably the hearing officer, should be allowed to void the rule violation report.

- A copy of the completed rule violation report should to be delivered to the inmate within five working days of the chief disciplinary officer's audit.
- The rule violation reports should be filed in the register of institution violations in a timely manner.

FINDING 10

The Office of the Inspector General found that the detention/segregation records for several inmates housed in the administrative segregation unit in Building D-7 did not record the inmate's exercise period or the reason the period was not provided.

The detention/segregation log (CDC Form 114-A) records the daily activities of each administrative segregation inmate—for example: breakfast, lunch, dinner, shower, exercise. This documentation is required by *California Code of Regulations*, Title 15, Section 3344 (b), which states:

> *A separate record will be maintained for each inmate assigned to administrative segregation, including special purpose segregated units. This record will be compiled on CDC Form 114-A, Detention/Segregation Record. In addition to the identifying information required on the form, all significant information relating to the inmate during the course of segregation, from reception to release, will be entered on the form in chronological order.*

In addition, *California Code of Regulations*, Title 15, Section 3343 (h), requires that inmates assigned to special-purpose segregation housing be permitted to exercise a minimum of one hour per day, five days a week, or at least three days per week for a total of not less than 10 hours a week, unless security and safety considerations preclude such activity.

The investigators found that the detention/segregation records for several inmates housed in the administrative segregation unit in Building D-7 did not record the inmate's exercise period or the reason the period was not provided. The inmates may have been denied exercise because the institution was locked down due to a state of emergency, but if so, this should have been noted in the files.

RECOMMENDATION

The Office of the Inspector General recommends that the warden ensure that the CDC Form 114-A, detention/segregation record, is completed as required.

FINDING 11

The Office of the Inspector General found that performance and probation reports for employees at High Desert State Prison are not being completed in a timely manner.

The Office of the Inspector General non-statistically selected 61 files of custody and non-custody personnel to determine whether they contained current performance evaluations. Of the 61 files reviewed, 13 were for employees who did not require an annual performance

evaluation, either because they were recent hires or because they had received a probation report within the last year. Of the 48 files for employees requiring an annual performance evaluation, only 17 contained a report completed within the required time frame.

The personnel files were also reviewed to determine whether employees serving a probationary period at High Desert State Prison received timely probation reports from their supervisors. The review revealed that only eight of 42 employees had a probation report in their file that had been completed within the required time frame, with the result that most employees had not received timely feedback on their performance during the probationary period.

Each month the personnel office prepares for the warden a list of all staff members who have not received their annual performance evaluations or probation reports. Also, the monthly in-service training bulletin lists all staff members for whom an annual evaluation or probation report is due that month.

Although the institution has appropriate procedures for notifying supervisors and managers of the need to prepare performance evaluations and probation reports, it is apparent that supervisors and managers are not being held accountable for this function. The failure to prepare annual evaluations and probation reports deprives management of its ability to enhance work efficiency, prepare employees for promotion, communicate and clarify work objectives, and distinguish between superior, average, and poor performance. In addition, if the need for adverse action arises, supervisors and managers lack written documentation of the employee's performance.

RECOMMENDATION

The Office of the Inspector General recommends that the warden hold managers and supervisors accountable for completing annual performance evaluations and probationary reports in a timely manner.

FINDING 12

The Office of the Inspector General found that the staff is not completing mandatory training courses in a timely manner. Also, the training files do not document the completion of training.

The Department of Corrections Operations Manual, Section 32010.13, requires that all employees receive 40 hours of training annually. Furthermore, all employees represented by Bargaining Unit 6 must complete 52 hours of training annually under the unit's memorandum of understanding with the State of California. Departmental policy also requires sexual harassment prevention training during employee orientation.

The Office of the Inspector General reviewed the prison's system for recording and tracking training courses attended by custody, non-custody, supervisory, and management staff members. The training files for 29 custody and 33 non-custody employees were non-

statistically selected for review to determine whether the employees had met their annual training requirements.

The first part of the review focused on mandatory training courses. Of the 29 custody employees whose files were reviewed, 11 were deficient in completing one or more of the mandatory courses within the required time frame. Of the 33 non-custody employees whose files were reviewed, 21 were deficient in completing one or more of the mandatory courses within the required time frame.

Following is a list of the courses where deficiencies most frequently occurred.

Course	Mandatory Courses Required	Failed to Meet Time Requirement	Percentage of Non-Compliance
Custody Staff			
Heat Related Pathology	29	6	20.7%
Fire/Life/Safety	29	4	13.8%
Sexual Harassment	29	3	10.3%
Non-Custody Staff			
Sexual Harassment	33	14	42.4%
Fire/Life/Safety	33	5	15.2%
Use of Force	33	4	12.1%

The second part of the review focused on supervisory and management training requirements. *California Code of Regulations*, Article 18 requires supervisors and managers to complete specific supervisory and management courses within specific time periods in their employment. These courses include: basic supervision; advanced supervision; management training program; and specific academies for correctional sergeants, correctional lieutenants, and correctional captains. The training files for 20 supervisors and managers were non-statistically selected to determine whether the mandatory classes were completed within the required time frame. Of the 43 courses required, there were 8 instances in which the staff failed to complete the course or to do so within the required time frame.

Finally, the Office of the Inspector General compared the documentation in the employee training files to the automated report prepared by the in-service training office to verify the accuracy of the report. A total of 24 training files were reviewed. Out of a possible 156 training classes, there were 55 cases in which the employee's training file contained no documentation of training. In addition, training information in the file frequently contained no date or signature by the instructor to confirm completion of the course. Most of the training documentation was in the form of a quiz taken by the employee that, in nearly all

cases, was not graded or signed by the instructor. Therefore, it is difficult to verify that the student was successful in meeting the goals and objectives of the training.

RECOMMENDATION

The Office of the Inspector General recommends that the institution hold employees accountable for completing mandatory training requirements. Furthermore, steps should be taken to ensure that the documentation in the training file is adequate to support the automated report.

FINDING 13

The Office of the Inspector General found that High Desert State Prison is budgeted for programs that have never been activated.

The original education staffing for the prison assumed that the institution would provide educational programs during the evening hours. According to the institution staff, headquarters has never approved this plan for implementation. The main issues appeared to be scheduling conflicts and lack of classroom space. Over the years, the institution reclassified some of the education positions to meet other institutional needs. For example, during fiscal year 2000-01, the prison reclassified 6.4 education positions to correctional officer positions, to provide additional security coverage. The Department of Corrections headquarters has also redirected positions from High Desert State Prison to provide additional support at other institutions.

Currently, the institution has 11 academic-teacher vacancies and 10 vocational-instructor vacancies. According to the supervisor of correctional education programs, the current staffing is sufficient to provide the necessary inmate programming. The vacancies in education assist the institution in meeting the 4.9% salary savings requirement and also offset expenditures not fully funded by headquarters, such as workers' compensation and overtime associated with special assignments, the Family Medical Leave Act, and the suicide watch. It should be noted that the current institution vacancy plan for correctional officers negotiated with the California Correctional Peace Officers' Association generates only a 2.6% salary savings. Therefore, other areas, such as education, facility operations, and administration, must generate higher salary savings in order for the prison to stay within the budget allocation.

High Desert State Prison was originally designated to implement an enhanced outpatient program to treat inmates with mental illness. Because of the difficulty of recruiting mental health staff to such a remote area, the program was never activated. However, the prison retains 3.6 correctional-officer positions in its budget for this program. The institution has correctly chosen not to activate the positions on the post assignment schedule, as there is no program to support the positions. According to personnel records, the institution was originally allotted 10.4 positions for the program and headquarters redirected only 6.8 of these to another institution. The 3.6 excess positions are helping the institution meet the 4.9% salary savings requirement and cover other budget deficiencies.

Leaving these positions vacant for extended periods of time, however, raises the potential that they will be lost. *Government Code* Section 12439(a) states, "Beginning July 1, 2001, and on each July 1 thereafter, the Controller shall abolish any state position that was vacant continuously for six consecutive monthly pay periods during the period between July 1 and June 30 of the preceding fiscal year."

RECOMMENDATION

The Office of the Inspector General recommends that the warden develop a plan to permanently redirect the excess positions for both the education and the enhanced outpatient programs to areas of institutional priority.

FINDINGS AND RECOMMENDATIONS
HEALTH CARE PROGRAM

FINDING 1

The Office of the Inspector General found deficiencies in the prison's documentation of chronically ill inmates.

The investigators found deficiencies in the health records of asthmatic patients, as well as those suffering from hypertension.

Asthmatic Inmates. A review of the health records of nine asthmatic inmates revealed inconsistencies in physician contact with the inmate and in the physician documentation contained in the inmate's health record. Specifically, the Office of the Inspector General found the following:

- Although inmates routinely had medications refilled by the physician, there was no notation in the medical file that the inmate had been seen by the physician for extended periods of time, and no indication that an assessment of the inmate's response to the medication had been sought. In one case, the physician did not see the inmate for almost three years, even though medication was consistently reordered.

- Theophylline blood level tests for the purpose of ensuring that inmates are taking their medication and that blood levels are therapeutic are not routinely ordered. In four cases, the inmate's last theophylline level test was more than a year old. The physician had initialed the laboratory slip, but no orders were written and no follow-up appointment had been arranged.

The chronic care guidelines published by the Department of Corrections Health Care Services Division stipulate that patients whose disease process is not well controlled are to be monitored through the chronic care program monthly or more frequently, as determined by the physician. Patients whose disease process is well controlled, as documented on two consecutive visits showing good control, may be seen every six months, as determined by the physician.

Inmates with hypertension. A review of the health records of 12 inmates with hypertension revealed that there is rarely documentation to demonstrate that the physician considered the inmate's blood pressure and weight when prescribing medication refills. Many of the records show that physicians ordered blood-pressure and weight monitoring, but there is no documentation that the physician obtained a current blood pressure and weight before renewing the inmate's medication. It should be noted that in all cases medication was consistently reordered as needed, with no apparent lapses between refills.

The chronic care guidelines published by the Department of Corrections Health Care Services Division provide that patients who suffer from hypertension should have their blood pressure checked monthly or more frequently, as clinically indicated. Patients whose disease process is well controlled on the current treatment regimen, as demonstrated by two consecutive visits showing good control, should be seen every six months.

RECOMMENDATION

The Office of the Inspector General recommends that physicians review an inmate's history and documentation before reordering medication. In addition, physicians should document their findings when conducting a chart review and should note the reason they renewed the medication without seeing the patient.

FINDING 2

The Office of the Inspector General found that inmate medications could be tampered with before they are administered and that inmate medications are not adequately documented in the medical file.

Medications are delivered to facility clinics daily from the pharmacy and are then delivered to the inmates by medical technical assistants. The medications may be categorized as hot medications—those requiring direct observation—or cold medications—those that can be issued to the inmate in their entirety. Hot medications are distributed on the second and third watches. Cold medications are distributed by the third-watch medical technical assistant during the evening pill line.

A review of the process for administering medications to the inmate population revealed two problem areas. First, due to workload constraints, the medical technical assistants currently prepare the hot medications at night to administer to inmates the following morning. As a result, the medications are left unsecured in the clinics overnight. This process is unsafe because the medications could be tampered with before the medical technical assistants administer them to the inmates. Second, the third-watch medical technical assistant places a medication label for cold medications in the clinic label book at each facility but does not enter this information into the unit health record. This practice is undesirable because if the inmate is transferred to another facility, the medication information does not follow the inmate.

RECOMMENDATIONS

The Office of the Inspector General recommends that the prison develop and implement a policy requiring the medical technical assistants to package the hot medications within two hours of the time they are administered. As an alternative, a pharmacy technician could prepackage the medication in unit doses for the medical technical assistant to administer.

The Office of the Inspector General also recommends that the medical staff immediately begin placing labels in the medication administration record for all cold medications

administered to inmates. The medical staff should also document in the record if the inmate receives or refuses the medication. After the medical administration record is documented, it should be sent to the unit health record for filing, so that there is a permanent record in the chart of the inmate receiving the medication.

FINDING 3

The Office of the Inspector General found that 13 inmates on psychotropic medication are not included in the mental health delivery system.

A comparison of pharmacy prescriptions for inmates receiving psychotropic medication to those inmates participating in the mental health delivery system revealed that 13 inmates were receiving psychotropic medication but were not receiving the accompanying mental health case management. Consequently, these inmates may not be receiving adequate medical care. The 13 inmates were not seen by a clinician and no treatment plan was prepared or implemented.

Without appropriate precautions, inmates receiving psychotropic medication could be subject to heat stroke.

RECOMMENDATION

The Office of the Inspector General recommends that the medical staff ensure that the inmates are included in the mental health delivery system before providing them with psychotropic medication.

FINDING 4

The Office of the Inspector General found that High Desert State Prison is not providing inmates with dental services required under state regulations.

State regulations require institutions to provide every new inmate with a dental exam and individual treatment plan within 14 days of arrival. The Office of the Inspector General found that High Desert State Prison routinely does not fulfill this requirement. Moreover, under its present procedures, the institution has no means of complying with the regulation. The audit also revealed that the institution has no centralized, computerized system for tracking dental services provided to inmates and therefore cannot determine which inmates have received dental services without looking at individual medical files for each inmate.

California Code of Regulations, Title 15, Section 3355.1 provides:

> *Each newly committed inmate shall within 14 days following transfer from a reception center to a program facility receive a complete examination by a dentist who shall develop an individual treatment plan for the inmate.*

Inmates arriving at High Desert State Prison do receive a cursory dental screening examination at the institution reception center. But in a review of the facility's four dental clinics, the investigators found that none of the clinics provides a comprehensive dental examination and individual treatment plan within 14 days of an inmate's arrival, nor are the

clinics notified when a new inmate arrives and the 14 days begin ticking. Instead, most of the efforts of the dental staff are devoted to emergency care. According to the dental staff, because of insufficient staff resources, clinics schedule dental services according to the urgency of the request, with the system driven by sick call slips filled out by inmates and picked up daily by medical or dental personnel. Inmates requiring emergency care, which usually includes severe tooth pain, receive priority over those needing preventive care, such as dentures, fillings, and cleanings. With a backlog at every clinic of between 30 and 200 cases, inmates may languish on a waiting list for preventive care for as long as nine months, by which time they may have left the institution. No inmate receives a comprehensive dental examination within 14 days of arrival and no inmate receives an individual treatment plan during his entire stay at the institution.

Lockdowns and a conflict in regulations exacerbate the problem. Two factors contribute to the failure of the institution to fulfill the Title 15 requirement. The first is the effect of the institution's frequent lockdowns on the ability of the clinics to provide dental services. During normal programming, some of the clinics see as many as 14 patients per day. But when a lockdown is in effect, the number of patients seen per day falls to between five and eight because during lockdowns the custody staff must escort inmates to the dental clinic and only one patient can be seen at a time.

The second contributing factor is an apparent conflict between Title 15, Section 3355.1 and Section 54050 of the *California Department of Corrections Operations Manual*, which allows institutions to give priority to emergency care and to limit care depending on available funding. Section 54050.1 of the manual provides: "Availability of funds, facilities, and staff shall govern the level of treatment provided." Section 54050.9.4 of the manual assigns the following priority to specified treatment levels:

> *Urgent/emergency care for inmates in considerable pain or acutely ill needing immediate dental services (24 hours a day, 7 days a week).*
>
> *Immediate care for conditions prohibiting inmates from carrying out daily assignment (within 24 to 48 hours).*
>
> *Routine care for conditions not requiring immediate treatment by a dentist.*

No central automated system to record dental care provided to inmates. The Office of the Inspector General also found that High Desert State Prison has no automated system in place for tracking sick call requests or services provided to inmates and no computerized central record showing which inmates in the prison population have received or not received required dental services. The dental staff relies instead on a manual chronological log to mark down services requested and rendered each day. As a result, the institution has no record other than the individual medical files of each inmate to show which inmates in the institution have received particular dental services. Also, if an inmate has been on a waiting list for dental care at one facility and moves to another facility, because no central record exists, the burden is on the inmate to maintain his place on the new waiting list by providing a copy of his previous request.

RECOMMENDATION

In order to improve inmate access to dental service, the Office of the Inspector General recommends that the following actions be taken:

- The California Department of Corrections should closely examine the existing policies and regulatory requirements governing dental care and take action to eliminate any inconsistencies between Title 15 requirements and those of the *California Department of Corrections Operations Manual*.

- The warden should provide additional custody personnel to escort inmates to dental appointments during lockdowns and additional custody coverage while inmates are in the dental clinic to allow more than one inmate to be served at a time.

- The health care manager should consider pursuing resources to automate the scheduling and tracking of dental services or explore other measures to increase the productivity of the dental staff.

FINDING 5

The Office of the Inspector General found that inmates are not provided with medical, psychiatric, and dental chrono forms in a timely manner, potentially affecting the inmates' health.

Physicians prescribe medical chronos (CDC Form 128 C) for inmates with medical conditions requiring special accommodations in their day-to-day living. For example, an inmate with a back problem may require placement in a lower bunk. The inmate is required to carry the medical chrono form with him at all times to inform non-medical staff members of the special accommodations. Before the medical chrono is issued, a chrono committee reviews the physician's recommendation for final approval. Therefore, a week or more may pass before the inmate receives his medical chrono form, and the delay could result in a liability for the institution. For example, an inmate assigned to an upper bunk could have a seizure while waiting for a chrono form specifying a lower bunk.

RECOMMENDATION

The Office of the Inspector General recommends that the medical department allow staff physicians to issue temporary chrono forms for a one- to two-week duration until the permanent chrono has been approved by the chrono committee.

FINDING 6

The Office of the Inspector General found that the controls over the tracking of prescription drugs are grossly inadequate.

During the Office of the Inspector General's review, a pharmacist conducting a routine monthly inspection of the medical clinics found 8,900 doses of psychotropic medications stored in bags at the Facility B clinic. These medications had enough potency and toxicity to

kill more than 100 people. The pharmacist informed the chief medical officer and the warden of this discovery, and the warden immediately assigned the Investigative Services Unit to conduct an assessment of the issuance of medication and to review the procedures at each of the medical clinics.

The Office of the Inspector General review found the following weaknesses in the control and tracking of medications by medical personnel.

- The pharmacist delivers the medications in clear plastic garbage bags to the facility control room, where clinic staff members pick up the shipment. There is no lock or seal on the bags to ensure that the contents are not compromised during shipment.

- There are no written uniform operating procedures for the medical clinics. The medical policies and procedures at the institution are specific to the Correctional Treatment Center, but they do not provide instruction for the medical clinics.

- Each facility appears to operate independently, and there is a lack of understanding as to who is responsible for tracking inmate medications. For example, the preliminary investigation by the Investigative Services Unit revealed that the pharmacist believes the clinics are to return unused medications to the pharmacy, while the clinic staff believes that the pharmacy staff picks up these medications monthly.

- The pharmacy does not maintain an inventory of the medications shipped, nor is there a shipping document that clinic employees can sign to acknowledge receipt of medications and retain for reconciling inventories. The pharmacy has a computer program that can record what is stocked in the pharmacy, but the clinics have no inventory procedure.

- Medical clinic employees do not inventory the medications received from the pharmacy, but rather rely on the pharmacist to deliver the correct amount for dispensing to the inmates. If there is a discrepancy, a medical error report is submitted to the pharmacy and additional medication is delivered. Without a reconciliation of what is shipped by the pharmacy and what is received by the clinic, there could be abuses of the system.

The Investigative Services Unit's preliminary investigation also revealed that medications are not securely stored in the clinics. The Investigative Services Unit staff found that, for Facility A and B clinics, the key that provides access to the nurse's station also provides access to the storage area where the medications are kept. Investigators also found, throughout the four clinics, plastic trays with medications for 33 inmates awaiting return to the pharmacy. On holidays and weekends, when the pharmacy is not open, the medical staff obtains medications from a DocuMed machine in a locked room. The machine records medications dispensed on a thermo tape inside the machine, and there is an accountability log that the staff is to fill out when using the machine. The pharmacist is responsible for reconciling the accountability log and the thermo tape. However, according to the pharmacist, the medical staff does not always fill out the accountability log, so reconciliation is not possible. The supervising nurse is responsible for controlling access to the room where the DocuMed machine is located, but there are apparently multiple keys to the room, so this control is circumvented.

RECOMMENDATION

The Office of the Inspector General recommends that the chief medical officer/health care manager implement the following actions:

- The plastic garbage bags used to transport medications should be replaced with a container that allows for a lock or a seal, to ensure that the contents are not compromised during shipment. The pharmacist should prepare a shipping order listing all medications included in the container. The clinic employees can sign the shipping order to acknowledge receipt of the medications. This would also provide documentation for both the pharmacy and the clinic to update their inventories. A similar procedure should be implemented for the return of medications from the clinics to the pharmacy.
- The pharmacy and the clinics should maintain a perpetual inventory of medications, because the medications are costly and are dangerous contraband in the institution.
- The medications from the pharmacy should be sent directly to the medical clinic, or the medical staff should pick them up at the pharmacy. The medications should not be left at the control room.
- Medications should be securely stored at all times due to their value and the danger of misuse in the institution.
- The supervising nurse should have sole responsibility for access to the DocuMed machine and for maintaining the accountability log.
- Written operating procedures should be prepared for the health care clinics to assist them in standardizing their operations and implementing proper controls.

ATTACHMENT A

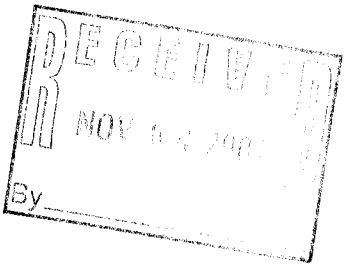
VIEWS OF RESPONSIBLE OFFICIALS

State of California

Department of Corrections

MEMORANDUM

Date : October 29, 2001



To : John Chen
Chief Deputy Inspector General

From : High Desert State Prison, P. O. Box 750, Susanville, CA 96127-0750

Subject : **DRAFT MANAGEMENT REVIEW**

I have reviewed the draft Management Review Audit report prepared by the Office of the Inspector General (OIG) involving High Desert State Prison (HDSP) and have noted the findings and recommendations, which show no major issues of concern regarding non-medical areas.

Following is HDSP's response to the findings and recommendations made by the OIG Management Review Audit.

Institution Program

Finding 1: The process for submitting inmate appeals does not ensure inmate complaints reach the Warden's designee for review and processing.

Recommendation: The Department of Corrections review the inmate appeals process and implement statewide procedural changes necessary to ensure inmate appeals are properly logged and processed.

Response: The recommendation regarding the appeals process will be forwarded to the Northern Regional Administrator for review as a departmental issue.

Finding 2: The institution cannot document that inmates received hot meals and showers during lockdowns.

Recommendation: Ensure staff members document services provided to each inmate during lockdowns to ensure that inmates are provided with mandated services to avoid potential litigation.

Response: As discussed at the meeting, this is not a regulatory or statutory requirement at this time. It is understood that the OIG is making this recommendation in an effort to avoid possible litigation. As this currently is not required by any known provision, HDSP will forward to CDC headquarters for consideration. In addition, HDSP will develop a suggested procedural process to be used during lockdowns to document services provided to inmates during lockdowns.

Finding 3: Appeals related to medical issues and to the Americans with Disabilities Act (ADA) were not processed within the prescribed time frames. Additionally, modification orders resulting in medical appeals were not implemented.

Recommendation: The Warden continue to oversee the inmate appeals process and the Health Care Manager hold his staff accountable for processing appeals and implementing modification orders in a timely manner.

Response: The Health Care Manager and I have addressed the appeal issue and have assigned a staff member dedicated to medical appeals to ensure processing times are within prescribed time limits. Modification orders will be tracked to ensure timely completion of the medical issues are implemented within the designated time frames.

Finding 4: Inmates paroling from Susanville prisons pay an extra $55 transportation charge compared to inmates paroled from Folsom institutions.

Recommendation: Both Wardens from the Susanville institutions work with CDC headquarters staff to have additional funds allocated to remotely located institutions, to make parolee costs more equitable among institutions.

Response: As discussed at the meeting, this is not a regulatory or statutory requirement at this time. However, HDSP will take the lead between the two prisons to request the Department review the finding and take appropriate action based on its findings.

Finding 5: Several procedural deficiencies and documentation lapses in the Administrative Segregation housing units (ASU) and control rooms.

Recommendation: Ensure that staff and inmates comply with institutional policy and procedures. An additional recommendation is to apply a non-slip surface to the metal steps leading from the ground floor to the control room in Facility C, Building #5.

Response: The ASU Lieutenant has been instructed to update ASU post orders, update operational procedures, and provide training for ASU staff regarding documentation and daily routine inspections of the ASU. Additionally, all 180 design control room stairs on Facilities C and D will be retrofitted with non-slip surfaces on stairwells leading to control rooms.

Finding 6: The design of the cells in the ASU does not allow custody staff to control the lights inside the cells.

Recommendation: That CDC design future construction projects to provide custody staff with the capability of controlling cell lights from the outside.

Response: A 100 bed ASU is under construction at this time that will incorporate this above-mentioned capability for custody staff to control the cell lights. Your recommendation is noted and will be elevated to the Northern Regional Administrator and CDC management for future consideration.

Finding 7: There are no security cameras to monitor yard activity.

Recommendation: HDSP install video cameras on the main exercise yards.

Response: On July 14, 1999, the Program Support Unit (PSU), Institutions Division, requested input from Level IV 180 design institutions to install digital cameras on the 180 design general population yards. A Capitol Outlay Budget Change Proposal was forwarded to PSU on July 14, 1999, for review and processing for fiscal year 2001/2002. HDSP will continue to pursue this issue with CDC for funding of recommended equipment.

Finding 8: Improvements are needed in documenting the preparation and maintenance of Category I investigations.

Recommendation: Ensure the Investigative Services Unit (ISU) Captain reviews the documentation used to support Category I investigations and implement a policy of storing witness interviews on separate tapes.

Response: The ISU Captain's position was vacant for an extended period of time, however, the position has been filled since July 2, 2001. The ISU Captain has implemented policy and direction for witness interviews to be recorded on separate tapes and to maintain the evidence within the ISU. Additionally, the ISU Captain has been directed to review all Category I investigations prior to submission to the Employee Relations Officer for action.

Finding 9: Several procedural errors in the inmate disciplinary process.

Recommendation: Implement policy and procedure to remedy the deficiencies in the inmate disciplinary process.

Response: Staff have been directed to implement policy ensuring that the original draft is attached to the completed Rule Violation Report (RVR) when the reporting employee is not available to sign the completed RVR. Chief Disciplinary Officers, Senior Hearing Officers, and staff assigned to disciplinary officer positions will be provided training regarding the RVR process.

Finding 10: The detention/segregation records for inmates housed in the ASU in Building D-7 did not record the inmate's exercise period or the reason the period was not provided.

Recommendation: The CDC 114A, Detention/Segregation Record, be completed as required.

Response: The ASU Lieutenant has been directed to provide training to all ASU staff to complete 114A's on all shifts.

Finding 11: Performance and probation reports for employees at HDSP are not completed in a timely manner.

Recommendation: Hold managers and supervisors accountable for completing performance and probationary reports in a timely manner.

Response: All managers and supervisors will be given expectations to complete annual performance evaluations and probationary reports within prescribed time frames.

Finding 12: Staff are not completing mandatory training courses in a timely manner. Additionally, employee training files do not document completed training.

Recommendation: Hold employees accountable for completing mandatory training requirements. Furthermore, steps should be taken to ensure that the documentation in the training file is adequate to support the automated report.

Response: Managers and supervisors have been directed to utilize employee progressive disciplinary action to hold employees accountable for completing mandatory training. The In-Service Training Manager has hired an Office Assistant to ensure employee training documentation is placed in the employee's training file.

Finding 13: HDSP is budgeted for programs that have never been activated.

Recommendation: Develop a plan to permanently redirect the excess positions for both the education and the enhanced outpatient programs to areas of institutional priority.

Response: The HDSP Personnel department has been directed to identify excess vacant positions and is currently redirecting these positions to other institutions as identified as part of the Department of Finance Personnel Year (PY) deletion exercise and reclassifying positions to other classifications that meet institutional needs.

Health Care Program

The Health Care Manager does take note of the OIG findings and recommendations regarding notable deficiencies in the health care delivery system.

Finding 1: Deficiencies in the prison's documentation of chronically ill inmates.

Recommendation: Physicians review an inmate's medical history and documentation before reordering medication. Physicians should also document their findings when conducting a chart review and note the reason they renewed the medication without seeing the patient.

The Health Care Manager has implemented Phase II of the Health Care Services Division policies and procedures for chronic care of inmates. Currently there is ongoing training for physicians, registered nurses, and Medical Technical Assistants (MTA) to schedule and document chronic health needs of identified inmates.

Finding 2: Inmate medications could be tampered with before they are administered and that inmate medications are not adequately documented in the medical file.

Recommendation: Develop and implement a policy requiring the MTA's to package the hot (direct observation therapy) medications within two hours of the time they are administered.

Response: The Health Care Manager has directed the Health Program Coordinator to implement policy and procedures to ensure that medications are processed and delivered per nursing scope and practice.

Finding 3: Thirteen inmates on psychotropic medication are not included in the mental health delivery system.

Recommendation: Medical staff ensure that the inmates are included in the mental health delivery system before providing inmates with psychotropic medication.

Response: The Health Care Manager will review the inmates prior to placing them on psychotropic medications for alternative treatment of medical conditions that are not considered as mental health issues. The Health Care Manager will ensure that all inmates placed on psychotropic medication for alternative medical treatment will be on the institutional heat risk medication list.

Finding 4: Inmates lack access to dental services, especially during lockdowns.

Recommendation: To improve inmate access to dental services.

Response: The Health Care Manager will elevate the recommendations of the Management Review Audit to Health Care Services Division for review and consideration. Facility managers will ensure custody staff escort and provide coverage for inmates to the dental clinics during lockdown situations.

Finding 5: Inmates are not provided with medical, psychiatric, and dental chrono forms in a timely manner, potentially affecting the inmate's health.

Recommendation: The Medical Department allow physicians to issue temporary chronos for a one to two week duration until the permanent chrono has been approved by the chrono committee.

Response: The Health Care Manager is developing policy to implement the issuance of temporary chronos by the attending physician.

Finding 6: Controls over the tracking of prescription drugs are grossly inadequate.

Recommendation: The Health Care Manager implement policy and procedure to:

- ✓ Transport medication in a secure container with a list of medications on the container; clinic employees to sign receipt of medications
- ✓ Maintain a perpetual inventory of medications
- ✓ Medications should be sent directly to facility clinics
- ✓ Medications are to be securely stored at all times
- ✓ The supervising nurse is to have sole responsibility for access to the DocuMed machine, and maintain the accountability log
- ✓ Implement operating procedures for facility health care clinics in order to standardize operations and implement proper controls

Response: The Health Care Manager is currently developing policy and procedure to adequately ensure the containment, documentation, and delivery related to medication issues at facility clinics and to ensure standardization.

I would like to thank the Office of the Inspector General and the Management Review Audit Team for their findings and recommendations. I recognize the importance of the management review as a tool to identify areas of the institution requiring attention and welcome your recommendations.

If you have any questions or concerns, please feel free to contact me at (530) 251-5050.

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