OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

AUDIT OF THE SALINAS VALLEY STATE PRISON INMATE APPEAL AND INMATE DISCIPLINARY PROCESSES

MARCH 2000

STATE OF CALIFORNIA

GRAY DAVIS, GOVERNOR

State of California

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

Memorandum

Date: July 7, 2000

To: CAL TERHUNE, Director
California Department of Corrections

From: STEVE WHITE
Inspector General

Subject: SALINAS VALLEY STATE PRISON

In March 2000, the Office of the Inspector General issued a report on its review of the systems and processes used by Salinas Valley State Prison for handling inmate complaints (CDC-602s) and for disciplining inmates for rule violations (CDC-115s). The report disclosed significant problems that threatened the health and safety of the staff and inmates at the prison. At approximately the same time, your department formed a "resource team" comprised of staff from other institutions to help Salinas Valley State Prison address the shortcomings that existed throughout the institution's operations. The resource team was to address the problems relative to the CDC-602 and CDC-115 processes.

We are interested in the results of the resource team's effort in making the needed improvements at the Salinas Valley State Prison. This office continues to receive a high number of complaints from inmates at this prison. Recognizing that the number of inmate complaints is but one of many performance indicators, we would appreciate your assessment of what progress the institution has made in addressing the previously noted deficiencies.

Please provide this office with a progress report or, if you prefer, a briefing session on the corrective action taken at the Salinas Valley State Prison. Your timely consideration of this matter is appreciated.

SW:vh

AUDIT OF SALINAS VALLEY STATE PRISON

REPORT

MARCH 15, 2000

This report presents the results of the Office of the Inspector General's audit of the disciplinary process and procedures for handling inmate complaints at Salinas Valley State Prison. The audit was conducted during February 2000.

BACKGROUND

In August 1999, the California Department of Corrections (CDC) formed a threat assessment team to assess the operations of the Salinas Valley State Prison (SVSP). The threat assessment was conducted at the request of then-Acting Warden Anthony A. Lamarque of SVSP over concerns about the possibility of a conspiracy by a gang or gangs to assault staff at the institution. The assessment also included an evaluation of general conditions affecting the overall operation of the state prison.

The threat assessment team issued its report on August 30, 1999 after interviewing more than 500 staff members and 50 inmates and reviewing more than 800 pieces of inmate correspondence and other documents. The assessment team report concluded there was no physical evidence of a conspiracy by inmates to assault staff at SVSP, but identified myriad conditions detrimental to the operation of the institution, including low staff morale, inmate discontent, and other serious problems. The report further concluded that "these deficiencies combined with lack of experience and a general disregard for the treatment of staff and inmates is creating an atmosphere of distrust, hopelessness, and depression."

On December 28, 1999, because of persistent complaints from SVSP staff and inmates, the Office of the Inspector General launched its own investigation of the prison. While the investigation was in progress, the Inspector General visited SVSP as a part of his effort to gain an in-depth understanding of the problems and issues confronting the prison system as a whole. The Inspector General observed conditions during the visit, confirmed by face-to-face interviews with several inmates and with staff members, that led him to believe the prison's environment posed imminent danger to SVSP staff and inmates. Following the visit he expanded the investigation to include an audit of the institution's disciplinary process and procedures relating to inmate complaints. This report presents the results of that audit.

Salinas Valley State Prison

The Salinas Valley State Prison is located in Soledad, California. It opened in May 1996 with a design capacity of 2,024 in four Level IV facilities and 200 in one Level I facility. At the end of December 1999, the prison's inmate population was 4,268, or approximately 192% of designed capacity. The State Controller's payroll records show the institution has 1,312 established positions. As of December 31, 1999, 1,014 positions were filled, leaving 289 positions vacant. Approximately 50% (140) of the vacancies were correctional officer positions.

Since its opening in 1996; SVSP has been besieged with problems of staff turnover and inmate unrest. Problems with inmates have led to constant total or partial lockdowns. According to the institution's records, the four Level IV facilities were in lockdown ranging from 181 days to 244 days in 1998 and from 211 days to 287 days in 1999.

SVSP operates a broad range of academic and vocational programs, but the persistent lockdowns seriously impair the inmates' ability to gain access to the programs.

SCOPE AND OBJECTIVES

The Inspector General directed the audit to focus on SVSP's process and procedures relative to:

- Resolving formal complaints or appeals that were filed by inmates through the use of CDC-602 and CDC-1824 forms. The inmates use CDC-1824 forms to file complaints alleging violations of the Americans with Disabilities Act. The CDC-602 forms are used for all other complaints.

- Addressing the inmates' requests for hearings when staff initiates disciplinary actions against inmates by issuing CDC-115 forms.

- Other administrative measures taken against inmates for less severe rule infractions using CDC-128 forms.

FINDINGS

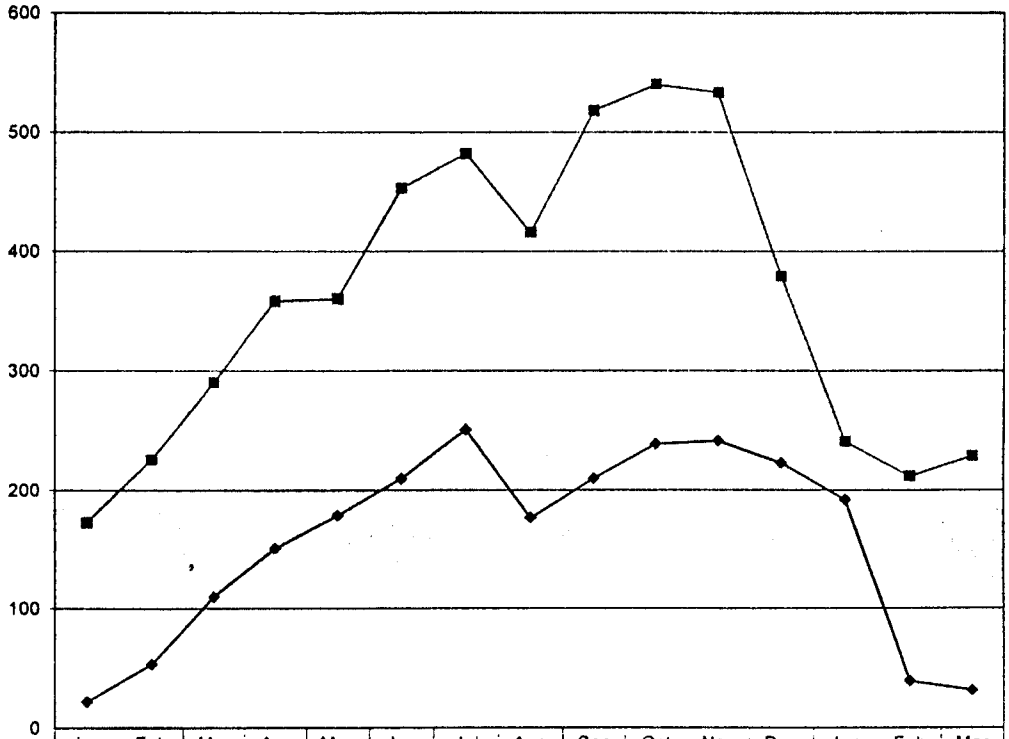
Consistent with the threat assessment team report, the Office of the Inspector General found serious problems in virtually every aspect of SVSP operations. Most of the findings in the threat assessment team report of August 30, 1999 remained unresolved as of January 2000. Specifically, the Office of the Inspector General noted the following conditions:

1. SVSP has had a significant backlog of overdue CDC-602s. The problem escalated during 1999.

According to the institution's records, 173 CDC-602s were overdue at the end of January 1999. The number spiked to 482 by the end of July 1999. A review of the threat assessment team's August 1999 report disclosed that SVSP was well aware of problems with timely processing of the CDC-602s. Yet, the number of overdue complaints continued to increase, reaching a peak of 540 in October 1999. Apparently, the institution did not make a concerted effort to address the problem until December 1999.

Further analysis disclosed a correlation between an increase in health-related complaints and the escalation of overdue CDC-602s during 1999. At the end of January 1999, SVSP had 22 overdue CDC-602s that were health-related. The number climbed steadily during 1999 until it reached a peak of 251 in July, declined slightly in August, and then peaked again in November. The institution apparently did not make a serious effort to address the health-related complaints until February 2000. The following graph shows SVSP's pattern of overdue CDC-602s and overdue health-related 602s from January 1999 through March 2000:

Salinas Valley State Prison Overdue 602 Appeals



	Jan 99	Feb 99	Mar 99	Apr 99	May 99	Jun 99	Jul 99	Aug 99	Sep 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00
HEALTH-RELATED APPEALS	22	53	110	151	179	210	251	177	210	239	242	223	192	39	31
TOTAL OVERDUE APPEALS	173	226	290	358	360	453	482	416	518	540	533	379	241	212	229

Source: Salinas Valley State Prison Appeals Office

In January 2000, CDC headquarters staff members conducted a review of SVSP's procedures for handling inmate complaints and appeals. The review disclosed that the institution had 300 overdue CDC-602s that required formal action. Of the 300 overdue

CDC-602s, 211 were health related. The review also disclosed various system and procedural problems to be addressed. With the assistance of the CDC staff members, SVSP has made progress in addressing the backlog problem. As of March 3, 2000, the institution had 229 overdue CDC-602s, only 31 of which were health related.

2. The institution's inability to address inmate complaints — particularly medically related complaints — in a timely manner adversely affected some inmates.

The Office of the Inspector General selected for review a sample of 96 overdue health-related complaints processed during the period January 28, 2000 to February 10, 2000. Of the 96 complaints, the Office of the Inspector General found that unreasonable delays had affected 32 complaints. The 32 cases are summarized as Attachment A to this report. Some examples include:

- A request for a cane and sunglasses because of permanent vision impairment (350 days in processing time).

- A request for a hearing aid and a green vest denoting hearing impaired (150 days in processing time).

- A request for an HIV test (400 days in processing time).

- A request for medication to treat diabetes and arthritis (154 days in processing time).

3. Inmates do not trust SVSP's complaint intake process.

The inmates interviewed uniformly voiced concerns and suspicion over SVSP's complaint intake process. They expressed the belief that their complaints would not reach the appeals office because the correctional officers would intentionally destroy or misplace them. Some inmates asserted that correctional officers have discarded or destroyed complaint forms in their presence. Although this assertion cannot be validated, it is apparent that the inmates do not trust SVSP's process and have resorted to using the U.S. Postal Service to submit complaints.

SVSP maintains 26 lock boxes throughout the institution to accept inmate complaints. According to the records of the SVSP appeals coordinator, the institution received only 14 complaints through the 26 lock boxes from the beginning of 2000 through February 7, 2000. This extrapolates into approximately 160 complaints on an annual basis. As SVSP typically receives more than 3,300 complaints requiring formal action each year and an undeterminable number that are addressed informally, it is evident that the inmates either cannot or choose not to use the lock boxes to file complaints.

The problem is further compound by the fact that SVSP has no means of tracking CDC-602s that supposedly were resolved informally. The SVSP appeals coordinator estimated the number of complaints resolved informally to be approximately twice the number of the 602s requiring formal action. That number would represent more than 6,000

complaints processed without documentation as to their existence and disposition. Without appropriate documentation, it would be difficult to resolve future disputes between SVSP staff members and inmates as to whether the complaints were filed and how they were handled.

4. SVSP does not have a system in place to ensure that CDC-115s (rules violation reports) are uniformly and accurately recorded and that they are processed in a proper and timely manner.

SVSP does not have a uniform system to record and process the CDC-115s. The Office of the Inspector General staff was told by SVSP staff members that the warden's office requests that each facility report only "serious," not administrative, 115s each month for the quarterly management report submitted to the CDC regional office and headquarters.

Without direction from the warden's office, each of the SVSP facilities uses its own procedures to record and process CDC-115s. One facility uses a computerized database to record and report the status of CDC-115s. Other facilities rely exclusively on manual records. The Office of the Inspector General noted, however, that the facilities do not regularly update the logs to track the status of the CDC-115s issued. In addition, the facilities are not required to know, and apparently do not know, the number of CDC-115s that are not heard within the prescribed limit of 30 calendar days. Rather than relying on the logs that are supposed to track the CDC-115s, some SVSP staff members told the Office of the Inspector General that they rely on the physical filing of CDC-115s in labeled distribution boxes to track cases.

The institution also apparently has had problems with missing CDC-115s. Facility B, for example, voided five CDC-115s from the log on November 30, 1999 because it could not locate the forms in the inmates' files. Similarly, on November 15, 1999, Facility B voided three CDC 115s because the forms were issued twice to the same inmates for the same incidents.

Without accurate and reliable information on how many CDC-115s have been issued, how many are outstanding, and the hearing deadline for the cases, neither the institution nor the facilities can manage the process effectively.

It is critically important that the institution resolve all CDC-115s in a proper and timely manner. Failure to adhere to regulatory prescribed time limits compromises the institution's ability to take action against inmates for inappropriate behavior. On the other hand, CDC-115s often result in punitive action being levied against inmates (such as being placed on administrative segregation status) while their cases are pending hearing. The processing delays unfairly penalize inmates while their cases are awaiting hearing and pose a source of friction between SVSP staff and inmates.

5. A high percentage of the CDC-115 cases were mishandled, suggesting that some SVSP staff members may not have the experience or knowledge to handle the process.

The CDC classification services unit conducts weekly audits at each CDC institution to evaluate completed disciplinary cases. CDC's statistics for the period June 28, 1999 to September 24, 1999, show that SVSP had the second-worst error rate in handling disciplinary cases of all of the state's correctional institutions. SVSP had a 24% error rate, ranking 32 out of the 33 institutions in error frequency. In comparison, the average error rate for all institutions for the same period was 11%.

A review of the cases rejected by the classification services unit disclosed serious mishandling of some of the cases. Some examples are noted below:

- An inmate was placed in the administrative segregation unit on April 28, 1999 for his involvement in a major disturbance on April 7, 1999. His CDC-115 was lost and the institution reissued the CDC-115 and reheard the case on July 21, 1999. On August 17, 1999, nearly four months after the inmate was placed in the administrative segregation unit, the classification services representative rejected the case because of the staff's failure to document the case and other errors. SVSP attributed the delay to a "state of emergency" existing since May 17, 1999. The Office of the Inspector General noted that the "state of emergency" that resulted in the lockdown did not occur until 40 days after the inmate was charged for the disturbance. The prescribed hearing limit is 30 calendar days.

- An inmate was placed in the administrative segregation unit on March 25, 1999 for his involvement in a multiple inmate fight on the yard. The hearing was not held until May 13, 1999, 49 days later, at which time errors were noted and the CDC-115 had to be reissued. The inmate was served a second time on June 23, 1999, but the rehearing did not take place until June 30, 1999, again in violation of the 30-day limit. SVSP discovered further mistakes on August 11, 1999 relative to the assessment of a credit loss. On October 20, 1999, the classification services representative rejected the case because of insufficient documentation and other hearing errors. The CDC-115 was reissued and reheard for the third time, extending the final disposition of the case until December 19, 1999. SVSP attributed the delay to lockdown. The Office of the Inspector General noted that the event occurred on March 25, 1999. The lockdown did not occur until May 17, 1999, seven weeks after the inmate was placed in the administrative segregation unit.

6. SVSP has no means of tracking CDC-128s, which are issued for less severe rule infractions by inmates.

SVSP staff members reported that they do not track these violations because CDC-128s do not result in punitive action against the inmates. Once issued, the CDC-128s are directly placed in the inmates' C-files, and as a result the institution has no way to determine how many have been issued.

Without accurate and reliable information showing trends and patterns in the nature of CDC-128s issued, the staff members who issued them, or the inmates who received them, it is difficult for SVSP to manage the process efficiently and effectively.

Furthermore, although CDC-128s do not prescribe punitive action, their existence in the inmates' files could affect decisions about the inmates' programming. SVSP's current process provides little control over the issuance of CDC-115s and could lead to abuse.

POTENTIAL CONSEQUENCES

The conditions described above could have serious consequences for operations at SVSP. The inmates lack faith that their complaints will be fairly addressed. The significant processing delays have led to the inmates' belief that the institution management has no interest in addressing inmate concerns. The fact that the institution staff initiates punitive action against inmates without affording timely hearings and properly addressing the issues has further contributed to a perception of inequity that is contributing to inmate unrest and could jeopardize the health and safety of SVSP staff members and inmates.

As previously discussed, SVSP has been in persistent lockdown since the institution opened in 1996. While numerous factors have led to this condition, the institution's inability to address the inmate complaint and inmate disciplinary processes in a proper and timely fashion has significantly contributed to inmate unrest.

The persistent lockdowns also have seriously disrupted the institution programs, causing further friction between SVSP staff members and inmates. Moreover, the lockdowns have created an additional workload, resulting in the need for staff overtime. According to the State Controller's payroll records, SVSP spent approximately $7.1 million for overtime during the 1998-99 fiscal year. Next to California State Prison, Corcoran at $9.3 million, SVSP's overtime spending is the highest among all of the CDC institutions. The persistent lockdowns and the high vacancy rate for correctional officers are the primary factors contributing to the high overtime use at SVSP.

The problems also could have serious legal consequences. The CDC threat assessment team report identified an incident in which an inmate lost his testicles following numerous requests over several weeks for medical treatment that were not adequately addressed. The institution's medical staff acknowledged that it has not been able to provide adequate medical services to the inmates. The medical staff attributed the problem to the prolonged lockdown of the institution's facilities and a shortage of medical personnel. Some of the medical services interrupted by the lockdowns were essential to the inmates' health. For example, insulin-dependent diabetics may have been without required medication for as long as three days; other inmates have not received psychotropic medications for several days; and inmates on medication for high blood pressure, asthma, and cardiac problems have not received ongoing care. The Office of the Inspector General has learned that at least two lawsuits are pending against SVSP for medical neglect. In addition, some inmates have said that they are compiling documents in anticipation of filing lawsuits against SVSP and the State.

PROBABLE CAUSES

The Office of the Inspector General's analysis shows that a number of factors contributed to the conditions described above, some of which are beyond the control of the institution. The primary factors include:

1. Lack of stability in leadership positions.

It is critically important, especially for a new institution, to have strong and stable leadership to provide focus and direction in the facility operations. This has not been the case at SVSP. Since its activation in May 1996, SVSP has had seven wardens or acting wardens as listed below:

- Tony Lamarque — (acting) June 1, 1999 to March 1, 2000; appointed March 1,2000
- Carl Larson — January 20, 1999 to June 1, 1999
- Deniese Mayle — October 16, 1998 to January 19, 1999
- Al Fillon — August 9, 1998 to October 16, 1998
- Eddie Ylst — May 26, 1998 to August 7, 1998
- Gerald Harris (acting) — March 1, 1998 to May 25, 1998
- Gary Lindsey — May 1996 to February 26, 1998

Assignment rotations also have resulted in numerous changes at the associate warden level. SVSP's records show that, from May 1996 to March 2000, the institution has had four associate wardens at Complex 1, three at Complex 2, four at Operations, and two at Business Services. Presently, two of the institution's five associate warden positions are vacant and correctional captains are acting in those positions.

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

2. High turnover and high number of vacancies in key staff positions.

Most of the SVSP staff members interviewed attributed some of the institution's problems to low morale that has caused high staff turnover in important staff positions. Based on the institution's records, the Office of the Inspector General calculated the staff turnover rates for the following positions for the period February 26, 1999 through March 3, 2000:

- Correctional Captains – 33% (2 of 6 filled positions)
- Correctional Lieutenants – 41% (11 of 27 filled positions)
- Correctional Sergeants – 27% (15 of 56 filled positions)
- Correctional Officers – 27% (153 of 565 filled positions)

There is no benchmark available to measure the significance of these turnover rates because SVSP has no historical trend on staff turnover and no such information is available from other CDC institutions. Nevertheless, the numbers appear excessive. In addition, because correctional lieutenants and correctional sergeants are primarily responsible for processing and hearing CDC-115s (rule violation reports), the high turnover rates at these two positions would inevitably have a negative impact on SVSP's ability to resolve backlogs in this area.

The SVSP staff members interviewed also complained that the high cost of living in the Salinas area created difficulties in SVSP's ability to staff key positions. From an analysis of the State Controller's Office payroll records showing vacancy rates in correctional institutions, the Office of the Inspector General found this concern to have merit. As of December 31, 1999, the vacancy rates in a number of key classifications at SVSP and at the neighboring Correctional Training Facility (CTF) were significantly higher than those of similar institutions. A comparison of vacancy rates between SVSP, CTF, and similar CDC institutions is shown below:

Comparison of Vacancies
Among Similar Institutions
As of December 31, 1999

	Salinas Valley State Prison	Correctional Training Facility	High Desert State Prison	Corcoran State Prison	Calif. State Prison Sacramento	Pelican Bay State Prison	Calipatria State Prison
Correctional Officer	20.8%	15.0%	10.7%	6.6%	10.7%	6.9%	8.5%
Correctional Sergeant	12.2%	26.2%	14.1%	13.9%	11.4%	6.7%	7.0%
Correctional Lieutenanct	14.3%	21.7%	11.0%	10.2%	8.7%	2.7%	7.7%
Registered Nurse	29.8%	23.7%	9.4%	23.4%	20.8%	4.5%	3.2%
Medical Technical Assistant	48.2%	11.1%	22.4%	5.3%	7.0%	3.6%	12.3%

Source: State Controller's Office

The combined effect of high staff turnover and high vacancy rates at key positions has contributed significantly to SVSP's problems. A 21% correctional officers' vacancy rate, coupled with a 27% staff turnover, mandates high overtime use. All of this, in turn, affects staff morale and increases tension at the institution. The high vacancy rates for registered nurses and medical technical assistants also would appear to seriously affect SVSP's ability to deliver medical services to the inmates.

3. The institution may not be budgeted with a sufficient number of correctional sergeants and correctional lieutenants.

Although CDC relies on numerous factors in establishing budgets, an institution's inmate population weighs heaviest in budget determinations. The Office of the Inspector General has not had the opportunity to assess CDC's budgeting process, but a comparison of budgeted positions at SVSP and the those of the neighboring Correctional Training

Facility (CTF) raises questions that should be addressed. Using the State Controller's Office payroll records, the Office of the Inspector General calculated the budgeted ratio of correctional sergeants and correctional lieutenants to correctional officers at the two institutions as of December 31, 1999. The calculation, presented below, shows that, from a budgetary standpoint, SVSP supervisors are responsible for a much larger number of

Comparison of Budgeted Positions
Between Salinas Valley State Prison and the Correctional Training Center
As of December 31, 1999

	SALINAS VALLEY STATE PRISON		CORRECTIONAL TRAINING FACILITY	
	SVSP Budgeted	Correctional Officer Ratio	CTF Budgeted	Correctional Officer Ratio
Correctional Officers	675.2		786.2	
Correctional Sergeants	70.6	9.6 : 1	112.4	7.0 : 1
Correctional Lieutenants	28.0	24.1 : 1	52.4	15.0 : 1

Source: State Controller's Office

correctional officers than supervisors at CTF. This disparity may be especially significant when one considers the respective missions of the two institutions.

As previously noted, both SVSP and CTF have high vacancy rates in these key positions. CTF apparently has been able to function with minimal problems and disruption, despite the high vacancy rates. SVSP, in contrast, has encountered major problems in virtually every aspect of its operations, raising further questions as to the appropriateness of the staffing levels for these institutions.

The SVSP warden reported that he has attempted without success to acquire additional budgetary resources to meet the institution's operational needs. The Office of the Inspector General recognizes that numerous other factors affect staff allocation and that SVSP's staffing pattern is comparable to that of other institutions with similar security levels, such as Corcoran State Prison and Pelican Bay State Prison. Nevertheless, because the institution is comparatively new and its staff is relatively inexperienced, it is critically important that staff members be properly supervised. At least on an interim basis, it appears prudent to allocate additional supervisory positions to SVSP until such time that the institution staff demonstrates that it can operate the facility effectively with less supervision.

4. Lack of policy and direction from CDC headquarters and the SVSP warden's office.

The problems at SVSP suggest the need for strong leadership from CDC headquarters and the warden's office in providing guidance and direction to staff and inmates. From the evidence gathered in this audit, the Office of the Inspector General concluded that not

enough was being done to proactively address the problems. For example, as previously noted, management was well aware that the processing of CDC-602s was deficient, yet SVSP took no action to address this problem until CDC headquarters became involved in the process.

Similarly, management apparently was aware that the processing of CDC-115s was a problem and a source of serious friction with the inmates. Again, each facility was allowed to continue to use its own procedures to process the CDC-115s. SVSP staff members told the Office of the Inspector General that the warden's office wants only "serious," not administrative, violations for reporting to CDC headquarters. The facilities could not readily identify how many CDC-115s have been issued, how many are still outstanding, and how many are overdue. Even as late as February 2000, there was no evidence to suggest that management was taking action to address this issue on its own initiative.

As another example, in a review of SVSP's complaint appeal process conducted by the CDC in January 2000, the department identified the problem that inmates were not receiving adequate medical care because of persistent lockdowns. The existence of a lockdown does not alleviate the need to provide vital medical services. The problem again appears to be well known throughout the institution. Yet, according to the CDC report, the problem apparently was not addressed promptly because of communication problems and procedural concerns between the warden's office and SVSP's health care manager.

5. Lack of accurate and reliable information to enable management to proactively identify and address problems.

The Office of the Inspector General's review of SVSP has found that the institution has no means of promptly and accurately identifying and tracking the number and status of the CDC-115s, CDC-602s, and CDC 128s issued. A review of SVSP's quarterly statistical reports, which are furnished to the regional office and headquarters, disclosed numerous errors and inconsistencies, suggesting that the problems extend to other areas as well.

The lack of accurate and reliable information impedes the ability of management to operate the institution effectively. As one example: according to the January 2000 CDC report on SVSP's complaint appeal process, the SVSP health care manager estimated that the institution had approximately 30 overdue health-related appeals. The SVSP's appeal office, in contrast, reported that the actual number of overdue health-related appeals at that time totaled 211.

RECENT ACTION BY THE CALIFORNIA DEPARTMENT OF CORRECTIONS

CDC is aware of the conditions disclosed in this report and of other management and system-related problems at SVSP. In February 2000, the department formed a special

task force to help SVSP address the institution's problems by temporarily transferring to SVSP approximately 50 staff members from other CDC institutions.

Given the urgent nature of the problems at SVSP the Office of the Inspector General supports that effort as necessary and appropriate, but unless action is taken to address the fundamental causes of the institution's deficiencies, the problems are likely to recur in the future.

RECOMMENDATIONS

The establishment of the special task force in February 2000 should adequately address the backlog in the processing of CDC-115s and CDC-602s. However, to ensure that the institution continues to be effectively managed in the future, the Office of the Inspector General offers the following recommendations:

Salinas Valley State Prison

- The SVSP warden's office should establish monitoring tools to ensure that CDC-115s and CDC-602s are processed promptly. At least on a weekly basis, either the warden or the chief deputy warden should review the status of the reports with the facilities and, if necessary, take appropriate action to ensure proper resolution.

- The SVSP warden's office, in consultation with the CDC task force members, should establish procedures to obtain the information necessary to effectively manage the institution. At a minimum, the institution should be able to accurately track the status of all CDC-115s, CDC-128s, and CDC-602s. The institution management should consider other information needs and develop a plan to obtain the necessary data.

- The SVSP warden's office, in consultation with the SVSP health care manager, should establish clear policies and procedures to ensure that the inmates are not denied vital medical services when facilities are under lockdown or as a result of any other circumstances.

- The SVSP warden's office should schedule immediate and periodic training for staff members on the proper procedures for issuing and handling CDC-115s and CDC-128s.

- The SVSP warden's office should explore ways to encourage inmates to use the institution's complaint intake process instead of submitting complaints through the U.S. Postal Service.

California Department of Corrections

- The CDC Director should assess the management structure of SVSP and take action to ensure management stability and effectiveness. The Office of the Inspector General

recommends that establishing a second chief deputy warden position be given serious consideration.

- In consultation with SVSP management and employee unions, the CDC Director should review staff patterns and compensation levels and, if appropriate, make interim and long-range adjustments.

SALINAS VALLEY STATE PRISON

EXAMPLES OF UNUSUAL DELAYS IN RESOLVING HEALTH-RELATED COMPLAINTS

CDC FORM 1824, REASONABLE MODIFICATION OR ACCOMMODATION REQUEST[1]

	Appeal Log #		Date Signed	No. of Days To Process	Summary of Appeal	Disposition - Comments
1.	SVSP-00-00494		7/28/99	194	Mobility impaired, requesting low tier & med services	Partially granted
2.	SVSP-B-99-00511		2/19/99	350	Requests leg brace, teeth and arthritis medication	Granted
3.	SVSP-00-00447		3/3/99	336	Permanently vision impaired, needs cane & sunglasses	Granted
4.	SVSP-D-99-02108		8/1/99	183	Present wheelchair is too wide, need 32" wheelchair	Granted
5.	SVSP-B-99-00638	*	4/27/99	274	Requests single cell due to mental & physical condition	Denied - did not meet criteria for single cell
6.	SVSP-C-99-02508		9/18/99	137	Requests repair wheelchair	Granted
7.	SVSP-A-99-03057		11/23/99	71	Paraplegic - medical supplies not given promptly	Granted
8.	SVSP-A-99-02424		9/1/99	154	Proper medication for diabetes & arthritis	Granted - not ADA issue for diabetes
9.	SVSP-B-99-02500		9/10/99	150	Requests hearing aid and green vest	Granted
10.	SVSP-D-99-01193		4/21/99	288	Blind inmate - arm to be re-evaluated and put in cast	Denied - not ADA complaint, medical attention
11.	SVSP-A-99-02423		8/24/99	162	Paraplegic - req. for meds prev. prescribed-back & legs	Partially granted - not ADA, requests medication

CDC FORM 602, INMATE / PAROLEE APPEAL FORM

	Appeal Log #		Date Signed	No. of Days To Process	Summary of Appeal	Disposition - Comments
1.	SVSP-B-00-00194		1/4/00	29	Request for medication for heart condition	Partially granted
2.	SVSP-B-99-00052		1/4/99	400	Request for HIV test	Granted - refused to sign consent on 1/26/00
3.	SVSP-A-98-01375		6/1/98	614	Blood lost for HIV test, requesting compensation	Denied - test completed 6/23/98
4.	SVSP-I-99-00144		12/24/98	398	Locate hearing aid at SVSP for repairs (now at CMC)	Granted - inmate has repaired hearing aids
5.	SVSP-A-99-00816		3/25/99	313	Req. for medication for epilepsy & $5.00 back to trust	Granted
6.	SVSP-B-99-02072		7/28/99	182	Requests medication for high blood pressure promptly	Partially granted
7.	SVSP-B-99-02007		7/27/99	195	Requests results of blood tests	Granted - follow procedures for requests
8.	SVSP-B-99-00665		3/8/99	333	Requests rod removed from leg	Denied - surgeon recommends against removal
9.	SVSP-B-99-01623		6/15/99	234	Medical needs not met	Partially granted
10.	SVSP-B-99-02123	*	9/30/99	127	Req. for back pain meds, back brace & soft soled shoes	Granted
11.	SVSP-C-99-02691	*	12/17/99	45	Dissatisfied with diagnosis and treatment to shoulder	Denied
12.	SVSP-A-97-01647	*	9/20/99	140	Requests dental services	Partially granted
13.	SVSP-B-99-02373		8/24/99	157	Medical services for back and eye problems	Partially granted
14.	SVSP-D-99-03183		11/4/99	89	Dental needs to be addressed	Partially granted
15.	SVSP-B-99-02468		9/12/99	136	Stronger medication for hay fever	Partially granted
16.	SVSP-B-99-02121		8/3/99	176	Adequate medical care	Partially granted
17.	SVSP-A-00-00172		8/29/99	164	Request for medication and test for head pain	Other - inmate transferred to Centinela
18.	SVSP-C-99-02770		9/7/99	155	Adequate mental health care	Granted
19.	SVSP-C-99-03182		9/16/99	138	Requests dental services	Partially granted
20.	SVSP-A-99-01282	*	5/4/99	269	Requests medical services	Denied
21.	SVSP-B-99-02388		8/22/99	166	Return of medical braces and being denied A-1A status	Partially granted

* = Denotes SECOND level review

"Number of days to process" is calculated from the "Date Signed" by the inmate to the date the chief medical officer or designee approves the disposition.

[1] For tracking purposes, Salinas Valley State Prison includes CDC - 1824s as part of the CDC 602 process. CDC - 1824s are the requests for accommodation under the Americans With Disabilities Act. These are supposed to be processed within 15 days instead of 30 days as with CDC - 602s.