OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

SIERRA CONSERVATION CENTER

WARDEN MATTHEW KRAMER

MAY 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: May 30, 2001

To: STEVE CAMBRA, Director (A)
California Department of Corrections

From: STEVE WHITE
Inspector General

I am pleased to forward to you the enclosed report of the management review audit of Sierra Conservation Center Warden Matthew Kramer, which was performed by the Office of the Inspector General. The management review audit was conducted pursuant to California Penal Code Section 6051.

Before the report was finalized, the Office of the Inspector General staff furnished a draft version of the report to Warden Kramer and held an exit conference with the warden and his staff to fully explain the draft report findings. The warden's written response to the draft report findings is included in the report as Attachment A. Comments by the Office of the Inspector General's on issues raised in the warden's response are included as Attachment B.

Throughout the course of the management review audit, the Office of the Inspector General staff received excellent cooperation from Warden Kramer and his staff. I wish to acknowledge and express my appreciation for the courtesy extended.

Please call me if you have questions concerning this report.

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency
Matthew Kramer, Warden, Sierra Conservation Center

OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

SIERRA CONSERVATION CENTER
JAMESTOWN, CALIFORNIA

WARDEN MATTHEW KRAMER

REPORT

MAY 2001

PROMOTING INTEGRITY

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EXECUTIVE SUMMARY

This report presents the results of a management review audit of Warden Matthew Kramer of the Sierra Conservation Center, which was conducted by the Office of the Inspector General from December 2000 through March 2001. The audit centered on institutional processes relating to personnel, training, communications, investigations, security, and financial matters. As stipulated in *California Penal Code* Section 6051, the Office of the Inspector General is required to conduct a management review audit of any warden in the Department of Corrections who has held his or her position for more than four years. Matthew C. Kramer was appointed warden of Sierra Conservation Center on September 18, 1996 and served as interim warden from March 1996 until his appointment.

Overall, the Inspector General found that Warden Kramer's performance in overseeing a custody operation that includes an aging institution and 20 geographically diverse conservation camps to be satisfactory. The Office of the Inspector General found that Warden Kramer encourages open communication with his managers and appears to be aware of issues concerning the institution.

As evidenced by a number of the findings described below, however, the Office of the Inspector General found several instances in which the institution should have focused more attention on safety and security. In one instance (Finding 1 [redacted] In another instance, an inmate committed suicide behind an unauthorized privacy curtain in a dormitory shower (Finding 2).

Other examples of safety and security concerns include: the failure to cover or repair holes in the dormitory ceilings (Finding 4); [redacted] (Finding 11); and the failure of the Tuolumne facility captain to retain possession of his assigned metal key tag when he is not in the unit (Finding 12).

The Office of the Inspector General recognizes that several factors influence the warden's ability to effectively address these concerns. Sierra Conservation Center is old and overcrowded. Opened in 1965, the 1,726-bed main institution today houses approximately 4,000 inmates. Prison dorms, designed to accommodate 16 minimum-custody inmates, now house 34 to 36. Both prison gymnasiums have been converted to dormitories to house another 450 inmates. More than 1,000 higher security inmates reside in the "new" 500-bed Level III facility built in 1987. Another 2,300 inmates live in 20 conservation camps, including three camps for women, which are run in cooperation with the California Department of Forestry and Fire Protection and the Los Angeles County Fire Department. In total, the warden is responsible for 6,300 inmates.

Added to this mix is the institution's projected $4.6 million budget shortfall. The deficit is the result of a number of factors, including increased workers' compensation costs, unfunded positions the prison was directed to fill, increased utility costs, and department-mandated budget reductions. With several staff members on extended medical leave, the warden has been forced

to leave key positions unfilled or has rotated inexperienced staff to cover these posts. Most severely affected are employee relations, inmate appeals, and training.

Because Sierra Conservation Center houses primarily minimum- and low medium-custody inmates, its security issues, while important, may be less critical than at institutions housing more dangerous inmates. Despite these factors, however, some of the findings of the Office of the Inspector General require immediate action by institution management. The most notable are:

- Failure to ensure that a key policy change was implemented;
- Failure to enforce restrictions on unauthorized privacy curtains;
- [redacted]
- Unsafe and deteriorating condition of the prison's aging dormitories;
- Failure to complete inmate appeals on time;
- Documentation deficiencies in processes related to adverse personnel actions, employee grievances, equal employment opportunity complaints, and inmate death reporting.

Throughout the review process, the audit team received excellent cooperation and assistance from Warden Kramer and the staff at Sierra Conservation Center.

INTRODUCTION

The Office of the Inspector General conducted its management review audit of Matthew Kramer, warden of the Sierra Conservation Center, pursuant to the provisions of *California Penal Code* Section 6051. *Penal Code* Section 6051 requires the Office of the Inspector General to conduct a management review audit of any California Department of Corrections warden who: (1) has held his or her position for more than four years; or (2) has been recently appointed, unless the Inspector General determines that the audit is not warranted at that time. A management review audit is a review intended to assess the warden's performance in carrying out the essential functions of the facility. The management review audit includes, but is not limited to, issues relating to personnel, training, communication, investigations, security, and financial matters. In areas where weaknesses are noted, the Office of the Inspector General makes recommendations to correct the problems.

BACKGROUND

Matthew Kramer was appointed interim warden of Sierra Conservation Center in March 1996 and was officially appointed as warden on September 18, 1996. Warden Kramer was the chief deputy warden at the California Correctional Center from February 1993 through March 1996 with the exception of a 12-month period during which he served as the acting warden of the California Correctional Center. He joined the California Department of Corrections in 1985 as the department's fiscal officer. Warden Kramer began his state service in 1970, working in the fiscal arena for the Department of Water Resources and the State Water Resources Control Board.

When it opened in 1965, Sierra Conservation Center became the second state prison with the primary mission of training inmates to fight wildland fires. Located on 420 acres near Jamestown in the heart of California's gold country, the prison and 20 conservation camps house approximately 6,300 minimum- to high medium-custody inmates.

The 4,000 inmates at the main prison are divided among three facilities: Calaveras and Mariposa units, the original dormitory units, and Tuolumne, a Level III (high medium-security) unit that includes administrative segregation housing. The 2,300 camp inmates reside in facilities scattered throughout central and southern California.

The institution's continuing mission is to train and place inmates in the conservation camp program. Camp inmates perform labor-intensive community service work, including wildland fire suppression, firebreak construction, flood abatement, and general conservation projects to assist local tax-supported agencies. The institution also operates academic and vocational education programs, community service crews, an Adopt-A-School program, computer refurbishing, and other inmate services programs.

Presently, Sierra Conservation Center employs nearly 1,200 full time staff — 1,000 at the main institution and 200 in the camps. With an annual operating budget of more than $95 million, the prison is the largest employer in Tuolumne County.

OBJECTIVES, SCOPE AND METHODOLOGY

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

1. Planning, organizing, directing, and coordinating all correctional, business management, educational, and related programs within the Sierra Conservation Center and camps; 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 mission focus, communications, institution safety and security, inmate programming, personnel, training, financial management, external relationships, and environmental responsibility. Those procedures included:

1. Performing analytical reviews of financial information, as well as reviewing Sierra Conservation Center Prison's data trends;
2. Conducting interviews with the warden, administrative staff, custody and non-custody employees, and inmates;
3. Distributing survey questionnaires to 140 randomly selected Sierra Conservation Center employees requesting responses regarding the warden's effectiveness in communication;
4. Touring the facilities and observing institution 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.

The Office of the Inspector General did not review the quality of health care services provided to inmates, but did review the inmate appeal CDC 602 process and the CDC 1824 process, which pertains to medical and disability accommodation issues.

FINDINGS AND RECOMMENDATIONS

Warden Kramer is to be commended for managing a complex, overcrowded correctional facility. More than one-third of the 6,300 inmates under his control are housed in conservation camps hundreds of miles from the main institution. To continuously train, transport, feed, clothe, and provide medical care to camp inmates scattered from Northern California to the Mexican border is a major accomplishment.

Although the dormitories in the Calaveras and Mariposa facilities were designed to house 16 inmates, each dorm usually holds 34 to 36 inmates. These overcrowded dormitories cause maintenance problems and, more importantly, can be a safety and security issue for staff and inmates. Despite limited resources and degraded conditions, the warden and his staff have done an adequate job of maintaining order within the inmate population.

At the main institution, the warden is responsible for the treatment of all incoming drinking water and the processing of all outgoing wastewater. Water quality has been a sensitive issue with the local community, which gets its drinking water from nearby Lake Tulloch. To protect local waters, the institution must adhere to all environmental permits and laws. According to the Regional Water Quality Control Board, the institution is successfully meeting the challenge. A new tertiary wastewater treatment plant has just begun operation and the institution is working on a long-term solution to potential overflows from its sewage treatment ponds.

The warden meets regularly with his management team. At the beginning of each workday, captains and above convene in the warden's conference room to discuss recent events and review upcoming activities. Once each week, the warden and chief deputy bring together the investigative services unit lieutenant, the employee relations officer, the personnel officer, the equal employment opportunity coordinator, and other top managers to review outstanding cases and discuss their potential impacts on the various disciplines represented.

To enhance institution safety, the warden installed high-quality cameras on all three yards (Tuolumne, Calaveras, and Mariposa) and inmate visiting areas. The cameras are used to document inmate activities and record staff responses in support of disciplinary actions or preventive measures. Institution security would be further enhanced if additional cameras were added at other strategic locations throughout the prison grounds. However, the audit team recognizes the fiscal limitations currently faced by the institution and the department.

The category I investigation files are well organized and maintained. All internal affairs investigations of peace officers have been completed within the one-year time limit mandated by the *California Penal Code.* Although the Findings section of this report identifies problems with some investigations, the audit team noted that the institution has made significant improvements in the quality of investigations since the beginning of 2000.

Sierra Conservation Center has done a better job of completing performance evaluation reports and documenting custody training than other institutions previously reviewed by the Office of

the Inspector General. In 93 percent of the personnel files reviewed, performance reports had been completed on time. Based on the institution's reports, less than 5 percent of the delinquent performance evaluations were overdue by four months or more. The Office of the Inspector General also determined that 98 percent of the custody staff is receiving mandatory training.

Nonetheless, the Office of the Inspector General found that the issues described below require immediate action.

FINDING 1 (REDACTED)

[redacted]

[redacted]

[redacted]

- [redacted]

FINDING 2

The Office of the Inspector General found that inmate and staff safety is jeopardized and illegal inmate activities may go unnoticed because inmates are allowed to erect unauthorized privacy curtains within the housing units.

While touring the prison's two gymnasium-turned-dormitories, the Office of the Inspector General's audit team noted that inmates had hung blankets from their bunks in a way that prevented observation by officers from across the room. The audit team also observed that privacy curtains had been erected in the dormitory showers. The secluded areas provided opportunity for inmate activities to take place without detection.

On July 27, 1999, an inmate fatally hung himself in the shower in a Mariposa unit dorm behind an unauthorized privacy curtain. Staff was alerted at 8:15 a.m. after inmates signaled "man down" by waving a white towel or rag from the dorm's bathroom window. According to one officer's report, a security walk-through of the dorm was conducted some time after 7:15 that morning. Another officer said in his report that when he responded to the alarm, he "saw nothing due to a state white sheet hanging in front of the shower."

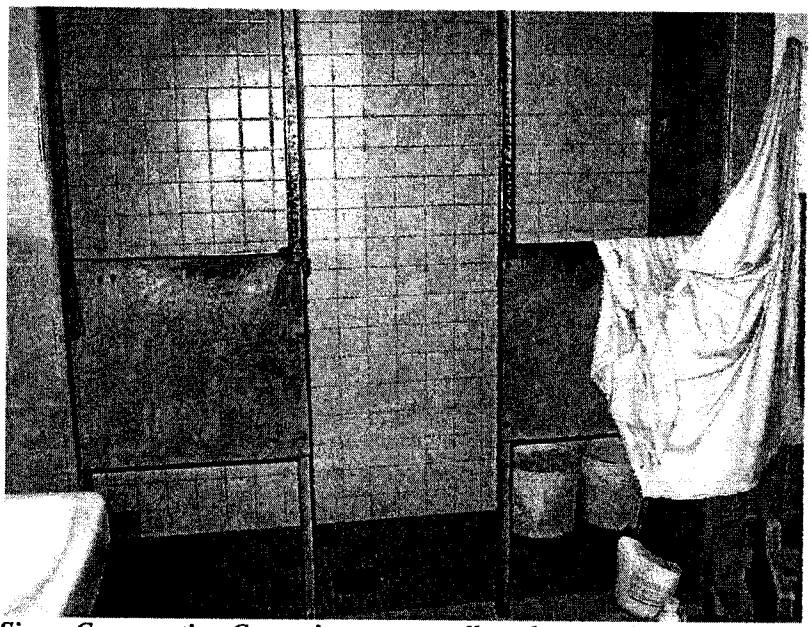
The institution's investigative staff responded to the scene and took charge of the investigation. They collected evidence, took photographs, identified staff and inmate witnesses, and fingerprinted and processed the deceased. All staff members who played a role in responding to the suicide were directed to complete a written report. Investigators interviewed all dormitory inmates and summarized their findings in a memorandum to the chief deputy warden.

During the interviews, some inmates said that the deceased had made comments suggestive of suicide to other inmates and to staff. The warden authorized internal affairs investigations of two officers who allegedly knew about the inmate's intentions. The investigations cleared both officers with the findings of not sustained.

The Office of the Inspector General reviewed the investigations and all documentation relating to the inmate suicide. Included were the complete incident package (with individual staff reports), the memorandum summarizing the inmates' interviews, minutes from the use-of-force review committee, and related documents.

Although the privacy curtain was mentioned in a staff report, the institution never formally addressed the issue in any of its proceedings. Therefore, it is not possible to determine whether the use of a sheet as a privacy screen may have prevented officers from detecting the hanging during security checks. This issue was not explored as a part of the suicide investigation and no administrative action was taken against custody staff for allowing the sheet to remain across the shower.

David Tristan, Deputy Director of the Department of Corrections Institutions Division singled out privacy screens in a strongly worded March 27, 2000 memorandum to all wardens on staff/inmate safety, stating, "The destruction of state sheets to make curtains and privacy screens must stop." The memorandum goes on to state, "Inmates have been allowed to make and keep privacy screens or curtains around their bunks. It is impossible to do counts; the inmates could be making weapons behind these curtains or assaulting their cellmates, or someone could be committing suicide and we would never know it." Noting that the practice involves the use of state-issued property, the memorandum concluded, "It is expensive, destructive, and dangerous."



Sierra Conservation Center inmates are allowed to use sheets as privacy curtains. When pulled across the shower, the curtains block staffs' view and could conceal dangerous or illegal behavior

RECOMMENDATION

The Office of the Inspector General recommends that the warden issue and enforce an order that staff remove all sheets and other makeshift privacy curtains from showers, bunks, and other areas that would obstruct the view of officers within the housing units.

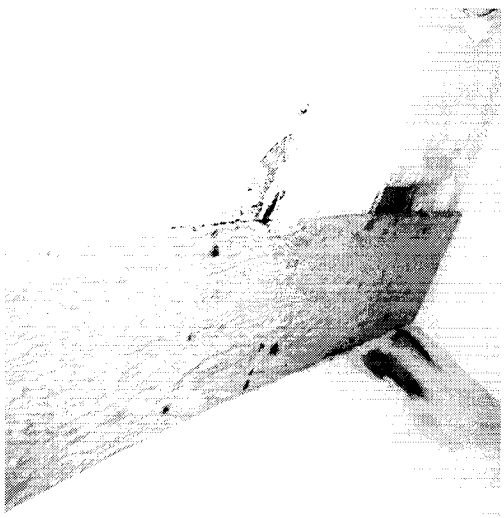
FINDING 3 (REDACTED)

[redacted]

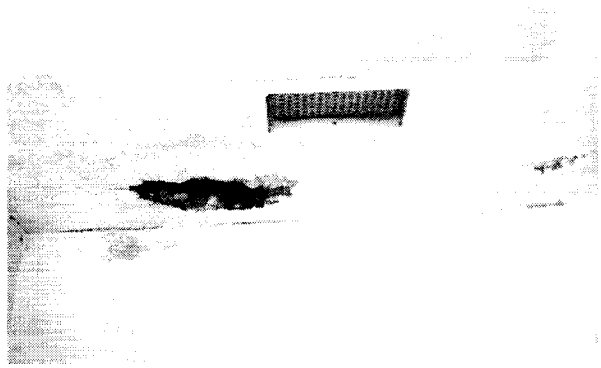
FINDING 4

The Office of the Inspector General found that prison dormitories showed signs of significant deterioration, creating health and safety risks.

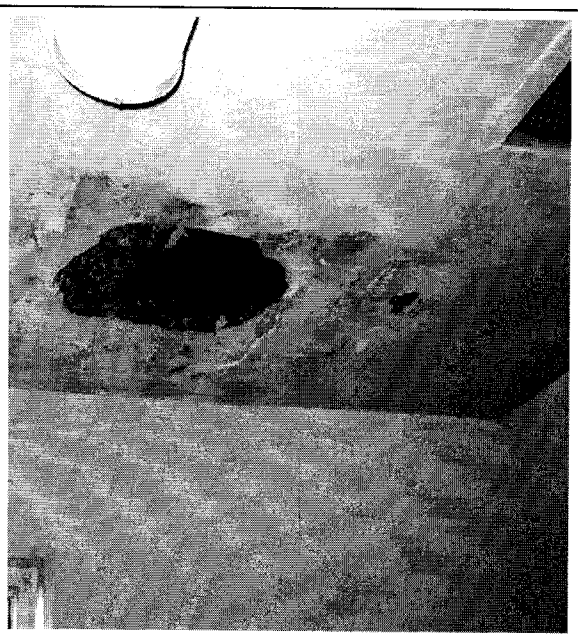
During its tour of dormitories in the Calaveras and Mariposa units, the audit team observed a number of holes in the first-floor ceilings, primarily in the bathrooms. Several holes in the ceilings are large enough to hide contraband, and others are large enough even to allow inmates to hide inside. Most of the holes had been left open, although the audit team noted that some of the large holes in dormitory 24 were covered with plywood.



This "temporary" fix to one of the Calaveras dormitory ceilings has been in place more than nine months.



The ceiling in this Mariposa dorm is typical of conditions throughout the institution's Level I and Level II facilities.



Leaking plumbing from the floor above has created large holes in Sierra Conservation Center dormitory ceilings, which the institution has failed to repair – risking the health and safety of staff and inmates.

The holes appear to be caused by plumbing leaks in second-floor dormitories. The leaks have caused the ceiling to deteriorate and likely are also responsible for similar problems in some of the walls. The institution previously patched some of the holes, but because the cause of the problem has not been addressed, the holes eventually reappear.

According to Warden Kramer, the institution does not have the funds to repair the plumbing and correct the problem. He said that covering the holes is only a temporary solution until the second-floor plumbing is repaired. Such a major project would require closing four dormitories simultaneously, displacing about 140 inmates at a time when the state's prisons are significantly overcrowded. In addition, because of the age of the facility, asbestos could be present throughout the institution, further complicating any major renovation project.

As long as the problems are allowed to continue, and even worsen, the institution faces significant risks that could compromise the safety of staff and inmates. Some risk factors include the following:

- Potential closure of housing units if the plumbing problems are not corrected;
- Continued waste of state resources on patchwork repairs that do not eliminate the problem;
- Liability and danger of incidents because the holes provide a place for inmates to store weapons and contraband; and
- Increased potential for inmate escapes because the dormitory walls also serve as the perimeter fence for the Calaveras unit.

The management at Sierra is aware of the problems, and reports that corrective measures are included in the department's five-year major capital outlay plan. Inclusion in the plan does not guarantee approval, however. Furthermore, the institution must renovate at least two dormitories in order to determine the magnitude of the problem and the cost or feasibility of completing repairs for the entire facility.

RECOMMENDATION

The Office of the Inspector General recommends that the institution temporarily cover the holes in the ceiling to prevent inmates from hiding themselves or concealing contraband. The warden should direct staff to monitor the repairs to ensure they remain in place.

The Office of the Inspector General further recommends that the Department of Corrections consider using a portion of its allotted $10 million special repair budget to correct this immediate threat to institutional health and safety.

As an alternative, the Office of the Inspector General recommends that the institution proceed with a separate budget change proposal to fix the problem. Although the request is in the department's five-year major capital outlay plan, the department should address the security and housing risks sooner.

FINDING 5

The Office of the Inspector General found deficiencies in many of the internal affairs investigations reviewed.

The Office of the Inspector General found significant deficiencies in six of the 14 category I cases and the one category II case reviewed. In two use-of-force cases, the not-sustained findings contradicted a use-of-force investigation or critique attached to the investigations. The investigation reports failed to address or reconcile the discrepancies. A memorandum in one of the files suggested that the subject might have received a letter of instruction before the investigation began.

In another use-of-force investigation, the audit team was able to confirm that the officer received a counseling record two weeks *before* the investigation of the incident was initiated. In fact, the counseling record was used inappropriately to support the sustained finding. Further, the investigation failed to consider or explore mitigating factors presented by the officer.

While the investigation referenced in Finding 1 did a credible job of identifying numerous systemic problems, the investigative services unit investigators failed to interview the captain who initiated the investigation even though their findings refuted some of his statements, and did not interview the correctional lieutenant who was over the unit, despite the fact that the captain implicated him.

In another case, an allegation of negligence by the supervisor of building trades was sustained even though the evidence included a memorandum from an associate warden removing the subject from the project and written confirmation of the removal by the employee's immediate supervisor. The investigation failed to adequately address or resolve these issues.

These and other serious deficiencies typically include the failure to:

- Clarify inconsistencies in statements of witnesses, subjects and related reports;
- Interview all witnesses;
- Include or discuss all evidence; and
- Explore every allegation.

Although the majority of the cases reviewed for the audit followed the appropriate investigative process, nearly every case reviewed had at least minor deficiencies, typically related to inadequate documentation. The documentation deficiencies led to a lack of consistency among investigations and the inability to track all aspects of the investigations.

The audit team also noted that investigation case logs did not list the date of the incident, making it difficult to monitor the one-year statutory limits for completing both the investigation and adverse action on peace officers. Although all investigations were completed within the one-year time limit for peace officers, at least one required 11 months from the date of discovery to complete, leaving little time for adverse action.

RECOMMENDATION

The Office of the Inspector General recommends that the Sierra Conservation Center investigative services unit take appropriate steps to prevent deficiencies in future investigations.

To correct the deficiencies, the investigative services unit should:

- Play a strong role in monitoring the quality of every investigation, ensuring that the issues are fully explored, relevant witnesses are interviewed, conflicting testimony is evaluated, evidence is complete, and findings are supported by the facts.
- Carefully monitor the timeliness of its investigations. One method would be to add a separate column to its investigation tracking log to identify the incident date.

FINDING 6

The Office of the Inspector General found that many of the inmate appeals at the Sierra Conservation Center are not processed within prescribed time limits and noted numerous other deficiencies in the Sierra Conservation Center's inmate appeals process.

Despite the institution's system for tracking and monitoring the formal appeal process, the Office of the Inspector General found that many inmate appeals are not processed on time.

The Office of the Inspector General reviewed a total of 86 inmate appeals: 64 at the first level only, 12 at the second level only, and 10 at both the first and second levels. The audit team noted that 25 of the 86 appeals (29%) were not processed within required time limits. Timeliness varied, depending on the level and type of appeal:

- 15 of 74 appeals (21%) assigned at the first level were overdue by one day to 49 days.
- 11 of 22 appeals (50%) reviewed at the second level were overdue by one day to 20 days.
- 8 of the 25 overdue appeals (32%) were medically related.
- 9 of the 25 overdue appeals (36%) concerned disciplinary issues.

Section 3084.6 of Title 15 of the *California Code of Regulations* addresses the requirements for appeal time limits. That section states:

> *First level responses shall be completed within 30 working days, second level responses within 20 working days, or 30 working days if first level is waived.*

Many of the other deficiencies noted by the audit team resulted from the frequent turnover in appeals coordinators and inadequate training in reviewing, screening, categorizing and responding to inmate appeals. The institution had at least six different appeals coordinators during calendar year 2000, most of whom were inadequately trained in reviewing, screening, categorizing, and responding to inmate appeals. For example, *Department of Corrections Operations Manual* Section 54100.8 stipulates that "The appeals coordinator or a delegated staff member shall screen all appeals prior to acceptance and assignment for review." However, the audit team noted four appeals that were screened out after the appeal had been assigned to a division for response. Two of these appeals were screened out after the due date.

On at least two appeals, the acting appeals coordinator did not conduct an inmate interview, incorrectly citing Title 15, *California Code of Regulation* Section 3084.5(f)(3)(A), which provides that a telephone interview "may be waived if the appeals coordinator determines an interview would not provide additional facts." The telephone interview provision, however, applies only if the appellant is not at the institution where the appeal was filed. In both of the appeals noted here, the inmates were located at the Sierra Conservation Center and an interview should have been conducted.

RECOMMENDATION

The Office of the Inspector General recommends that the Sierra Conservation Center take immediate steps to remedy the deficiencies identified in the inmate appeals process.

Specifically, the following actions should be taken:

- The warden's office should implement monitoring tools to ensure that inmate appeals are processed promptly at the formal levels. At least weekly, 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 appeals coordinator should receive comprehensive training in the appeals process and the rules and regulations governing inmate appeals.
- Staff should properly complete and date the appeal forms.

Additional recommendations to improve tracking and monitoring of staff complaints are the following:

- The institution should create a form to enable the chief deputy warden to document the review, assignment, and disposition of staff complaint appeals.
- The institution should create a log of staff complaints as a management tool, possibly using computer spreadsheet software that identifies the staff person and the appellant.

FINDING 7

The Office of the Inspector General found that in some instances the inmate disciplinary system at Sierra Conservation Center is not regularly meeting statutory, constitutional, or procedural mandates.

The audit team reviewed a non-statistical sample of inmate rule violation reports (CDC Form 115) from the institutional register and noted the following instances of noncompliance with *California Penal Code* Section 2081; *California Code of Regulations*, Title 15, Section 3312; and *Department of Corrections Operations Manual* Sections 52080.3.3, 52080.15.1, and 52080.3.1:

- Numerous CDC Form 115s were signed by someone other than the reporting employee.
- Several CDC Form 115s were signed by someone other than the hearing officer or senior hearing officer.
- Timeframes were not met in providing a copy of the completed CDC Form 115 to the inmate within five working days following the chief disciplinary officer's review.
- Numerous void sheets had no stated reason for voiding the rule violation report; some forms had no authorizing signature.
- In some instances the CDC Form 115 was voided because employee signatures exceeded time constraints or were missing.

- In several instances time constraints were not met and inmates could not be assessed credit forfeitures.

- In several cases, CDC Form 115s that were "dismissed in the interest of justice" were not provided to the chief disciplinary officer to be maintained as part of the institutional register and files.

- Several rule violation reports were logged in the institutional register as having completed hearings, but the institutional copies were missing from the register files.

The Office of the Inspector General noted a number of other deficiencies; for example, institutional registers were incomplete and were missing information for assigned log numbers of the CDC Form 115s. Entries in the disciplinary action log, CDC Form 1154, at one facility were not properly completed. The logs showed the hearing dates, but were missing other dates, such as the chief disciplinary officer's review, final copy to the inmate, and copy to records/register. Also, the facility captain failed to review and sign the log for several months.

During its review, the audit team also noted that two facilities had not regularly updated the institutional register. Furthermore, Sierra Conservation Center management did not regularly review the disciplinary action log to determine the status of the CDC Form 115s issued.

RECOMMENDATION

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

Specifically, the warden should ensure that:

- CDC Form 115s are processed promptly. On a regular 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.

- A written explanation is required of the official authorizing the voiding or dismissal of a CDC Form 115. Furthermore, for proper monitoring and auditing purposes, a copy of the voided and dismissed CDC Form 115 should be included in the chief disciplinary officer's institutional registers and files.

- The institutional registers are completed promptly and properly.

- Reporting employees and hearing officers sign the CDC Form 115 to authenticate the reports. In the rare instances in which the employee is not available, the signed draft reports should be attached to the completed CDC Form 115 for verification of authenticity. [Note: Following discussion with the audit team, the associate wardens issued a joint memo to the Central and Tuolumne Divisions establishing the appropriate policy. However, the Camp Operations Division also should be included in the directive.]

- A copy of the completed CDC Form 115 and 115-A is delivered to the inmate within five working days of audit by the chief disciplinary officer.

- The disciplinary actions logs (CDC Form 1154) at all facilities are completed properly and contain all necessary dates and signatures.

FINDING 8 (REDACTED)

[redacted]

[redacted]

FINDING 9 (REDACTED)

[redacted]

FINDING 10 (REDACTED)

[redacted]

[redacted]

FINDING 11

The Office of the Inspector General found that utility closet doors in the administrative segregation building were unlocked, jeopardizing institution safety.

California Code of Regulations, Title 15, Section 3270 states, "The requirement of custodial security and of staff, inmate and public safety must take precedence over all other considerations in the operation of the programs and activities of the institutions of the department."

During its tour of the administrative segregation building in the Tuolumne facility, the audit team observed that the doors to the utility closets between cells were left unlocked. Custody staff explained that this measure allowed them to shut off the water quickly when an inmate purposely floods his cell, thereby minimizing damage. An open closet door, however, blocks access to the adjacent cell door. If the door is left ajar, the protruding edge could endanger staff or inmates during an incident requiring use of force. The audit team discussed these concerns with the warden. The following day, the audit team noted that the utility closet doors in the administrative segregation unit were locked.

RECOMMENDATION

The Office of the Inspector General recommends that staff continue to keep the utility closet doors in the administrative segregation unit locked.

FINDING 12

The Office of the Inspector General found that the Tuolumne facility captain circumvents key control by failing to retain possession of his assigned metal key tag when he is not in the unit.

Employees are provided with metal key tags to be used as receipts for keys issued by the control room. As a matter of convenience, the Tuolumne facility captain leaves his assigned metal key tag in the control room. This practice undermines staff accountability and violates the purpose of departmental key control policy as outlined in both *California Code of Regulations*, Title 15, Section 3303, and *Department of Corrections Operations Manual* Sections 55020.1 and 55020.14.

During a follow-up tour of the unit, the audit team noted that the facility captain's metal key tag was no longer left in the control room, but learned that no formal action was taken against the captain for this security breach. The warden said he conducted a verbal counseling, but there is no documentation of that action.

RECOMMENDATION

The Office of the Inspector General recommends that the warden enforce adherence to the key control policies, requiring employees to exchange assigned metal key tags for the keys issued.

FINDING 13

The Office of the Inspector General found that the non-custody staff at Sierra Conservation Center is not fulfilling training requirements and that completion of training courses cannot be readily verified in the training files.

Department of Corrections Operations Manual Section 32010.13 requires that all employees receive 40 hours of training annually. According to *Department of Corrections Operations Manual* Section 32010.14, sexual harassment prevention training must be provided during employee orientation. Bargaining unit 6 employees must be provided with 52 hours of training annually, based on its memorandum of understanding with the State. Sierra Conservation Center's monthly training bulletin lists the mandatory annual classes required of all staff.

The Office of the Inspector General reviewed Sierra Conservation Center's system of recording and tracking training hours for courses attended by custody, non-custody, supervisory, and management staff. A review of 59 in-service training staff reports printed from the training database showed that custody staff is fulfilling training requirements: the records showed a compliance factor of 98 percent. However, non-custody staff has a compliance factor of only 80 percent for non-medical classifications and 71 percent for medical classifications.

When the audit team compared the in-service training staff reports to the respective training files, it was able to verify completion of only three of the six specific mandatory courses it audited for compliance. Particularly evident is a lack of documentation for the completion of sexual

harassment prevention courses. The quizzes for the injury/illness prevention program and the escape prevention courses also were not documented in the training file.

After being told of the audit team's findings, the in-service training lieutenant took corrective action. He told the audit team that quizzes for mandatory classes would be kept on file and replaced annually with the most recent quiz. The lieutenant designed and forwarded to the warden and headquarters a certificate to be issued when staff completes sexual harassment prevention training.

RECOMMENDATION

The Office of the Inspector General recommends that the institution take appropriate steps to ensure that non-custody staff fulfill training requirements.

Specifically, the Office of the Inspector General recommends that:

- The warden take steps to emphasize the importance of non-custody staff fulfilling mandatory training requirements.
- Supervisors use the rating guide published in the monthly training bulletin when completing an employee's annual performance evaluation. If employees fail to comply with training requirements, supervisors should issue a poor evaluation in the area of training.
- The in-service training staff ensure that quizzes for all mandatory courses are dated and documented in the training files.
- The Department of Corrections consider issuing a certificate, as proposed by Sierra Conservation Center, or some other means of documenting completion of sexual harassment prevention training.

FINDING 14

The Office of the Inspector General found that adverse personnel action case files at Sierra Conservation Center are not adequately monitored, tracked, or documented.

When the management review audit for Sierra Conservation Center began in December 2000, the institution had no system for logging and tracking adverse actions. The most recent log ended in September 1998. Following the audit team's request, the institution developed an adverse action log. The first version, dated January 8, 2001, listed 30 adverse action cases beginning in February 1999. The log was designed to track 24 items in the adverse action process, but the January 8 version contained information for just eight of the items. This log also included a number of misspellings and typographical errors.

During the audit period, the institution improved and expanded upon the log. By January 26, 2001, the log listed a total of 51 cases. The typographical errors appeared to have been corrected.

However, the audit team noted that the employee relations officer did not assign unique adverse action log numbers. Instead, the institution used the internal affairs investigation case number. Without a sequential case number by year, it is difficult to determine the number of adverse action cases initiated within a given time period or to ensure that every case is being tracked.

At the time of the audit, the employee relations officer was new, untrained, and had only recently returned to full-time status. The office had no clerical support and the adverse action files were in disarray. Although the warden assigned the former employee relations officer to the office to assist on a short-term basis, the problems of inadequate staffing and lack of training remained significant throughout the duration of the audit.

RECOMMENDATION

The Office of the Inspector General recommends that the institution take steps to improve the monitoring, tracking, and documentation of adverse personnel action cases.

Specifically, the Office of the Inspector General recommends that:

- The employee relations officer receive immediate training to allow him to better manage his caseload;
- The warden ensure that the employee relations officer receives adequate clerical support;
- The employee relations officer assign sequential case numbers by year for all incoming adverse actions; and
- The employee relations officer reorganize his files to ensure that all necessary documents are included in the same general order. Every effort should be made to complete the adverse action checklist and a case chronology log to note any significant changes, directives, or actions taken on a case.

FINDING 15

The Office of the Inspector General found that the institution does not have a process to adequately monitor or track employee grievances and that, as a result, the institution may not be in compliance with the memorandum of understanding for each bargaining unit.

The handwritten employee grievance log contains only limited information. It does not note the due date at each level of grievance or the name of the staff person assigned to respond. Further, the employee relations officer did not seem to be aware that response times for employee grievances vary depending upon the memorandum of understanding for each bargaining unit. As a result, the institution may not be abiding by contract requirements. In addition, the employee relations officer was unable to locate one of the grievances selected for review.

Based upon its review of 15 employee grievances filed in 1999 and 2000, the audit team was able to determine that the institution failed to meet required time limits in at least three cases (20 percent). Because dates were missing from some forms, not all timeframes could be verified.

Nearly half of the grievance files reviewed (seven of 15) contained incomplete documentation, including missing pages, unsigned and undated forms, and no grievance decision noted. One form did not show either the date received by the employee relations officer or the grievance log number. In some cases, only the first side of the two-sided form was included in the file.

The bargaining unit 6 memorandum of understanding requires that a grievance conference be held before completion of the grievance response, but none of the seven unit 6 grievances reviewed included evidence that a conference had occurred.

Depending on who did the filing, employee grievances are filed by the last name of either the grievant or the representative filing on behalf of the grievant, but not by log number. As some employees have filed numerous grievances, the employee relations officer may have to sort through each one to find the correct log number. Files also have not been adequately purged. The audit team found grievances dating back to 1993 in the file drawer.

RECOMMENDATION

The Office of the Inspector General recommends that the employee relations officer improve the system for logging and tracking employee grievances.

Specifically, the following measures should be taken:

- Computerize the log and add columns indicating response due dates for each level of grievance and the name of the staff person assigned to respond.
- Prepare a matrix identifying the submission and response time frames and key provisions related to employee grievances for each bargaining unit.
- Reorganize the employee grievance files, purging outdated files, organizing the remaining files by log number, and ensuring that documentation is complete and accurate.

FINDING 16

The Office of the Inspector General found that equal employment opportunity complaint and investigation case files lack a standardized organizational format.

During its review, the audit team noted that the equal employment opportunity files were not consistently organized. None of the cases included a case diary to indicate when the complaint was received or the steps taken to address the complaint. Documents related to the complaint were not stamped confidential and frequently did not identify the case log number. If an employee filed more than one complaint, documents from each complaint were filed in the same folder. Without an identifying log number, it was not possible to determine which documents belonged to each complaint.

Contents of the five files reviewed by the audit team were inconsistent: three had no copy of the contact letter to the respondent; four had no closure letter to the respondent; one did not contain the equal employment opportunity counselor's intake analysis; and several had no complaint forms.

The audit team could not determine whether the missing documents were not prepared or whether copies of the completed documents had not been made for the file.

RECOMMENDATION

The Office of the Inspector General recommends that the institution's equal employment opportunity coordinator develop a standardized filing system for equal employment opportunity complaints that includes a case diary to document all contacts, documents received, and documents prepared.

The Office of the Inspector General further recommends that the equal employment opportunity files be organized and that all documents in the file include the case number, be marked confidential, and be bound in the file to prevent accidental loss.

FINDING 17

The Office of the Inspector General found that the process of and responsibilities for documenting and reporting an inmate's death are not clearly defined, making it difficult to determine if the Sierra Conservation Center has adequately fulfilled its medical and legal responsibilities.

The policies and procedures required following an inmate death have evolved over time. Neither *Department of Corrections Operations Manual* Section 51070 nor the institution's supplement clearly define the process, which includes both medical and custody protocols. This bifurcated system involves two separate divisions within departmental headquarters. The incident package (CDC Form 837 A, B, and C) and custody-related documentation are sent to the Institutions Division. Medical-related forms and information go to the Health Care Services Division. The process is further complicated by the fact that the Sierra Conservation Center staff member responsible for coordinating and monitoring reports of inmate deaths has numerous other duties.

The audit team reviewed the institution's files relating to nine inmate deaths. With the exception of a 1997 death involving medical malpractice, all deaths occurred in 1999 or 2000. In reviewing these files, the audit team noted the following:

- Materials were not consistently organized within the files.
- Most files did not include either the medical emergency response timeline or the inmate death worksheet, which the institution developed to help track the events surrounding an inmate death.
- Most timelines and worksheets, even when included, were not filled out completely.
- The design of the timeline and worksheet forms fails to include:
  - √ The name and CDC number of the inmate who died;
  - √ The date and time of death;
  - √ The incident report number;

√ The name, title, date, and signature of the staff member completing the form.

- The documents noted on the worksheet (such as the death certificate, fingerprint cards, and photographs of decedent) frequently were missing; and
- There were multiple copies of some documents.

According to Warden Kramer, most issues related to an inmate death are resolved during the use-of-force review meetings, which include representatives from both medical and custody staffs.

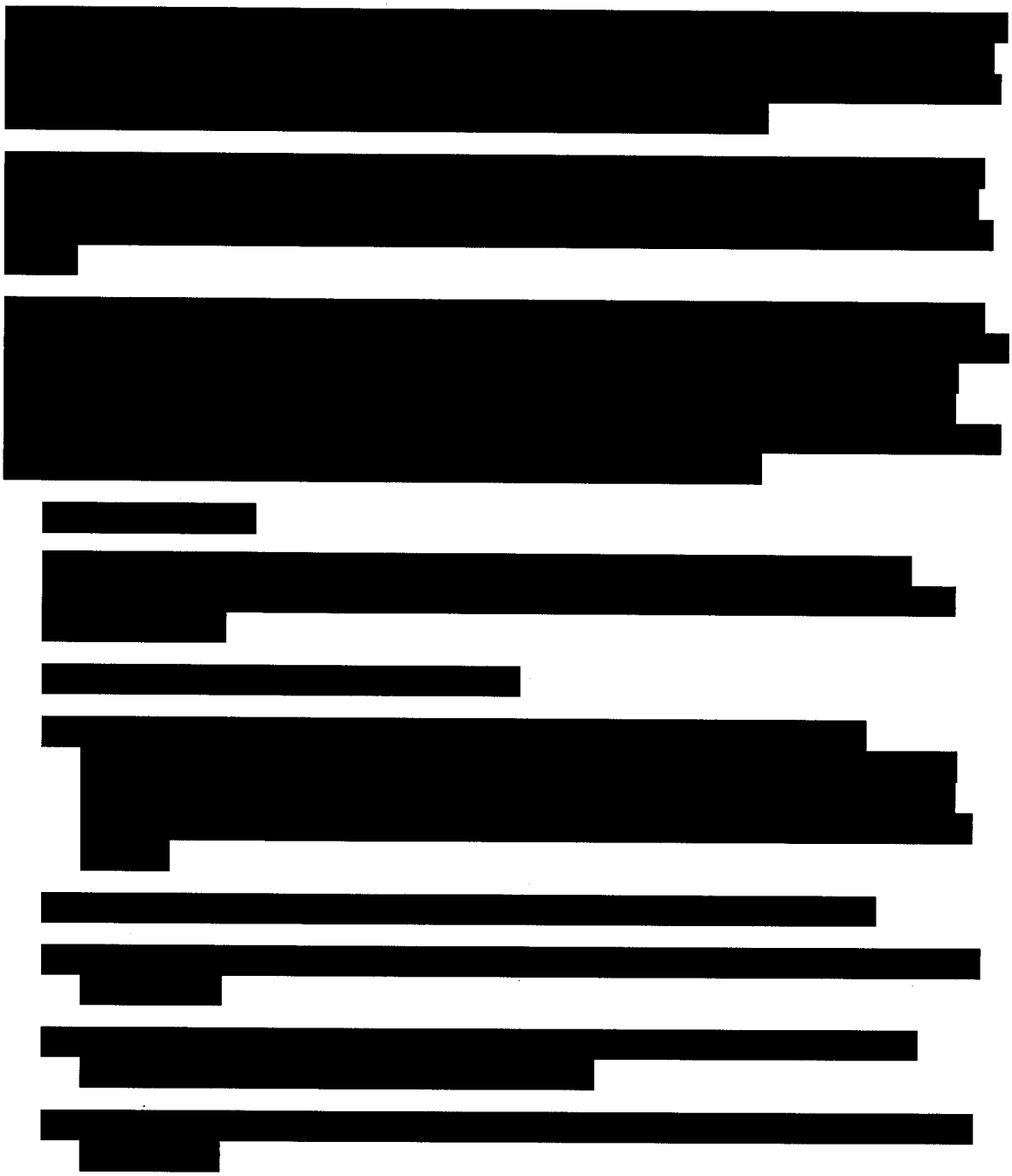
RECOMMENDATION

The Office of the Inspector General recommends that the institution improve its process for documenting and reporting inmate deaths.

Specifically the institution should:

- Clearly outline the steps and requirements related to an inmate's death, noting who is responsible and indicating when and by whom each step is to be completed. Affix the outline to each file as a checklist to ensure that all necessary steps have been taken.
- Organize each file so that reports and documents are readily accessible.
- Modify the medical emergency response timeline and inmate death worksheet to include the inmate's name, number, and date and time of death as well as the name, title, and signature, with date, of the employee completing the form.
- Work with the chief medical officer and relevant staff at headquarters to incorporate the recommended changes into an up-to-date *Department of Corrections Operations Manual* supplement.

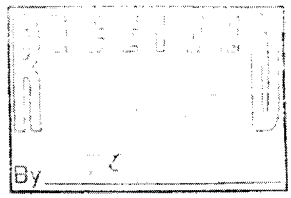
FINDING 18 (REDACTED)



ATTACHMENT A

STATE OF CALIFORNIA-YOUTH AND ADULT CORRECTIONAL AGENCY GRAY DAVIS, GOVERNOR

DEPARTMENT OF CORRECTIONS
SIERRA CONSERVATION CENTER
P O BOX 497
JAMESTOWN, CA 95327-0497
(209) 984-5291



April 27, 2001

John Chen
Chief Deputy Director
Office of the Inspector General

Subject: SIERRA CONSERVATION CENTER MANAGEMENT REVIEW AUDIT

Dear Mr. Chen:

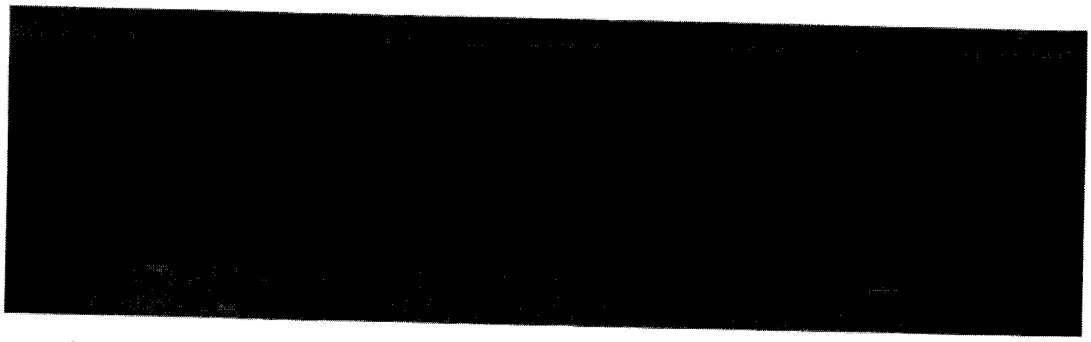
Thank you for the opportunity to comment on the April 2001 draft report on the Management Review Audit of Sierra Conservation Center (SCC). Your staff was courteous and professional during their audit and I appreciate the recommendations made.

As noted in the Scope and Methodology section of the OIG report, communications, safety and security, inmate programming, personnel, training, financial management, external relationships and environmental responsibility were also reviewed. SCC is pleased to note that no findings were made in these areas. Based on the OIG review, major operational components of one of the largest prisons in the State of California were found to be functioning as designed is due to the dedication and quality of staff at all levels in the institution.

Although SCC does not concur with a few selected findings and conclusions, I want to assure you that each and every finding has been taken seriously, and steps have been or will be taken to rectify those areas that are deficient. The constructive recommendations made by your staff have already resulted in improvements in our operations.

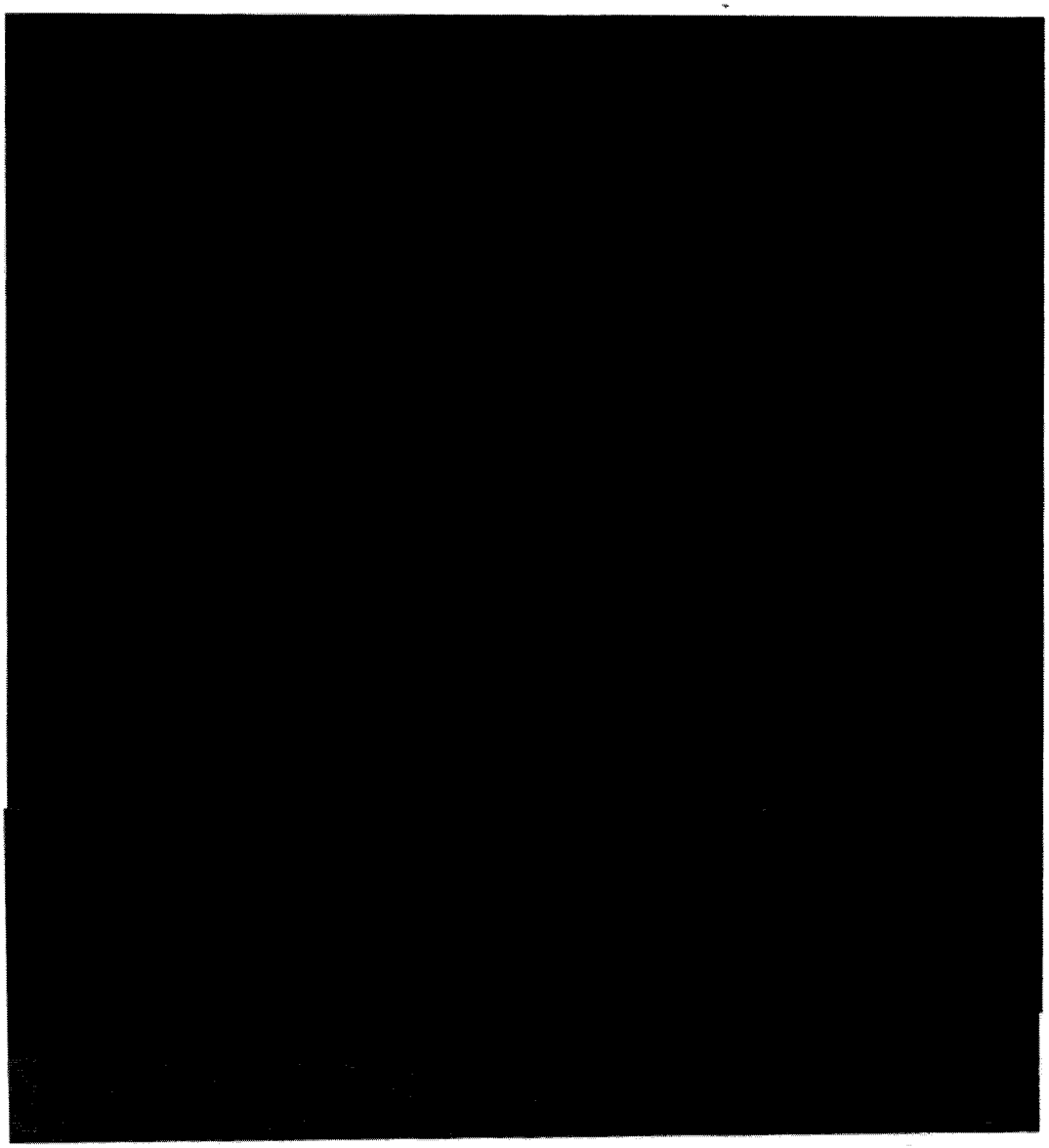
My staff and I have reviewed the report and prepared responses to each of the findings and recommendations.

1. (REDACTED)



SCC Response:

(REDACTED)



2. **Finding:**

The Office of the Inspector General found that inmate and staff safety is jeopardized and illegal inmate activities may go unnoticed because inmates are allowed to erect unauthorized privacy curtains within the housing units.

Recommendation:

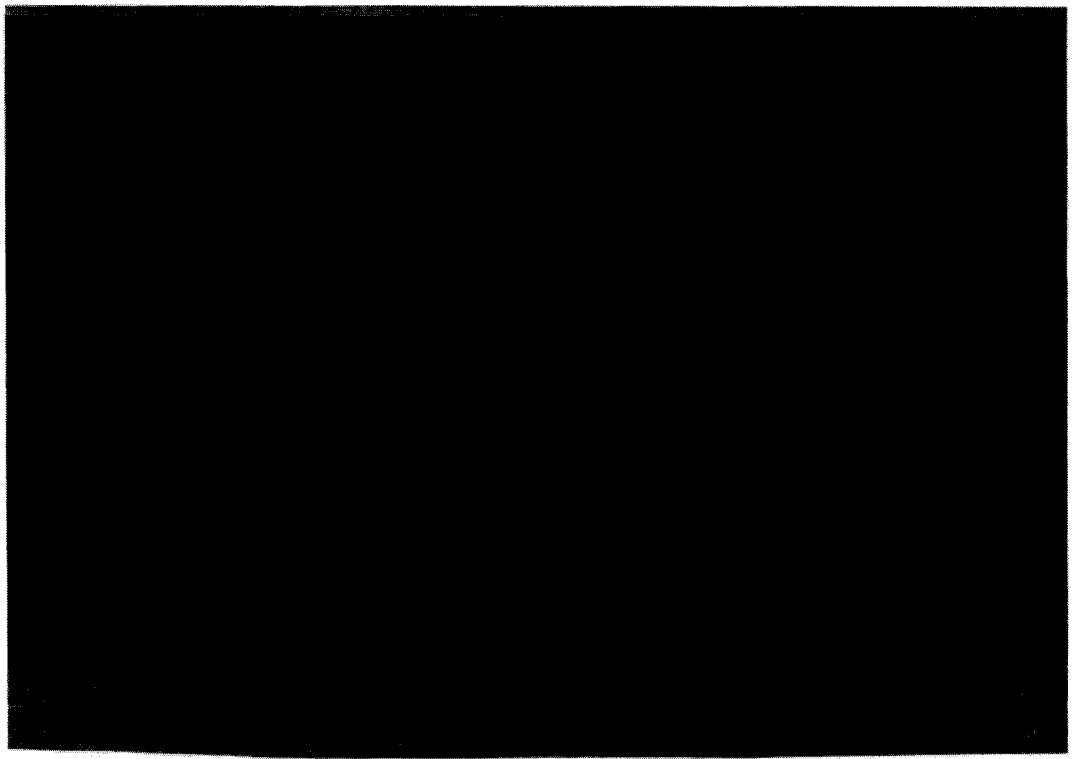
The Office of the Inspector General recommends that the warden issue and enforce an order that staff remove all sheets and other makeshift privacy curtains from showers, bunks, and other areas that would obstruct the view of officers within the housing units.

SCC Response:

This issue has been resolved. The warden issued an order dated March 28, 2001, directing staff to remove all sheets and other makeshift privacy curtains from showers, bunks, and other areas that would obstruct the view of officers within the housing units. Facility Captains have instructed their respective sergeants and correctional officers to monitor the dorms daily until inmates' compliance has been established and adhered to. Progressive disciplinary action will be taken with any inmate who continues to violate this policy. SCC will continue monitoring for future compliance.

Neither the investigation nor the medical time line of the death of the inmate referenced in the report suggested that the privacy curtain was a contributing cause to the inmate's suicide. There was no alarm raised earlier by inmates in the dorm. The reports do not indicate any suspicious activity or unauthorized shower curtain noted by the dorm officer during his routine walk through one hour before the alarm was sounded. It should be noted that this suicide, like all inmate deaths, underwent extensive reviews by SCC management, Health Care Services Division, CDC Headquarters and the Tuolumne County District Attorney's Office. These extensive management reviews did not find a nexus between the shower curtain and the suicide.

3. (REDACTED)



4. **Finding:**

The Office of the Inspector General found that prison dormitories showed signs of significant deterioration, creating health and safety risks.

Recommendation:

The Office of the Inspector General recommends that the institution temporarily cover the holes in the ceiling to prevent inmates from hiding themselves or concealing contraband. The warden should direct staff to monitor the repairs to ensure they remain in place.

SCC Response:

SCC agrees with the OIG recommendation to cover the holes in the dorm ceilings but at best this is a stopgap measure. SCC has submitted a request for funding to completely renovate the dorms. The request includes funding to abate any asbestos, upgrade the Heating and Ventilation Systems, repair or replace plumbing fixtures, and repair or replace water damaged floors and ceilings. In light of the lengthy process to secure funding for a project of this magnitude, SCC will prepare a request for special repair funding for a downsized project limiting the scope of work to repairing the plumbing, floors, and ceilings. In addition, SCC will begin repairs to one set of dorms in May 2001.

SCC agrees with the recommendation for a complete renovation of these 36-year old buildings which are at 220% of design capacity, to repair the infrastructure. A request for funding has been submitted in the 5-year plan while work on the dorms in the worst condition will continue.

5. Finding:

The Office of the Inspector General found deficiencies in many of the internal affairs investigations reviewed.

Recommendation:

The Office of the Inspector General recommends that the Sierra Conservation Center investigative services unit take appropriate steps to prevent deficiencies in future investigations.

SCC Response:

SCC agrees that we can always strive to improve the quality of our Internal Affairs Investigations. Of the six cases cited in the report in which the OIG noted discrepancies, we can only agree that one of the six was, in fact, deficient. A review of the log of the Investigative Services Unit (ISU) revealed that in the past two years, 128 Category I and II investigations have been conducted. While some minor deficiencies may be noted, overall the unit is doing a good job. (2)

The recommendations made by the OIG are already in place. The Investigative Services Lieutenant, the Employee Relations Officer, the Chief Deputy Warden, and the Warden closely monitor all investigations for quality. All investigations are carefully monitored for timeliness on a weekly basis. It is unclear what additional steps could be taken to improve the quality and timeliness of investigations with existing staff limitations.

It should be noted that all investigations are also reviewed by departmental staff in CDC headquarters prior to action being taken. Headquarters staff are very satisfied with the quality of investigations conducted at SCC. None have been returned for changes.

6. **Finding:**

The Office of the Inspector General found many of the inmate appeals a the Sierra Conservation Center are not processed within prescribed time limits and noted numerous other deficiencies in the Sierra Conservation Center's inmate appeals process.

Recommendation:

The Office of the Inspector General recommends that the Sierra Conservation Center take immediate steps to remedy the deficiencies in the inmate appeals.

SCC Response:

SCC agrees with the OIG recommendation. A recent departmental interpretation of the appeals procedures relating to timelines for response resulted in a number of appeals being found not in compliance. The institution has shortened response times for due dates by one week to allow the Appeals Office to log in the appeal and make the required copies prior to returning the appeal to the inmate.

The Medical Department recently hired a Medical Appeals Coordinator which will improve the content and timeliness of medical appeals. However, now the Health Care Manager will sign all Second Level Medical Appeals, rather than the Warden/Chief Deputy Warden.

Appeals that were granted an extension were not getting the due date changed on the appeal forms; therefore, they erroneously appeared to be overdue. This has been corrected by having the units change the due date on the appeal when the extension is granted.

The Warden/Chief Deputy Warden receives an overdue list weekly. The report gives the status of each overdue appeal. The Warden/CDW also receive a Monthly Status Report on all appeals. These reports are discussed at the weekly Associate Warden meetings chaired by the Chief Deputy Warden.

It should be noted that the Appeals Coordinator is also the institution's Litigation Coordinator, which limits the amount of time spent on appeals. The institution has requested funding for a full time Litigation Coordinator but has been unsuccessful to date.

The Appeals Coordinator monitors all appeals and is ensuring they are complete, including staff responses and dating the appeals.

A form has been devised to document staff complaints and a weekly copy will be provided to the Warden. This form is currently under review. A spreadsheet has also been created to log all staff complaints, which identifies the staff person and the complainant.

SCC has a continuing problem with appeals from inmates who have transferred to another facility or to one of our 20 Conservation Camps. One third of SCC's 6300 inmates are in camps that are located geographically from Placerville to the Mexican

border. The physical distances involved contribute to delays in timely processing of appeals.

7. **Finding:**

The Office of the Inspector General found that in some instances the inmate disciplinary system at Sierra Conservation Center is not regularly meeting statutory, constitutional, or procedural mandates.

Recommendation:

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

SCC Response:

We agree with the recommendation made by the OIG. SCC disagrees that inmate's due process rights were violated during the disciplinary process. (3)

SCC also disagrees with the findings relative to statutory violations in the disciplinary process. The only violation was the failure to give the inmate his copy of the RVR within 5 days; all other statutory requirements were met.

In February 2001, SCC conducted In-Service Training to staff relative to the Reporting Employee (RE) responsibilities when authoring Rule Violation Reports (RVR). Instructors with expertise in the disciplinary process provided this training, which emphasized RE requirements to review and sign the typed RVR.

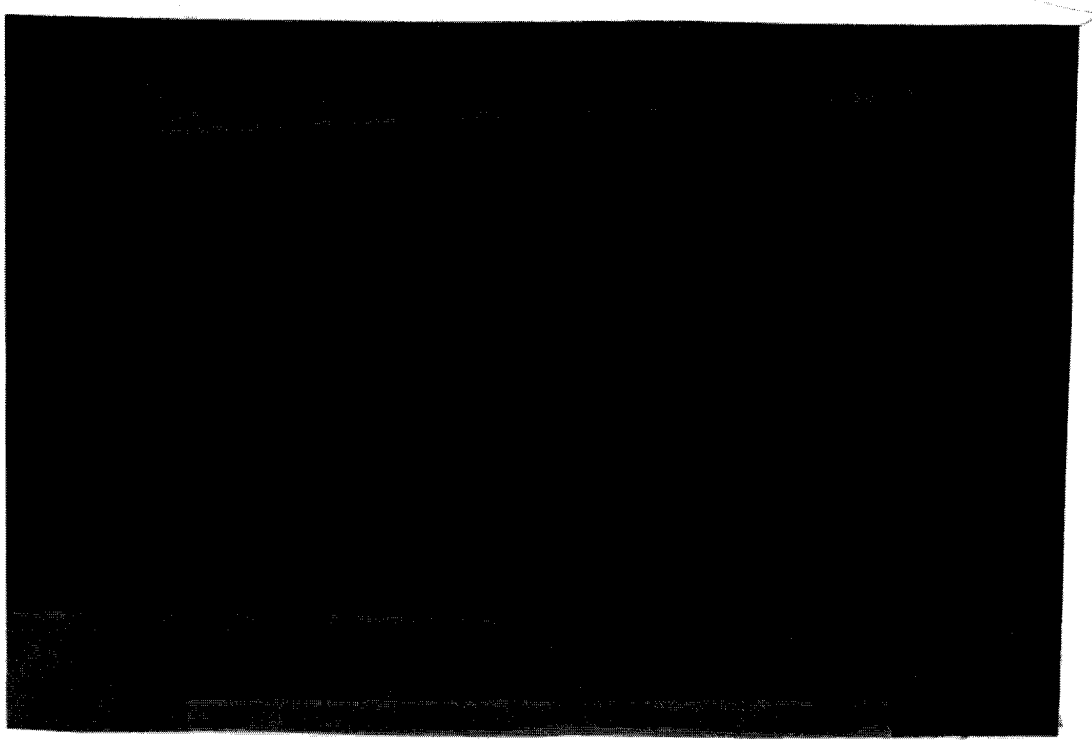
A memorandum dated January 25, 2001, titled Disciplinary Reports/Handwritten Rough Drafts, directs staff to follow up on their own reports. In the event the employee is unable to sign the disciplinary report, the unit supervisor will determine if the violation will be reduced to a Counseling Chrono, and/or have another staff sign the report.

Division heads have met with their respective Facility Captains and instructed them to direct their sergeants and lieutenants to state the reason and sign the RVR when the report is voided or dismissed.

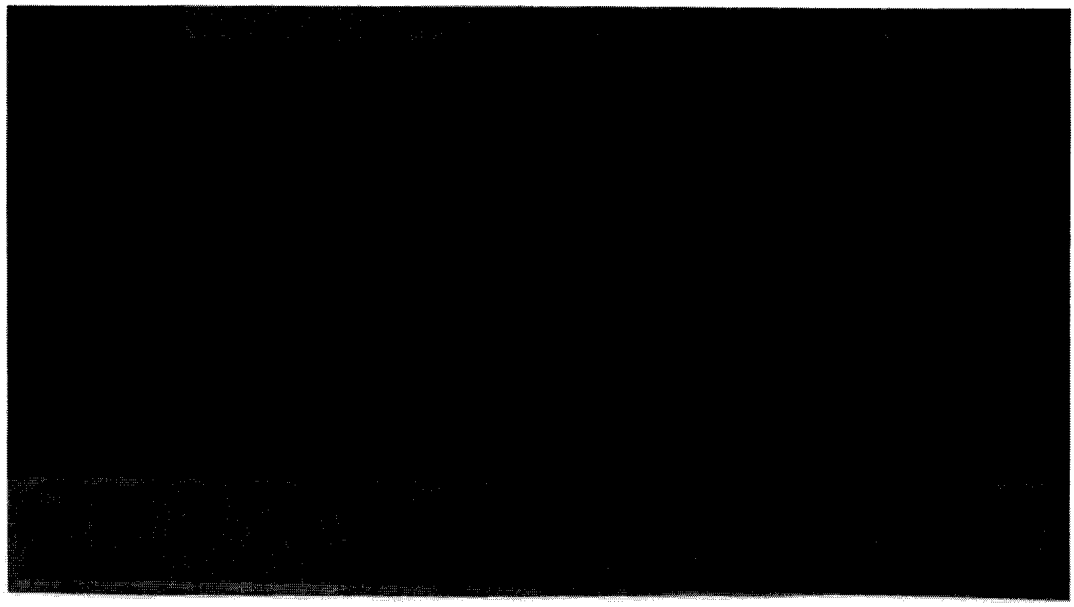
The issue of Facility Captains failing to review and sign the log had been noted by SCC management prior to the Inspector General's audit. After a joint review by the institution and headquarters staff, the determination was made that the Facility Captains are to review the logs monthly. SCC management continues to monitor documentation by the Facility Captains that this monthly review is enforced.

The Warden has the authority to designate the Chief Disciplinary Officer (Associate Warden) to review RVR's which is a standardized practice statewide. The Warden and Chief Deputy Warden do review these reports during their weekly chairing of the Institutional Classification Committee (ICC) and when responding to Second Level Inmate Appeals.

8. (REDACTED)



9. (REDACTED)



10. (REDACTED)

SCC Response:

(REDACTED)

11. Finding:

The Office of the Inspector General found that utility closet doors in the administrative segregation building were unlocked, jeopardizing institution safety.

Recommendation:

The Office of the Inspector General recommends that staff continue to keep the utility closet doors in the administrative segregation unit locked.

SCC Response:

SCC agrees with the OIG recommendation however, the unit is a controlled unit and all inmates are handcuffed and escorted at all times. When the unit was constructed, the utility chase key was not readily available to the unit staff. Frequently, inmates flood the tiers in the Administrative Segregation Unit. Based on the recommendation of the Inspector General, all utility doors have been and continue to be secured. Work orders have been submitted to place the utility closet door key on each officer's key ring. This practice of locking the doors is for staff safety, not security concerns.

12. Finding:

The Office of the Inspector General found that the Tuolumne facility captain circumvents key control by failing to retain possession of his assigned metal key tag when he is not in the unit.

Recommendation:

The Office of the Inspector General recommends that the warden enforce adherence to the key control policies, requiring employees to exchange assigned metal key tags for the keys issued.

SCC Response:

SCC agrees with the OIG recommendation however, does not concur with the Inspector General's findings. The Tuolumne Facility Captain's key ring is very clearly marked "Tuolumne Facility Captain." It is not possible for an "unauthorized" person to take the keys and place the Facility Captain's metal tag on the keyboard. The retention of the key tag does not ensure the security of a facility. The materials to make key tags can be purchased at any hardware store. Security of keys remain the responsibility of the staff issuing the keys. Staff are not authorized to draw keys not used in their daily assignments. Control rooms are secured areas and unauthorized persons do not enter the area and do not check out keys. However, corrective action has been taken and Captain Fox maintains possession of his key tags, as well as the expectation that staff assigned to

(4)

the Control Room fully understand the importance of Key Control. Access to this area is tightly controlled; unauthorized persons cannot simply enter and take keys.

As previously discussed with the auditors, SCC strongly feels that this minor isolated incident is inappropriate as a "finding". The Captain exercised poor judgement in allowing his key chit to remain in Control instead of taking possession of his key chit when he turned in his key ring. However, there is no evidence that the Captain's poor judgement undermined staff accountability or violated any departmental policy. The key ring was accounted for at all times. There has never been a breach of security by the Captain not taking his key chit. The Warden did conduct a verbal counseling session with the Captain when this matter was brought to the Warden's attention. Verbal counselings do not require written documentation. The verbal counseling is appropriate for this minor infraction. SCC cannot agree that this issue is a security concern.

13. **Finding:**

The Office of the Inspector General found that the non-custody staff at Sierra Conservation Center is not fulfilling training requirements and that completion of training courses cannot be readily verified in the training files.

Recommendation:

The Office of the Inspector General recommends that the institution take appropriate steps to ensure that non-custody staff fulfill training requirements.

SCC Response:

SCC is in agreement that efforts should be taken to improve documented training for non-custody staff. The training curriculum will be expanded to address training needs for non-custody staff.

In the specific area of documented training in Sexual Harassment Prevention, SCC has had difficulty with documentation on some of our long-term employees. The training was mandated for all employees over 12 years ago. At that time there was no computer database to track training records and now hard copies no longer exist, or the training was received at another institution and not forwarded to SCC. We will continue to monitor and ensure training compliance.

14. **Finding:**

The Office of the Inspector General found that adverse personnel action case files at Sierra Conservation Center are not adequately monitored, tracked, or documented.

Recommendation:

The Office of the Inspector General recommends that the institution take steps to improve the monitoring, tracking, and documentation of adverse personnel action cases.

SCC Response:

SCC is in agreement to take steps to improve the monitoring, tracking and documentation of adverse personnel action cases. Of note is that there were no violations of departmental policy or Government Code cited. As of the date of this report, the staff member assigned as the clerical support has returned to work from an extended medical leave. The logs have been revised and updated.

SCC does wish to thank the staff of the OIG for their recommendations on a filing and tracking system, it has already proved to be beneficial.

15. **Finding:**

The Office of the Inspector General found that the institution does not have a process to adequately monitor or track employee grievances and that, as a result, the institution may not be in compliance with the memorandum of understanding for each bargaining unit.

Recommendation:

The Office of the Inspector General recommends that the employee relations officer improve the system for logging and tracking employee grievances.

SCC Response:

SCC is in agreement with the findings and recommendations in this area of employee grievances. All recommendations are in the process of being implemented.

16. **Finding:**

The Office of the Inspector General found that equal employment opportunity complaint and investigation case files lack a standardized organizational format.

Recommendation:

The Office of the Inspector General recommends that the institution's equal employment opportunity coordinator develop a standardized filing system for equal employment opportunity complaints that includes a case diary to document all contacts, documents received, and documents prepared.

SCC Response:

SCC agrees with the OIG recommendation. The Equal Employment Opportunity Coordinator for all current and future cases is developing a standardized filing system. Each case file will include a Case Diary, Reference Sheet, and all documentation will be stamped confidential and contain the respective case number.

Although the findings provided an adequate assessment of the need for a standardized and organized filing system, we disagree with the audit teams reference of the five file reviews, such as:

1. Files are missing the Complaint Form (CDC Form 693).

The CDC Form 693 is a format that is provided to the complainant to advise the employee of their rights and assist the Equal Employment Opportunity Counselor to obtain additional information to resolve the issue. There are no requirements to fill out or submit the CDC Form 693 in the complaint process. It is the option of the employee to complete and return the form to the counselor, should they choose to do so.

2. Files are missing, i.e., Contact Letters, Respondents, Closure Letters, and Intake Analysis Reports.

Departmental Policy recently mandated the requirement of a notification to the Respondent. This policy was distributed to all institutions via a memorandum dated January 11, 2000, titled "Notification of Persons Under Investigation", authored by Richard J. Ehle, Jr., Assistant Director, Office of Internal Affairs. EEO files prior to January 2000 would not have contact letters.

The Intake Analysis format was received by the Headquarters Equal Employment Opportunity Office within the last six months. There are prior Equal Employment Opportunity cases already closed that would not contain these documents.

The CDC Form 1807 is a tool utilized by Headquarters for tracking Equal Employment Opportunity cases that are active. There are cases where a CDC Form 1807 may not be submitted in that the matter may have been referred to another area for resolution, for example, a supervisory issue. The future tracking of these documents in the Case Diary to determine what documents are provided and processed for each new case file will enhance the organization and standardizing of the Equal Employment Opportunity filing system.

17. **Finding:**

The Office of the Inspector General found that the process of and responsibilities for documenting and reporting an inmate's death are not clearly defined, making it difficult to determine if the Sierra Conservation Center had adequately fulfilled its medical and legal responsibilities.

Recommendation:

The Office of the Inspector General recommends that the institution rectify the deficiencies in its process for documenting and reporting inmate deaths.

SCC Response:

SCC agrees that we can and should improve the processing of documentation relating to inmate deaths and we are taking steps to do so. We are hampered in that state law declares that medical information, even on an inmate, is confidential to all those outside the medical department. However, even with processing and confidentiality issues, there were no violations of codes or procedures on any of the deaths at SCC.

The Institutional Death Coordinator also has the additional duties of Use of Force Coordinator, DOM Coordinator, and Emergency Response Review Coordinator. Increased staffing would allow more time to create more comprehensive procedures and

standardized files. A Budget Concept Proposal was submitted early this year to increase staff for this purpose.

In developing local procedures, various staff from medical, custody, and administration convened at several meetings to review and comment on the content. The multi-disciplinary approach focused on clarification of duties and assigning responsibility for documenting and reporting.

A local operational procedure is now being drafted, which will add ERRC information and define the functions of the Emergency Response Review Committee, the ERRC Coordinator's duties, the tracking system, and tracking/checklist examples.

The original report of any ERRC review (including deaths) is sent to the Health Care Services Division with a copy to Institutions Division. Both include the same data; however, there are confidential medical documents that can only be viewed by medical staff and sent directly to HCSD; these cannot be included in the ERRC review file.

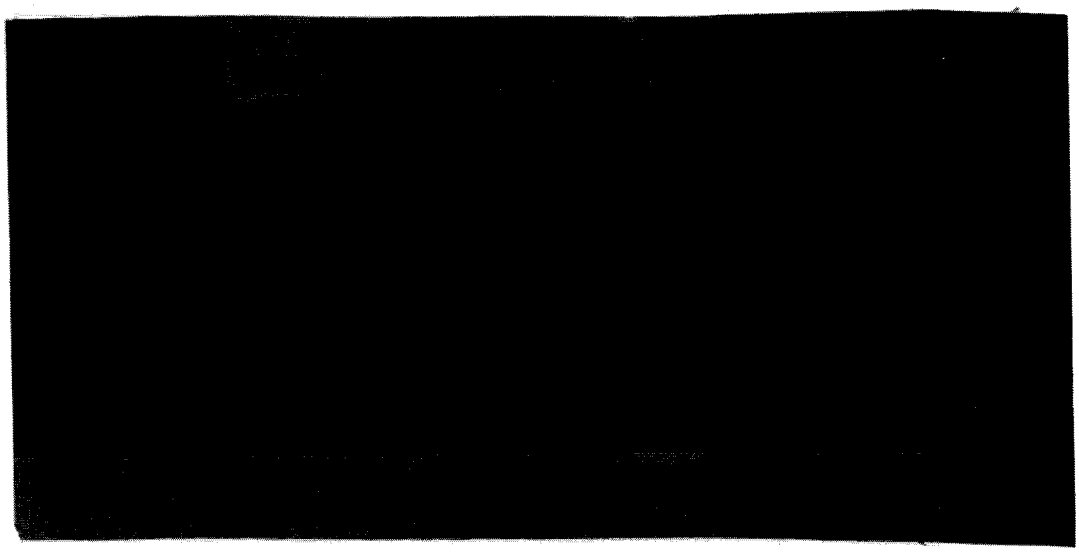
Timelines and checklist forms are not mandated, but were created for SCC in-house use only. In March 2001 the forms were revised to include some of OIG suggestions. The only currently mandated timeline requirements for custody staff is that the Watch Commander document:

- Date & time of notification of ambulance
- Date & time of arrival of ambulance at the sallyport
- Date & time the ambulance departs from sallyport

Most timelines and worksheets (which are not mandated) on file were not filled out completely due to the fact that some issues do not apply to each inmate death.

The ERRC Coordinator's job is to verify the respective SCC Departments receive the items such as death certificates, fingerprint cards, and photographs. The coordinator is not mandated to keep copies of these documents in the inmate death file.

18. (REDACTED)



[redacted]

Conclusion:

Again, thank you for the opportunity to comment on the OIG Management Review Audit of Sierra Conservation Center. We were pleased that the audit was conducted in a very positive, constructive manner. The OIG recommendations and verbal discussions with you, Tom DeWitt and his staff have already improved management practices and procedures at SCC.

If you have any questions or require additional information, please contact me directly.

Sincerely,

MATTHEW C. KRAMER
Warden

[redacted]

ATTACHMENT B

COMMENTS OF THE OFFICE OF THE INSPECTOR GENERAL

1. (REDACTED)

2. The Office of the Inspector General found that six of the 14 category I investigations sampled had serious deficiencies. The deficiencies are fully noted in the report. The fact that the institution has made improvements in the quality of its investigations and documentation is also acknowledged in the report.

3. The institution misconstrued this finding. The Office of the Inspector General did not report that inmates' due process rights were violated. The finding was that the institution was not in compliance with the Department of Corrections Operations Manual requirement that the inmate be delivered a copy of the completed CDC form 115 within five working days after review by the chief disciplinary officer. In addition, it was found that the institution needed to improve its documentation when processing CDC form 115s and the related registers and files.

4. Control and accountability over keys is an important security element in a correctional facility. To maintain this control and accountability, the Department of Corrections instituted a procedure whereby employees are issued metal tags to be exchanged when keys are removed from the control room. The exchange of metal tags for keys provides receipt and acknowledgement of the individual's responsibility. This is especially true for the facility captain, who acts as an example to the facility correctional staff. If keys are misplaced or lost, the responsible individual can be held accountable and receive appropriate disciplinary action. The facility captain circumvented this control and accountability procedure by not personally retaining his assigned metal tag.