OFFICE OF THE INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

Valley State Prison for Women
Chowchilla, California

FINAL REPORT

JANUARY 2001

Gray Davis, Governor • Promoting Integrity

CONTENTS

EXECUTIVE SUMMARY

This report presents the results of a management review audit of the warden of Valley State Prison for Women conducted by the Office of the Inspector General from August through November, 2000. The purpose of the audit was to provide a baseline review in accordance with *California Penal Code* Section 6051. The audit focused on institutional processes relating to personnel, training, communications, investigations, security, and financial matters.

Governor Gray Davis appointed the warden of Valley State Prison for Women on May 25, 2000, pending legislative confirmation. The warden had been serving as the institution's acting warden since January 4, 1999. Near the end of the Office of the Inspector General's field work at Valley State Prison for Women and before his confirmation hearing was scheduled, the warden announced his retirement from state service. As of the date of this report, the California Department of Corrections had not named the warden's successor. Nonetheless, the findings and recommendations presented in this report are relevant to the continuing operations of the institution without regard to the individual occupying the warden's post.

The most significant finding from the Office of the Inspector General's audit concerns the warden's inability to effectively communicate with administrative and custody staff, resulting in extremely poor morale throughout the institution. The warden's communication and management style created an atmosphere at Valley State Prison in which employees felt they had no voice in making decisions affecting their working conditions and careers. The Office of the Inspector General found that the poor morale among Valley State Prison staff is pervasive and may affect the institution beyond the warden's tenure.

During the management review audit, the Office of the Inspector General's staff interviewed many supervisory and management employees, as well as custody and non-custody employees. Some of the interviews were conducted in the course of normal audit procedures, while others were conducted at the request of Valley State Prison staff. The overwhelming consensus among the employees is that the warden's relationship with the staff was severely strained, although a few key employees were complimentary of the warden's administrative abilities.

The Office of the Inspector General distributed an anonymous survey questionnaire to approximately one-quarter of the institution's staff, including all supervisory- and management-level employees. The results of that survey corroborated testimonial evidence obtained through the direct interview process. The questionnaire, a standard management review audit procedure, solicited employees' views on the warden's communication abilities and his overall effectiveness as leader of the institution. The warden initially objected to the Office of the Inspector General's use of the survey questionnaire because he felt that a small percentage of staff (three to five percent) did not like working for him. The survey results revealed that a majority of those responding (64 percent) did not like working for the warden. Although distribution of the questionnaire to randomly selected employees was non-scientific and cannot be statistically extrapolated to the entire employee population at Valley State Prison, the significant number of negative comments is noteworthy. During its field work, the Office of the Inspector General also observed instances of the warden's inability to effectively communicate with staff.

In addition, the Office of the Inspector General's audit team discovered various issues at Valley State that require immediate action by the institution management. Among the most notable of these issues were:

- Incomplete and untimely Category I investigations;
- Untimely and incomplete rules violation reports (Form CDC 115);
- Untimely completion of inmate appeals (Form CDC 602);
- Valley State Prison staff not completing required training courses;
- Late performance and probation reports;
- Inadequate control over drug disposal; and
- Projected budget deficit for fiscal year 2000-01.

Throughout the review process, the audit team received excellent cooperation and assistance from the warden and the staff at Valley State Prison for Women.

INTRODUCTION

The Office of the Inspector General conducted its management review audit of the warden at Valley State Prison for Women pursuant to its authority under *California Penal Code* Section 6051. That code section stipulates that the Inspector General shall conduct management review audits of any warden in the Department of Corrections who has held his or her position for more than four years or of any Department of Corrections facility following the confirmation of a new warden. The management review audit includes, but is not limited to, issues relating to personnel, training, communication, investigations, security, and financial matters. In addition, *California Penal Code* Section 6126 gives the Office of the Inspector General broad audit and investigative authority.

BACKGROUND

Having served as the acting warden of Valley State Prison for Women since January 4, 1999, the warden was appointed by the Governor as warden of Valley State Prison on May 25, 2000. The warden's appointment was still awaiting confirmation by the Legislature when he announced his retirement from state service on November 3, 2000. The warden was the chief deputy warden at the California Rehabilitation Center from July 1994 through December 1998 with the exception of an eight-month period during which he served as the acting warden of the California Rehabilitation Center. He began his state career in 1973 with the California Department of Justice, joining the California Department of Corrections in 1980 where he worked in various correctional institutions before his appointment at Valley State Prison for Women. Prior to his state service, the warden worked in the private sector and for the City of Vallejo. He served as an officer in the United States Army, and holds a bachelor of arts degree in government and a master of public administration degree from California State University, Sacramento. He has completed course work at McGeorge School of Law, University of the Pacific.

Valley State Prison for Women opened in May 1995 and is located on 640 acres in Chowchilla, California. With more than 900 employees and an operating budget of approximately $71 million, the institution was designed to house 1,980 inmates, but regularly houses approximately 3,500 inmates in facilities at Levels I through IV, in addition to a reception center and a security housing unit.

Valley State Prison for Women is designed as a work-based, fully programmed prison, providing legally mandated programs and services, including vocational programs in auto mechanics, cosmetology, dry cleaning, eyewear manufacturing, graphic arts, janitorial services, landscape gardening, mill and cabinetry, office services, pre-vocational education, refrigeration and air conditioning, small engine repair, upholstery, and welding. The Prison Industry Authority operates an optical laboratory and a laundry at Valley State Prison.

OBJECTIVES, SCOPE AND METHODOLOGY

The objectives of the management review audit were to establish a baseline for future reviews by evaluating the institution's performance in:

1. Planning, organizing, directing, and coordinating all correctional, business management, work-training incentive, educational, and related programs within Valley State Prison for Women ; 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 comparing Valley State Prison for Women to other institutions as well as reviewing Valley State Prison's data trends;
2. Conducting interviews with the warden, administrative staff, custody and non-custody employees, and inmates;
3. Distributing survey questionnaires to randomly selected Valley State Prison for Women employees requesting responses regarding the warden's effectiveness in communication;
4. Touring the facilities and observing their operations; and
5. Gathering, reviewing, and analyzing pertinent documents related to key systems, functions, and processes to substantiate the observations made through on-site visits and interviews.

The Office of the Inspector General did not review the quality of health care services provided to inmates but did review the inmate appeals process (CDC Forms 602, and 1824) pertaining to medical and disability accommodation issues.

In addition to performing field work at the institution between August 9, 2000 and November 8, 2000, the Office of the Inspector General obtained and reviewed payroll and financial information maintained by the California State Controller and the California Department of Corrections. This information was reviewed to determine potential areas of risk by comparing Valley State Prison for Women data to other state institutions as well as reviewing significant trends in financial information.

NOTEWORTHY ACCOMPLISHMENTS

Shortly after the warden was appointed, he significantly expanded the staff in the institution's investigative services unit from two (one supervisor and one officer) to nine (one lieutenant, two sergeants, and six officers). The expanded staff has focused much of its efforts on drug interdiction. The impact of the staff augmentation became evident beginning in June 1999, when incident reports showed an increasing number of inmates involved in drug-related activities. By monitoring inmate telephone conversations and developing contacts with housing unit staff, the investigative services unit was able to gather sufficient intelligence to identify, arrest, and prosecute inmates for drug trafficking. The investigative services unit also collaborated with outside law enforcement agencies and the United States Postal Service to arrest non-inmates involved in bringing drugs into the prison. Since 1999, the investigative services unit has helped interdict more than 250 grams of heroin, nearly 100 grams each of methamphetamine and cocaine, and about 45 grams of marijuana. The Office of the Inspector General believes that with the eventual purchase of new drug interdiction equipment (see Finding 14), the investigative services unit will be even more successful in its drug interdiction efforts.

The warden also instituted mandatory random urinalysis for inmates found guilty of drug possession and for all inmates enrolled in the substance abuse program. He also brought in canine units from outside law enforcement agencies to conduct drug searches on a quarterly basis.

Also, under the warden's watch, Valley State Prison for Women received a six-year term of accreditation from the Western Association of Schools and Colleges. This honor was bestowed upon Valley State Prison's vocational education program by the Association members. The accreditation expires on June 20, 2006.

FINDINGS AND RECOMMENDATIONS

FINDING 1

The Office of the Inspector General found that morale at Valley State Prison for Women was poor under the warden's leadership. The audit revealed that employees' distrust of the warden was deep-seated and their respect for him low.

The Office of the Inspector General's audit team first became aware of the morale problems through written complaints from several Valley State Prison for Women employees. The warden himself acknowledged these problems at his initial meeting with the audit team by stating that he

was the target of a large number of unfounded complaints brought by a small faction of disgruntled employees. He characterized employee complaints as negative reaction to his policy of denying "convenient, permissive overtime" and noted that the pending status of his gubernatorial appointment as warden of Valley State Prison for Women led certain employees to view his tenure as "temporary," thus diminishing his authority in their eyes.

The audit team's presence at Valley State Prison eventually led to several employees providing unsolicited comments concerning the warden's communication and management skills. The frequency and number of such contacts from employees increased during the period of the audit team's field work, eventually culminating in unsolicited requests by Valley State Prison employees for off-site interviews with audit team members. The majority of employees requesting such interviews were critical of the warden.

In addition to those the audit team interviewed, dozens of other Valley State Prison for Women employees submitted written comments expressing the overwhelming opinion that the warden's communication techniques and methods of management at Valley State were the source of low employee morale.

Comments from staff focused on the warden's inability to communicate with his management staff, thereby negatively affecting employee morale at the institution. Examples of these comments follow.

- **Failure to consider the opinions of management staff**

  I think communication could be improved if the warden would meet with supervisors on at least a quarterly basis, where questions could be asked and answered.

  * * * * *

  The warden has the potential and knowledge to be a warden; however, he has demonstrated little want to do so. The staff at VSPW possess skills that he takes little notice in. . . . It would greatly benefit the warden if he were to take advantage of the majority of wonderful staff that are working at VSPW. The staff do not respect him for the decisions he makes; only for the position he holds.

  * * * * *

  As a supervisor, I should have access to information to relay to staff. I continuously receive information from inmates which is later confirmed. . . . He does not listen to staff issues and acts as if he can do whatever he wants, regardless of policy and without repercussion because he is the warden.

  * * * * *

  He is not open for criticism from anyone that I know of, and he certainly does not ask the opinion of institution operations from his line staff.

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- **Employee morale**

I think this warden is unconcerned about staff morale and the personal issues of his employees. . . . He does not trust his staff to do a professional quality job, and this contributes to making VSPW a hostile working environment.

* * * * *

The warden doesn't care about the extremely low morale or poor working conditions. Sick leave is rampant because people hate going to work. The warden has shown that he is vindictive and retaliates against anyone who dares question him or his policies.

* * * * *

Morale is at an all time low because of the warden's communication skills and as a result nobody will believe him even when he is telling the truth. Everything he does is viewed in the negative, even if it is a good thing.

* * * * *

I used to be proud of working at this facility. It had the greatest staff I've encountered in several other institutions. It has deteriorated in the past several years.

* * * * *

He has publicly embarrassed me in the past while promoting his self-righteous badge of respect at the same time. He has destroyed our institution and created a divided staff unable to function in a common role.

It is important to note that each of the above quotes came from a different Valley State Prison employee, and that many employees said that they feared reprisals from the warden for expressing themselves should he learn their identities.

Many of the Valley State Prison staff members with whom the Office of the Inspector General's audit team came into contact expressed frustration over the fact that, although they had complained to department management, the warden remained Valley State Prison's warden. Those comments included the following:

Our prison was operating efficiently and staff, even across divisional lines, got along well until the warden was appointed. Staff at all levels have continually complained about his management skills. We have had internal reviews by retired wardens where valid complaints were actually verified. The Institutions Division Deputy Director and the Central Regional Administrator have cautioned him about complaints from staff and there have been several mini-investigations conducted about his poor supervisory skills and lack of understanding about the intricacies of running a prison. After all these reviews have been conducted and the complaints have been verified, he is still the warden.

* * * * *

We have given your office and the Department a ship load of issues on this warden. If we had given the same information to a private attorney, I feel we could easily have proven

our case. I think that you use . . . our complaints so that you can plan your rebuttal when necessary.

Although the results of the Office of the Inspector General's survey of Valley State Prison employees cannot be given the weight of a scientific, statistically valid study, the overwhelmingly negative response from approximately two-thirds of the respondents is compelling evidence of a serious problem.

A noteworthy example of the warden's shortcomings in communicating with staff occurred during the audit team's field work at Valley State Prison when the institution conducted a hiring examination for three vacant professional-level positions. An interview panel composed of three managers interviewed more than 20 candidates throughout a two-day period in what the panelists and candidates believed to be a competitive process to identify the strongest candidates for the three positions. At the end of the interview process, the panelists divided the candidates into three ranking strata, designating the top rank "highly competitive," and ranked the candidates within each of the strata so that the names of the candidates appeared in order with the highest-rated at the top of the list.

After receiving the rating list from the panel, the warden appointed three individuals, two of whom were not among the interview panel's highest-rated candidates. It is important to note that, with few exceptions, each of the candidates was technically eligible for appointment irrespective of their ranking by the interview panel, but the warden's selection of the three candidates was negatively received by a large number of Valley State Prison employees. While the panelists realized that the warden could have made the appointments without requiring two-days of their time, the candidates felt that the competitive interview format was little more than a charade. In addition to those involved, many employees who observed the process expressed suspicion that the warden had decided whom he intended to hire even before the panel conducted the interviews.

While the warden did not act illegally in exercising his hiring authority, viewed as a whole, the process led many Valley State Prison employees to cite this incident as a prime example of the warden's disregard for the time and efforts of his subordinates.

RECOMMENDATION

The Office of the Inspector General recommends that the Valley State Prison management take immediate steps to regain employees' trust and respect. This should be initially achieved by the following actions:

- Acknowledging the extent to which cynicism and distrust affects the employee population;
- Meeting with employees to identify and define the issues most important to them;
- Responding immediately to as many of the initially identified employee concerns as practically possible by introducing policy changes, permitting activities, or making other innovations that can be implemented without compromising institutional security or agency policy;

- Forming a committee of representatives from various employee areas (administration, custody, facilities, programming), to provide a forum for identifying factors relating to employee morale, recommending solutions, and monitoring the effectiveness of the solutions implemented; and
- Conducting regular walking tours of the institution, visiting all work sites to talk with employees about the institution's mission and receiving information directly from employees responsible for carrying out that mission.

FINDING 2

The Office of the Inspector General found that the institution's Category I investigations are delayed unnecessarily and are often inadequate.

Category I investigations, as defined by the *Department of Corrections Operations Manual,* involve performance-related employee misconduct, in contrast to Category II investigations, which are concerned with serious employee misconduct outside the scope of normal employee supervision. While Category I cases are investigated internally at the institution, Category II cases are under the domain of the Department of Corrections Office of Investigative Services.

The Office of the Inspector General's review of Category I investigations conducted at Valley State revealed that 13 of the 17 cases examined exhibited various deficiencies such as:

- Failure to explore issues fully;
- Failure to interview witnesses or the subject of the investigation;
- Incorrect or unsupported findings; and
- Inadequate documentation.

In addition to the deficiencies noted above, five of the cases examined were not concluded in a timely manner. The Public Safety Officers Procedural Bill of Rights (*Government Code* Section 3304) requires an employer taking adverse action against a peace officer to complete both the investigation and any related adverse action within one year of discovering the misconduct. Historically, the Department of Corrections has extended to *all* employees the rights and protections afforded to peace officers. Thus, the one-year limitation effectively applies to every investigation of employee conduct within the department.

In four instances in the past two years, delays in processing Category I investigations prevented the institution from taking adverse action against employees, even though those investigations resulted in sustaining the misconduct allegations, because the one-year time limit had passed. Similarly, in two Category II investigations, results were too late to take adverse action within time limits.

Much of the delay in processing can be attributed to the warden's practice of checking both "Category I" and "Category II" boxes on the form transmitting the cases to the Office of Investigative Services, leaving the classification determination, and therefore the decision to accept or reject the case, to that office. Of the 71 Category I cases listed on the institution's log

for calendar year 2000, 19 had been first submitted to the Office of Investigative Services and rejected because they did not meet the definition of Category II misconduct. Of the 19 cases that the Office of Investigative Services rejected and returned to the institution, only six actually resulted in Category I investigations. The remainder were reduced to fact-finding inquiries, handled as supervisory issues, or referred to the Equal Employment Opportunity Office. Several weeks, sometimes months, are lost in this way before the institution can begin investigating these Category I cases.

In discussing this issue with the audit team, the warden said that he had received directives to refer any and all cases potentially involving charges of sexual misconduct to the Office of Investigative Services, although only one of the 19 cases submitted involved sexual misconduct allegations. He also said that, in the past, the Office of Investigative Services had questioned his judgement about classifying some cases as Category I matters, and he was therefore inclined to err on the side of caution.

RECOMMENDATION

The Office of the Inspector General recommends that the Investigative Services Unit at Valley State Prison carefully monitor the timeliness of its investigations. Adding a separate column to the incident tracking log for recording the incident date would help to flag the approach of the one-year deadline imposed by *Government Code* Section 3304(d). The Investigative Services Unit's newly-appointed lieutenant should play a strong role in monitoring the quality of every investigation, ensuring that issues are fully explored, relevant witnesses interviewed, conflicting testimony evaluated, and findings supported by sufficient facts and evidence.

In addition, the Office of the Inspector General recommends that the Valley State Prison warden exercise good judgment in making the necessary distinctions between Category I and Category II investigations. In cases where the determination is open to interpretation, the warden should consult with the manager of the Office of Investigative Services, Central Region, in making a decision.

FINDING 3

The Office of the Inspector General found that the inmate disciplinary process at Valley State Prison for Women is not regularly meeting statutory mandates with respect to timeliness and documentation.

The Office of the Inspector General found a number of instances in which inmates were not provided with copies of the rules violation report (CDC Form 115) within five days of review by the chief disciplinary officer, and other instances in which the institutional register did not document the date on which inmates were provided with copies of the CDC Form 115. In addition, the Office of the Inspector General noted examples of CDC Form 115s being "voided" with no documented explanation, and of CDC Form 115s not being issued to the inmate within

15 days of the incident date. One such example discovered during the audit team's field work detrimentally affected an inmate's time credits as follows:

> The CDC Form 115 acknowledged that time constraints had not been met and yet the inmate was still assessed 90 days forfeiture of credit. The chief disciplinary officer's audit of the CDC Form 115 did not reveal the due process violation at the time of the review. When brought to the attention of the current chief disciplinary officer, the issue was raised with the institution classification committee and the inmate's earliest possible release date was adjusted to restore the loss of credit resulting from the rule violation report.

Because practices for managing and maintaining voided CDC Form 115s differ among housing facilities within the institution, copies of voided forms are not consistently provided to the chief disciplinary officer as part of the institutional register, nor are the reasons for voiding the forms documented to facilitate monitoring and auditing.

The housing facilities are likewise inconsistent in managing dismissed CDC Form 115s, sometimes failing to provide copies of the dismissed forms to the chief disciplinary officer for entry to the institutional register. Documentation for dismissing disciplinary actions often consists of a brief notation, "Dismissed in the interest of justice," with no further explanation. Consequently, the institutional register has missing or incomplete information for the CDC Form 115s generated by the institution's four housing facilities.

The audit team's review of disciplinary action logs (CDC Form 1154) at individual housing facilities disclosed 29 incomplete entries for one particular month, including omitted dates for critical events such as hearings and for delivery of copies of CDC Form 115s to inmates. The captain responsible for the facility did not sign the log for that particular month. Another facility's disciplinary action log contained memoranda noting several CDC Form 115s as missing and unaccounted for after attempts to locate them failed.

Title 15 of the *California Code of Regulations,* Section 3312(b), states that all disciplinary methods and actions shall be reviewed by the chief disciplinary officer. In addition, Section 52080.3.3 of the *Department of Corrections Operations Manual* requires that after an inmate disciplinary hearing, the chief disciplinary officer shall complete an audit of the violation report to ensure, among other things, that:

- Forms CDC 115 and 115-A are complete and copies are delivered to the inmate within five working days of the audit;
- Due process and time constraints are observed; and
- Disposition of the matter under investigation is justified by documentation.

Copies of each rules violation report are to be maintained in chronological order in the institutional register, pursuant to Section 52080.15.1 of the *Department of Corrections Operations Manual.*

RECOMMENDATION

The Office of the Inspector General recommends that the warden's office regularly review the disciplinary action logs (CDC Form 1154) at each of the institution's four housing facilities to identify any incomplete CDC Form 115s.

In addition, the warden's office should implement procedures requiring written justification by any official voiding or dismissing a CDC Form 115. Finally, to facilitate proper monitoring and auditing, copies of voided CDC Form 115s should be provided to the chief disciplinary officer for inclusion in the institutional register.

FINDING 4

The Office of the Inspector General found that inmate appeal forms (CDC Form 602) are not being processed within the time limits required by Title 15 of the *California Code of Regulations,* Section 3084.6.

The audit team observed that at least 17 of 78 CDC Form 602 inmate/parolee appeals reviewed were not processed in a timely manner at the informal level or at the first or second formal review level. The 78 appeals were non-statistically selected from the total listing of Valley State Prison appeals. Specific findings included the following:

- Three informal appeals were from five to 33 days overdue;
- Ten first-level appeals were from one to 59 days overdue;
- Four second-level appeals were from three to seven days overdue;
- Nine of the overdue appeals were medically related.

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

> *Informal level responses to inmate appeals shall be completed within 10 working days. 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.*

Valley State Prison has an automated system capable of tracking appeals and generating various management reports. One such report is an inmate/parolee overdue appeal report, which is generated weekly for the warden's office, division heads, supervisors, and managers**.** Although the collection, tracking, and reporting of inmate appeals is the ultimate responsibility of the warden, the chief medical officer of Valley State Prison is directly responsible for the disposition of medical appeals.

The overall administrative burden for managing the appeals process can dramatically increase when appeals are not resolved in a timely manner. If inmates perceive that their concerns are not being addressed properly and promptly, their dissatisfaction may jeopardize the overall safety of other inmates and custody staff. Similarly, the lack of responsiveness can exacerbate the appeals process because inmates will begin to file new appeals on previously unresolved issues.

Valley State Prison's system of filing completed CDC Form 602s is cumbersome. The completed forms are filed by year in groups of 50 to 100 forms per individual folder. Although the file folders are numbered sequentially, the forms within each folder are not arranged in any particular order, requiring anyone desiring to locate a particular form to search through each form in the folder.

RECOMMENDATION

The Office of the Inspector General recommends that the warden's office implement effective monitoring processes to ensure that inmate/parole appeals are processed promptly.

For any monitoring process to be effective, it must be combined with appropriate action to enforce adherence to required deadlines. In addition, the warden's office should consider the necessity of providing additional training on Valley State Prison's policies and procedures for processing inmate appeals. Furthermore, the institution's appeals coordinator should begin filing completed CDC Form 602s in sequential order within the individual appeals folders.

FINDING 5

The Office of the Inspector General found that Valley State Prison for Women's training records are inadequate to document that staff members have attended mandatory training classes and completed the minimum hours of required annual training.

The Office of the Inspector General reviewed Valley State Prison's system of recording and tracking training hours for courses attended by custody, non-custody, supervisory, and management staff. The review determined that Valley State Prison does not have an adequate system in place to ensure that all employees receive 40 hours of required annual training, as well as other mandatory training classes. For example, the Office of the Inspector General non-statistically selected the training records of 51 staff for review — 33 custody and 18 non-custody. The audit team reviewed training printouts provided by Valley State Prison's in-service training office, as well as the individual training files of the employees included in the sample. The results revealed that of the staff members in the sample:

- Seven non-custody staff members (39 percent) did not complete the required minimum of 40 hours of annual training;
- One staff member had yet to register with the in-service training office and had no training records available;
- Eleven custody staff members (33 percent) did not attend the mandatory 7K training classes;
- Ten staff members did not complete emergency operations training;
- Five staff members did not complete escape procedures training;

- Five staff members did not complete fire safety training; and
- Fifteen staff members did not complete the tuberculosis (TB quiz) training.

Similarly, the audit team reviewed the training records of 20 randomly selected supervisory and management staff members to determine whether mandatory training courses were completed. The team was unable to find evidence in the training records showing completion of the mandatory training courses for 53 percent of the supervisory staff and 51 percent of the management staff in the sample.

The main reason for Valley State Prison's inability to properly track training is that its training database is not linked with those of other institutions in the state. As a result, when staff transfer to Valley State Prison, their historical training records are not transferred to the institution's training database unless they provide a disk to the in-service training office giving their individual training history. The audit team recognizes that staff may have completed some of the mandatory supervisory and management courses at other institutions, but verification with those institutions is beyond the scope of the management review audit. The team also reviewed the personnel files of the individuals in question and located additional training documentation not recorded on the institution's training database for those individuals. In addition, Valley State Prison's in-service training staff said that training hours are often recorded improperly. The audit team noted instances where training courses were erroneously coded or duplicated on individual training printouts. Because these control weakness extend to all Valley State Prison staff, it presents a serious impediment to management's ability to ensure that required training is completed. Without accurate training documentation, management cannot hold staff accountable for implementing Department of Corrections policies and procedures. More importantly, the lack of documentation creates potential legal liability for both Valley State Prison and the department.

RECOMMENDATION

Valley State Prison and Department of Corrections management must place greater emphasis on maintaining complete and accurate training records for Valley State Prison staff. In addition, the warden should require the in-service training staff to provide training printouts periodically to supervisors and managers so that they can monitor staff training status.

FINDING 6

The Office of the Inspector General found that employee probation and performance reports are not completed in a timely manner.

Valley State Prison's system for ensuring that staff probation and annual performance reports are completed in a timely manner is inadequate. The audit team non-statistically selected 52 custody and non-custody personnel files to determine whether probation and performance reports were completed by required due dates and whether those files contained current, complete performance and probation reports. Of the 52 employee personnel files reviewed, 35 files (67 percent) showed evidence that performance and probation reports were received past their required due dates. In addition the audit team noted the following:

- Seven files were missing at least one of the required probation reports;
- Nine files were missing current performance reports, with five of those performance reports overdue by more than one year and one overdue by three years;
- Three probation and performance reports were missing appropriate employee signatures and dates; and
- In six instances annual performance reports were skipped and replaced by the most current annual report. According to Valley State Prison staff, employees who fall behind more than a year on probation or performance reports can avoid preparing those overdue reports by completing the most current report. This apparently is a current practice at Valley State Prison.

The audit team also received status reports for January 1999 and August 2000 prepared by the associate warden of business services itemizing all past-due performance reports at Valley State Prison. According to Valley State Prison staff, the status reports are prepared monthly for the warden's approval before distribution to the appropriate division heads for follow-up. According to the warden, significant focus has been placed on eliminating the backlog of past-due performance reports. The audit team also obtained an internal memorandum dated May 18, 2000 addressed to all custody supervisors concerning the assignment, tracking, and completion of apprenticeship, probationary, and annual performance reports. The memorandum established procedures and affixed responsibilities for timely completion. The Office of the Inspector General noted a reduction in past-due reports between January 1999, when 162 reports were past due, and August 2000, when 57 reports were past due. The most current report, however, shows several employees, notably medical staff, with two or more delinquent reports. One employee has four delinquent reports, three of which date back to 1998.

The Office of the Inspector General also found that several staff members who were enrolled in the Correctional Peace Officer Standards and Training apprentice program lacked probationary reports in the apprenticeship files reviewed.

Although the institution is making progress in eliminating the backlog of past-due probationary and performance reports as well as meeting current due dates, more work needs to be done.

RECOMMENDATION

The Office of the Inspector General recommends that the warden and his management team emphasize the importance of preparing employee performance and probationary reports in a timely manner.

The warden must stress to his administrative staff that late reporting adversely affects the entire institution. Monthly status reports for all staff should be reviewed at executive staff meetings where the warden and his staff can ensure that supervisors and managers are taking appropriate action to reduce the present backlog of late reports.

FINDING 7

The Office of the Inspector General found that control over the storage and disposal of drugs at Valley State Prison is inadequate.

Valley State Prison staff did not perform an independent count of drugs immediately prior to their disposal at the Crows Landing destruction site. Valley State Prison's Investigative Services Unit is responsible for the destruction of drugs no longer needed as evidence for the courts. The drugs were disposed of in a joint effort with staff from Central California Women's Facility. Valley State Prison's current process deviates from that recommended in the *Department of Corrections Operations Manual,* which requires that the disposal be coordinated with local law enforcement or the State Department of Justice. Neither the Valley State Prison staff nor the Central California Women's Facility staff independently verified or documented the type and amount of drugs turned over to the facility for disposal at the destruction site. As a result, there was no formal confirmation that all drugs were disposed of.

The Office of the Inspector General's audit team also found deficiencies in control of access to the Valley State Prison drug evidence storage area and an absence of periodic independent inventories to document the evidence stored.

Controlled substances discovered in the institution are kept in the locked evidence room of the Investigative Services Unit under the control of two correctional officers responsible for maintaining security over the drugs from discovery to disposal. The evidence room is locked at all times, with the key secured in a red lock box in the Investigative Services Unit office. At the beginning of the Office of the Inspector General's audit, the evidence room keys and all Investigative Services Unit vehicle keys were stored in the same red box. Every staff member assigned to Investigative Services Unit had a key to this box and therefore access to the evidence. Following discussions with the Office of the Inspector General, the institution installed a second lock box to hold only the evidence room keys. The two assigned evidence control officers are now the only staff members with keys to the box holding the keys to the evidence room.

Institution controls do not provide a clear delineation of responsibility if discrepancies in drug counts are encountered. Even though a daily count of the evidence is performed by the two correctional officers responsible, no written record of that inventory is maintained, nor are periodic inventories performed by an independent third party to confirm the accuracy of daily counts. Without written inventories, there is no audit trail documenting the inventory results either confirming counts or identifying discrepancies, which places additional liability on the individuals responsible for maintaining security.

RECOMMENDATION

The Office of the Inspector General recommends that the Valley State Prison warden implement the following procedures:

- Coordinate the destruction of drugs with local law enforcement as required by the *Department of Corrections Department Operations Manual.* If this is not practical, Valley State Prison's Investigative Services Unit should transport the drugs to the destruction site in conjunction with Central California Women's Facility staff. Staff from the two institutions should trade and inventory each others' drugs, and sign an acknowledgement verifying counts or identifying discrepancies immediately prior to destruction;
- Appoint one correctional officer as Valley State Prison's evidence officer and restrict drug access to only that individual; and
- Require that Investigative Services Unit supervisors conduct unannounced inventories of the evidence room at least monthly. The inventories should be documented and maintained for review.

FINDING 8

The Office of the Inspector General found that Valley State Prison for Women is projecting a budget deficit of $1.2 million for the coming fiscal year.

Valley State's non-medical budget has shifted from a projected surplus of $1.3 million in fiscal year 1999-2000 to a projected deficit of $1.2 million in fiscal year 2000-2001. Section 32 of the 1999 Budget Act stresses the importance of operating an institution within the approved budget and forbids expenditures in excess of appropriations without prior consent by the Department of Finance. In essence, managers are expected to operate within the budget or go through proper channels to augment the budget.

The $2.5 million swing in the budget can be attributed to additional personal service expenditures as follows:

- Increased medical guarding costs as a result of sending more inmates outside the institution for health care;
- Increased Department of Corrections salary savings requirements resulting in a $420,000 budget reduction;
- Sick leave use exceeding budgeted levels;
- Increased staffing for the Investigative Services Unit;
- Establishing a post at the entrance gate during second watch without going through the budgetary process; and
- Increased security costs for suicide watch.

Some of these expenditure increases should have been addressed through the budget change proposal process. Other increases should have been counter-balanced by reducing expenditures. The negative $2.5 million trend could be serious if appropriate action is not taken immediately. In past years, Valley State Prison's surplus could be used to address specific local problems or to offset deficits in other institutions. Unless action is taken promptly, Valley State may become a fiscal liability for the Department of Corrections.

RECOMMENDATION

The Office of the Inspector General recommends that the warden take immediate action to control expenditures and eliminate future budget deficits. This effort requires reducing expenditures by eliminating posts and preparing budget change proposals to augment the institution's budget.

FINDING 9

The Office of the Inspector General found that Valley State Prison failed to respond expeditiously to an inmate's request under the Americans with Disabilities Act, thereby violating a court-ordered remedial plan and subjecting the institution to potential civil liability.

The Office of the Inspector General's audit team reviewed Valley State Prison's Americans with Disabilities Act requests dating from January 1, 2000 and selected a non-statistical sample of twelve requests for follow-up review. The follow-up included a detailed review of medical records for ten different inmates (with one inmate submitting three separate requests). The audit team noted that generally, the Valley State Prison staff handled Americans with Disabilities Act requests professionally and expeditiously. However, one case stands out as a major exception:

> On January 14, 2000, a post-polio inmate formally requested that the institution either return the leg brace that was taken away when she was admitted into custody or that the institution staff provide her with a wheelchair. A review of the inmate's file showed that the institution doctor had authorized the inmate's use of the brace, according to a hand-written response dated January 16, 2000. However, in the interim the inmate was relegated to using crutches while awaiting delivery of either the leg brace or the wheelchair.
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> On January 23, 2000, nine days after the formal request, the inmate broke her leg in a fall in the institution yard, requiring emergency surgery. On February 17, 2000 the institution authorized the inmate's use of a wheelchair. The next crucial entry in the inmate's medical file after her surgery is dated March 30, 2000, when the institution medical staff authorized her to wear a full leg brace.
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> In a second formal request dated May 27, 2000, the inmate expressed dissatisfaction with her treatment, indicating that her current brace did not fit and that she had been measured for a new brace but had yet to consult with a doctor. The institution's June 22, 2000 response to the formal request stated that a new brace and shoe would be provided and mentioned her consultation with a physician on June 8, 2000. The audit team also noted an entry in the medical file mentioning that the inmate was unable to bend her knee after her recent surgery.

On September 11, 2000, three months after the doctor's visit, the inmate submitted a third formal request for a leg brace. The inmate received a properly fitted leg brace on September 20, 2000.

Valley State Prison's Operational Procedure Number 83080.08, "Issuance of Wheelchair and Other Assistive Devices Procedure," appears to conflict with both the *Armstrong v. Davis* Court-Ordered Remedial Plan and the institution's disability placement procedure, which was implemented on July 1, 2000. The plan states: "No inmate shall be deprived of a health care appliance that was in the inmate's possession upon entry into the CDC system…unless for documented safety or security reasons or a Department physician or dentist determines that the appliance is no longer medically necessary or appropriate." In contrast, the institution's assistive device procedure requires that a physician verify the inmate's need for the device.

The chronology of events shows that it took the institution nearly eight months to accommodate the inmate's initial request to replace the leg brace taken from her by the institution staff in January 2000. In the intervening eight months she submitted two additional Americans with Disabilities Act requests, fell, broke her leg, and underwent emergency surgery after which, according to her medical file, she was unable to bend her knee. It is noteworthy that the Prison Law Office made a formal request for her medical records on October 6, 2000.

RECOMMENDATION

The Office of the Inspector General recommends that the warden immediately modify the institution's operational procedure for assistive devices to correspond with the departmentally issued remedial plan and its own disability placement procedure. In addition, the warden should thoroughly investigate this incident and take steps to lessen or eliminate the potential for any similar incident to occur.

FINDING 10

The Office of the Inspector General found that Valley State Prison's quarterly tool audits do not accurately reflect actual conditions at various inventory sites throughout the institution.

The institution's quarterly tool audit completed on July 18, 2000 showed that every segment of the institution was in compliance with respect to three areas reviewed: inventory, critical tools, and tool identification. When the audit team asked why the July 18, 2000 tool control audit showed no deficiencies, the institution's tool control officer replied that it was his practice to correct any deficiencies as he discovered them, and that each area of the institution was in compliance by the time he left. As a result of this practice, the warden does not receive an accurate summary of the problems the tool control officer actually encounters, and is thus deprived of any opportunity to take corrective action to improve the institution's system of tool controls.

The Office of the Inspector General's audit team conducted a spot audit of the Prison Industry Authority optical program, and discovered a number of problems, including:

- The door to the tool room left unlocked and unattended;
- No inventories of tools contained either in tool boxes or tool pouches;
- Four tool pouches added to the tool board without the supervisor's knowledge;
- The September 2000 inventory showed tools added and deleted, but not itemized on the add/delete list; and
- The optical lab's filing system did not permit lab employees to correlate purchase orders with tool inventory and employees could not locate documents of receipt for added tools or for disposal of deleted tools.

The security lapses in the Prison Industry Authority optical area provide inmates with access to weapon stock as well as opportunities for undetected theft of tools or other inventory.

As a continuation of its review, the audit team made a second spot audit of the vocational automotive repair shop. With the exception of some paperwork, the automotive repair shop's tool control practices were exemplary. The tool room was locked and all tools were clean, orderly, and color-coded. Each toolbox contained a complete, easy-to-read inventory. Tools on the wall were hung against a shadow board that included the tool number also scribed on the tool. According to the vocational instructor, all tools had been re-inventoried in August 2000, with none missing or unaccounted for. However, the instructor was not able to locate the requisition or the purchase order for new tools that had recently been added to the inventory.

RECOMMENDATION

The Office of the Inspector General recommends that the tool control officer document all corrective action taken during tool audits and bring all serious policy violations to the warden's attention. Further, any corrective action taken by the tool officer should be summarized in the completed quarterly tool audit report presented to the warden.

FINDING 11

The Office of the Inspector General found that adverse personnel action case files at Valley State Prison are not adequately monitored, tracked, or documented.

From January 1, 1999 through mid-September 2000, there were 18 adverse employee actions filed at Valley State. The Office of the Inspector General audit team examined case files for eight of these 18 actions and noted that the case records were incomplete. In addition, in six potential adverse action cases, processing delays exceeding one year since discovery of the incident underlying the case prevented further action pursuant to *Government Code* Section 3304(d), irrespective of investigative findings.

RECOMMENDATION

To mitigate the potential for exposing the institution and the department to civil liability, as well as to lessen the possibility of having cases unresolved for unacceptable periods of time, the Office of the Inspector General recommends that the institution's employee relations officer develop a system to track and monitor adverse action cases.

The process should include periodic reviews to ensure that all required documentation is present in the files and that critical deadlines are met in order to preserve the institution's ability to invoke all available disciplinary and legal actions.

FINDING 12

The Office of the Inspector General found that equal employment opportunity complaint and investigation case files contain inadequate documentation.

Of the 66 equal employment opportunity files opened at Valley State Prison from January 1, 1998 through mid-August 2000, the audit team reviewed 14 individual case files and discovered that all 14 were missing documentation recording critical steps in the complaint and investigation process. Without complete and proper documentation, the institution is open to potential liability stemming from litigation.

Specifically, in three cases, CDC Form 1807 (discrimination complaint) was incomplete. In other cases, the case files lacked complete documentation noting such items as the basis for complaint, date received, names of assigned investigators, and dates of disposition.

Section 33030.1 of the *Department of Corrections Operations Manual* establishes the department's intent to promote administration of sound personnel policy and standards by establishing a uniform method of investigating, reporting, and processing complaints involving possible violations of *Government Code* Sections 19572(w) and (x), concerning discrimination and retaliation.

Neglecting to periodically monitor and update case files increases the risk of cases remaining unresolved for unacceptable periods of time. In addition, the lack of documentation recording critical events may have detrimental ramifications to the institution and the department should a complaint become the subject of civil litigation.

RECOMMENDATION

The Office of the Inspector General recommends that the institution's equal employment opportunity coordinator develop a system to track and monitor equal employment opportunity cases to ensure that cases are resolved in a timely fashion and that all critical documentation is complete.

Development and maintenance of such a system should not prove difficult, as only 66 cases were filed at the institution during the two and one-half year-period the Office of the Inspector General examined. The most critical element of this system will be regular monitoring of the caseload to identify the cases most urgently in need of attention. The monitoring function is a task for which one individual, preferably the equal employment opportunity coordinator, must be ultimately responsible.

FINDING 13

The Office of the Inspector General found a number of deficiencies in institutional security at Valley State Prison for Women.

Specifically, the Office of the Inspector General found the following:

- The training records of two sergeants assigned to armed posts showed that more than three months had elapsed since the officers' last range qualification. The *Department of Corrections Operations Manual* (Section 32010.19.7) and Valley State Prison's lesson plan require that personnel assigned to armed posts qualify quarterly on all weapons.
- The institution has inadequate controls to ensure that authority to take home institutional keys resides only with those employees whose current job assignments require assignment of take-home keys. Current institutional procedures do not include a requirement for employees to return take-home keys following a change in assignment, nor is the locksmith notified about assignment changes affecting the issuance of take-home keys.
- There are no written guidelines covering the information the watch commander is to record on the electrified fence log. Consequently, entries made during the month of September 2000 were incomplete and often did not bear the watch commander's signature.

Collectively or individually, any of these deficiencies has the potential for exposing the institution to legal liability.

RECOMMENDATION

The Office of the Inspector General recommends that the institution take the following steps to improve institution security:

- Have managers and supervisors conduct periodic audits of training records for employees assigned to armed posts to ensure that those employees meet the quarterly proficiency requirements with the weapons maintained in armed post positions.
- Modify and expand the *Valley State Prison for Women Operations Manual,* Supplement 55020 to require staff with take-home keys to return those keys to the locksmith after changes in their assignments eliminate the necessity for such keys. In conjunction with this, the institution's personnel office should provide a monthly list of all assignment changes to the locksmith, who would provide written notice to employees assigned to

posts not requiring take-home keys to turn them in, and who would distribute copies of such notification to the employees' supervisors.

- Modify and expand the *Valley State Prison for Women Operations Manual,* Supplement 55080 to direct watch commanders to complete the electrified fence log at the end of each watch. Valley State Prison should also provide training on proper completion of the electrified fence log for supervisors and managers and should institute a policy of having the security captain periodically review the log for completeness and report any problems to the warden.

FINDING 14

The Office of the Inspector General found that the Valley State Prison warden has failed to purchase drug interdiction equipment mandated by the Department of Corrections.

In a March 23, 2000 memorandum, the deputy director, Institutions Division, directed all wardens to purchase approved security systems, develop appropriate written procedures and division operational manual supplements, and to "ensure these systems are operational at all institutions … by September 1, 2000." A follow-up memorandum, dated September 8, 2000, reiterated "the expectation that the new equipment would be in place by September 1, 2000" by further stating that "it is imperative that staff are adequately trained in the operation of the detection equipment." The specific equipment required was outlined in the original memorandum.

Valley State Prison for Women, as yet, has made no plans to purchase the required equipment to aid in its drug interdiction efforts. The Office of the Inspector General found the Valley State Prison Investigative Services Unit staff members working on drug interdiction to be conscientious, highly motivated individuals. Their successes to date demonstrate their commitment to operating a high-level drug interdiction program. The drug interdiction equipment would greatly enhance the Investigative Services Unit staff's ability to continue this successful program.

RECOMMENDATION

The Office of the Inspector General recommends that the warden comply with the departmental directive to purchase the approved security systems outlined in the March 23, 2000 memorandum. Furthermore, Valley State must provide the necessary training to its staff to enhance its current drug interdiction efforts.

FINDING 15

The Office of the Inspector General found that Valley State Prison's emergency operations plan was not submitted in a timely manner.

Valley State Prison's warden signed the emergency operations plan on February 11, 2000 and submitted it to the Department of Corrections Institution Division Emergency Operations Unit on March 2, 2000 — two months past the January deadline. The absence of an updated emergency operations plan with current procedures could delay response times during an emergency.

RECOMMENDATION

The Office of the Inspector General recommends that the warden implement procedures to ensure that the emergency operations plan is updated and ready for submittal to the Department of Corrections for review each January.