OFFICE OF THE INSPECTOR GENERAL

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STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

SUPERINTENDENT EUGENIA ORTEGA

VENTURA YOUTH CORRECTIONAL FACILITY
CAMARILLO, CALIFORNIA

JUNE 2002

GRAY DAVIS, GOVERNOR

State of California

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

Memorandum

Date: June 27, 2002

To: JERRY HARPER, Director
California Youth Authority

From: STEVE WHITE
Inspector General

Subject: AUDIT OF THE VENTURA YOUTH CORRECTIONAL FACILITY

Enclosed is a copy of the final report of the management review audit conducted by the Office of the Inspector General of Superintendent Eugenia Ortega of the Ventura Youth Correctional Facility. Your response to the draft report and the response of Superintendent Ortega are included in the report as Attachment A.

As the audit revealed significant problems at the institution, the Office of the Inspector General will conduct a follow-up audit of the facility in approximately one year to review corrective actions taken in response to the audit.

Please call me if you have questions concerning this report.

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency
Eugenia Ortega, Superintendent, Ventura Youth Correctional Facility

OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

SUPERINTENDENT EUGENIA ORTEGA

VENTURA YOUTH CORRECTIONAL FACILITY
CAMARILLO, CALIFORNIA

REPORT

JUNE 2002

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EXECUTIVE SUMMARY

This report presents the results of a management review audit conducted by the Office of the Inspector General of Superintendent Eugenia Ortega and the Ventura Youth Correctional Facility. *California Penal Code*, Section 6051 requires the Office of the Inspector General to conduct a management review audit of any California Youth Authority superintendent 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 superintendent's performance in carrying out the essential functions of the facility. In areas where weaknesses are noted, the Office of the Inspector General's management review team makes recommendations to correct the problems. The management review audit of the Ventura Youth Correctional Facility resulted from the recent appointment of Superintendent Ortega.

The Office of the Inspector General found serious problems at the Ventura Youth Correctional Facility as a result of the audit. Underlying many of the problems is the difficulty of operating the facility as a coeducational yet segregated institution. This separation of males and females, which is the result of several incidents between wards of both genders, has created duplication of services and a strain on resources. The institution's problems encompass the full spectrum of the facility's operation, including ward treatment services, medical services, mental health services, education, fundraising, internal investigations, and institution security. In her short tenure at the institution, Superintendent Ortega has recognized many of these problems, but some of the problems, such as those relating to ward education, are out of her control and will require action from the Department of the Youth Authority headquarters.

Because of the problems resulting from operating the Ventura Youth Correctional Facility as a coeducational institution, the Office of the Inspector General recommends that the director of the California Youth Authority work with the superintendent to convert the facility (or another facility within the Youth and Adult Correctional Agency) to an all female institution.

The Office of the Inspector General also recommends that Superintendent Ortega develop a comprehensive strategic plan to correct the serious problems identified in this report. Because some key problems noted in the audit are beyond the control of Superintendent Ortega, she needs strong support and assistance from the California Youth Authority administration to address the issues raised. In addition, because some of the problems stem from a lack of oversight and clear policy direction from the California Youth Authority administration, it is likely that many of the deficiencies also exist in other California Youth Authority facilities. The seriousness of the problems cited above necessitates follow-up by the Office of the Inspector General. Accordingly, approximately one year from the date of this report, the Office of the Inspector General will conduct a follow-up audit to ensure that Superintendent Ortega has developed and implemented a strategic plan and that problems identified in this report have been corrected.

The specific findings from the management review audit of the Ventura Youth Correctional Facility are summarized below.

FINDING 1

Operating the Ventura Youth Correctional Facility as a coeducational institution significantly limits the ability of the institution to provide programs and services for wards and results in wards at the facility not receiving the services provided to wards at other institutions.

Efforts to keep male and female wards physically separated cause services to be duplicated, delayed, or otherwise hampered; prevents the institution from providing equal services to males and females; and results in wards at the Ventura Youth Correctional Facility not receiving services provided to wards at other institutions. In particular:

- Access to medical and dental services is limited for both genders.
- Education is disrupted because of the proximity of male and female wards to each other, especially during times of school movement.
- Access to the gymnasium is restricted because both genders cannot share it simultaneously.
- The youth drug counselor's time is split between the male and female residential substance abuse treatment programs.
- There are two assistant superintendents, the primary responsibilities of whom are separated along male and female lines.

FINDING 2

Ventura Youth Correctional Facility wards have not been provided with required treatment services.

Wards at the Ventura Youth Correctional Facility are consistently denied the treatment services to which they are entitled by the *California Welfare and Institutions Code* and Title 15, Division 4, of the *California Code of Regulations.* A sampling of 113 ward files revealed that only 47% of the wards received required formal weekly structured counseling sessions. Further, the wards' initial case conferences were frequently late; in 40% of the cases the initial meeting did not take place within five weeks of the ward's arrival on the living unit, and in only 54% of the cases did the ward receive timely progress case conferences. In addition, 35% of the wards did not receive program orientation within ten working days of the wards' arrival. Further, 41% of wards who were eligible for school placement were not assigned to school within four days of arrival at the institution. Moreover, the facility's residential substance abuse treatment program is out of compliance with grant requirements. Specifically, one position is not providing consistent services required by the grant, drug testing of wards is not random, and the chain of custody for urine samples is inadequate.

FINDING 3

Female wards at the Ventura Youth Correctional Facility are not receiving required mental health assessment services in a timely manner.

Only 29% of 55 female wards sampled had received treatment needs assessments within the required three weeks of arrival at the facility. Instead, these wards were tested an average of 46 days after their admission date. Furthermore, female wards who were receiving psychotropic medication had not received the required global assessment of functioning.

FINDING 4

Some institution practices jeopardize the health of female wards, the infants of female wards, and wards in general by failing to provide timely access to quality medical care and providing inadequate protection against communicable diseases.

Pregnancy care for female wards is inadequate despite the fact that in the sixteen months from January 2001 through April 2002, 16 babies have been born to wards. Consultations with specialists were frequently late. One late consultation led to inadequate care for a ward's urinary infection and contributed to the costly premature birth of a baby. In addition, some facility nursing staff lacked awareness of the basic needs of pregnant wards, and the provision of ward medical transportation to care outside the facility was disorganized. Further, wards with communicable diseases were working in food service positions, thereby needlessly exposing staff and other wards to potentially significant health risks. Moreover, the segregation of male and female wards limits their access to medical services.

FINDING 5

The academic achievement of Ventura Youth Correctional Facility's wards is low compared to that of other California Youth Authority facilities.

Standardized test scores at the institution's Mary B. Perry High School have declined. In 2001, 67% of the wards ranked below the 25th percentile nationally, whereas 56% ranked below the 25th percentile in 1998. The Office of the Inspector General also found that there are significant periods when no academic or vocational instruction is provided because of teacher absences, teacher vacancies, security concerns, and other facility-initiated class closures. As a result, for fiscal year 2000-01, class closures averaged 644 per month, which resulted in wards receiving only 54% of their assigned educational programming. In addition, the high school failed to report average daily attendance eight out of the 12 months reviewed, and overstated the attendance significantly. Lastly, Mary B. Perry High School is behind schedule in its efforts to achieve accreditation.

FINDING 6

Fundraising activities conducted by staff at the Ventura Youth Correctional Facility are not properly administered.

The Staff Recognition Committee improperly conducts staff fundraisers that generate profits from the sale of items to wards. The eight most recent fundraisers collectively generated $5,000 in profits, a profit margin of 65%. Furthermore, the staff recognition committee conducted fundraising during state time, even incurring overtime while doing so. The account into which the money was deposited and disbursed from was not approved by the Director of Finance, and accounting and reporting requirements were not met. Also, the institution permitted ward benefit fund monies to be used for purposes not directly benefiting wards.

FINDING 7

There are significant deficiencies in the institution's practices and procedures in conducting investigations.

Investigation plans are inadequately prepared; conflict of interest statements are not used; investigation files are poorly secured, and institution investigators are not thoroughly screened. In addition, preliminary investigations are not adequately performed, managed, or reviewed.

FINDING 8

[Note: for reasons of confidentiality, Finding 8 is being transmitted under separate cover.]

FINDING 9

The Office of the Inspector General found that the disciplinary decision-making system at the Ventura Youth Correctional Facility has serious defects.

The facility lacks adequate control over Level B rules violations, which allows wards to potentially escape consequences for misbehavior. The disciplinary decision-making system also has many deficiencies in the recording, tracking, and compilation of quantifiable data. In addition, disciplinary decision-making system data is not reported to the superintendent.

FINDING 10

The Ventura Youth Correctional Facility has a good working system for ward grievance monitoring and tracking, but some aspects of the process prevent management from holding facility staff accountable.

The facility staff frequently loses or misplaces ward grievances. In addition, grievances not resolved within department-mandated time limits are not accurately reported to department headquarters and institution management. Monthly internal reporting of grievances to the superintendent also lacks accountability.

FINDING 11

A large portion of the institution's projected budget deficit of $2 million for fiscal year 2001-2002 is attributable to high costs of overtime, external contracts, and increased utility expenditures.

FINDING 12

The Office of the Inspector General found deficiencies in the operation of the Ventura Youth Correctional Facility warehouse.

There are inadequate controls over access to the warehouse and deliveries are made without prior notification.

FINDING 13

The Office of the Inspector General found that the Ventura Youth Correctional Facility assigns some wards to more than one paid job.

There are a limited number of jobs available at the institution and these are in high demand, yet some wards have more than one job. This practice violates *California Code of Regulations,* Title 15.

FINDING 14

The Office of the Inspector General found that staff performance appraisals and probationary reports are not completed on time.

A review of a sample of personnel files found that 46% did not contained the required annual performance review and that 54% did not contain current duty statements.

INTRODUCTION

California Penal Code Section 6051 requires the Office of the Inspector General to conduct a management review audit of any California Youth Authority superintendent 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 superintendent's performance in carrying out the essential functions of the facility or to serve as a baseline for newly appointed superintendents. In areas where weaknesses are noted, the Office of the Inspector General makes recommendations to correct the problems.

Pursuant to the provisions of *California Penal Code* Section 6051, the Office of the Inspector General has conducted a management review audit of the Ventura Youth Correctional Facility as a result of the recent appointment of Eugenia Ortega as superintendent of the institution. The superintendent is an exempt employee appointed by the Governor.

BACKGROUND

The Ventura Youth Correctional Facility is one of eleven youth correctional institutions operated by the California Youth Authority. The Ventura Youth Correctional Facility assists the California Youth Authority in meeting its mission of protecting the public from criminal activity by providing diagnostic, educational, training, and treatment services for youthful offenders committed by the courts. Located in Camarillo, California, the Ventura Youth Correctional Facility houses all female youthful offenders in state custody and is the only coeducational institution in the California Youth Authority. The original facility, which served only females, opened in 1916 and was located on the northern outskirts of Ventura, California. In 1962, the facility was relocated to its current site as the Ventura Youth Correctional Facility for Girls in Camarillo. The first males were admitted to the facility in 1970.

Eugenia Ortega began her tenure as superintendent of the Ventura Youth Correctional Facility in November 2001. She is the fourth superintendent at the facility in the past five years. Both of her assistant superintendents have also served as acting superintendent of the facility. This is Superintendent Ortega's second assignment as a superintendent within the California Department of the Youth Authority. Her first superintendent assignment began in April 1999 at the Karl Holton Youth Correctional Drug and Alcohol Abuse Treatment Facility in Stockton, where she had served as assistant superintendent for the two preceding years. Superintendent Ortega reported to the Ventura Youth Correctional Facility from the Holton facility. A California Youth Authority employee for 22 years, Superintendent Ortega began her career with the agency as a bilingual teacher assistant. Since starting with the California Youth Authority, she has held increasingly responsible positions. Superintendent Ortega holds a master's degree in clinical psychology.

As of May 1, 2002 the Ventura Youth Correctional Facility housed approximately 302 male wards, 73 of whom resided in the Sylvester Carraway Public Service and Fire Center camp outside the facility's secured perimeter. In addition, the facility housed 278 female wards,

including 21 in the Miramar cottage associated with the Carraway fire camp. The camp's female wards constitute the California Youth Authority's first all-female fire crew. Male wards at the Ventura Youth Correctional Facility are between 17 and 25 years of age, while female wards range in age from 13 to 25.

Although considered a coeducational facility, the Ventura Youth Correctional Facility separates male and female wards for all daily activities. One assistant superintendent oversees the activities of the male wards, and the other assistant superintendent is responsible for the activities of the female wards.

The facility has several specialized functions. It is a reception center-clinic for all female wards admitted to the California Youth Authority. It provides female wards who are acutely suicidal or have been diagnosed as having mental illness with an intensive treatment program. The institution also has a specialized counseling program, which provides services to female wards with less severe emotional problems. For both male and female wards, the facility offers formalized drug programs.

As of January 10, 2002, the Ventura Youth Correctional Facility had a budgeted staff of 465.1 personnel years and an operating budget of $31,773,200. Staff positions include administrators, medical and dental professionals, administrative support personnel, youth correctional officers, and youth correctional counselors. In addition there are academic and vocational education instructors, administrators, and support staff, all of whom report to the California Youth Authority Education Services Branch, rather than to the superintendent.

Wards at Ventura Youth Correctional Facility are housed in eleven living units known as cottages. Six of the cottages house female wards, four house male wards, and one serves as a detention unit with segregated wings for males and females. Each cottage has a Spanish name consistent with the area's history and geography. In addition to sleeping, showering, and carrying out other aspects of daily living in their cottages, wards also participate in programs in their living units, including group and individual counseling based on individual needs. Several cottages house general population wards, while others specialize in receiving newly arrived female wards (Miramar cottage), providing intensive treatment (Alborada cottage), providing specialized counseling (Buenaventura cottage), and treating substance abusers (Casa de Colegio cottage for males and Mira Loma cottage for females).

Wards leave the living units to participate in other ward programs at various locations on the institution grounds. The programs include attending the facility's Mary B. Perry High School and obtaining vocational training in animal grooming, culinary arts and technology, janitorial services, and computers and keyboards. (A promising graphic arts program closed recently for lack of funding.) Wards also leave their living units to obtain medical and dental services at the institution's hospital and clinic and to attend religious services at the facility's chapels.

OBJECTIVES, SCOPE AND METHODOLOGY

Given Superintendent Ortega's short tenure at the institution, the objective of the Office of the Inspector General's management review audit was to conduct a baseline evaluation of the Ventura Youth Correctional Facility in order to identify areas of operation the superintendent

should improve. To that end, the Office of the Inspector General management review team reviewed the following functions: treatment services, including reception center operations, counseling and mental health; medical services; residential substance abuse treatment; suicide prevention assessment and response; security; internal affairs investigations; ward rights; academic education; institutional communication; and selected business and personnel practices. The inspection team did not review vocational education or staff training.

The Office of the Inspector General's management review team performed the following procedures in conducting the management review audit:

- Interviewed Superintendent Ortega, members of her administrative staff, and various employees and wards at the institution to gain insight and perspective on various issues.
- Administered a survey questionnaire to the Ventura Youth Correctional Facility staff regarding the administration's communication with staff and wards.
- Conducted on-site visits and inspections of living units and ward programming areas, including Mary B. Perry High School and various vocational education sites, and of administrative offices and facilities throughout the institution.
- Reviewed various laws, policies, and procedures and other documents related to key institution systems, functions, and processes.
- Gathered and reviewed institution logs, files, records, and transaction documents in various operational areas.
- Performed various analytical techniques, including sampling, to assess compliance with legal and procedural requirements.

FINDINGS AND RECOMMENDATIONS

FINDING 1

The Office of the Inspector General found that operating the Ventura Youth Correctional Facility as a coeducational institution significantly limits the ability of the institution to provide programs and services for wards and results in wards at the facility not receiving the services provided to wards at other institutions.

Males first arrived at the Ventura Youth Correctional Facility in 1970 after the department decided to reduce the excessive administrative and operational costs incurred from operating the facility as an institution with a small female-only population. Moving males to the Ventura site lowered the overall per capita cost of housing wards and eased the burden of housing male wards at other facilities, which at that time were operating at capacity. Initially male and female wards attended classes at the same time, but after several incidents between the two genders, administrators decided to separate the two genders in their daily activities, while keeping the males on site to retain the perceived cost benefits.

Since that time the institution has received resources to physically separate the male and female wards inside the facility. In fiscal year 1998-99 the department received $847,000 to construct a fence inside the perimeter of the institution, and in fiscal year 2000-01, the institution received 12.3 positions and additional resources totaling $897,000 for the security and education sections to complete the separation of the wards. A fence now separates male and female living areas inside the secured perimeter; male and female wards attend segregated classes; and medical sick call days are rotated to ensure that male and female wards have no contact. One assistant superintendent oversees the activities of the male wards, and the other assistant superintendent is responsible for the activities of the female wards.

The Office of the Inspector General found that efforts to keep male and female wards physically separated cause services to be duplicated, delayed, or otherwise hampered; prevents the institution from providing equal services to males and females; and results in wards at the Ventura Youth Correctional Facility not receiving services provided to wards at other institutions.

Following are examples of services that are limited because the male and female wards must be kept separate.

- Medical and dental services are limited for wards. Male wards are allowed to participate in sick call two days per week and female wards can participate for three days per week.

- The intensive treatment program does not have a dedicated recreation yard or dedicated classrooms as do other institutions with the same program. Instead, because of a drain on

limited education resources resulting from the need to duplicate services to accommodate each gender, intensive treatment wards, who are mentally unstable, are required to attend class in the same area as the general population. Members of the institution staff told the Office of the Inspector General numerous stories about emotionally unstable wards being victimized when mixed with the general population. Rather than having specialized teachers specifically for wards in the intensive treatment program, the teachers simultaneously instruct a subject for both the general population and the mentally or emotionally unstable wards.

- Education services are disrupted because of the proximity of the male and female wards. Often classes are disturbed because wards know when wards of the opposite gender are being moved. In addition, when a ward chooses to leave the classroom for the day, the session is interrupted until custody staff can escort that ward back to the appropriate living unit while continuing to keep the genders separated.

- Males and females do not have access to the same vocational programs or the same academic courses.

- Access to the gymnasium is limited because males and females cannot participate simultaneously.

- Visits from family or friends are primarily limited to one day per week. The schedule is alternated on a weekly basis, with males having visitation on Sundays of one week and on Saturdays the subsequent week and vice versa.

- The counselors' services in the residential substance abuse treatment program are split between genders. Therefore, males and females do not have complete access to the counselor's services. In addition, the psychologist for the program said that the males lose out on services because the females require disproportionately more attention.

- Males and females do not have access to the same job assignments for paid positions. For instance, the paid kitchen jobs are available for males from Mondays through Fridays, while females can be assigned to the same paid jobs only on Saturdays and Sundays. Still other paid job assignments, such as the jobs at the canteen, are available only to males.

The Office of the Inspector General identified a number of other adverse effects of operating the institution as a co-educational facility. Specifically:

- There are a number of services at the institution that are either duplicative, delayed, or hampered. Some examples include the dual assistant superintendent functions, the need for extra administrative time for ward advisory committee meetings, inefficient services such as sick call, excessive security search and escort functions for ward movements to and from education or medical, and the inability to use ward labor to assist in the delivery and retrieval of laundry and food to and from the various living units.

- Throughout the audit, staff often commented that the female wards require more time and effort than the male wards. During the post and bid process for posted positions, the posts related to male wards are often the ones bid on first. Due to the contract language the most senior personnel receive the posts they request. This can adversely affect the type of service and treatment that wards receive.

- Wards intentionally "act out" so that they can be sent to the coeducational lock-up unit, thereby enabling them to see or at least communicate with wards of the opposite gender.

RECOMMENDATION

The Office of the Inspector General recommends that the director of the department consider converting the Ventura Youth Correctional Facility (or another facility within the Youth and Adult Correctional Agency) into a female-only institution. In addition to other scenarios, the following should be considered:

- One approach is to make the Ventura Youth Correctional Facility a female-only institution. This scenario would significantly increase the per capita costs of housing wards. It would also entail the closure of at least four living units and significantly reduce staff levels. However, this scenario would significantly increase services to female wards. Male wards would have to be housed at other institutions. The male wards currently in the college program would need to be transferred to institutions that provide that level of education. The Department would have to determine whether or not to close the Sylvester Carraway Public Service and Fire Center to male wards because they currently receive medical services inside the institution.

- Another approach is to consider a combination of conversions within the CYA institutions. Due to the low number of female wards, an option is to convert the Northern Youth Correctional Reception Center and Clinic into a female-only institution. That institution already has an intensive treatment program and its design capacity (305) supports the female population. The facility is near California State University at Sacramento and would have the use of student interns who need to complete field work. It is also close enough to the training academy to be used for on-the-job training. Another phase in this scenario would be to move the wards from the Fred C. Nelles Youth Correctional Facility to the Ventura Youth Correctional Facility. The total design capacity (641) for the Ventura site is practically equal to that (640) of the Fred C. Nelles site. The Fred C. Nelles site could be closed and sold. The site has a number of deteriorating historical buildings that are very costly to maintain and have received damage from earthquakes.

- Another scenario would be to close both the Ventura Youth Correctional Facility and the Fred C. Nelles Youth Correctional Facility. The current Northern Youth Correctional Reception Center and Clinic operation could be moved to one of the

Stockton facilities and then it could be converted into an institution for the intake of female wards. The male wards could be placed in different institutions depending on their age, commitment offense, maturity level, sophistication, and other factors. Closing two institutions would help immensely in reducing the State budget deficit. Closing the Ventura site would require the closing of a fire camp. Although this would hamper fire-fighting efforts, some California Department of Corrections fire camps are not far from the area. There are fire camps located in Malibu, San Luis Obispo, and Saugus (just northwest of Burbank).

With the current state fiscal situation, the declining ward population, and the services hampered by a coeducational setting, the timing dictates that the department evaluate various options and develop a solution.

FINDING 2

The Office of the Inspector General found that Ventura Youth Correctional Facility wards have not been provided with required treatment services.

Wards at the Ventura Youth Correctional Facility are consistently denied the treatment services to which they are entitled by the *California Welfare and Institutions Code* and Title 15, Division 4, of the *California Code of Regulations.* Consistent with these laws, Section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual* specifies the various types and frequency of treatment services wards are to receive. To evaluate the institution's compliance with these statutes and regulations, the Office of the Inspector General reviewed a sampling of 113 ward files from the ten permanent living units. The sample represented 20% of the ward population at the Ventura Youth Correctional Facility during the audit team's review. The review of the files revealed the following:

- ***A majority of wards are not receiving required counseling services.*** Only 53 (47%) of 113 male and female wards in the sample reviewed received the required weekly formal, structured counseling sessions as specified in the *California Youth Authority Institutions and Camps Branch Manual.* Further, less than one-third of the females in the sample from the general population received the required counseling sessions. Section 4050 of the *California Youth Authority Institutions and Camps Branch Manual* requires a formal, structured counseling program that includes planned, scheduled staff time for counseling and provides for a minimum of one hour of formal counseling (individual or small group) per ward per week. In Alborada cottage, the intensive treatment program serving the female wards most in need of counseling, six of the nine youth correctional counselors reviewed failed to meet the standard. In Casa de Los Caballeros cottage, the files of two male wards under one youth correctional counselor showed no counseling notes for an entire year. In other living units, the Office of the Inspector General found periods of up to seven months in which wards received no counseling. In Mira Loma cottage, which houses a formalized drug program for females, there were pronounced deficiencies in providing ongoing counseling services; for example, a youth correctional counselor listed a three-month gardening project as her counseling for one ward, and there was no record of any kind of counseling for six of the

other nine months reviewed. It should be noted that even in living units with major non-compliance problems, some youth correctional counselors exceeded the requirement for one weekly counseling session. For example, while Montecito cottage had significant counseling deficiencies, two youth correctional counselors consistently provided counseling to their wards. The performance of these staff members clearly indicates that the standard is reasonable and that professionalism is possible in their working environment.

- ***Wards' initial case conferences were frequently late.*** Pursuant to *California Youth Authority Institutions and Camps Branch Manual* Section 4025, the superintendent is required to ensure that each living unit has a case conference committee that consists, at a minimum, of the ward's youth correctional counselor, parole agent, and when possible, a teacher. The case conference committee is important because, using the ward's input, the committee assesses the ward's needs and sets realistic, deadline-driven treatment objectives that form the basis of the ward's treatment program. To get wards into treatment promptly, *Institutions and Camps Branch Manual* Section 4030 specifies that the initial case conference take place within five weeks of the ward's arrival at the institution. However, in only 68 (60%) of the 113 cases sampled did the initial case conference occur within five weeks of the ward's arrival. Late initial case conferences ranged from a few days overdue in some living units to as much as 10 months overdue in Alta Vista cottage, a female general population living unit. In Casa de Los Caballeros, seven of 12 initial case conferences reviewed were late, with three overdue more than four months. In Montecito cottage, one ward did not have an initial case conference for nearly four months because he was assigned to orientation almost the entire time; yet, the orientation program is required to be completed within the first 10 working days of a ward's arrival at the institution. By way of contrast, in the Mira Loma cottage, which houses a formal drug program for females, eight of 10 initial case conferences reviewed were held on time because of the parole agent's organized approach to case management.

- ***Many wards did not receive timely progress case conferences.*** Only 61 (54%) of the 113 wards in the sample received timely progress case conferences. To keep wards focused on their short-term and long-term treatment program goals, Section 4035 of the *Institutions and Camps Branch Manual* provides that the case conference committee is to hold a progress case conference no more than 60 days following the initial case conference. The six general population units tended to perform more poorly than the units with special programs. While the units with special programs held timely progress case conferences slightly less than 70% of the time, the general population units held timely progress case conferences only 44% of the time.

- ***Orientations were not timely.*** Orientation for 40 (35%) of the 113 wards sampled occurred more than ten working days after the ward's arrival. Section 4015 of the *Institutions and Camps Branch Manual* provides that wards are to receive orientation within the first ten working days of their arrival at the institution. Moreover, a required orientation item, the "three strikes" notification, was missing from the orientation curriculum.

- ***Wards were not assigned to school within required time limits.*** Only 41 (59%) of the 70 wards in the sample who were eligible for school placement were assigned to school within four days of arrival at their permanent living unit. Section 4010.2 of the *Institutions and Camps Branch Manual* requires wards to be assigned to school within four days of arrival at their permanent living unit. The average delay in enrolling late wards was three days, with late enrollments ranging from one to 11 days.
- ***The substance abuse treatment program does not comply with grant requirements.*** The facility's formal drug program, the residential substance abuse treatment program, operates under a grant from the Office of Criminal Justice Planning. The grant funds several staff positions, including a youth drug counselor who is to provide services to the female wards in Mira Loma cottage and the male wards in Casa del Colegio cottage. The grant also requires mandatory urine testing for wards entering and leaving the program, as well as random drug testing during the program. The Office of the Inspector General found that the program is not operating according to design and that deficiencies in program operation place the institution at risk of losing the grant funding. Specifically, the youth drug counselor of the residential substance abuse treatment program frequently was not providing the drug counseling services required by the grant. Instead, she was typically performing basic youth correctional counselor duties, such as supervising school movements and recreational activities, conducting patdown searches of female wards, and relieving other youth correctional counselors as needed. Further, the drug testing of wards was systematic and predictable rather than random because it was conducted in a rotational manner based on the wards last tested. In addition, the chain of custody for drug samples was inadequate, leaving test results vulnerable to challenges. The Mira Loma procedure allowed for the sample to change hands as many as five times, while up to 14 people had access to the refrigerator where the samples are stored.

These deficiencies in the institution's treatment programs are depriving wards of the fundamental assessment, counseling, and testing activities intended to facilitate their growth and development and prepare them for reintegration into society. The program inadequacies diminish the wards' chances to lead productive lives and put them at increased risk of committing new crimes and returning to state custody.

The Office of the Inspector General identified the following factors as contributing to deficiencies in the institution's ward treatment services:

- ***Lack of emphasis on counseling and casework by staff and administrators.*** Members of the counseling staff said that the importance of counseling and treatment had not been emphasized to them. Administrative decisions appear to reflect the apparently low priority placed on counseling services. For example, two casework specialist positions in the intensive treatment program were reassigned to a general population unit for six months for the purpose of covering vacant positions. On another occasion, a youth correctional counselor was redirected to escort a Department of Forestry fire captain following the escape of three female wards from the fire crew, while male fire crews continued to perform their duties with only a Department of Forestry fire captain present.

- ***Poor coverage of counseling responsibilities during absences.*** The Office of the Inspector General observed that senior youth correctional counselors, parole agents, and treatment team supervisors frequently did not fill in for youth correctional counselors when they vacated the positions, were sick for extended periods, or went on vacation. Instead, counseling and casework simply did not occur.
- ***Failure of supervisors to adequately monitor subordinates' work.*** There was little evidence in ward case files or other documents of systematic review of casework by supervisory staff. Senior youth correctional counselors did not regularly review the work of the youth correctional counselors. Further, the treatment team supervisors (who are responsible for monitoring the work of their subordinates, the parole agents) did not routinely note problems of the sort identified in this report and instruct their subordinates to take corrective action.
- ***Failure of supervisors to hold staff accountable for unsatisfactory casework.*** When supervisors did note deficient casework by their subordinates, they did not routinely use progressive discipline to hold staff members accountable for their work and effect corrective action. The Office of the Inspector General found no work improvement discussions, letters of instruction, or other documents associated with the progressive discipline system in the files of treatment staff.
- ***Infrequent enrollment of wards in education programs.*** The school assignment officer updates the education roster only once weekly, thereby hampering the prompt enrollment of wards.
- ***A lack of skill and knowledge.*** The youth drug counselor lacks subject matter expertise, which requires training. In addition, the coordinators of the drug programs in Mira Loma and Casa del Colegio cottages, who are responsible for drug testing, lack knowledge regarding random testing and chain of custody procedures.

RECOMMENDATIONS

The Office of the Inspector General recommends that the institution management take the following actions to improve ward assessment and counseling:

- Continuously emphasize to all staff members the importance of counseling, case management, and testing to the mission of the institution.
- Develop a casework management system that meets the content and frequency criteria laid out in Section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual*. Of particular importance is weekly individual and small group counseling and the prompt conducting of initial and progress case conferences. This system should include: (1) the treatment team supervisors' monthly auditing of at least five ward files per living unit; (2) the timely reporting of the audit results up and down the chain of command; and (3) the prompt administration of progressive discipline for staff failing to perform duties. The audits should be the basis of the institution's annual Section 4000 report to the Institutions and Camps Branch.

- Use annual performance appraisals and progressive discipline to hold treatment team supervisors, the parole agent III, and the program administrator accountable for monitoring the work of parole agents, senior youth correctional counselors, and youth correctional counselors, and for ensuring proper redistribution of workload when staff members are absent and positions are vacant.
- Provide subject matter training to the youth drug counselor so she can properly carry out her duties under the residential substance abuse treatment program contract.
- Provide guidance to the drug program coordinators on how to randomly select wards for drug testing and how to provide the proper chain of custody for the samples collected.
- The school principal should require the school assignment officer to enroll wards at least twice a week in education programs.

FINDING 3

The Office of the Inspector General found that female wards at the Ventura Youth Correctional Facility are not receiving required mental health assessment services or do not receive these necessary services in a timely manner.

The Office of the Inspector General found that female wards at the Ventura Youth Correctional Facility are consistently denied the treatment services to which they are entitled by the *California Welfare and Institutions Code* and Title 15, Division 4, of the *California Code of Regulations.* Consistent with these statutory and regulatory provisions, the types and frequency of treatment services wards are to receive are specified under Section 6250 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual.*

To identify at-risk wards who may need specific types of treatment services at the time of admission, the California Youth Authority has implemented a treatment needs assessment process, which provides indicators of potential mental health problems. The treatment needs assessment tests for thought disorders, suicide risk, mental distress and restraint, depression, anxiety, and anger. Wards whose treatment needs assessment indicates a need for more in-depth evaluation are to receive a global assessment of functioning, which is the California Youth Authority's primary instrument for identifying special treatment needs for wards. The global assessment of functioning provides a 100-point scale for measuring psychological, social, and occupational functioning. Under department guidelines, scores of between 40 and 60 indicate a need for specialized counseling, and scores of 40 and below point to a need for intensive treatment and possible assignment to an intensive treatment program bed. Under California Youth Authority regulations, the treatment needs assessment is required to be administered within three weeks of a ward's arrival at the institution and is to be scored on the first working day following the test. California Youth Authority regulations also require that the global assessment of functioning be administered by a team consisting of two mental health

professionals, one of whom must be a clinical psychologist or a psychiatrist, while the other may be a mental health professional in casework service. In addition, department regulations provide that psychotropic medication may be prescribed to wards only when justified by a full DSM-IV[1] diagnosis following a global assessment of functioning examination.

To evaluate the facility's compliance with statutory and regulatory requirements, the Office of the Inspector General reviewed a sample of 80 female wards who were admitted in calendar year 2001. The sample represented 29.5% of the 271 female wards at the Ventura Youth Correctional Facility as of April 1, 2002. The review of the files revealed the following:

- ***Female wards are not screened for treatment programs in a timely or consistent manner.*** Of the 55 female wards whose tests were reviewed, only 16 (29%) received the treatment needs assessment test within the required three weeks of their arrival at the facility. On average, the wards received the treatment needs assessment 46 days after the admission date—25 days late. The number of days delinquent ranged from one calendar day to 245 calendar days. None of the 55 wards' treatment needs assessments were scored on the following working day. Instead, the treatment needs assessments were scored an average of 78 calendar days after the test date, with the scoring date ranging from seven calendar days to 198 calendar days after the test.
- ***Inconsistencies and irregularities in administering the global assessment of functioning.*** Inexplicably, the number of global assessment of functioning tests administered to wards at the Ventura Youth Correctional Facility declined by 29% from calendar year 2000 to calendar year 2001. In calendar year 2000, the Ventura Youth Correctional Facility administered global assessment of functioning tests to 163 female wards, or 32.7% of the 498 female wards admitted that year. In calendar year 2001, the facility administered only 116 tests to female wards, or 23.7% of the 490 female wards admitted. In addition, the Office of the Inspector General noted the following irregularities in reviewing the unified health records for 12 female wards who were on psychotropic medication:
    - Seven (58%) of the wards on medication had received a treatment needs assessment, but not a global assessment of functioning evaluation. One ward was recommended for a global assessment of functioning, but the evaluation had not been done.
    - Three (25%) of the wards had received global assessment of functioning scores from only one psychologist or psychiatrist instead of from two mental health professionals.
    - One ward had received a global assessment of functioning score of 50, indicating the presence of serious symptoms, such as inability to stay in school, feelings of isolation, confrontational behavior, sexual acting out, a consistent self-description of being "stressed," self-manipulation, and lack of respect for people and property. Under department guidelines, a ward with a score in this range is supposed to be referred for a specialized counseling program; yet, even though the specialized counseling program at the institution was operating at 66% of capacity at the time of the review, the ward remained in the general population with no counseling services.

[1] DSM-IV refers to the American Psychiatric Association, *Diagnosis and Statistics Manual of Mental Disorders,* Fourth Edition, 1994.

- ***Wards receiving psychotropic drugs were not assessed for other mental health treatment.*** As of April 30, 2002 48 female wards in the general population were receiving psychotropic drugs as outpatients. Although many of these wards might benefit from assignment to either an intensive treatment program or a specialized counseling program, and despite available space, none of the wards had been assigned to the programs. As of April 1, 2002 the Ventura Youth Correctional Facility had 16 vacancies in the specialized counseling program unit in Buenaventura cottage and three vacancies in the intensive treatment program in the Alborada cottage.

The Office of the Inspector General also reviewed the suicide prevention assessment and response program at the Ventura Youth Correctional Facility for compliance with Section 5525 of the *California Youth Authority Institutions and Camps Branch Manual* and found the following:

- The daily suicide risk list does not designate each ward's suicide risk level as low, moderate, or high.
- The first watch control sergeant does not prepare each unit's daily suicide risk list. Instead, the parole agent III is responsible for preparing the daily suicide risk list, but as he does not work on weekends and holidays, the living units lack an updated daily suicide risk list.
- The risk management officer is not ensuring that the duty lieutenants are visiting wards on suicide watch at least once daily and documenting any exceptions in the Daily Operation Report.
- Thirteen of 21 youth correctional counselors interviewed did not know how often a Suicide Risk Screening Questionnaire (YA 8.281) is to be administered to a ward being extended on temporary detention.
- The Ventura Youth Correctional Facility is not using Part C of the SPAR Referral and Disposition Report (YA 8.282) when discontinuing a ward from suicide watch at the conclusion of a face-to-face interview by the mental health clinician.
- In the Alborada cottage, the eight newly purchased suicide-safe mattresses do not fit into the sleeping areas in the suicide units.

The effects of the mental health deficiencies cited above are significant. Female wards deprived of fundamental assessment, counseling, and testing activities designed to facilitate their stability are not adequately prepared for reintegration into society. Failing to use the treatment needs assessment in a timely manner places at risk the health and safety of the ward, other wards in the facility, and staff members who may not know that the ward is suicidal, assaultive, or suffering from other mental disorders.

In addition, inconsistent and untimely mental health assessment tests have contributed to the 19 vacant slots in the Specialized Counseling Program in the Buenaventura cottage and in the Intensive Treatment Program in the Alborada cottage. These 19 vacancies could have been filled by some of the 48 female wards whose need for specialized mental health services was demonstrated by their need for psychotropic drugs.

The factors contributing to inadequate and untimely mental health treatment services include the following:

- There is inadequate supervision of the mental health program by the senior psychologist. The senior psychologist did not equitably rotate assignments to psychologists, including the global assessment of functioning evaluations. Further, he did not ensure the repair of the Scantron machine for scoring the treatment needs assessment and the machine has been broken for long periods of time. Finally, he has not prepared performance evaluations for six of his seven psychologists in more than three years.
- The mental health casework specialist is neither scheduling nor proctoring the treatment needs assessment to all newly admitted female wards in a timely manner.
- Scored treatment needs assessments were not submitted to the senior psychologist for evaluation. Without the senior psychologist's evaluation, alternative mental health treatment programs cannot be recommended.

The deficiencies noted in the facility's suicide prevention assessment and response program are relatively minor and can be rectified easily. However, because the facility has a high-risk female ward population the risk of ward suicide is constant. In addition to the loss of a young life, suicides and attempted suicides leave the state open to potential lawsuits.

The Office of the Inspector General found that the deficiencies in the Suicide Prevention Assessment and Response Program were caused by the following:

- Lack of adequate management supervision and oversight by the risk management officer over the duty lieutenant, as well as the failure of the first watch control sergeant to follow department policies and procedures relative to the Suicide Prevention Assessment and Response Program.
- The Local Area Network manager's failure to respond to the risk management officer's need to modify the suicide risk list in order to distinguish the level of suicide risk for each ward.
- The lack of training for all staff members of the Suicide Prevention Assessment and Response Program.
- The failure of the risk management officer to obtain proper Suicide Prevention Assessment and Response Program forms from California Youth Authority headquarters.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the Ventura Youth Correctional Facility take the following actions to improve its mental health and suicide prevention programs:

- Develop a tracking system to monitor the treatment needs assessment process to ensure that:
  - All incoming female wards are scheduled for a treatment needs assessment within three weeks of admission.

- The treatment needs assessment test booklets are scanned and scored no later that the next working day.
- If a treatment needs assessment scoring report shows a "red flag," that the senior psychologist is notified before the end of the next workday.
- The treatment needs assessment profile and scoring report is filed in the mental health section of the unified health record.
- The treatment needs assessment data is transmitted to the Ward Information Section of the California Youth Authority Research Division.

- The senior psychologist should provide adequate oversight over the treatment needs assessment process by:
  - Ensuring that all equipment, such as the Scantron machine, is fully functional.
  - Ensuring consistent screening for treatment programs through the use of the standardized California Youth Authority global assessment of functioning screening report (YA Form 8.218).
  - Reviewing the treatment needs assessment scoring report and referring any ward with "red flags" for additional mental health evaluation, such as a global assessment of functioning.
  - Establishing a global assessment of functioning review panel to review the results of a random sample of the global assessment of functioning screening reports on a monthly basis. To distribute workload equitably, the mental health professionals should participate on the review panel on a rotational basis. The panel should consist of a psychiatrist, a psychologist, and a related mental health professional.
  - Identifying wards who would receive the most benefit from the intensive treatment and specialized counseling programs.
- Correct the deficiencies in the Suicide Prevention Assessment and Response Program by:
  - Appointing a chaplain and a representative from the California Correctional Peace Officers Association to the facility's suicide prevention and response committee.
  - Ensuring that all staff members, including teachers, receive suicide prevention and response program training at the time of appointment and refresher training annually.
  - Having the local area network manager or another computer support staff member develop a daily suicide risk list that differentiates the level of suicide risk for each ward.
  - Having the first watch control sergeant print, review, and update the suicide risk list daily.

- Having the risk management officer hold the duty lieutenant responsible for visiting all wards on suicide watch at least once daily during each shift and documenting any exceptions in the daily operation report.
- Providing instruction and training to living unit security staff and the youth correctional counselors regarding policies and procedures for administering the suicide risk screening questionnaire (YA 8.281) when temporary detention is extended.
- Acquiring and using Part C of the suicide prevention and response referral and disposition report (YA 8.282) when wards are discontinued from suicide watch.

- Using progressive discipline, hold the senior psychologist accountable for managing the mental health program and supervising the psychologists under his direction.

FINDING 4

The Office of the Inspector General found that some institution practices jeopardize the health of female wards, the infants of female wards, and wards in general by failing to provide timely access to quality medical care and providing inadequate protection against communicable diseases.

Providing quality medical care to wards and protecting them from communicable diseases is an essential institution function. Healthy wards are able to work and attend class regularly, and are thus able to benefit from the many programs intended to correct their criminal behavior. Wards who do not have timely access to medical care, who are deprived of quality medical care, and who are not protected from communicable diseases suffer in a variety of ways. First, they miss opportunities to program. Second, their acute health problems can deteriorate to the point of being chronic, and thus more expensive to treat. Third, they can acquire chronic communicable diseases such as Hepatitis-C—which has no cure and is costly to treat in its later stages. When wards suffer health problems as the apparent result of malpractice or neglect, they may file lawsuits that can be costly to defend or settle.

The Office of the Inspector General found that some institution practices place the health of wards, particularly female wards and the infants of female wards, at risk. These practices are discussed below:

- ***Prenatal care for female wards is inadequate.*** In the sixteen months from January 2001 through April 2002, 16 Ventura Youth Correctional Facility wards gave birth to infants. The Office of the Inspector General's review of the care provided to these wards and their babies revealed that the wards' consultations with obstetricians were not always timely, that some members of the facility nursing staff lacked awareness of basic needs of pregnant wards, and that efforts to provide transportation to wards for appointments outside the facility were disorganized. The following cases illustrate the preceding points:

- The facility's contracted obstetrician frequently cancels his visits to the facility. The facility lacks a backup obstetrician and a contingency plan and therefore accepts the physician's rescheduling of the missed appointments for two weeks following the original appointment dates. In one case, while conducting a preliminary examination in preparation for the obstetrician's visit, a registered nurse detected symptoms of a possible urinary tract infection in a ward. The obstetrician subsequently canceled the visit and rescheduled it for two weeks later. In the interim, the suspected infection apparently created side effects that contributed to the premature birth of the ward's baby at 26 weeks. Although the one-pound, eight-ounce baby survived, the infant requires such intensive care that hospital bills to date are reported to exceed $568,000. Further, the ward is contemplating legal action against the state for medical negligence.

- At medical sick call, a pregnant ward requested a blanket and a different mattress because she was experiencing chills and back problems. The nursing staff at sick call rejected the requests, erroneously stating that such requests must be approved by the living unit staff. In fact, the medical staff can authorize such items, and a supervising registered nurse said that the medical staff has "egg crate" mattresses for pregnant wards because they often experience back discomfort. When her contractions began at 8:40 a.m. on December 25, 2001, the ward went to the clinic. Despite a registered nurse's notation in the ward's file that she remain at the clinic "…as she is full term due anytime," she was shunted back and forth three times between the clinic and her living unit with instructions to time her own contractions with the assistance of wards or staff. When the Office of the Inspector General presented this scenario to the supervising registered nurse, she acknowledged that the living unit staff and wards are not properly trained to meet their responsibilities.

- The transportation of wards to community clinics is hampered by a misunderstanding by security staff about the importance of prompt medical care for wards. The chief of security said he believed that only medical emergencies deserve priority transportation. Consequently, the transportation of wards to community clinics is not given high priority by the security staff. The officer who provides the transportation has collateral duties, including that of recruitment officer, which interfere with transporting wards. The officer's daily duty hours of 6:00 a.m. to 2:00 p.m. further limit his ward transportation availability to approximately one-half day. As a result of this misunderstanding, the Office of the Inspector General noted an instance in which the chief medical officer herself had to plead to institution management for transportation for a ward suffering a spontaneous abortion. In another case, a male ward broke his hand but was unable to see an orthopedist until transportation was arranged 10 days later.

The cause of these problems is an absence of effective policies and procedures governing the medical care of female wards in particular and the medical transportation of wards in general. Although the *California Youth Authority Institutions and Camps Branch Manual* does discuss

ward pregnancy and ward medical transportation, the department lacks policies and procedures by which to assign high priority to obstetrical care, ensure pregnant wards' appointments with specialists are timely, and ensure that the medical transportation of wards is given high priority and is well-coordinated between the medical and security functions. In contrast, female institutions in the Department of Corrections have detailed policies and procedures for the obstetrical care and transportation of inmates.

The chief medical officer of the Ventura Youth Correctional Facility acknowledged that the institution needs detailed, written policies and procedures governing these issues. When shown such policies and procedures from one Department of Corrections female institution, the chief medical officer told the Office of the Inspector General that she would develop similar policies and procedures for her facility.

- ***Wards with communicable diseases were serving as food service workers.*** California Youth Authority policy is to protect staff and wards from needless exposure to communicable diseases. To this end, the department requires its institutions to maintain a "communicable disease list" of wards with communicable diseases. The purpose of the list is to keep the staff informed about wards with such diseases so that the staff can exclude infected wards from work assignments such as food services that could expose staff and other wards. To protect the privacy of infected wards, the list is not to be shown to the ward population. The state's contract with Bargaining Unit 6 of the California Correctional Peace Officers Association requires the list and stresses the importance of the list to protecting employees. However, the Office of the Inspector General's review of the facility's communicable disease list found that four of the 10 wards on the list were employed as food service workers. All four had hepatitis. Two worked in the staff dining facility while the other two worked in a ward dining room.

  The cause of the above problem is two-fold. First, the California Youth Authority's policies and procedures for controlling communicable diseases were vague and thus difficult to implement. When the Office of the Inspector General communicated this finding to the chief of the California Youth Authority's health care services, the chief clarified the department's policy in a memorandum dated March 28, 2002 to all superintendents and chief medical officers.

  Second, the facility has not effectively communicated the means by which employees are to learn who is eligible (and ineligible) to work in food services and other sensitive assignments. In an effort to protect the wards on the list, the institution has restricted the list to the duty lieutenant's office, making it inconvenient for treatment team supervisors and others to learn the names on the list each day. The ward information network system has a 4-D subsystem with a "KP clearance box" that uses automated check boxes to clear workers for daily food service duty. This box could be used in a similar fashion to identify workers cleared for other jobs. However, staff members said that they were unaware of the feature and had not been trained on it. As a result, the two wards working food services jobs in the ward dining room were allowed to work even though the KP clearance box did not have checks next to their names.

- ***Segregating male and female wards limits their access to medical services.*** During management review audits of other California Youth Authority institutions, the Office of the Inspector General noted that the facilities' medical clinics generally hold sick call five days a week for their wards, all of whom are male. At the Ventura Youth Correctional Facility, sick call is also five days per week, but sick call for females is restricted to Mondays, Wednesdays, and Fridays. Males are restricted to sick call on Tuesdays and Thursdays. Therefore, neither gender has the benefit of daily sick call.

The presence of female and male wards at the same facility, coupled with the policy of keeping the genders segregated from each other, has created this disparity in access to medical services between the Ventura Youth Correctional Facility and the other California Youth Authority facilities. According to the facility's chief medical officer, studies have shown that female wards have five times the medical needs of male wards. Thus the disparity in sick call opportunities is particularly serious for the female wards.

RECOMMENDATIONS:

The Office of the Inspector General recommends that California Youth Authority and institution management take the following actions to improve medical care to female wards and to wards in general:

- The Institutions and Camps Branch and the chief medical officer should develop comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general. At a minimum, these policies and procedures should do the following:
  - Assign high priority to the obstetrical care of wards.
  - Ensure that contingency plans exist so that appointments canceled by obstetricians and other specialists do not result in unreasonable delays in care. Options to be explored should include contracting with backup specialists or modifying contracts to require priority rescheduling of canceled appointments.
  - Ensure that the transportation of wards to medical appointments receives proper priority and that available transportation hours reflect that priority.
- While protecting the privacy of wards with communicable diseases, the institution should review and, if necessary, modify its policies and procedures for informing the staff about wards who cannot perform food service and other duties. Once this has been accomplished, the facility should inform the staff about the policies and procedures. If the ward information network or a similar system is to be used, the staff should be provided orientation.
- If the facility continues to incarcerate both female and male wards, the Institutions and Camps Branch, the superintendent, and the chief medical officer should explore alternatives for increasing the sick call opportunities for female wards. These

alternatives should include, but should not be limited to, extending hours of daily operation as well as extending opportunities to weekends.

FINDING 5

The Office of the Inspector General found that the academic achievement of Ventura Youth Correctional Facility's wards is low compared to that of other California Youth Authority facilities.

An integral component of the California Youth Authority's mission is to provide education, training, and treatment services to wards in order to return them to society with the skills necessary to succeed and to avoid a return to criminal behavior. To this end, the California Youth Authority has adopted various policies and procedures that stress the importance of academic and vocational training.

The Office of the Inspector General's review of the academic education programs at the Ventura Youth Correctional Facility found that the wards' educational needs are not being met. Specifically, the Office of the Inspector General found the following:

- ***Mary B. Perry High School standardized test scores have declined.*** The percentage of wards below the 25th national percentile in Standardized Testing And Reporting (STAR) scores increased to a high of 67% in 2001. In 1998, 56% of the Ventura wards taking the standardized test placed below the 25th national percentile. This trend is also represented in the disparity between Ventura wards and statewide STAR scores for other California Youth Authority facilities. In 11 of 15 grade level subjects, Mary B. Perry scored below statewide averages by the largest margin since 1998 when scores were first recorded. While scores across the state improve, the wards at Ventura are failing to keep pace. Furthermore, STAR scores at the Ventura Youth Correctional Facility ranked the sixth worst of all California Youth Authority schools in 2001.
- ***Class cancellations are frequent.*** Perhaps helping to account for declining performance of Mary B. Perry High School wards in STAR testing, the Office of the Inspector General found that there are significant periods when no academic or vocational education is provided because of teacher absences, teacher vacancies, security concerns, and other facility-initiated class closures. For example, in May 2001, 764 class periods were canceled. In August 2000, 762 class periods were canceled, and in October 2000, 753 class periods were canceled. For fiscal year 2000-01, class closures averaged 644 per month. Similarly, 31% of female ward classes were closed and 28% of male ward classes were closed. The class closures at Ventura Youth Correctional Facility are reflected in a relatively low effectiveness rating — the measure used by the Education Services Branch to compare actual ward attendance and classes held to potential ward attendance and classes held. The Ventura Youth Correctional Facility's effectiveness rating amounts to 54%, meaning that on average, wards received only 54% of their assigned educational programming during fiscal year 2000-01.
- ***Mary B. Perry High School is not reporting average daily attendance.*** The Office of the Inspector General's review of reports and documents used to assess academic operations

revealed that Mary B. Perry High School failed to submit monthly attendance reports to the department's Education Services Branch. During fiscal year 2000-01 Mary B. Perry High School submitted only four monthly average daily attendance reports. The Education Services Branch based its average daily attendance on those four months, which according to Office of the Inspector General calculations, overstated average daily attendance by 107.44 in fiscal year 2000-01. The non-reporting of average daily attendance continued into fiscal year 2001-02 when on January 22, 2002, the principal prepared a memo to the Education Services Branch citing computer programming difficulties as causing the delay. A review of the principal's monthly education reports through April 2002 indicated that these reports were not prepared because the "formula is being corrected."

The effects of low academic and vocational educational achievement are significant to both wards and the California Youth Authority. Most importantly, inadequately educated wards are ill prepared to acquire the jobs necessary to facilitate their return to productive lives in free society. Further, wards who are not attending academic and vocational education classes are not receiving the programming prescribed by the California Youth Authority and the Youthful Offender Parole Board. As a result, they may remain in state custody, at state expense, longer than necessary.

Low achievement also jeopardizes the accreditation of Mary B. Perry High School, potentially diminishing the value of a diploma or certificate earned from the Ventura Youth Correctional Facility. In 1996, the California Education Authority was created as a school district within the California Youth Authority, and the Western Association of Schools and Colleges began visiting and accrediting California Youth Authority high schools. After a visit to the Ventura Youth Correctional Facility, the Western Association of Schools and Colleges on April 28, 1999 granted Mary B. Perry High School candidacy accreditation for a period of three years.

As part of the candidacy status, Mary B. Perry is required to submit an annual progress report. This report was submitted for 2000, but Mary B. Perry received a waiver for its 2001 progress report. The Western Association of Schools and Colleges was scheduled to visit the school in April 2002, but on November 21, 2001 the principal postponed the site visit until November 2002. The principal's monthly education reports for November 2001 through April 2002 made no mention of the postponement of the Western Association of Schools and Colleges site visit. Ironically, the annual outcomes for the 2001-02 academic year included the provision that "each student will attend a WASC fully accredited high school by July 2002." Because the site visit was postponed, that annual outcome was not obtainable. Admissions by staff working on the accreditation process claim that the school had several false starts in preparing its self-study report. In contrast, three other California Youth Authority high schools have received full Western Association of Schools and Colleges accreditation and four more are expected to receive accreditation by October 2002.

Several factors contribute to the wards' low achievement in academic and vocational education programs. The policies and practices of the Ventura Youth Correctional Facility administration and the Education Services Branch are a significant component. However, the wards themselves must bear some of the responsibility. Unless they are willing to make the commitment to learn and cooperate with each other and the faculty to create an atmosphere conducive to learning, it is unrealistic to expect high levels of achievement.

The Office of the Inspector General identified the following factors that have contributed to the Ventura Youth Correctional Facility's problems with its educational programs:

- The Ventura Youth Correctional Facility has a shortage of teachers and qualified substitutes willing to work inside the facility. Teaching inside a youth correctional institution is potentially dangerous. Present California Youth Authority teacher compensation is below statewide averages and does not include a premium commensurate with the risk associated with the position. The Office of the Inspector General confirmed that comparable public school district pay scales were, on average, 4% higher than those offered by the California Youth Authority.
- Classes are frequently canceled. During fiscal year 2000-2001, the high school canceled 30% of its possible classes (7,727 out of 25,859). Sixty-four percent (4,966 out of 7,727) of the cancellations occurred because the school did not have substitutes available to cover teacher shortages and absences. Some absences were attributable to the principal approving alternative work schedules for teachers. One schedule, known as the 10-12 schedule, allows teachers to work 10 months of the year while being paid for 12. However, teachers under the 10-12 schedule did not always have replacements. Another 12% of the cancellations were made to enable students and staff to attend special events. The remaining cancellations took place because of security issues, staff development needs, or lack of funds.

RECOMMENDATIONS:

In order to improve attendance and academic and vocational achievement at the Ventura Youth Correctional Facility, the Office of the Inspector General recommends that the institution management take the following actions:

- Work with ward representatives and institution education administrators as well as Education Services Branch administrators to provide the best possible learning environment. The superintendent should encourage the exchange of ideas through regular meetings between living unit staff, security, institution administration, and teachers. Focus on understanding roles and teamwork should be emphasized between these groups.

The management of the Education Services Branch of the California Youth Authority and the institution's education administrators should:

- Promptly fill teaching vacancies. Work to provide competitive teacher compensation by upgrading pay scales, using compensation exceptions provided for by law, and other suitable methods.
- Make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.

- Explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid reasons, and that all alternatives to cancellation have been explored.
- Insist on the accurate and timely reporting of ward attendance by the school principal and instructors. Provide training as necessary and implement supervisory review and signature controls.
- Comply with all recommendations of the Western Association of Schools and Colleges in order to obtain full accreditation for Mary B. Perry High School.
- Study the factors contributing to the frequent cancellation of classes and the need for substitutes. These factors should include the impact of alternative work schedules on class cancellations.

FINDING 6

The Office of the Inspector General found that certain fundraising activities conducted by staff at the Ventura Youth Correctional Facility are not properly administered.

Various committees at the institution conduct fundraisers, the majority of which are geared to enhance the ward benefit fund, which is used for the general welfare, education, or entertainment of wards and to generate donations to certain charitable organizations outside the institution. For example, the Sylvester Carraway Public Service and Fire Center, located on the northwest section of the institution grounds, has a daily car wash fundraiser for the benefit of wards. The ward benefit fund serves as the depository for car wash revenues. Proceeds are used to replenish car wash supplies; surplus funds may be spent for the benefit of wards.

However, in reviewing the institution's fundraising activities for compliance with applicable rules governing fundraising events, the Office of the Inspector General found a number of significant problems. Specifically:

- ***One committee uses funds raised from the sale of items to wards to benefit the staff.*** The institution's staff recognition committee conducts fundraisers that generate profits from the sale of items to wards. The proceeds support staff recognition events such as Employee of the Month, the annual staff recognition luncheon, Peace Officer Week, and ethnic celebrations. At some of these events, institution employees receive gifts or awards purchased from fundraising or obtained through private donations. *The Ventura Youth Correctional Facility Operational Manual* states in Section 9010 that "no financial transaction will be permitted between wards, wards and staff, or wards and volunteers." Section 2086 also states that "no employee shall be permitted to receive or give, buy or sell, or trade any article with any ward. No employee shall purchase an item for a ward either with the ward's money or the employee's money." In addition, Section 2145 of the *California Youth Authority Institutions and Camps Branch Manual* states that "personal transactions (i.e., selling, trading, lending, etc.) shall not be permitted between an employee and a ward." A typical staff recognition committee fundraising event involves selling food items to wards at a price generating a

relatively high margin of profit; the eight most recent fundraisers collectively generated $5,000 in profits, representing a profit margin of 65%, the proceeds of which benefit the staff.

- ***One committee conducted fundraising activities during state time.*** The staff recognition committee conducted fundraising activities during state time, even incurring overtime while doing so**.** Section 8002.5 of the *State Administrative Manual* states that "employees involved in activities which are not an integral part of State programs or operations must be involved *only on their own time and without the use of State equipment or supplies*." Pursuant to *California Government Code* Section 19990, "a state officer or employee shall not engage in any employment, activity, or enterprise which is clearly inconsistent, incompatible, in conflict with, or inimical to his or her duties as a state officer or employee." Activities falling into those categories include "using the prestige or influence of the state or appointing authority for the officer's or employee's private gain or advantage or the private gain of another." Also included in those categories is "using state time, facilities, equipment, or supplies for private gain or advantage." Nonetheless, the staff recognition committee incurred overtime costs or accrued compensating time off credits to perform fundraising activities, such as planning and conducting the events. The Office of the Inspector General's review of calendar year 2001 sign-in sheets for staff who serve on the staff recognition committee revealed that members worked a minimum of 150 overtime hours, in addition to 423 hours, which can be credited as "compensating time off". The compensating time off hours are at a rate of one and one-half times the hours worked. In addition, two of the staff recognition committee members accrued compensating time off hours performing fundraising functions while employed in positions that are federally-funded through education grants.

- ***The institution failed to obtain authority to open an account for fundraising proceeds.*** The institution did not obtain proper authority to open the account used for collecting and disbursing fundraising proceeds from the staff recognition committee's activities. Section 8001 of the *State Administrative Manual* states that "except when otherwise authorized by the Director of Finance or unless deposited directly in the State Treasury, all money in the possession of or controlled by any agency will be deposited in the centralized State Treasury System (STS), subject to disbursement upon order of the agency." Departments having statutory authority to deposit moneys in banks outside the State Treasury System are required under Section 19462 of the *State Administrative Manual* to "notify the State Treasurer by letter stating the name and location of the bank, amount, source, and purpose of the funds to be deposited, and the type and term of the deposit arrangement" and to report the balance of each account annually to the State Controller's Office and to the State Treasurer's Office. Despite the above requirements, the institution failed to secure authority from the Department of Finance when it opened the "VYCF Staff Recognition Fund Account" at a local Bank of America office on November 22, 2000. Account activity through March 31, 2002 consists of deposits totaling $20,079.68, withdrawals totaling $18,832.38, and bank fees of $131.86 leaving a balance of $1,115.44. The institution does not report any of the account's activity or its balance to outside agencies.

- ***Lack of adequate accounting controls for some fundraising accounts.*** The institution has failed to establish and maintain adequate accounting controls for the Ventura Youth Correctional Facility staff recognition fund account and for the car wash activities of the Sylvester Carraway Fire Center. *California Government Code* Section 13402 requires agencies to establish and maintain a system of internal accounting and administrative control over funds under those agencies' custody. A total of 96 transactions occurred in the staff recognition fund between the date the account was opened and the time of the management review audit. The institution staff recorded only 49 of these transactions in the check register, four erroneously. The staff was able to provide receipts totaling only $3,224.35 for disbursements made from the account. Of those receipts, $1,696.45 match specific checks drawn on the account. The remaining $1,527.90 in receipts are insufficient to account for the remaining $17,135.93 in disbursements. Additionally, while some checks are made payable to specific businesses, staff personnel often make direct purchases of items for staff events and subsequently receive reimbursement from the account. Of the $3,631.09 in direct disbursements to staff, purchase receipts support only $1,080.56.

  The car wash fundraising transactions for the Sylvester Carraway Fire Center are conducted entirely in cash. Car wash fundraising efforts have produced $5,240 in revenues between June 2001 and April 2002. Of these revenues, $2,320 was spent for additional supplies or ward functions, $2,870 was deposited to the ward benefit fund, and $50 was stored in the safe at the camp office. The camp administrator, the senior youth correctional counselor, and the secretary have access to the safe's combination, and make purchases of supplies for car wash functions. The secretary, in addition to having access to the safe's combination, records the account activity and keeps receipts for the purchases. From a control standpoint, these conditions constitute inadequate segregation of duties and increase the risk of errors and irregularities.

- ***Ward benefit money used for purposes other than benefiting wards.*** The institution permitted ward benefit fund money to be used for purposes not directly benefiting wards. *Welfare and Institutions Code* Section 1752.5 provides that money from the ward benefit fund is to be "used for the benefit of the wards resident at the institution or camp." *California Code of Regulations*, Title 15, Section 4723 states that "each superintendent of an institution or camp shall maintain a benefit fund account which shall be expended *only* for the general welfare, education, or entertainment of the wards in the institution or camp at the discretion of the superintendent." In October 2001, two employees participating in car wash fundraising activities incurred damage to the paint on their vehicles when institution employees permitted two untrained wards to perform car wash duties. Although a subsequent investigation cleared the wards of any fault in the incident, the institution paid $1,950 from the ward benefit fund to compensate the two employees for damage to their vehicles, rather than directing the employees to file claims with the State Board of Control pursuant to *California Government Code* Sections 900-965.9.

The effects of the conditions cited above are significant. By allowing employees to conduct fundraising activities during regular working hours, incurring overtime while doing so, the institution:

- Increases its budget deficit for functions not critical to the continued operation of the facility.

- Risks losing education grants because the federal grantor agency would not approve the use of its resources to conduct fundraising events.

- Places an unnecessary workload on its accounting office through additional ward trust fund account activity caused when wards participate in fundraising functions.

- Places itself at risk of a negative perception by the public and by wards who become aware that profits made from sales to wards are used for employee functions.

In addition, the institution would have difficulty refuting allegations that staff members gain personally from fundraising functions, since the accounting for fund activity is grossly inadequate.

Lack of accounting controls over the car wash fundraising results in:

- Potential loss of interest earnings by failing to deposit cash receipts on a bi-weekly basis.

- Failure to safeguard assets by allowing a person with access to the safe to also make purchases and record the transactions.

- Spending ward benefit funds inappropriately, diminishing the wards' opportunity to purchase items for their general welfare, education, or entertainment.

Several factors contributed to the conditions cited above. They include:

- ***Lack of training and knowledge regarding fundraising activities.*** The business manager's position at the institution was vacant when the Ventura Youth Correctional 'Facility staff recognition fund' was established. The current business manager was hired two weeks later and did not question the fund's existence or activities; he was unaware that a state agency is required to obtain approval from the Department of Finance prior to opening a bank account.
- ***Failure of accounting staff to question fundraising activities.*** A perception that management established and endorsed the Ventura Youth Correctional Facility staff recognition fund led to the accounting staff's acceptance of the fund and reluctance to question its function or existence. Staff members further cite an inability to question management decisions in this area.
- ***Lack of understanding on the part of management about the ward benefit fund***. Institution management believed that regulations permitted expenditures from the ward benefit fund to compensate the state employees whose cars were damaged. Further, the office of the deputy director of the Institutions and Camps Branch approved the expenditure.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the institution management take the following actions regarding fundraising activities:

- Discontinue fundraising sales to wards when proceeds are to be used to benefit staff members. While the institution may use other methods such as donations from local businesses, the time required to secure these donations should be volunteered by staff without incurring overtime pay or compensating time off hours. If fundraising activity that benefits staff conducted under these terms conflicts with applicable collective bargaining agreements, the activity should be discontinued.

- Immediately close the Bank of America checking account used for the Ventura Youth Correctional Facility staff recognition fund. Any account balance should be deposited into the ward benefit fund.

- Update the facility's operational manual to define acceptable financial transactions between wards and staff, such as those involving canteen purchases or fundraisers for the sole benefit of wards, and provide training to business office staff, accounting staff, and other employees involved in fundraising activities.

- Deliver cash revenues from car washes to the accounting office weekly to facilitate deposit to a bank within ten working days. The safe at the camp should be used to store cash only until it is delivered to the accounting office.

- Develop procedures to purchase supplies for the car wash program or other ward benefits through the procurement section of the institution. This would separate the duties of staff members who purchase items from those who have custody of the revenues.

- Reimburse the ward benefit fund for $1,950 to correct the erroneous use of the funds, and explore obtaining reimbursement of those funds from the State Board of Control. (It is possible in certain cases to submit claims up to 12 months after the date of the incident.)

- Provide training for the institution's business management and staff in the proper use of ward benefit funds.

- Review the actions of members of the Ventura Youth Correctional Facility staff in participating in fundraising activities for the staff recognition committee for possible disciplinary action.

In addition, the Institutions and Camps Branch should take the following actions:

- Update the *Institutions and Camps Branch Manual* to provide clear guidance to institutions on fundraising and financial transactions between staff and wards.

- Provide training to branch administrators in the proper use of ward benefit funds.

FINDING 7

The Office of the Inspector General found significant deficiencies in the institution's practices and procedures in conducting investigations.

Investigations of allegations against staff in a correctional setting are an important and sensitive matter. Well-conducted investigations can both exonerate innocent employees and ensure that wrongdoing by guilty employees is dealt with effectively. Poorly conducted investigations can adversely affect the careers of innocent staff members, lead to litigation, perpetuate the wrongdoing of guilty employees, and cause wards and staff to doubt the fairness and impartiality of the institution's management. *California Penal Code* Section 6065 and the *California Youth Authority Internal Affairs Investigations Handbook* recognize the need for well-planned, impartial, professionally conducted investigations that are done in the utmost confidentiality. However, the Office of the Inspector General found significant deficiencies with the manner in which the Ventura Youth Correctional Facility has conducted its investigations. Specifically:

- ***Investigative plans were not adequately prepared.*** Section 1000 of the *California Youth Authority Internal Affairs Investigations Handbook* requires a thorough, organized work plan for each investigation. Section 1000 states that investigative plans are to provide an outline of anticipated investigative procedures, names of witnesses, evidence needing consideration in performing the investigation, and other information. The Office of the Inspector General's review of five of 45 investigations performed in calendar years 2000 and 2001 determined that in each investigation the investigators failed to include adequate investigative plans. Subsequent interviews with seven facility investigators confirmed that they did not routinely compile investigative plans. The omissions in the investigations included the following: failure to identify investigative procedures; not listing witnesses; and failure to identify evidence or collateral data. One case contained an assignment memorandum instructing the investigator to review certain documents. While this memorandum was helpful, it failed to substitute for an actual investigative plan. The *California Youth Authority Internal Affairs Investigations Handbook* requires a senior investigator to review the plans to provide guidance in the investigative process. Because all of the cases reviewed were missing investigative plans, the benefit of supervisory review to both the investigation and the professional development of the investigators is nonexistent.

- ***Conflict of interest statements were not used.*** A basic tool of professional investigating is the conflict of interest statement. *California Penal Code* Section 6065 states that investigations by the California Youth Authority shall be performed "…with honesty, credibility, and without any conflicts of interest." By signing the statement the investigative team members attest to their impartiality in assigning, conducting, processing, and reviewing the case. The inclusion of such a statement is particularly important when the investigators

are employees within the institution. Despite the importance of the conflict of interest statement, none of the five case files reviewed contained such statements. Interviews with the seven facility investigators confirmed that the investigators neither routinely signed conflict of interest statements themselves nor asked their supervisors or management staff in position to influence the case to sign the statements.

- ***A non-confidential secretary transcribed investigative reports.*** A fundamental means of enhancing the confidentiality of investigations is the use of confidential employees. Confidential employees are trusted employees who have been oriented to the sensitive nature of their work and have signed statements that they will not disclose information about their work to outside parties. During the management review audit, the Office of the Inspector General identified an investigator who used non-confidential secretarial staff to type investigative reports. This practice not only jeopardizes the confidentiality and privacy of the person under investigation and witnesses, but it also discourages complainants and witnesses from coming forward in future cases.

- ***Investigation files were poorly secured.*** To guarantee confidentiality and prevent information tampering, investigation files need to be locked in file cabinets within secured areas when not being used. However, the Office of the Inspector General observed investigative case files stacked on top of desks and filing cabinets in a vacant, inadequately secured office. Preliminary investigation files were located in boxes in a utility closet.

- ***Investigators were not thoroughly screened.*** Investigators were not screened through supplemental background and psychological evaluations**.** *California Penal Code* Section 6065 requires that peace officers who are selected to conduct internal affairs investigations undergo a complete and thorough background check in addition to the original background screening that was conducted when the person was hired as a peace officer. An important part of the background check is a psychological evaluation. The Office of the Inspector General's interviews of seven facility staff who perform internal affairs investigations disclosed that none had supplemental background checks or psychological evaluations prior to assignment as an investigator.

- ***Internal affairs investigator conducted investigations despite sustained allegations.*** Despite state law to the contrary, an institution internal affairs investigator continued to conduct investigations after serious allegations were sustained against him. *California Penal Code* Section 6065 states that any person who has been the subject of a sustained, serious disciplinary action should not become an investigator. The Office of the Inspector General found, however, that an investigator who was the subject of a Level II (serious) investigation and against whom allegations had been sustained was nonetheless allowed to conduct investigations. The allegations that were sustained consisted of the following: use of racial preference in hiring ward workers; failure to adequately supervise wards; over-familiarity with wards; failure to report ward misconduct; failure to report contact with a parolee; placing a sports bet with a ward; and failure to report staff misconduct.

- ***Preliminary investigations were inadequate.*** Preliminary investigations are reviews intended to determine whether sufficient evidence of possible wrongdoing exists to merit a

full investigation. The Office of the Inspector General identified three preliminary investigations that were not conducted or managed with due diligence. Significant errors and inappropriate institution-level decisions resulted, including the failure to forward a serious investigation to the California Youth Authority Internal Affairs unit. The three preliminary investigations in question are described below:

- A preliminary investigation of an employee's suitability to work with wards was closed with no investigation when, contrary to what had been alleged, the investigator concluded that court records showed no recent arrests. However, the court records were not included as evidence with the preliminary investigation report, and the investigator did not interview the employee. Basic investigative work by the Office of the Inspector General found that the employee had been incarcerated in the Ventura County jail on the dates alleged and had been on vacation from the facility at the time he was jailed. The preliminary investigation should have resulted in a formal investigation.

- The preliminary investigation of a peace officer employee for alleged inappropriate behavior with staff and wards resulted in a recommendation for a formal investigation, but the formal investigation was not requested. The facility prepared a request to the California Youth Authority Internal Affairs unit for an investigation, but the request was never submitted. On the request form is a hand written note indicating that the superintendent's secretary checked the request on April 26, 2001 and confirmed it had not been submitted to Internal Affairs and that the record was removed from the database. Because the one-year statute of limitations had not expired, the Office of the Inspector General, upon learning of the case, informed the superintendent and forwarded the matter to the California Youth Authority Internal Affairs unit. An investigation was conducted and the employee retired.

- A preliminary investigation was conducted into a citizen's allegations of check forgery by a peace officer employee, but it appears from the preliminary investigation that the officer was neither made aware of the allegations against him nor informed that a preliminary investigation was being performed. The Public Safety Officers Procedural Bill of Rights Act requires that when a peace officer is the subject of an investigation, if possible, the officer is to be informed of the allegations. Further, *California Penal Code* Section 832.5 and *Institutions and Camps Branch Manual* Section 3071(b) require that all complaints from a citizen be in writing. In this case, the citizen's complaint was not in writing. The final notation with respect to the preliminary investigation was a request dated February 28, 1999 for further instructions as to whether any additional investigative procedures were necessary. The Office of the Inspector General found no recommendation regarding whether the case should be formalized as a Level I or Level II investigation or whether it should be dropped altogether. The matter still had not been resolved by the end of the management review audit fieldwork.

- ***The institution's investigation logs were incomplete.*** *California Penal Code* Section 6065 (b)(2) requires that all internal affairs allegations or complaints, whether investigated or not, be logged and numbered sequentially on an annual basis. The log is to be made available to the Inspector General. The Office of the Inspector General tested

the accuracy of the institution's investigation logs by comparing their contents with those of the California Youth Authority Internal Affairs unit and the department's Education Services Branch. The test disclosed eight cases at the facility that were not included in the institutional logs. Five of those cases involved the teaching staff, two involved the volunteer staff, and one involved a youth correctional officer. The allegations in these cases included over-familiarity with wards, being under the influence at work, excessive force, sexual misconduct with a parolee, and possession of contraband.

The Office of the Inspector General identified the following underlying causes of the problems: inadequate training and supervision of investigators and secretarial staff; poor monitoring of investigators and their case files; and inadequate communication between the institution and the Education Services Branch. According to investigators interviewed, none had undergone substantial reviews of their work or received feedback from their supervisors. Investigators complained that the lack of feedback left them unsure of their results. The California Youth Authority Internal Affairs unit has implemented a mentoring program, but few investigators knew of it and none regularly took advantage of the service.

Investigations conducted of the teaching staff, who are members of the California Youth Authority Education Services Branch, do not go through the superintendent's office. The branch notifies the superintendent of an investigation via a memorandum from the branch's southern administrator. By doing so, the branch affords the superintendent minimal information on the activities of employees within the institution.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the institution management take the following actions to improve institutional investigations:

- In the short term, the superintendent should request the director of the California Youth Authority to allow the institution to refer all preliminary investigations and Level I investigations, as well as Level II investigations, to the California Youth Authority Internal Affairs unit until the institution is prepared to conduct them.

- In the long term, the superintendent and her staff should develop an institutional plan for conducting well-planned, diligently conducted investigations. At a minimum, this plan should require the following:

    - Thorough screening of investigator candidates using supplemental background investigations and psychological tests.

    - Signed conflict of interest statements for investigators and all staff in a position to affect the outcome of an investigation.

    - Use of well-developed, written investigative plans.

- Use of confidential employees for clerical and other support services.
- Proper securing of investigation case files, including the use of locking file cabinets and other devices as appropriate.
- Prompt disqualification of any investigator found to be the subject of a sustained, serious disciplinary action.
- Careful supervision of investigators' work by their supervisors.
- Timely feedback to investigators on their performance.
- High-level monitoring of all cases by the superintendent to ensure their accurate, timely disposition.

The Office of the Inspector General also recommends that the Education Services Branch provide the institution with pertinent and timely case information for tracking in institutional investigation logs. This case information should include the following:

- Internal Affairs unit or Education Services Branch case number
- Subject name
- Allegations
- Incident date
- Discovery date
- Investigator name
- Case closure date
- Case conclusions

FINDING 8

[Note: For reasons of confidentiality, Finding 8 is being transmitted under separate cover.]

FINDING 9

The Office of the Inspector General found that the disciplinary decision-making system at the Ventura Youth Correctional Facility has serious defects.

The disciplinary decision-making system is a process developed by the California Youth Authority to ensure that wards have the right to due process in disciplinary matters. *California Youth Authority Institutions and Camps Branch Manual*, Sections 7300 through 7495, list specific policies and procedures to be followed in disciplinary actions. The manual categorizes ward violations as minor misconduct, Level A (intermediate misconduct), and Level B (serious misconduct). At the Ventura Youth Correctional Facility, the disciplinary decision-making tracking system is maintained on two different databases. The system currently in use is the department-wide Ward Information Network 2000 database, which was installed in stages. The previous system used for disciplinary decision-making, called "4-D," is still available for retrieval on past disciplinary decision-making actions against wards prior to March 2002. Both systems allow Ventura Youth Correctional Facility staff to log, monitor, and dispose of disciplinary decision-making system cases in a timely manner.

Nevertheless, the Office of the Inspector General determined that the facility's management of the disciplinary decision-making system process has some serious defects. Specifically, the Office of the Inspector General found the following:

- ***Inadequate control over Level B rules violation reports.*** The Ventura Youth Correctional Facility does not have adequate control over the submission of behavior reports on wards committing serious Level B rules violations under the disciplinary decision-making system. (A behavior report is a California Youth Authority document that describes a ward's behavior and charges the ward for behavior that violates the department's ward behavior policy.) The Office of the Inspector General found that serious Level B rules violations committed by wards against the facility staff may never reach the facility's Ward Rights Office for recording and processing, allowing the ward to potentially escape any adjudication or discipline for the ward's actions. In many instances, serious behavior reports filed by youth correctional counselors and submitted for approval to a senior youth correctional counselor or treatment team supervisor were never forwarded to the facility's Ward Rights Office for recording and processing.

  Below are examples of Level B behavior reports obtained by the Office of the Inspector General of which there is no record in any disciplinary decision-making database. Therefore, there was no resolution of the report.

  - A ward attempted to bite a staff member.
  - A ward threw a chair at staff and then spit food at staff.

- Two wards plotted to assault staff. One of the two wards allegedly stated, "when I get to stabbing somebody, I just get into it and start tearing their shit up inside."
- A ward cursed at and threatened to spit on Youthful Offender Parole Board members.
- A ward wrote a note to the staff saying, "I might jump off on staff, I don't care any more." The ward has an assault history, including recently assaulting a nurse, and her commitment offense is an assault on her grandmother.

The Office of the Inspector General recognizes that many female wards at the Ventura Youth Correctional Facility have mental and emotional problems that must be considered in applying discipline under the disciplinary decision-making system. However, even when discipline is mitigated by the ward's mental and emotional state, the resolution of the disposition must be documented appropriately and recorded in the Ward Information Network database.

Serious rules violations by wards may be halted from adjudication at the supervisory and managerial levels. Senior youth correctional counselors and treatment team supervisors have the authority to take any of the following actions after reviewing a Level B behavior report:

- Approve the behavior report as a Level B violation and forward the behavior report to the Ward Rights Office for recording, processing, and fact finding;
- Downgrade the behavior report to a Level A or minor misconduct, keeping the behavior report within the living unit; or
- Disregard or throw out the behavior report as unsubstantiated or determine there was a mistake or correction in charging the ward.

The Office of Inspector General also found many instances in which behavior reports originated as Level B, but the ward received minimal punishment (Level A type disposition). For example:

- A ward threatened several times to spit on staff members while screaming, banging items, and threatening the staff. The ward received a 20-day privilege loss.
- A ward verbally harassed a female staff member while trying to incite an altercation. The ward also said she was going to "rush" the staff the following day. This behavior report was dropped due to time constraints.

When the behavior report is downgraded to a Level A violation or dismissed, the Ward Rights Office is not made aware of the existence of a behavior report. As a result, the Ventura Youth Correctional Facility is not tracking the number of disciplinary decision-making cases originated. Each living unit has access to the Ward Information Network to input behavior reports into the system, but according to the ward rights coordinator and the facility LAN manager, there is currently no report or query search feature for compiling monthly reports on the volume of Level A or Level B disciplinary activity. Such a report also is not required by California Youth Authority headquarters.

These deficiencies in the disciplinary decision-making system undermine control and accountability over the actions of supervisory and managerial staff, allowing them to circumvent department policy in order to reduce their workloads and avoid the time, effort, and additional paperwork needed to hold a fact-finding and disposition hearing.

- ***Disposition hearings are not held at the Alborada living unit.*** Disposition hearings are not conducted for the Alborada living unit wards, relieving wards with sustained Level B actions of any punishment or consequence. Sustained Level B disciplinary actions are serious behavior violations by wards, punishment for which could result in referring the ward for prosecution to the local district attorney's office or extending the ward's parole consideration date. The Office of the Inspector General's review of 99 sustained Level B disciplinary decision-making system cases revealed that in 21 (21.2%) of the 99 cases in calendar year 2001, no disposition hearing was held following the fact-finding hearing, as required by *Institutions and Camps Branch Manual* Section 7425. Of the 21 cases without a disposition, all but one came from the Alborada living unit. While the disciplinary decision-making system policy allows for exceptions to the disposition for wards with mental and emotional disturbances, the system still requires a resolution to Level B incidents. The disposition may require only that the ward be referred to the treatment team for alternative disposition, but this must be reflected in the Ward Information Network database to constitute a completed disciplinary decision-making system action.

- ***Deficiencies in the disciplinary decision-making system database.*** The disciplinary decision-making system database has many system deficiencies in the recording, tracking, and compilation of quantifiable data. The Office of the Inspector General found that the present disciplinary decision-making system has no audit capability as did the previous system. The Ward Rights Office personnel cannot determine who changed, corrected, or modified a disciplinary decision-making system case finding and disposition. Under the previous 4-D database system, only Ward Rights Office personnel had access to modify or correct inaccuracies in case data.

  As noted earlier, Ward Rights Office personnel are unable to generate custom query, data search, or extraction reports from the database. The Office of the Inspector General was unable to obtain reports listing the following:

  - The number of originating Level B cases "by living unit" for any period of time.
  - The number of sustained Level B cases for any period of time.
  - The number of Level A cases for any period of time.
  - The number of Level A cases "by living unit" for any period of time.

  As a result, the Office of the Inspector General had to use the Ward Rights Office manual log of originating Level B cases for calendar year 2001 to manually compile statistical data on the disciplinary decision-making system. However, the data in the manual log is subject to error because there are no controls to ensure that every originating Level B case is forwarded to the Ward Rights Office. This limitation makes it nearly impossible to audit Level A disciplinary cases because a listing of Level A cases from the Ward Rights Office or from

each living unit cannot be accomplished. One would have to know specifically which wards have received a Level A disciplinary action in a given time frame in order to obtain the details of the case. This limitation also made it impossible for the Office of the Inspector General to determine whether members of the facility staff are meeting the department's policy on time limits when holding a disposition hearing with a ward.

Also, the institution staff has not received training on using the Ward Information Network 2000 system and there is little support for the staff from either the facility's LAN manager or from California Youth Authority headquarters in implementing and using the Ward Information Network 2000 database system.

- ***Disciplinary decision-making system activity is not reported to the superintendent.*** Because of the technology limitations in generating custom query reports from the Ward Information Network for disciplinary decision-making system activity, the superintendent and upper management have not been monitoring the current climate of ward behavior, its related disciplinary decision-making system activity, and the performance of the facility staff. As a result, it is difficult for the superintendent to determine whether staff members are carrying out their duties and meeting the time limit requirements for holding fact-finding and disposition hearings with wards. Ideally, the superintendent should be provided with statistical data at least monthly on the number of Level A and Level B behavior reports that have been initiated and sustained by each living unit, and this information should be compared with prior periods in order to assess trends.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management take the following actions to improve the disciplinary decision-making system:

- Until technological improvements can be made to the Ward Information Network 2000, require each living unit to manually record each initiated Level A and Level B behavior report, with appropriate details of the rule violation, and report this information to the superintendent, assistant superintendents, and the Ward Rights Office at least monthly. The outcome and disposition of the behavior report should also be listed, including whether time limits were exceeded in processing the behavior report. Details of each case, such as the Ward Information Network case number, the ward's name, the date of the incident, the date of the behavior report, and the name of the staff writing the behavior report, should be listed.

- Require the facility LAN manager, with the assistance of the California Youth Authority headquarters staff responsible for the Ward Information Network 2000 database, to help program useful reports for database users.

- Migrate all historical information on ward disciplinary decision-making system activity from the former database to the current database.

- Train all staff members involved in the ward disciplinary decision-making system process. The training should cover the procedures recommended above, items identified in the *Institutions and Camps Branch Manual,* and specific procedures unique to the Ventura Youth Correctional Facility or described in its operations manual. Specifically, the superintendent should ensure that:
  - All members of the staff are provided with training on the disciplinary decision-making system process at least annually.
  - Hands-on training is offered on how to navigate through the Ward Information Network 2000 database and how to use it for the disciplinary decision-making system process.

FINDING 10

The Office of the Inspector General found that the Ventura Youth Correctional Facility has a good working system for ward grievance monitoring and tracking, but some aspects of the process prevent management from holding facility staff accountable.

In reviewing the ward grievance process, the Office of the Inspector General found that the processing procedures and oversight provided by the facility's Ward Rights Office are functioning well and in a timely manner. Despite using a manual system, the Ward Rights Office has highly competent personnel effectively tracking each ward grievance and performing weekly audits to determine which grievances are overdue. In other areas of the ward grievance process, however, management is prevented from making facility staff accountable. Specifically, the Office of the Inspector General found the following:

- ***Ward grievances are often misplaced.*** Despite oversight by the Ward Rights Office of outstanding and overdue grievances, members of the facility staff frequently lose or misplace ward grievances. The Office of the Inspector General's analysis of ward grievance dispositions for January 2000 through December 2001 found that a high percentage of ward grievances were classified as "withdrawn." Thirty-two percent of all grievances were recorded with a disposition of withdrawn on the facility's monthly grievance reports. Further analysis revealed that 82% of the withdrawn grievances fell under the responsibility of the facility staff, while 18% of the withdrawn grievances were a result of the ward withdrawing the grievance before submission to facility staff.

  An analysis of the withdrawn grievances under facility staff control revealed that 83.6% were ward grievances submitted by female wards, while male wards submitted 16.4% of the withdrawn grievances. Of the 83.6% submitted by female wards, 29% were filed by wards living in the Alborada cottage and another 29% were filed by wards living in the El Toyan cottage.

  Although a ward may withdraw a grievance after submitting it to the Ward Rights Office for assignment and disposition, the Office of the Inspector General found from an analysis of

entries in the master grievance log obtained from the Ward Rights Office that this happens infrequently. The high number of withdrawn grievances from the Alborada cottage and El Toyan cottage suggests that the senior youth correctional counselors and treatment team supervisors responsible for these two units may not being taking ward grievances seriously.

There are various reasons for the high percentage of withdrawn grievances under facility staff control, but the data suggests that facility staff are losing a large number of grievances from female wards. When the Office of the Inspector General interviewed female grievance clerks about the high number of withdrawn grievances, they said most of the withdrawn grievances pertain to "fast-track, staff action" grievances. They said that these grievances, which allege serious staff misconduct, are submitted directly to the facility's watch office or to the on-duty staff officer to be forwarded to the superintendent's secretary for logging. The female grievance clerks claim, however, that the grievances are not being forwarded, but instead are lost or destroyed.

As a result, when Ward Rights Office personnel perform a monthly audit of outstanding and overdue grievances, they identify by grievance number grievances that have been submitted as "fast-track, staff action" from the ward grievance clerk's monthly log sheets. But because these types of grievances do not get processed initially through the Ward Rights Office, and instead are supposed to be forwarded directly from the watch office or the on-duty staff officer to the superintendent's office, they are susceptible to becoming lost or destroyed by the facility staff. When a grievance is lost, the Ward Rights Office has no recourse but to have the ward who originally submitted the grievance withdraw the original grievance and resubmit another.

Another factor contributing to the confusion over withdrawn grievances is that some facility staff members are miscoding grievances as withdrawn instead of "denied." This miscoding was noted on grievances responded to by the facility's chief of security. The facility staff should know the difference between a grievance response being denied and one in which the grievance was withdrawn by the ward.

Lack of training for the facility staff on the ward grievance process exacerbates the staff's misunderstanding of the grievance process. In a January 31, 2002 report titled, *"Evaluation of the Ward Grievance Procedure,"* independent consultants hired by the California Youth Authority found that only four employees at the Ventura Youth Correctional Facility had undergone refresher training on the ward grievance process in calendar years 1999 and 2000.

- ***Grievances exceeding time limits are not being reported accurately.*** Grievances that are not resolved within department time limits are not being reported accurately to California Youth Authority headquarters and Ventura Youth Correctional Facility management. In the two-year period from January 2000 through December 2001, monthly grievance reports filed by the Ventura Youth Correctional Facility with California Youth Authority headquarters reflected a 12% overdue rate on ward grievances. In contrast, a test sample of 118 ward grievances conducted by the Office of the Inspector General disclosed a 27% overdue rate. Similarly, in the January 31, 2002 report mentioned above, a significantly higher overdue rate was noted by the independent consultants. Using a sample size of 13 randomly selected "regular" level ward grievances from calendar years 1999 and 2000, the consultants found

that only 53.8% were responded to within department time limits. In a randomly selected sample of 12 "emergency" ward grievances, the consultants found that only 33.3% were responded to within department time limits. The results of the sample tests indicate that the facility materially understated the frequency of grievances exceeding time limits. The inaccurate reporting is caused by the failure of the ward grievance clerks to accurately analyze and record monthly grievance activity on overdue grievances in their "Monthly Grievance Chrono Log by Cottage," a sheet upon which each clerk records and monitors ward grievances.

- ***There is no monthly internal reporting of grievances to the superintendent.*** There is no internal reporting of monthly ward grievance activity to permit upper management or the superintendent to effectively gauge the climate of ward attitudes at the facility and identify staff members delinquent in responding to overdue grievances. The Office of the Inspector General noted that ward grievance activity is not among the items each senior youth correctional counselor reports monthly to upper management. Monthly grievance data for each living unit is readily available and compiled in the Ward Rights Office by the institution ward grievance clerk. Tracking monthly ward grievance activity for each living unit and making comparisons going back 13 months can provide relevant information to management on trends and the current climate of ward attitudes at the facility.

  This information was not being kept until the Office of the Inspector General began its fieldwork. The institution ward grievance clerk said she was not told to keep details of ward grievance activity by living unit. Instead, after preparing the facility's Monthly Grievance Report for California Youth Authority headquarters, she would throw away the compilation sheet used to record ward grievance activity by living unit.

  The ward rights coordinator does not report overdue grievances directly to the superintendent. Nor does the ward rights coordinator report withdrawn grievances pertaining to fast-track staff action allegations. As a result, the superintendent is unaware of which living units and staff members are the source of overdue grievances and of withdrawn fast-track staff action grievances. That the ward rights coordinator reports directly to one of the two assistant superintendents at the facility may sometimes hamper or prevent the communication of negative information to the superintendent.

RECOMMENDATIONS:

In order to improve the ward grievance process, the facility management should take the following actions:

- Immediately investigate the cause of "withdrawn" fast-track, staff action grievances.

- Require the ward rights coordinator to report overdue grievances to the superintendent, assistant superintendents, and all staff involved in the grievance process at least monthly.

- Establish an oversight function to monitor the ward grievance process, regularly report any deficiencies directly to the superintendent, and hold staff members accountable for their responsibilities. Within this framework, the ward rights coordinator should report directly to the superintendent.

- Implement a "lock-box" near the watch office for wards and ward grievance clerks to ensure that for every ward grievance submitted, a copy is forwarded to either the Ward Rights Office or the superintendent's office.

- Train all staff members involved in the ward grievance process. The training should cover the procedures recommended above, items required by California Youth Authority policy as identified in the *Institutions and Camps Branch Manual*, and specific procedures unique to Ventura Youth Correctional Facility or described in its operations manual. The superintendent should ensure that the staff is provided with training on the ward grievance process, including the correct disposition of a ward grievance, at least annually.

- Implement an online database or electronic spreadsheet and tracking system that includes the following information:

    - Grievance number
    - Grievant's name (last and first)
    - Grievant's California Youth Authority number
    - Cottage
    - Date filed
    - Type of grievance
    - Staff member responsible for action
    - Due date for response
    - Appeal status
    - Due date for appeal
    - Resolution status

This tracking system should be established either on the Ward Information Network 2000 system, or, in the short run, on a stand-alone system developed by the facility.

FINDING 11

The Office of the Inspector General found that a large portion of the institution's projected budget deficit of $2 million for fiscal year 2001-2002 is attributable to high costs of overtime, external contracts, and increased utility expenditures.

Because budget overruns by one institution must be made up by reducing expenditures either in the California Youth Authority headquarters operation or in the department's other institutions and camps, accurate fiscal forecasting and the control of expenditures by institutions are essential

to the sound fiscal operation of the California Youth Authority. The only alternative is for the department to request more funds from the Department of Finance, but such funding is limited in today's economy. Section 32 of the Fiscal Year 2001-2002 Budget Act (Chapter 106, Statutes of 2001) recognizes the need for fiscal prudence by providing that officers of various departments, boards, commissions, and institutions are forbidden to make any expenditure in excess of appropriations without the prior consent of the Department of Finance.

Notwithstanding the need for accurate forecasting and expenditure controls, the Ventura Youth Correctional Facility has an operating deficit of approximately $2 million that will have to be made up elsewhere in the department's budget. The Office of the Inspector General noted several factors contributing to the projected budget deficit at the Ventura Youth Correctional Facility:

- ***Approximately $740,000 of the deficit is attributable to personnel services***. This is a result of high overtime costs and the costs associated with paying permanent intermittent employees consisting mainly of youth correctional officers used for relief coverage. The institution has 22 permanent intermittent employees working essentially full-time. Relief coverage for employees on sick leave also has increased as a result of eliminating the "Extraordinary Use of Sick Leave" sanctions in the newly ratified Bargaining Unit 6 contract. Finally, the majority of the custody positions at the institution are filled, lessening the institution's ability to fulfill its salary savings requirement.

- ***The remaining deficit, approximately $1.2 million, is attributable to operating expenditures and equipment.*** Nearly $470,000 of this amount is related to utility costs, with another $430,000 in the projected cost of external contracts, which may not be fully realized. An additional $290,000 represents expenses such as resident clothing, medical and pharmaceutical supplies, and uniform allowances. The major causes of the operating expenditures and equipment deficit are the following: the 2001-2002 allotment is approximately $1.1 million less than that of the previous year; the department has not received a baseline adjustment to compensate for increased utility costs over the past two years; and the institution has had to absorb the increased costs of a high number of pregnancies among female wards placed in state custody.

- ***The post assignment schedule has not been updated to reflect budget effects.*** The Ventura Youth Correctional Facility's post assignment schedule, which converts the Governor's budget into identifiable staff positions at the institution, has not been updated to reflect the effects of the 2001-2002 Governor's budget or the proposed fiscal year 2002-2003 budget. The schedule failed to exclude staffing for the Casa de Alma cottage, which was closed and is temporarily being used as a medical clinic. In preparing the post assignment schedule, the institution calculated the number of hours budgeted for relief positions using a formula that counted vacation days, holidays, and sick leave days twice, thus inflating the budgeted relief hours by 7,804 hours. In addition, the formula failed to account for the Cesar Chavez state holiday, understating required relief hours by 1,278, leaving a net overstatement of 6,526 hours, or roughly 3.7 personnel years. Failure to have a post assignment schedule that reconciles with the Governor's budget leaves the institution without a current and accurate

document to support staffing levels and funding for the security and living units authorized in the Governor's budget.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the institution management and the California Youth Authority take the following actions to reduce the budget deficit:

- Although the end of the 2001-2002 fiscal year is near, the superintendent should continue to reduce expenditures wherever possible, while developing a plan to prevent a deficit from re-occurring in subsequent years. While the California Youth Authority has already submitted Section 27.00 Deficiency Notifications seeking current year funding to cover increased utility costs and the increasing costs of care for pregnant wards, it should continue to seek an increase in its base budget to offset the effects of unforeseen items that create an added fiscal burden, such as the effects of eliminating the Extraordinary Use of Sick Leave sanctions from the new Bargaining Unit 6 contract.

- The institution, working in conjunction with headquarters, should update and correct the post assignment schedule so that the expenditures authorized in the Supplementary Schedule of Salaries and Wages in the Governor's budget reconcile with the institution's master roster detailing the security and counseling positions required to operate the institution.

FINDING 12

The Office of the Inspector General found deficiencies in the operation of the Ventura Youth Correctional Facility warehouse.

The management of materials and supplies is an important function within a youth correctional institution such as the Ventura Youth Correctional Facility. An integral component of the function is the warehouse, which serves as the repository for thousands of dollars worth of food, supplies, and other items critical to the efficient operation of the facility. The institution has an expendable goods inventory of over 400 items. Without strict internal control over functions such as accessing warehoused items and the scheduling of deliveries of supplies and equipment, there is significant potential for theft, fraud, and spoilage. Accordingly, the State has adopted specific requirements for the orderly management of the State's warehousing functions. The requirements are outlined in *California Government Code* Sections 13402 and 13403 and the *State Administrative Manual.*

The Office of the Inspector General inspected the operation of the Ventura Youth Correctional Facility warehouse for compliance with sound management practices consistent with the *California Government Code* and the *State Administrative Manual.* The review disclosed non-compliance in the following areas:

- ***There are inadequate controls over access to the warehouse.*** Contrary to the access restrictions intended by *California Government Code* Section 13403, several members of the staff have access to the warehouse because of poor control over the warehouse keys. The warehouse manager said that on some occasions he has found the warehouse unlocked upon his arrival. On other occasions he has arrived to find that pallets of items have been moved or that items have been moved into the warehouse. Further, he has encountered employees who do not work in the warehouse inside the warehouse seeking to obtain items. The warehouse manager said that management employees, security staff, and plant operations personnel have keys to the warehouse. Such wide access to the warehouse violates fundamental tenets of internal control and invites theft and fraud.

- ***Deliveries are made without prior notification.*** Section 3510.2 of the *State Administrative Manual* requires specific accounting for deliveries to ensure that the deliveries are not late, incorrect, incomplete, of substandard quality, improperly packaged, or damaged. To accomplish this type of accounting, a receiving clerk must be present to inspect each delivery. However, the Office of the Inspector General noted some pallets of merchandise in the warehouse for which the warehouse manager could not explain the origin. These items, which turned out to have been ordered by the headquarters staff, were not properly received because the staff ordering the items had failed to notify the warehouse of the items' impending arrival. This practice, too, invites theft and fraud as well as erroneous ordering and spoilage.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the institution management take the following actions to improve warehouse controls:

- Restrict access to the warehouse to warehouse staff, the superintendent, and the control center (for emergency use).
- Re-key the locks with keys that cannot be duplicated and distribute the keys only to the personnel identified above.
- Require that all staff, including those from headquarters, arrange for the retrieval of items through the warehouse, with prior notification.
- Require that only orders that can match a purchase order (including orders initiated from headquarters) be accepted by the warehouse staff. All other orders should be rejected.

FINDING 13

The Office of the Inspector General found that the Ventura Youth Correctional Facility assigns some wards to more than one paid job.

Job assignments are an important aspect of ward life in an institution. Jobs teach responsibility to wards and provide them with skills that can be used in the future when wards are released from custody. Jobs also allow wards to earn money that can be used to purchase food and other items while incarcerated. However, there are a limited number of jobs available and their corresponding funds are limited. Consequently, there is significant demand for jobs. To ensure that as many wards as possible benefit from paid jobs, *California Code of Regulations*, Title 15, Section 4725 states that "a ward shall not be assigned to more than one pay position at one time, regardless of the source of funds."

The Office of the Inspector General's review of the ward assignment rosters for two time periods revealed, however, that some wards were assigned to two paid positions. The roster covering the end of November 2001 through part of December 2001, which contains 96 paid jobs, lists seven wards (7.2%) with two paid jobs. The roster covering parts of February 2002 and March 2002, which contains 98 paid positions, lists six wards (6.1%) with two paid jobs. While some of the wards listed with two jobs were considered alternates for one of the positions, this fact does not excuse the institution from complying with Section 4725.

Other wards have been assigned to more than one paid job because they are in a headquarters-funded "direct construction" position while also assigned to an institution-funded position such as kitchen worker. Direct construction positions are managed and funded by the Facilities Planning Division at headquarters. The headquarters-funded jobs entail performing construction-related work within the facility. The institution's business manager manages the job assignments at the facility.

The business manager said there is a waiting list of wards seeking paid jobs. By assigning specific wards to more than one job, the institution prevents wards on the waiting list from learning and performing skills that could be used to obtain jobs upon their release. Further, wards on the waiting list are deprived of the opportunity to earn money that could be used for their personal benefit.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the institution and the California Youth Authority Facilities Planning Division take the following actions to comply with *California Code of Regulations* Title 15, Section 4725 and to increase the number of wards with paid jobs:

- The business manager should ensure that alternate positions go to wards on the waiting list rather than to wards already assigned to regular paid assignments.

- The business manager should ensure that wards assigned to a "direct construction" position are not also assigned to another paid job assignment.

FINDING 14

The Office of the Inspector General found that staff performance appraisals and probationary reports are not completed on time.

Evaluating and providing timely feedback to employees on their performance is important to effective management. Employees informed of positive and negative aspects of their job performance can continue to develop their strengths while working to correct their deficiencies. The result is more productive employees whose efforts help accomplish the organization's mission and goals. Employee performance appraisals documenting satisfactory performance can be the basis of merit salary increases and promotions. In addition, consistently unsatisfactory performance can provide justification for dismissal.

The State of California recognizes the need for and value of performance appraisals by requiring such appraisals for state employees. *California Government Code* Section 19992 requires that a system be in place to evaluate the performance of state employees and that performance reports be kept on file and made available to each employee. *California Government Code* Section 19172 requires regular evaluation of the work and efficiency of state employees during their probationary periods. Probationary reports are especially important. New employees need prompt feedback, and it is easier to terminate poor performers during probation than after they have achieved permanent status.

The review by the Office of the Inspector General revealed that Ventura Youth Correctional Facility personnel do not receive performance appraisals and probationary reports on time. Permanent employees are to be evaluated annually; probationary employees generally are appraised more frequently, every 60 days or every 120 days, depending on their job classification. The team reviewed a sample of 13 personnel files and found that six files (46%) did not contain the required annual performance appraisal. Given the employees' time with the facility, the files of five employees should have contained probationary reports, yet in all of the five cases, the probationary reports were either delinquent or never completed. In addition, seven of the files (54%) did not contain current duty statements as required by Section 2045 of the facility's operational manual. The duty statements are to be updated with each annual performance appraisal.

The personnel staff said that a task force determined that it was the individual supervisors' responsibility to submit timely performance appraisals and to track those that are delinquent. the personnel staff also said that they track the due dates of probationary reports and remind supervisors and the training officer when the reports are due. However, it appears that supervisors and managers regard generating performance appraisals and probationary reports as a low priority compared with their other duties.

RECOMMENDATIONS:

The Office of the Inspector General recommends that the superintendent take the following actions to ensure prompt evaluation of employee performance:

- Notify every staff member of the importance of performance appraisals and probationary reports to the mission of the Ventura Youth Correctional Facility.
- Instruct the personnel officer to develop a system that does the following: systematically logs the due dates for all performance appraisals and probationary reports, notifies supervisors when such appraisals and reports are due, and compiles information on supervisors who are delinquent in completing appraisals and reports. This log should be submitted to the superintendent monthly and made a regular topic of management meetings.
- Include the responsibility for timely performance appraisals and probationary reports in supervisors' and managers' own performance expectations and performance appraisals.

ATTACHMENT A

VIEWS OF RESPONSIBLE OFFICIALS

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

DEPARTMENT OF THE YOUTH AUTHORITY
4241 Williamsbourgh Drive, Sacramento, California 95823
Internet www.cya.ca.gov Telephone (916) 262-1467

June 24, 2002

Mr. Steve White, Inspector General
Office of the Inspector General
801 K Street
Sacramento, CA 95814

Dear Mr. White:

Please find attached a response to the report generated by representatives of your office after a recent visit to Ventura Youth Correctional Facility. Superintendent Eugenia Ortega has addressed issues that are within her span of control at that site. Technological and investigative items will be addressed at the Department level.

If you have any questions, please feel free to contact.

Sincerely,

Jerry L. Harper
Director

Department of the Youth Authority
State of California

Ventura Youth Correctional Facility

3100 Wright Road, Camarillo, CA 93010 (805) 485-7951 • Fax (805) 988-1861

June 21, 2002

John Chen
Chief Deputy Inspector General
Office of the Inspector General
3927 Lennane Drive, Suite 220
Sacramento, California 95834-8780

Dear Mr. Chen,

I am in receipt of the Management Review Audit (MRA) Report conducted by your office. Upon receipt of the MRA, I, along with both Assistant Superintendents, met with the Audit Team to obtain further clarification on the findings identified. During this meeting, I provided feedback on the report as follows:

I concluded that the findings can be responded in the following manner: 1) In the findings where the data clearly supports deficiencies, a strategic plan of action will be developed to ensure full compliance with policies and procedures. An implementation method will be developed with a built-in monitoring system for continued review. 2) Some findings are issues that were brought to my attention at the time of the Audit Team's visit and were corrected at that time or upon receipt of this report. 3) Lastly, some findings appeared to result from situational incidents and will require further review before we can develop a response or corrective action plan. Although this is only a preliminary response to the Executive Summary, the attached document provides initial feedback on the 14 findings in the format outlined here.

Ventura YCF and the Department will implement the same methodology as that used at Fred C. Nelles and Heman G. Stark Youth Correctional Facilities. The Executive Team will meet with the Ventura Management Team on July 19, 2002, to review more thoroughly Ventura's corrective action plan.

I would like to extend my appreciation to the Audit Team. The baseline provided by this report will become an essential component of our Risk Management plan for the upcoming year. I am confident that upon your return to Ventura to re-evaluate the progress made, you will be pleased to see the commitment in correcting the deficiencies identified.

If further clarification is needed on any of the above or attached, please feel free to give me a call.

Sincerely,

Eugenia Ortega

Eugenia Ortega
Superintendent

Attachment

Office of the Inspector General
Management Review Audit -- June 2002

Ventura Youth Correctional Facility

FINDING 1: Operating the Ventura Youth Correctional Facility as a coeducational institution significantly limits the ability of the institution to provide programs and services for wards and results in wards at the facility not receiving the services provided to wards at other institutions.

The Department will be thoroughly evaluating this entire issue along with the stated recommendations. Although having both males and females in the same institution presents unique operational issues, a more detailed review is needed to determine what measures can best address the concerns identified.

FINDING 2: Ventura Youth Correctional Facility wards have not been provided with required treatment services.

This area will become VYCF's primary focus in developing a systematic method to ensure full compliance. There is no question whatsoever that this area requires 100% support from all staff and administration alike. The institution was already aware of deficiencies in the areas of counseling and treatment. The deficiencies, as well as the corrective action needed to reach compliance, were outlined in the institution's I&C, Section 4000 Report dated April 29, 2002. To date, measures already taken are reviews and audits by the Office of the PAIII as well as the Assistant Superintendents. The casework sheet used by the Audit Team has been adopted and is being implemented on a regular basis. A more strategic plan will include specific objectives, implementation schedule, as well as a method for accountability.

FINDING 3: Female wards at the Ventura Youth Correctional Facility are not receiving required mental health assessment services in a timely manner.

A number of changes have already been implemented in addressing some of the concerns related to the mental health needs of the female wards. Part of the problem related to the TNA assessment stemmed from malfunctioning equipment. Since the time of the report, a new software program has been installed and the scanning is being done in a timely manner. Files will be re-audited in August 2002 to ensure compliance. GAFs are also being handled differently: all female wards arriving at Ventura will be GAF'd upon arrival to the receiving unit. This change became effective May 20, 2002. The concerns related to SPAR will be furthered reviewed and addressed. In addition, the supervisory issues will also be addressed.

FINDING 4: Some institution practices jeopardize the health of female wards, the infants of female wards, and wards in general by failing to provide timely access to quality medical care and providing inadequate protection against communicable diseases.

The Medical Department at VYCF is staffed by Board Certified Pediatricians and Board Certified Internists who provide the highest quality of medical care delivered in a timely and

qualified manner. However, attention is needed in developing treatment guidelines for pregnant wards. The issue regarding the communicable disease was addressed at the time the Audit Team brought it to our attention. Although the facility was following established policy at that time, the Department has since made additional changes to which we are adhering. Although sick call is limited according to gender, any and all medical concerns needing immediate attention are handled accordingly.

FINDING 5: ***The Ventura Youth Correctional Facility's educational classes are poorly attended and the wards' academic achievement is low compared to that of other California Youth Authority facilities***

At least 6 months prior to standardized testing, VYCF will conduct workshops for all education staff on study skills instruction; integrate study skills instruction across the curriculum; using the WASC and case conference process, collaborate with treatment staff in preparing students for tests; improve attendance; reduce class cancellations; and initiate the mandated homework policy. A new Daily Briefing format is being established to track class cancellations. The data collected will be reviewed with the goal of assessing those factors contributing to excessive cancellations, as well as high student absenteeism. A corrective action plan will follow. In addition, greater emphasis will be placed on the proper reporting of average daily attendance. .

Finding 6: ***Fundraising activities conducted by staff at the Ventura Youth Correctional Facility are not properly administered***

All fundraising activities with ward participation involving staff functions have been ceased. We will work with the Branch and the Department to ensure that all fundraising activities remain legal and within established guidelines.

Finding 7: ***There are significant deficiencies in the institution's practices and procedures in conducting investigations.***

This issue will be the direct responsibility of the Office of the Superintendent. Measures will be taken to address the deficiencies. Specific attention will be focused on the concerns noted. To date, the Chief of IAU has been contacted to request additional training and support for institutional staff. Although VYCF staff no longer conduct any formal investigations, preliminary investigations need improvement as well. Collaboration with the Liaison IAU Investigator will be increased. In addition, better tracking and logging methods will be established.

Finding 8: ***The California Youth Authority and the institution have failed to comply with department-mandated security requirements.***

On June 13, & 14, 2002, the Department's Compliance Unit conducted a security audit of VYCF's security operations. Methods for the proper inventory of tools and other security equipment will be enhanced. Additionally, we will work with the Department on other issues such as the hostage policy.

FINDING 9: ***The Office of the Inspector General found that the disciplinary decision-making system at the Ventura Youth Correctional Facility has serious defects.***

The DDMS and Ward Grievance Procedure will also require great attention. In addition to developing a tighter system ensuring compliance to timeframes, appeals, etc., assistance from Central Office will be requested in bringing the computer program into full operations.

FINDING 10: ***The Ventura Youth Correctional Facility has a good working system for ward grievance monitoring and tracking, but some aspects of the process prevent management from holding facility staff accountable.***

As stated above, the WGP needs much attention. A detailed strategic plan to address deficiencies will be developed.

FINDING 11: ***A large portion of the institution's projected budget deficit of $2 million for fiscal year 2001-2002 is attributable to high costs of overtime, external contracts, and increased utility expenditures.***

Internal methods directly spearheaded by the Office of the Superintendent are being established to aggressively address Ventura's deficit. Some measures include: approving only those expenditures necessary for the safe operations of the institution, alignment of the institutional schedules with the Post Assignment Schedules, the monthly review of blankets, the establishment of an incentive program for high sick leave balances, remaining proactive in anticipating vacant positions to avoid unnecessary overtime, as well as increasing the intermittent pool to minimize filling vacant shifts at time and a half. Continued attention to this area will be diligently maintained.

Finding 12: ***The Office of the Inspector General found deficiencies in the operation of the Ventura Youth Correctional Facility warehouse***

Adequate controls over access to the warehouse will established along with developing a system to ensure deliveries are made with prior notification.

FINDING 13: ***The Office of the Inspector General found that the Ventura Youth Correctional Facility assigns some wards to multiple paid jobs.***

It is our goal to remain within Title 15 and Departmental policy. Measures will be established to ensure compliance.

FINDING 14: ***The Office of the Inspector General found that staff performance appraisals and probationary reports are overdue.***

All performance appraisals will be brought up to date. Moreover, a systematic process in monitoring the timeliness of these reports will be established with built-in methods to hold all supervisors accountable.