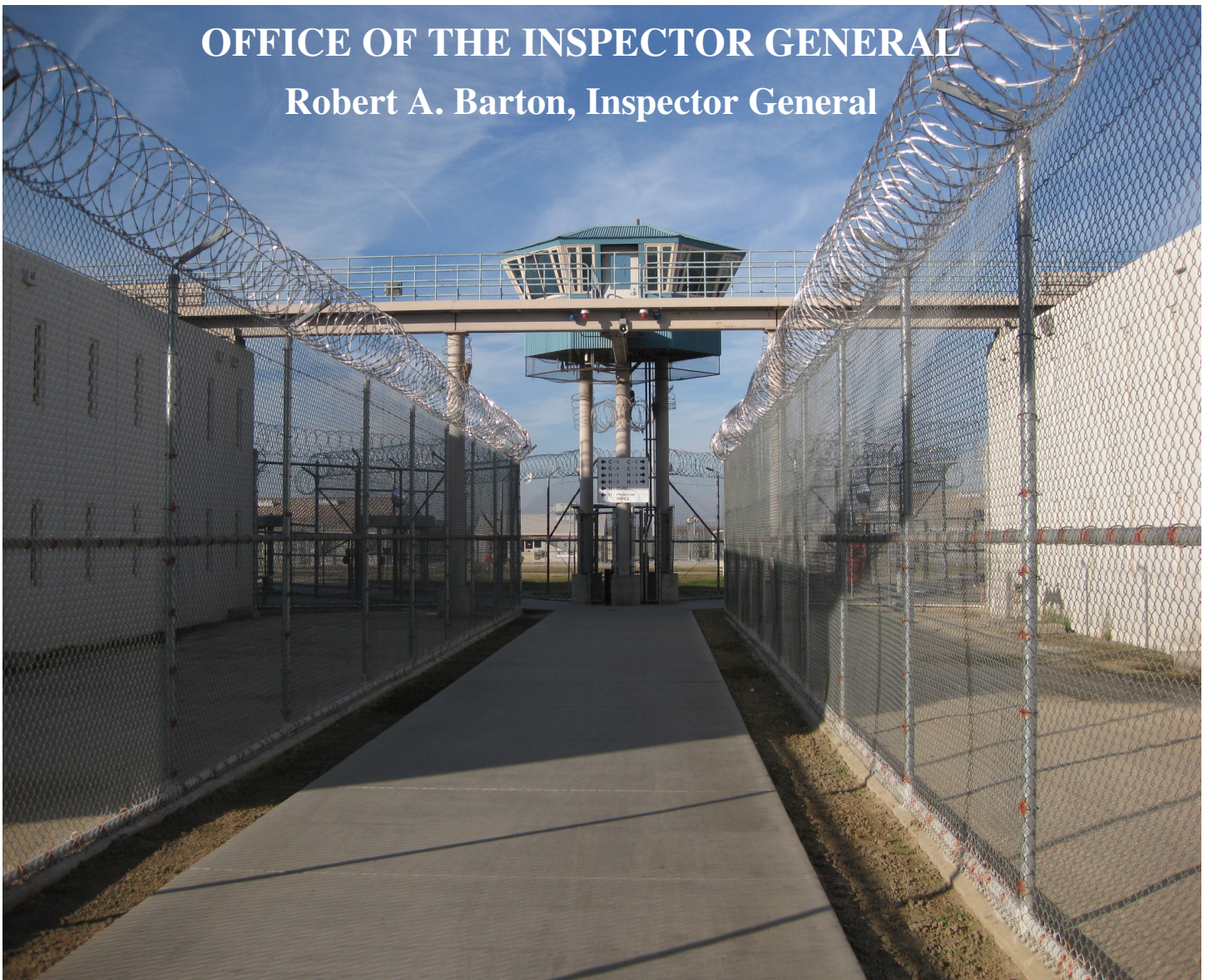




2011 ANNUAL REPORT



Contents

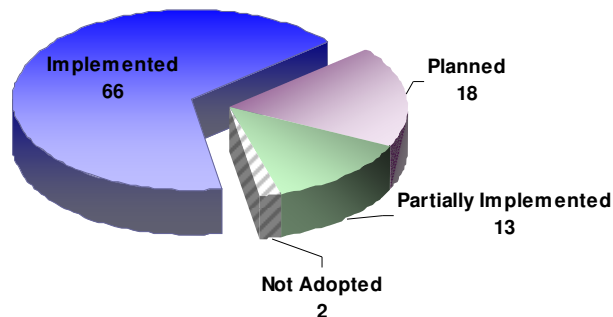
A MESSAGE FROM THE INSPECTOR GENERAL	1
DUTIES OF THE OFFICE OF THE INSPECTOR GENERAL	3
ORGANIZATIONAL OVERVIEW	4
CHAPTER 1: KEY ISSUES.....	5
<i>Safety and Security.....</i>	<i>5</i>
<i>Waste, Fraud, and Abuse.....</i>	<i>7</i>
<i>Accountability.....</i>	<i>10</i>
<i>Civil Rights</i>	<i>12</i>
<i>Rehabilitation</i>	<i>16</i>
CHAPTER 2: ANNUAL REPORT OF MONITORING ACTIVITIES.....	17
<i>Critical Incident Monitoring</i>	<i>17</i>
<i>Internal Affairs and Discipline Monitoring.....</i>	<i>17</i>
<i>Use-of-Force Reviews</i>	<i>18</i>
APPENDIX: REVIEWS RELEASED IN 2011	19

A MESSAGE FROM THE INSPECTOR GENERAL

2011 was a year of change for the Office of the Inspector General (OIG). Change can often be challenging, but it can also be a catalyst for improvement and innovation. The major changes for the office included legislation that went into effect mid-year, which re-defined parts of the OIG mission. There were also budgetary actions that reduced our budget by approximately 44 percent. This resulted in the need for a major reduction in staff and reorganization of the remaining resources. Finally, I was sworn-in as the new Inspector General on August 29, 2011.

In 2011, the OIG released 39 formal reports and 9 letter reports. The recommendations in these reports and letters resulted in greater transparency, taxpayer savings, process improvements, increased accountability and higher adherence to policies and constitutional standards. To date, the California Department of Corrections and Rehabilitation (CDCR) has fully implemented 66 of the OIG recommendations, and has partially implemented an additional 13 recommendations. CDCR plans to implement 18 final recommendations by December 2012. This will represent a 98 percent acceptance and implementation rate of OIG recommendations overall.

Implementation status of 99 OIG recommendations in 2011.



While the legislation in 2011 redirected our independent audit and investigation functions to other state agencies, these functions were replaced with performance and policy reviews of CDCR as authorized by the Governor or Legislature. In October of 2011, our first such review demonstrated our increased responsiveness reviewing CDCR issues under this new model. The OIG assembled a team to review the mass inmate hunger strikes within CDCR and issued a report with our analysis and recommendations to the Senate, in less than a month. Our other traditional core functions have remained intact, but in order to fulfill them, we have changed our methodology from utilizing specialists sent out from Sacramento who traveled statewide, to cross-training our staff to perform all functions, putting more staff in regional offices, and drawing on those resources to accomplish field work for warden vettings, discipline and use-of-force monitoring, medical inspections, and authorized reviews. This has improved efficiency and productivity, and reduced associated costs.

In addition, this new model allows even more frequent contact between our OIG monitors and the prisons in their regions. Our regional teams now interact with the local prisons on matters processed by our statewide intake team that require immediate attention. We have expanded our regional discipline monitoring units (DMU) to include

use-of-force monitoring as well as our traditional monitoring of serious internal affairs investigations and employee disciplinary processes. In 2011, we issued our first semi-annual use-of-force report.

Our medical inspection unit completed the second cycle of medical inspections at all 33 institutions in 2011. Preliminary results indicate steady improvement in the quality and timeliness of health care within the prison system. It is my belief that the OIG is an invaluable component in the remedial efforts of the federal *Plata* litigation concerning inmate healthcare. Just as we assisted the department in meeting the constitutional standards required by the federal oversight in the *Madrid* litigation involving the employee discipline process, we provide the same assistance to the department in the *Plata* case.

In 2011, the federal court ended its oversight in the *Madrid* case, noting the improvement of the internal discipline process based on OIG involvement. By utilizing the OIG as independent, objective oversight to monitor CDCR's compliance with their own policies and ensuring constitutional standards, we replace federal oversight, saving the State millions of dollars. We also serve to prevent the kinds of conditions that led to the *Madrid* litigation in the first place.

We continue to provide recommendations to the Governor for the appointment of warden candidates. CDCR has a critical need for qualified leaders in the prison system. In response to this need we have streamlined our process and the first warden evaluation completed after my appointment was done in 58 days, down from a previous average of 85 days. I am committed to keeping this process timely, with the goal of completing our warden evaluations in fewer than 60 days.

We have also retained our statutory duties for the California Rehabilitation Oversight Board (CROB) for which I serve as the chairperson. Members of my staff also serve as executive director, board secretary, and legal counsel. We also continue our retaliation complaint duties and our monitoring of Sexual Abuse in Detention Elimination Act (SADEA) complaints.

Despite some of the changes in our functions and processes, the overall mission of OIG oversight remains the same. We will provide transparency for CDCR operations by monitoring and reporting on their adherence to policy and best practices, and whenever necessary, making recommendations to improve CDCR performance and reduce the liability to the taxpayers of California.

I am proud of the accomplishments of my staff during this year of transition. The following report evidences our commitment to fulfilling our mission even during difficult circumstances. We are committed to serving the State with the same dedication going forward.



Robert A. Barton
Inspector General

DUTIES OF THE OFFICE OF THE INSPECTOR GENERAL

As a result of legislation enacted in 2011, the duties of the OIG were revised. Senate Bill (SB) 78, SB 87, and SB 92 significantly reduced the OIG's budget; removed the peace officer status of OIG employees; removed the mandate that the OIG conduct audits and investigations of the California Department of Corrections and Rehabilitation (CDCR) and replaced it with the requirement that the OIG instead conduct policy and performance reviews of the CDCR (at the request of the Governor, the Senate Rules Committee, or the Speaker of the Assembly); removed the requirement that the OIG conduct quadrennial facility operation reviews and one-year warden follow-up audits; and codified the OIG's medical inspection program. The duties of the OIG are:

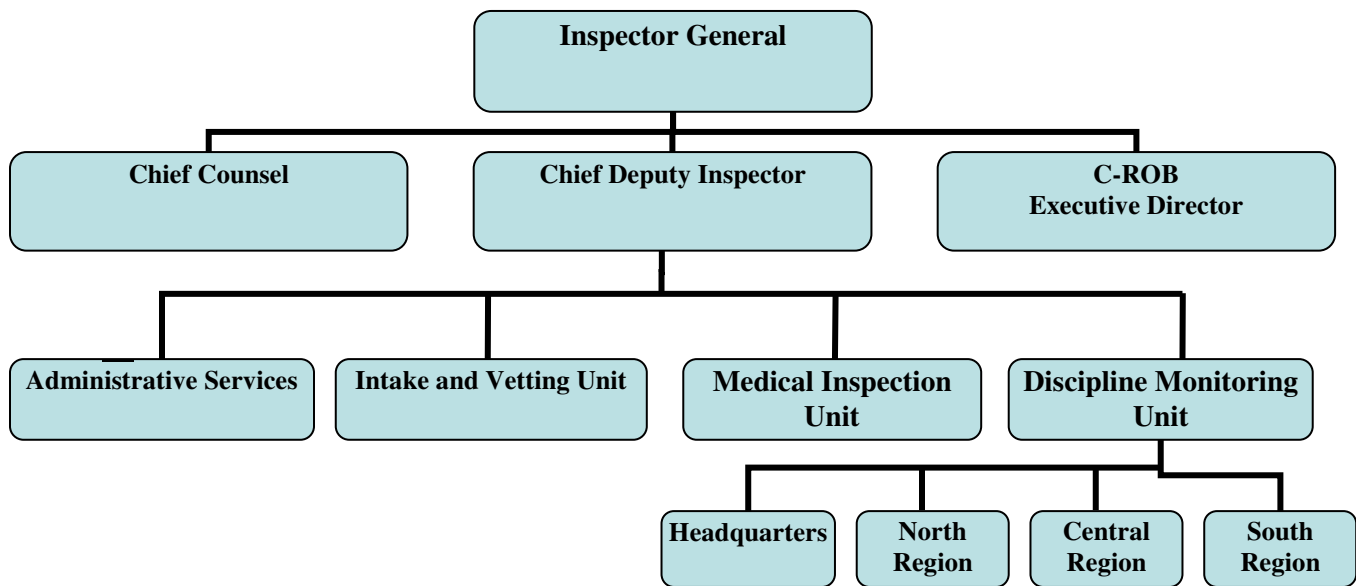
- Provide contemporaneous oversight of internal affairs investigations and the disciplinary process of the CDCR. Monitor use-of-force reviews conducted by CDCR and CDCR response to critical incidents within the institutions. Report the results of these activities on a semi-annual basis.
- When authorized by the governor, State Assembly, or State Senate, conduct reviews of CDCR policies, practices, and procedures; and, upon completion, report back to the authorizing entity on the findings and recommendations resulting from the review.
- Review the qualifications and backgrounds of the Governor's candidates for appointment to serve as wardens in the State's prisons and as superintendents for the State's juvenile facilities. Upon completion of the review, provide the Governor with a recommendation as to the qualifications of the candidate.
- Conduct an objective, clinically appropriate, and metric-oriented medical inspection program to periodically review delivery of medical care at each State prison.
- Maintain a statewide intake function and process, including a toll-free public telephone number, to receive communications from any individual regarding allegations of improper activity within the CDCR. Initiate a review of any alleged improper activity.
- Conduct assessments of retaliation complaints submitted by CDCR employees against a member of CDCR management. If the complaints state a prima facie case, review the complaint to determine the merits.
- Chair and direct the California Rehabilitation Oversight Board (C-ROB) within the OIG. Conduct quarterly C-ROB meetings to examine CDCR's various mental health, substance abuse, educational, and employment programs for inmates and parolees. Report biannually to the Governor and Legislature on C-ROB's findings.
- Review the mishandling of sexual abuse incidents within correctional institutions, maintain the confidentiality of sexual abuse victims, and ensure impartial resolution of inmate and ward sexual abuse complaints through the Sexual Abuse in Detention Elimination Ombudsperson.
- Annually report a summary of the OIG's reports and CDCR's responses to OIG recommendations.

ORGANIZATIONAL OVERVIEW

Because statutory revisions in July 2011 refocused the OIG's responsibilities, the office implemented a significant reorganization of its operational structure. Specifically, the OIG significantly reduced its workforce, eliminated the separate bureau designations, re-distributed its duties, and regionalized its workforce according to need. The following represents the organization of the OIG at the close of 2011:

- The OIG is comprised of a skilled team of professionals, including attorneys with expertise in internal affairs investigations and criminal and employment law and inspectors experienced in correctional policy, operations, and investigations.
- On January 1, 2011, the OIG had 151 authorized positions. Effective July 1, 2012, the OIG will have 87 authorized positions. These positions include a staff of attorneys serving as special assistant inspectors general, a team of deputy inspectors general trained in audits and investigations, and a team of support staff who facilitate the mission of the OIG.
- In addition to headquarters operations in Natomas and Rancho Cordova, the OIG is regionally organized into three areas: North, Central, and South Regions. The North Region is in Rancho Cordova, the Central Region is in Bakersfield, and the South Region is in Rancho Cucamonga, all co-located with CDCR's Internal Affairs offices.
- California Penal Code Sections 2641, 6125 et seq., and 6141 provide the statutory authority for the OIG's establishment and its operations.

2011 Organizational Chart



CHAPTER 1: KEY ISSUES

SAFETY AND SECURITY



Safety and security have always been the top operational priorities for correctional administrators, government policymakers, and the public. Since its inception, the OIG has identified safety and security deficiencies in California's correctional system. In 2011, OIG inspectors continued to identify opportunities for CDCR to address weaknesses in these areas.

Complaint Assessments and Reviews

In 2011, the OIG completed 19 case reviews related to complaints it received relating to allegations of improper activities. These included one criminal, eleven administrative, three retaliatory, and four preliminary assessments and reviews. Many of these reviews directly impacted safety and security within the CDCR. Subsequent to July 2011, the OIG no longer initiates independent investigations of these matters.

The OIG received an average of 211 complaints each month by mail and through a toll-free telephone line. Similar to prior years, most complaints concerned staff misconduct, the inmate appeal and grievance process, and the quality or lack of access to medical care. When necessary, the OIG now refers these matters to regional staff to monitor departmental response.

One-Year Warden Reviews

In 2011, prior to the changes in statute, the OIG issued one-year reviews on the performance of the wardens at four California prisons: Mule Creek State Prison, Salinas Valley State Prison, Deuel Vocational Institution, and California Correctional Institution. These reviews assessed the wardens' performances during the year following their appointments to the positions. During these reviews, the OIG performed the following tasks: surveyed employees, key stakeholders, and CDCR executives; analyzed operational data compiled and maintained by CDCR; interviewed employees, including the wardens; and completed onsite inspections of the prisons. The performance reviews gathered information and focused on four key areas, one of which was safety and security.

During these four reviews, we found the institution staff saw all the new wardens as strong leaders in the area of safety and security. When surveyed, the majority of staff members at all four prisons indicated positive opinions about each prison's safety and security. On average, 81 percent of employees within the four prisons shared this

sentiment. When employees made negative comments about safety and security, they often balanced their criticism with praise for their wardens' efforts to remedy existing problems.

Community Involvement

In 2011, the OIG hosted a meeting of the Prison Crimes Council, a voluntary organization comprised of State and local corrections officials, prosecutors, and law enforcement officials working as equal partners to promote public safety throughout the State correctional system.

The council tackled multiple issues impacting the correctional community. For example, the council discussed Assembly Bill (AB) 109 (Public Safety Realignment) impacts and overviews, law enforcement personnel records and the impact of dishonesty allegations on prison crimes prosecutions, updates on the officer involved shooting Memorandum of Understanding, and District Attorney referral agreements with CDCR. Other legislative and legal updates were also discussed.

California Department of Corrections and Rehabilitation's Implementation of the Non-Revocable Parole Program (May 2011)

To alleviate overcrowding in California prisons, legislation enacted in 2009 and 2011 mandated a system in which specified non-violent parolees would not be returned to prison unless convicted of another felony offense, and the supervision of these offenders would eventually be shifted to local governmental agencies. Parolees on non-revocable parole (NRP) are not supervised and are not subject to arrest or re-incarceration in prison for parole violations. As a result, the screening process to determine an inmate's non-revocable parole eligibility must be accurate in the interest of public safety. CDCR developed the California Static Risk Assessment (CSRA) tool to determine an inmate's risk of re-offending.

We found the CSRA inaccurately assessed some offenders, used incomplete conviction data in many cases, and inconsistently applied juvenile data when calculating risk assessment scores. Further, CDCR initially incorrectly issued a policy that ignored the juvenile records of adult offenders who, when they were minors, were tried as adults and convicted of serious and violent felonies. CDCR later corrected its policy.

In May 2011, we issued a report on our review of the program. We made six recommendations to address the deficiencies found during this review. In its Corrective Action Plan, updated in November 2011, CDCR reported it had completed the implementation of four of the six recommendations and was in the process of implementing one other recommendation.¹ CDCR determined that one recommendation was no longer applicable.

¹ The OIG will continue to track CDCR's implementation of corrective action plans for unresolved issues, as deemed necessary.

WASTE, FRAUD, AND ABUSE

In a time of limited State resources and tightening of department budgets, promoting economy and efficiency within the State's correctional system is a necessity. Prior to July 2011, the OIG's mission included conducting investigations into allegations of financial waste, fraud, and abuse made against CDCR and conducting audits of CDCR's prisons. A key component of our current mission is to assist in bringing transparency to CDCR's processes.



Special Report: Mule Creek State Prison Must Improve Its Oversight of Some Employees' Work Hours and Timekeeping (April 2011)

In April 2011, we issued a special report regarding the oversight of employees' work hours and timekeeping at Mule Creek State Prison (MCSP). We concluded that many of the prison's mental health and educational employees were fully paid, but did not work an average full day. We found these employees' work hours ranged between 33 and 39 hours per week, which amounted to \$272,900 over our three-month test period. At this rate, the unaccounted-for hours would cost nearly \$1.1 million a year.

In addition, when we sampled employees' timesheets, we found that timekeeping mistakes on some employees' timesheets resulted in leave hour overcharges that totaled more than \$6,500 and leave hour undercharges that totaled nearly \$102,000. These mistakes were made by employees and the prison's personnel office. We made 15 recommendations to CDCR that addressed these issues. In its October 2011 Corrective Action Plan, the CDCR reported it had fully or substantially implemented 14 of the 15 recommendations and partially implemented one other recommendation. The CDCR plans to complete its implementation of all recommendations by April 2012.

California Prison Health Care Receivership Corporation's Use of State Funds for Fiscal Year 2009-10 (April 2011)

In April 2011, we issued our fourth annual report concerning how the California Prison Health Care Receivership Corporation spent State funds to carry out its federal court mandate to oversee California's prison medical system during the 2009-10 fiscal year. The review highlighted how the receivership spent \$12.4 million in State funds for its operating costs and long-term capital assets, significantly less than the \$91.2 million spent in fiscal year 2008-2009. Of the \$12.4 million, the receivership spent \$9.3 million on construction to improve the medical facilities at Avenal State Prison and San Quentin State Prison. In January 2012, the receivership reported it had completed its implementation of the one recommendation we identified in our report.

Letter: Review of Operations at California State Prison, Sacramento (September 2011)

In September 2011, we completed an operations review of California State Prison, Sacramento (CSP, Sacramento) and issued a letter to CDCR's Secretary informing him of the results. We determined that over half of the 34 non-custody employees' timesheets we reviewed contained errors that, if not corrected, could cost the State \$42,257. We also found that CSP, Sacramento could have reallocated psychiatrists' work schedules and saved approximately \$480,000. In addition, the Psychiatric Physician On-Call program was vulnerable to overtime abuse due to a lack of supervision; and we also identified weaknesses in CSP, Sacramento's screening of inmate appeals.

In total, we made 16 recommendations to help the prison improve operations. In its October 2011 Corrective Action Plan, the CDCR reported that it had fully implemented 14 of the 16 recommendations and partially implemented one other recommendation. The CDCR reported that it had not yet implemented the remaining recommendation because it was still researching a related policy issue.

Letter: Review of CDCR Accounts Receivable from Employee Wage and Benefit Overpayments (September 2011)

In September 2011, we issued a letter to CDCR's Secretary informing him that we completed a review of CDCR's accounts receivable from employee wage and benefit overpayments. However, since the State Controller's Office (SCO) issued an audit report on a similar topic in July 2011 that confirmed many of our observations, we only informed CDCR of the employee debt problems not identified in the SCO report.

During our review, we discovered CDCR personnel employees did not follow established payroll procedures, resulting in 74 instances of preventable employee debt valued at



approximately \$729,000. We identified three areas of preventable employee debt: delayed or incorrectly entered payroll system transactions, failure to verify whether absent employees have sufficient leave credits, and inaccurately calculated wages for employees on military leave. To minimize CDCR's overpayments to its employees, we provided five recommendations. In its Corrective Action Plan updated in January 2012, CDCR reported it had fully implemented three of the five recommendations. Of the two remaining recommendations, CDCR had partially implemented one and expects to complete its implementation of both recommendations by the end of June 2012.

Letter: Review of CDCR Employee Leave Accruals (October 2011)

In October 2011, we issued a letter to CDCR's Secretary informing him we completed a review of CDCR's processing of leave accruals. CDCR erroneously gave employees about 55,000 hours of accrued time off, worth nearly \$2 million. Most of these hours—nearly 34,000—were for holiday credits. The most egregious errors included two employees who were credited with over 800 hours of holiday credit in a single pay period and a prison that over-credited eight hours to almost half its employees in one month.

We determined several factors could have contributed to the mistakes such as human error, lack of training, or inadequate oversight. CDCR officials generally agreed, and indicated that increased staff workload may have also contributed. CDCR and the SCO planned to acquire a timekeeping system with system controls, but had not yet established an implementation date for the timekeeping system. We cautioned CDCR that if not corrected, employees with unearned leave hours could use the hours for paid time off or receive the cash value of those hours when they separate from State service. We provided three recommendations to CDCR in this letter. In its Corrective Action Plan, updated in December 2011, the CDCR reported it had partially implemented two of the three recommendations and had not yet implemented the remaining recommendation. The CDCR expects to complete its implementation of all three recommendations by the end of April 2012.

Letter: Preliminary Review of CDCR Employee Leave Transactions (October 2011)

Based on our April 2011 report entitled *Mule Creek State Prison Must Improve Its Oversight of Some Employees' Work Hours and Timekeeping*, we were concerned that similar over and undercharges of employee leave time existed throughout CDCR. We conducted some preliminary analyses and testing to determine whether employees' leave hours in 2010 were appropriately entered into the accounting system. Due to legislative changes in OIG's authority in 2011, we did not complete our review. However, in October 2011, we sent a letter to CDCR's Secretary notifying him of the potential problem and identifying four tentative recommendations to provide CDCR the opportunity to examine and correct the issue. Specifically, we recommended CDCR conduct an in-house audit and correct discovered errors; provide timesheet training to employees; evaluate personnel specialist and timekeeper staffing needs; and provide personnel-related rules and procedures training to personnel specialists, timekeepers, and their supervisors. In its Corrective Action Plan, updated in December 2011, the CDCR reported it had partially implemented three of the four recommendations and had developed a plan to address the remaining recommendation. The CDCR plans to complete its implementation of all four recommendations by December 2012.

ACCOUNTABILITY



Public accountability of the State's correctional system is crucial to enacting reforms and bringing transparency to CDCR's operations. In addition to conducting authorized special reviews, we review retaliation and favoritism complaints, and evaluate the governor's warden and superintendent candidates. During 2011, we also conducted regular facility inspections and assessed CDCR's progress in implementing prior recommendations.

Warden and Superintendent Evaluations

Penal Code Section 6126.6 requires that the OIG evaluate the qualifications of every candidate whom the governor nominates for appointment as a State prison warden or a youth correctional facility superintendent and report the recommendation in confidence to the governor. During 2011, by request from the Governor, the OIG began seven warden evaluations. Including those evaluations started in 2010, the OIG completed evaluations of eight warden candidates and presented its recommendations to the Governor's Office for final determination.

The California Department of Corrections and Rehabilitation's Monitoring of Employee Discipline (March 2011)

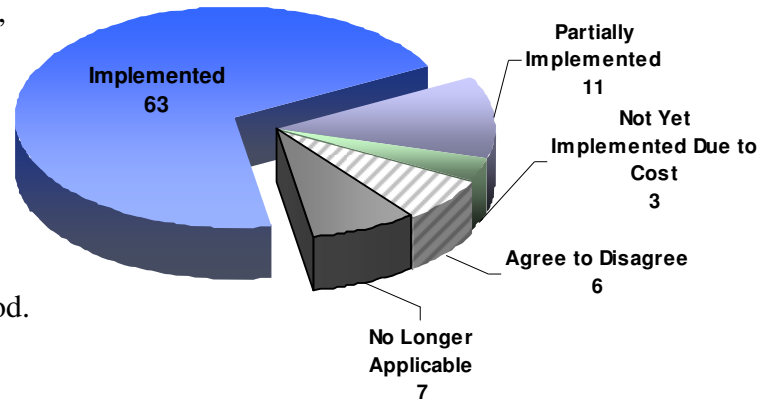
In March 2011, the OIG issued a special report on CDCR's imposition of disciplinary actions against employees who violate policies, State laws, or regulations governing employee conduct. We found employee discipline cases in which the prescribed monetary discipline was misapplied, causing employees to be either over- or under-penalized. In some cases, the prescribed discipline was not imposed at all. Finally, our report found cases in which financial penalties imposed upon disciplined employees were never collected. We made nine recommendations to CDCR in our report. In its January 2012 Corrective Action Plan, CDCR reported it had fully or substantially implemented four of the nine recommendations and has proposed action plans to address the five remaining recommendations. The CDCR intends to complete those action plans no later than January 2013.

2011 Accountability Audit (May 2011)

In May 2011, the OIG issued its 2011 Accountability Audit to assess progress of CDCR and the California Correctional Health Care Services (CCHCS) in implementing past recommendations. The audit covered 90 unresolved recommendations from nine prior reports and special reviews issued in 2008 and 2009.

The OIG found CDCR and the CCHCS satisfactorily implemented 70 percent of the OIG recommendations, and have partially implemented an additional 11 recommendations, with plans to fully implement the remaining 14 still applicable recommendations. This will represent an 86 percent acceptance and implementation rate for OIG recommendations made during this period.

Accountability Audit: Implementation status of 90 OIG recommendations from 2008-2009.



Letter: Out-of-State Facilities Follow-Up Review and Inspection (September 2011)

In September 2011, the OIG issued a letter to CDCR’s Secretary informing him of the results of our 2011 follow-up review of CDCR’s out-of-State incarceration program. During this review, we inspected two out-of-State facilities, the North Fork Correctional Facility in Sayre, Oklahoma in May 2011, and the Tallahatchie County Correctional Facility in Tutwiler, Mississippi in June 2011. Both facilities are operated by a private contractor, Corrections Corporation of America (CCA). This follow-up review focused primarily on whether CDCR took corrective action on 33 concerns we identified during our 2010 inspections of CDCR’s out-of-state facilities. Overall, we found CDCR fully or substantially corrected 18 issues and partially corrected 13 issues. Two remaining issues were not addressed: one related to family visiting video-conferencing and one related to inmates being provided with required classification documents.

In addition, we identified seven new concerns during our inspection of the two facilities. We found that CCA custody officers did not consistently document when administratively segregated inmates received or refused services such as meals, showers, or exercise, incorrectly logged 30-minute welfare checks for these inmates, inconsistently disciplined inmates in possession of serious contraband, and did not routinely conduct required cell searches. In addition, the subsidiary company used by CCA to transport inmates between States only carried inmate escape bulletins from one facility and did not use vehicles equipped with seat belts. Finally, we found that CDCR’s response to an inmate appeal could have been delayed up to three weeks since CDCR retrieved appeals only when a CDCR representative visited the facility.

In its Corrective Action Plan updated in January 2012, CDCR reported that it had fully or substantially implemented corrective actions to address six of the seven new concerns we identified during our 2011 inspection. In addition, of the 13 concerns remaining from our 2010 inspection that CDCR previously reported as only partially corrected, the CDCR now reports it has fully or substantially corrected 11 of them. The CDCR determined the remaining concerns from 2010 were either not applicable or would not be implemented.



It is incumbent upon CDCR to ensure inmate civil rights, such as adequate medical care, are protected. In 2008, under the authority of California law and at the request of the federal receiver, the OIG developed a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 33 adult prisons. In addition, we conducted several special reviews during 2011 where we identified civil rights issues.

Medical Inspections

During calendar year 2011, the OIG Medical Inspection Unit (MIU) conducted 26 medical inspections. The MIU also published 23 medical inspection reports plus a report analyzing the findings of the OIG following completion of the first cycle of inspections at all 33 prisons, which ended in June 2010. The second cycle of inspections at all 33 prisons was completed in December 2011. A cycle two report comparing the findings of cycle one and cycle two will be completed in calendar year 2012.

Summary and Analysis of the First Cycle of Medical Inspections of California's 33 Adult Prisons (May 2011)

In May 2011, the OIG reported on its completion of the first full cycle of medical inspections at all 33 prisons, which provided a baseline measurement for *Plata* litigation stakeholders.² The report analyzed and summarized the prisons' overall scores and their scores in up to 20 components of prison medical care. The report also included analysis of the scores in five general medical categories: medication management, access to medical providers and services, continuity of care, primary care provider responsibilities, and nurse responsibilities.

The cycle one inspections revealed that CDCR achieved an average weighted score of 72 percent for the provision of medical care overall. The inspections found 24 of the 33 prisons had low adherence to policies and procedures, 9 prisons moderately adhered, and no prison achieved high adherence. In general, all prisons scored particularly poorly in two areas: preventive services and inmate hunger strikes. We also assessed five general medical categories and noted two significant recurring problems: nearly all prisons were ineffective at ensuring inmates received their medications, and, in general, inmates had poor access to medical providers and services.

² We used the Receiver's scoring criteria for three levels of adherence to policies and procedures. We did not determine a constitutional standard of medical care. That determination remains with the Court.

In cycle one, it appeared that a system had not yet been implemented which would ensure CDCR medical policies and procedures and medical community standards are followed across the prison system. However, our cycle one inspections revealed that system-wide improvement can be achieved.

Summary and Analysis of the Second Cycle of Medical Inspections of California's 33 Adult Prisons

In December 2011, the MIU completed the second round of inspections at all 33 prisons. The remedial efforts that began as the result of the class action lawsuit *Plata v. Brown* continued in 2011 and preliminary results from the second round of inspections showed continuing improvement in the delivery of healthcare at all prisons. Analysis of the results from cycle two of the medical inspections will be published in 2012 in a separate report comparing the results of cycle one with cycle two and providing comparative results amongst all of the prisons.

Special Report: CDCR's Revised Inmate Appeal Process Leaves Key Problems Unaddressed (September 2011)

In September 2011, the OIG issued a special report regarding its review of CDCR's revised inmate appeal process that became effective on January 28, 2011. We concluded that some of the appeal process changes benefited both the department and the adult inmate and parolee populations. However, we identified three areas of concern.

- The revised appeal process lacks accountability. CDCR cannot verify an inmate submitted or that an institution employee delivered an inmate's appeal.
- Appeals coordinators do not provide inmates with the information necessary to resubmit a rejected appeal.
- CDCR's rapid implementation of the revised appeal process caused confusion and presented additional challenges.

We made nine recommendations in the report to provide further accountability in the inmate appeal process. In its Corrective Action Plan, updated in December 2011, CDCR reported it had substantially or partially implemented seven of the nine recommendations and expects to complete its implementation of the remaining two recommendations by June 2012.

Letter: Review of CDCR's Religious Programs (September 2011)

The OIG completed a review of CDCR's religious programs in September 2011 and sent a letter report to CDCR's Secretary informing him of our findings. We determined CDCR did not provide consistent and detailed guidelines to its prisons regarding permissible religious practices, meals, and artifacts. Due to the absence of departmental rules, some prisons developed their own rules which sometimes conflicted with other prisons. We found inmates may have used these conflicts as the basis for inmate grievances, and as a result, CDCR may have needlessly exposed itself to litigation.



We also found CDCR could have improved inmate access to chaplaincy services by hiring chaplains according to its inmate demographics and maximizing its volunteer base. We suggested CDCR consider using a statewide volunteer database coupled with a standardized process for clearing volunteers.

We made five recommendations to CDCR in this review. In its January 2012 Corrective Action Plan, the CDCR reported it had partially implemented four of the five recommendations and expects to complete the implementation of all five recommendations by December 2012.

Letter: Allegations of Inmate Civil Rights Abuse at High Desert State Prison (October 2011)

In October 2011, the OIG issued a letter to the Senate Rules Committee to report the results of our review into various potential civil rights violations, policy failures, and improper activity in the Z-Unit at High Desert State Prison (HDSP). Although we determined that the majority of the allegations were unfounded, we identified four concerns related to inconsistent laundry exchange practices, lack of policy direction for staff regarding cold weather searches, inadequate law library access, and failure to provide inmates the required 10 hours of exercise yard-time per week. We made nine recommendations to prison management addressing those concerns. In its October 2011 Corrective Action Plan, the CDCR reported it had fully implemented all nine of the recommendations.

Letter: CDCR's Response to the July 2011 Inmate Hunger Strikes (October 2011)

In October 2011, the OIG issued a letter to the Senate Rules Committee to report on our review of CDCR's response to the inmate hunger strikes that occurred at Pelican Bay State Prison during the time periods July 1-20, 2011 and September 26, 2011 through October 13, 2011.

Pelican Bay inmates initiated a hunger strike on July 1, 2011 protesting CDCR's policy regarding gang validation and indeterminate Security Housing Unit (SHU) confinement. This strike eventually spread statewide and ended on July 20, 2011. CDCR met with striking inmates and agreed to conduct a comprehensive review of SHU policies and to revisit the gang validation process. In addition, CDCR agreed to provide other privileges to those inmates housed in the SHU. On September 26, 2011, inmates reinitiated their hunger strike alleging that CDCR had not followed through on promises that were made at the end of the first hunger strike.

At the end of the first hunger strike, CDCR established an advisory group to address inmates' primary concerns about prison gang validation processes, SHU policies, and food service. In our review, conducted during the second hunger strike, the OIG determined that CDCR made good faith efforts to honor commitments it made to inmates at the conclusion of the July hunger strike regarding expanded privileges. In addition, we found that CDCR made significant progress in establishing standardized statewide policies and procedures for hunger strikes. Furthermore, our inspectors examined post-hunger strike Rules Violation Reports (RVRs) that were issued after the July hunger strike. Inmates alleged that they were retaliated against for their hunger strike activity. While we noted an increase in the enforcement of gang related RVRs immediately following the hunger strike, they appeared to be legitimately justified. The second hunger strike ended following our review of the hunger strike issues.

We recommended CDCR continue its current efforts to completion, determine if the new hunger strike medical practices and policies were effectively implemented, and ensure discipline was fairly and consistently applied to inmates following the hunger strikes. OIG also inserted a monitor into the Wardens Advisory Group formed by CDCR to review current gang management programs and to develop recommendations for improvement.

The OIG continues to monitor CDCR's efforts in this area, and will review the final revised SHU and gang policies. To date, we have made a total of five recommendations to CDCR to address areas of concern. In its October 2011 Corrective Action Plan, CDCR reported that four of those five recommendations were fully or partially implemented. For one other recommendation, reported as not implemented, CDCR plans to complete its corrective action to address the recommendation by April 2012.



National research has revealed that for every \$1.00 invested in rehabilitation programs for offenders, at least \$2.50 is saved in correctional costs.³ In 2011, the California Rehabilitation Oversight Board within the OIG continued to examine CDCR's progress in implementing and providing rehabilitation programs.

The California Rehabilitation Oversight Board

The OIG's mission was broadened in May 2007 with the enactment of the Public Safety and Offender Rehabilitation Services Act of 2007 (Assembly Bill 900). The legislation established the California Rehabilitation Oversight Board (C-ROB) within the OIG. Chaired by the Inspector General, C-ROB is a statewide board of 11 members who have expertise in State and local law enforcement, and in the education, treatment, and rehabilitation of criminal offenders.

C-ROB regularly met and reported to the governor and the Legislature on the rehabilitative programming CDCR provided to the adult inmates and parolees under its supervision. By statute, these reports addressed findings in the following areas:

- Effectiveness of treatment efforts for offenders.
- Rehabilitation needs of offenders.
- Gaps in rehabilitation services.
- Levels of offender participation and success.

C-ROB published two reports during 2011, one in March and the other in September 2011. The reports addressed CDCR's progress in implementing and providing rehabilitative programming between July 2010 and July 2011. In its September report, C-ROB described how CDCR reassessed its academic service delivery models and replaced its five academic models with three academic structures, and the board expressed its concern about CDCR's implementation of AB 109 (Public Safety Realignment), which will reduce CDCR's inmate population by shifting the incarceration and supervision of low level offenders to the counties.

³ "California Rehabilitation Oversight Board Amended Biannual Report, March 15, 2011," Office of the Inspector General, Sacramento, Ca. March 15, 2011, p. 1.

Also, the board expressed its concern about the \$101 million reduction in CDCR's rehabilitative programming budget for fiscal year 2011/12, on top of the \$250 million reduction in fiscal year 2009/10. The board urged the Governor, the Legislature, and the department itself to place a moratorium on any future budget cuts to rehabilitative programming.

C-ROB reports are available on the OIG's website at:
<http://www.oig.ca.gov/pages/c-rob/reports.php>

CHAPTER 2: ANNUAL REPORT OF MONITORING ACTIVITIES

California Penal Code Section 6133(c)(1) mandates the OIG publish a summary of its oversight of CDCR internal misconduct and use-of-force allegations. Prior to July of 2011, the OIG monitored these areas through its Bureau of Independent Review (BIR). Following the reorganization of the OIG as previously discussed, these activities continue to be conducted by the OIG's regional Discipline Monitoring Units (DMU).

Critical Incident Monitoring

Since its inception, the OIG has maintained a notification process with CDCR for critical incidents within the department including, but not limited to: use of deadly force, unexplained deaths in custody, homicides, suicides, large scale riots, escapes, and other serious incidents. The OIG maintains regional on-call monitors who can respond 24/7 to critical incidents that are reported to our office from any of the State's correctional institutions. The OIG monitors the incident and any subsequent investigation with special emphasis on determining what led up to the incident, whether it was handled appropriately, and what, if any, action should be taken afterward. At times, the OIG will recommend a secondary personnel investigation if neglect or misconduct is suspected. Other times, the OIG may recommend policy or practice evaluations to prevent future occurrences or to conform to best practices. In some instances, the OIG obtains a systemic viewpoint on a particular issue that needs to be addressed statewide. In 2011, the OIG monitored 190 critical incidents.

Internal Affairs and Discipline Process Monitoring

The OIG monitoring of CDCR's internal employee discipline cases includes monitoring of the complaint intake process, the investigation phase by CDCR's Office of Internal Affairs (OIA), the decision-making process by the hiring authorities, and the handling of the matter by the CDCR attorneys or vertical advocates, referred to as the department's Employee Advocate Prosecution Team (EAPT) - all the way through State Personnel Board proceedings, if necessary. During 2011, the OIG published two reports, one in

April and one in October. These reports covered 453 monitored disciplinary cases and documented the performance by the department.

Use-of-Force Reviews

The OIG monitors CDCR's use-of-force review process. In 2011, CDCR reported 7,762 use-of-force incidents in the adult program. The OIG attended 206 use-of-force review meetings at the department, and performed an additional 2,747 use-of-force reviews. In addition, the OIG participated as a non-voting member of CDCR's Deadly Force Review Board.

In August 2010, the CDCR implemented a new use-of-force policy with input from the OIG. On November 18, 2011, the OIG published its first report discussing our monitoring of CDCR's use-of-force process for the period of September 2010 through June 2011. Within our November 2011 use-of-force report, we made five recommendations to CDCR to improve its use-of-force practices and policies.⁴ We will continue issuing reports semi-annually, containing our use-of-force review results.

Detailed assessments of the OIG's case monitoring activities and use-of-force reviews are found in its semi-annual reports posted on the OIG's website at: <http://www.oig.ca.gov/pages/reports/bir-semi-annual-sar.php>

⁴ Because we issued this report in late November 2011, we did not ask CDCR to provide the status of corrective actions taken to address our recommendations. We will report on current corrective action in our 2012 Use-of-Force report.

APPENDIX: REVIEWS RELEASED IN 2011

Medical Inspection Reports

- California State Prison, Sacramento - Medical Inspection Results (February 2011)
- California Institution for Women - Medical Inspection Results (March 2011)
- California Medical Facility - Medical Inspection Results (March 2011)
- Richard J. Donovan Correctional Facility - Medical Inspection Results (April 2011)
- California Rehabilitation Center - Medical Inspection Results (April 2011)
- Centinela State Prison - Medical Inspection Results (May 2011)
- Pleasant Valley State Prison - Medical Inspection Results (May 2011)
- Central California Women's Facility - Medical Inspection Results (May 2011)
- California Men's Colony - Medical Inspection Results (June 2011)
- Sierra Conservation Center - Medical Inspection Results (June 2011)
- North Kern State Prison - Medical Inspection Results (August 2011)
- California State Prison, Los Angeles County - Medical Inspection Results (September 2011)
- California Correctional Institution - Medical Inspection Results (September 2011)
- Valley State Prison for Women - Medical Inspection Results (September 2011)
- Kern Valley State Prison - Medical Inspection Results (September 2011)
- California Substance Abuse Treatment Facility and State Prison, Corcoran - Medical Inspection Results (September 2011)
- San Quentin State Prison - Medical Inspection Results (September 2011)
- Deuel Vocational Institution - Medical Inspection Results (October 2011)
- High Desert State Prison - Medical Inspection Results (October 2011)
- Folsom State Prison - Medical Inspection Results (November 2011)
- California Correctional Center - Medical Inspection Results (December 2011)
- California State Prison, Corcoran - Medical Inspection Results (December 2011)

- Correctional Training Facility - Medical Inspection Results (December 2011)
- Summary and Analysis of the First Cycle of Medical Inspections of California's 33 Adult Prisons (May 2011)

One-Year Warden Reviews

- Mule Creek State Prison Warden Michael Martel One-Year Audit (April 2011)
- Salinas Valley State Prison Warden Anthony Hedgpeth One-Year Audit (April 2011)
- Deuel Vocational Institution Warden Socorro Salinas One-Year Audit (May 2011)
- California Correctional Institution Warden Fernando Gonzalez One-Year Audit (May 2011)

Special Review Reports

- The California Department of Corrections and Rehabilitation's Monitoring of Employee Discipline (March 2011)
- Special Report: Mule Creek State Prison Must Improve Its Oversight of Some Employees' Work Hours and Timekeeping (April 2011)
- California Prison Health Care Receivership Corporation's Use of State Funds for Fiscal Year 2009-2010 (April 2011)
- California Department of Corrections and Rehabilitation's Implementation of the Non-Revocable Parole Program (May 2011)
- 2011 Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation 2010-2011 (May 2011)
- Special Report: CDCR's Revised Inmate Appeal Process Leaves Key Problems Unaddressed (September 2011)

Special Review Letter Reports

- Review of CDCR Accounts Receivable from Employee Wage and Benefit Overpayments (September 2011)
- Review of CDCR's Religious Programs (September 2011)
- Out-of-State Facilities Follow-Up Review and Inspection (September 2011)
- Review of Operations at California State Prison, Sacramento (September 2011)
- Preliminary Review of CDCR Employee Leave Transactions (October 2011)

- Review of CDCR Employee Leave Accruals (October 2011)
- CDCR's Response to the July 2011 Inmate Hunger Strike (October 2011)
- Allegations of Inmate Civil Rights Abuse at High Desert State Prison (October 2011)

California Rehabilitation Oversight Board (C-ROB)

- March 15, 2011 C-ROB Biannual Report
- September 15, 2011 C-ROB Biannual Report

Quarterly Reports ⁵

- Quarterly Report July – September 2010 (January 2011)
- Quarterly Report October – December 2010 (May 2011)
- Quarterly Report January – March 2011 (July 2011)
- Quarterly Report April – June 2011 (September 2011)

Semi-Annual Reports

- Bureau of Independent Review Semi-Annual Report, July – December 2010 (April 2011)
- Bureau of Independent Review Semi-Annual Report, January – June 2011 (October 2011)
- Initial Report on Use of Force within the CDCR, September 2010 – June 2011 (November 2011)

Annual Report

- 2010 Annual Report (October 2011)

⁵ Because of legislation enacted in 2011, the OIG no longer issues quarterly reports.



ANNUAL REPORT

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STATE OF CALIFORNIA
March 2012