Robert A. Barton
Inspector General

Office of the Inspector General

2016 ANNUAL REPORT

February 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer

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FOREWORD

OIG Mission
To safeguard the integrity of the State's correctional system by providing oversight and transparency through monitoring, reporting, and recommending improvements on policy and practices of the California Department of Corrections and Rehabilitation.

OIG Vision
To transform the State's correctional system into a model for inmate rehabilitation, employee conduct, health care delivery, and transparency in correctional programs.

As I write this, I realize that it will be the last annual report of my current term as Inspector General. This realization causes reflection not only on what the agency has done this last year, but what we have done for the past five years. I would be remiss if I did not acknowledge the hard work and dedication of my staff over that time, and the staff of the California Department of Corrections and Rehabilitation (CDCR or the department) who have made great strides in improving the correctional system in California for the benefit of all.

When I began my term in 2011, the Inspector General's office was in turmoil and required a complete reorganization and new focus on accomplishing its mission. There were massive budget cuts, a change of statutory authority, new mandates, and a new Administration with a bold vision for the future of the correctional system. A system was envisioned where offenders could be rehabilitated, public safety could be protected upon their release, and future victimization of citizens would be reduced. During this time recidivism has dropped from 67 percent to 44 percent, inclusive of those who have been re-incarcerated locally as a result of AB 109. Severe overcrowding and the problems that go with it have greatly diminished. The discipline system that ensures legitimacy within the system has improved. The rehabilitation opportunities have multiplied, and staff and inmates alike are supporting a culture that values positive change more than ever before.

The Office of the Inspector General (OIG) over this time has constantly grown and changed, adding value to the system by providing transparent oversight and recommendations for improvement in several different critical areas. Gains have been achieved by forging working relationships with CDCR and policy makers emphasizing our shared goal of improving the correctional system; a monumental task given the size and complexity of the California Department of Corrections and Rehabilitation. There is still much more that can be done, but we have also come a long way from the time when suspicion of corruption within the system was a daily news item, and accusations of abuse were commonplace. One of the major benefits of an independent oversight agency is the transparency it provides for everyone. Bad things can, and do still happen within prisons, but the alleged layer of secrecy and *cover-ups* is much less possible given the role of our agency and the unfettered access we have to the prisons.

The OIG role continues to expand as new challenges are identified. For example, the OIG has consulted and provided expertise and personnel to assist the California Health and Human Services Agency with the creation of its own internal affairs and discipline oversight program.

The OIG staff and I go to great lengths to educate the diverse stakeholders about our agency and what it offers the correctional system. We are constantly in the prisons and meeting with people

and organizations inside and outside of CDCR. The OIG complaint Intake process has become more interactive, and we now report on those complaints that are referred out to our regional staff in the field who can problem solve directly with wardens and key prison staff. This would not be possible without the cooperation we have developed over the last several years. OIG powers are generally limited to making recommendations, but when the department knows we share its goals for improvement, and the focus is on solving problems rather than advertising blame, there is more willingness to work together.

We have also increased our monitoring and reporting of Sexual Abuse in Detention Elimination Act (SADEA) cases and encourage the department to continue its forward progress in this area. Once again, when problems like prison rape are taken seriously, and inmates have an outlet for their concerns, it builds legitimacy that encourages both the incarcerated, and their families, to buy into a justice system they previously rejected.

The Office of the Inspector General has also grown in other ways. During my term, we have established a contraband watch monitoring program that has seen the use of this procedure diminish dramatically. The time people are kept on contraband watch has also drastically reduced. This is a significant cost-savings, and eliminates many of the prior concerns about potential abuses of the process, health risks to offenders, as well as the subsequent lawsuits they engendered. The OIG use-of-force monitoring program has evolved and embraced technology that allows us to monitor trends in a way that can serve as an early warning system for potential areas of concern. The OIG shares this information with the department on a regular basis, and the OIG has redoubled efforts to review a higher percentage of use-of-force incidents than ever before. Officer training in this area is critical, as improper application of force can cause danger to staff, needless injuries, abuse, complaints and lawsuits. It also may illustrate where bigger problems exist.

The OIG plays a role in the risk management of critical incidents within the prisons. OIG staff respond 24 hours per day, 7 days per week to homicides, large scale riots, deadly force incidents, and other critical incidents within CDCR. The OIG presence provides transparency for the public and enhanced confidence that matters will be handled in a thorough and fair manner with outcomes that are appropriate. This is another area where the OIG presence within the individual prisons on a constant basis benefits the interaction and ability to *get it right*.

Perhaps one of the biggest evolutions within the OIG has been the ever more crucial role our Medical Inspection Unit serves for the system. Over the last few years it has gone through a metamorphosis. What started as a simple medical policy auditing function has now become a full compliance and quality evaluation monitoring and reporting team, staffed by qualified medical experts. This role is much more aligned with our statutory mandate. As a result, there is now an attendant benefit to the state and inmates. The OIG reports are now utilized by the department to make improvements to healthcare that benefit the inmates, and are considered by the Federal Receiver and the Federal Court as one factor in determining the cessation of the long-running *Plata* lawsuit. The main goal is ensuring adequate healthcare is provided. This in turn also adds to the legitimacy of a prison system that is among the largest in the world.

Another duty the OIG takes very seriously, given the impact on the entire system, is the review of qualifications and recommendations for warden and superintendent placements. In my term, I have personally been involved in this process at every institution in the system and some more than once. I have conducted over 60 such reviews and as a result have met many promising

executives who can help CDCR progress into the future. I can say without hesitation that as an overall group, the current wardens are the most supportive of programming and public safety since I started with the OIG in 2005.

The OIG in my term has created a unit dedicated to the assessment and oversight of rehabilitation efforts within CDCR. This unit helps to fulfill not only the duties of the California Rehabilitation Board (C-ROB) by conducting fieldwork to determine the status of programming, but also assists in monitoring CDCR's adherence to its rehabilitation goals as stated in its strategic plans (the *Blueprint* and the follow up to the *Blueprint*). The OIG's rehabilitation unit continually travels to prisons and researches what is working in California and elsewhere. This work goes into reports that are published on the current successes and challenges within the system. They too make recommendations to CDCR staff regarding programming opportunities.

As demonstrated by the Department's response to the OIG's recommendations, our reporting on all these efforts has had a meaningful impact. Since 2012, we have made 169 recommendations in our Special Review, C-ROB, Semi-Annual, and Use-of-Force reports. This is in addition to the specific recommendations given to individual prisons in our medical reports. Eighty-three of those recommendations have been fully implemented, 17 substantially implemented, 32 partially implemented, 10 still pending, and only 27 (16 percent) have not been implemented. All of the OIG's reports are available on the website, and this annual report explains OIG's function in more detail.

The credit of course for any of the gains achieved in California's correctional system goes to the hardworking and conscientious staff doing a very difficult job, very well, every day. It also goes to an Administration and policymakers that value the possibility of human redemption and how that approach benefits public safety for all of us in the long run. Finally, recognition should also be given to dedicated volunteers and the many entities outside of the 'system' that also dedicate countless hours to its improvement. The OIG's existence and vigilance is now an integral part of keeping the system on track, continuing to move in a positive direction, and ensuring that gains already achieved are not lost.

Robert A. Barton
Inspector General

OIG OUTREACH

The Office of the Inspector General (OIG) constantly seeks opportunities to better assess and recommend improvements within the California Department of Corrections and Rehabilitation (CDCR or the department). This requires communication with departmental staff, the institutions, and outside stakeholders. The OIG also educates these entities about the OIG mission and solicits input from them. Finally, the OIG searches for ways to discover best practices to recommend for the State's correctional system. All of this requires constant outreach by the agency.

The OIG provides public transparency for the state correctional system. One of the ways to have an impact and become aware of issues within corrections is to have a personal presence within the institutions. In addition to daily presence through OIG staff monitoring and providing on-scene response to incidents, the Inspector General or Chief Deputy Inspector General visits every adult institution and youth correctional facility at least once annually. In 2016, the Inspector General conducted 35 institution visits and the Chief Deputy Inspector General conducted 13 institution visits. The Inspector General and Chief Deputy Inspector General also visited the two out-of-state correctional facilities that house California inmates—Tallahatchie County Correctional Facility in Mississippi, and La Palma Correctional Center in Arizona. In total, the Inspector General and Chief Deputy conducted 50 institution visits in 2016.

Above and beyond the staff who monitor systems within the prisons on a daily basis, OIG staff are specifically tasked to assess the rehabilitation and education operations as part of a review for the California Rehabilitation Oversight Board (C-ROB) and *Blueprint* monitoring function at least twice per year.

The Office of the Inspector General staff make presentations to the CDCR Office of Internal Affairs academy regarding the role and function of the OIG. OIG also presents to correctional officer candidates in the Galt academy, and at CDCR leadership conferences. Additional presentations on the OIG's role and function were provided to various entities when requested, such as the Division of Adult Parole Operations, Life Support Alliance, the American Civil Liberties Union (ACLU), Statewide Inmate Family Council, etc.

The OIG continues to liaise with senior management at the department. The Inspector General meets monthly with the Secretary of CDCR, the Director of Rehabilitative Programs, and the Director of Adult Institutions. The Inspector General also meets regularly with representatives from the Legislature and Governor's office. The Chief Deputy Inspector General holds monthly meetings with the Director of Adult Institutions, the Director of Adult Parole Operations, the Chief Counsel for the Office of Legal Affairs, and the Director of Internal Oversight and Research. These meetings allow for high-level discussions of issues and problems and their timely resolution. In addition, the Assistant Chief Deputy Inspector General has monthly meetings with the Chief Counsel for the Employment Advocacy and Prosecution Team, the OIA Chief of Field Operations, the Deputy Director for the Office of Internal Affairs, the regional Assistant Chief Counsels for the Employment Advocacy and Prosecution Team, and regional Special Agents in Charge for the Office of Internal Affairs. These meetings delve into more day-to-day operational issues and have been extremely helpful in resolving issues at the field

level. The Inspector General and OIG staff also attend noteworthy events throughout the State to maintain contact with the department and the public in order to educate and establish working relationships with stakeholders.

The Inspector General personally:

- Attended and presented at the annual National Association for Civilian Oversight of Law Enforcement (NACOLE) conference
- Attended CDCR's Medal of Valor Ceremony hosted by the California Correctional Supervisors Organization
- Attended the 23rd annual community service awards dinner for the Asian Peace Officers Association, Inc.
- Contributed to an article for the California Schools quarterly publication "Breaking the Silence"
- Attended the Anti-Recidivism Coalition's screenwriting workshop world premiere of "They Call Us Monsters" at the Los Angeles film festival
- Presented at the Mountain Oaks Adult Education Center Commencement Ceremony
- Spoke at the Golden Hills Adult School training event at Avenal State Prison
- Presented at the Office of Correctional Education's central region staff development conference
- Spoke at the Children of Incarcerated Parents conference presented by Friends Outside of Los Angeles County
- Attended the California Prison Industry inmate graduation at the Folsom Women's Facility
- Attended and presented at CDCR's Warden's meeting in Galt
- Attended and presented at the Division of Adult Parole's Administrative Professional's Development Training in Fresno

Children of Incarcerated Parents Conference

Folsom Women's Facility Graduation Ceremony

Staff of the OIG from the C-ROB, Publications, and Rehabilitation unit:

- Observed 45 inmate leisure time rehabilitative program groups at 35 institutions
- Participated in the Reentry Solutions training conference
- Participated in CDCR's Internet Protocol Television Integration Content Selection Committee
- Participated in the Prison University Project Training Conference

- Coordinated an agency-wide book drive collecting over 1,500 books for CDCR libraries and a local women and children's shelter
- Attended briefings on crime trends and prison capacity challenges held at the Public Policy Institute of California in Sacramento
- Attended Lifer Awareness Group, an inmate-led activity group, graduation at California Men's Colony
- Participated in University of California, San Diego (UCSD) Cross-Training for custody staff and contracted treatment providers
- Participated in the 2016 California Coalition on Sexual Offending training conference

Other staff of the OIG:

- Presented and attended quarterly Prison Crimes Council meetings with CDCR
- Coordinated an agency-wide toy and clothing drive for Saint John's women's shelter for at-risk women with children
- Participated in an annual OIG All-Staff meeting that included CDCR speakers and other stakeholders

Expert Assistance Provided to the California Health and Human Services Agency

Pursuant to consultations with the Governor's office, the legislature, and the California Health and Human Services Agency (CHHS), the OIG has continued to provide expert assistance in the creation of a discipline oversight and monitoring program for the California Department of Developmental Services and the Department of State Hospitals. The OIG has provided two highly experienced monitors on a contractual basis to help develop a robust internal affairs program, an independent monitoring program for the handling of discipline cases and a transparent public reporting process. The OIG is committed to providing ongoing assistance to CHHS.

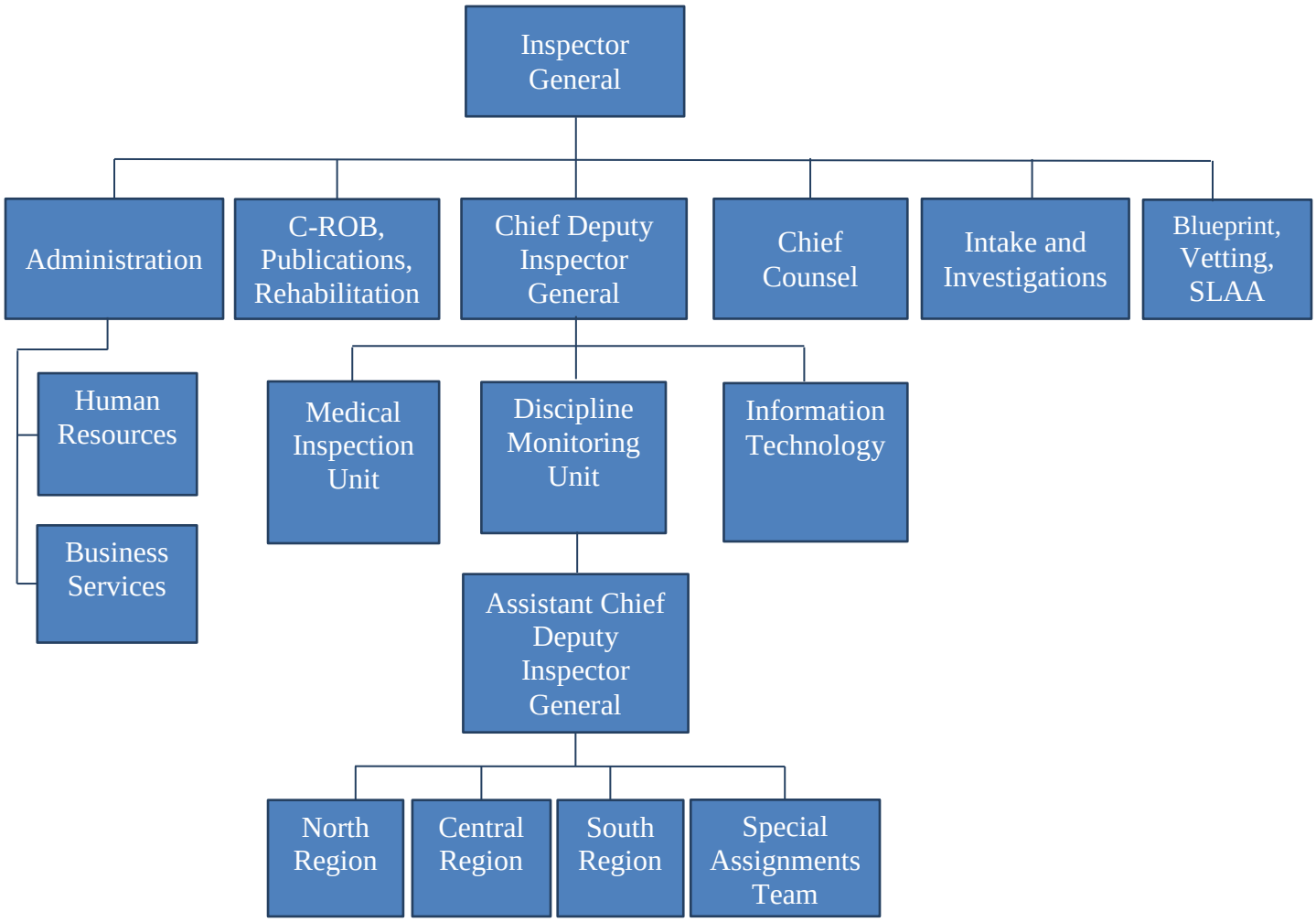
ORGANIZATIONAL OVERVIEW

The OIG is organized into three regions: North, Central, and South. The North Region is co-located with executive and administrative operations in Sacramento (Rancho Cordova), the Central Region is in Bakersfield, and the South Region is in Rancho Cucamonga.

California Penal Code Sections 2641 and 6125 et seq. provide the statutory authority for the OIG's establishment and operations. The OIG staff is a skilled team of professionals, including attorneys with expertise in internal affairs investigations, criminal law, and employment law, as well as inspectors knowledgeable in correctional policy, operations, and investigations.

The OIG also has a cadre of medical professionals in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. There are also analysts and various support staff within the OIG, all of whom are integral in achieving the OIG mission.

OIG Organizational Chart



FUNCTIONS OF THE OFFICE OF THE INSPECTOR GENERAL

California Penal Code Section 6125 establishes the Office of the Inspector General as an independent agency and provides for the Inspector General to be appointed to a six-year term by the Governor, subject to Senate confirmation. Robert A. Barton was appointed on August 29, 2011, and his term will expire in 2017.

California Penal Code Sections 2641 and 6125 et seq. set forth the functions of the Office of the Inspector General.

Statewide General Intake

The OIG maintains a statewide intake process to receive communications from any individual regarding allegations of improper activity within CDCR. Any complaints of misconduct are brought to the department's attention.

The OIG Intake Unit logs, reviews, analyzes, and responds to every non-duplicative complaint it receives. Intake Unit staff screen all complaints within 24 hours of receipt to identify potential safety concerns. During 2016, Intake Unit staff contacted institutions 38 times indicating potential safety concerns based on letters and messages left on the toll-free public phone line, calls received on the main OIG telephone number, and complaints submitted electronically. These complaints expressed potentially unsafe conditions, such as enemy concerns, threatening behavior, or other indicators that there may be a safety or security risk for staff or inmates. Intake Unit staff request CDCR provide a status of the situation to ensure the department rectifies any safety concerns and provides appropriate intervention to mental health inmate patients.

In non-urgent matters, staff directly contact institutional personnel to remedy issues that may be addressed informally, such as failure to accept an appeal, failure to schedule a classification hearing, or failure to schedule medical appointments. The Intake Unit focuses OIG staff resources on the most serious complaints by using a matrix of common prison issues that receive priority attention. Lack of access to grievance processes or health care, serious due process violations, unnecessary extended stays in segregation units, sexual abuse, serious staff misconduct, and inappropriate uses of force are among the higher priority issues in the matrix. However, if a trend of lesser policy violations is identified, the Intake Unit makes efforts to remedy any potential systemic issues. In most instances, the Intake Unit encourages complainants to utilize CDCR's grievance processes to resolve their issues before contacting the OIG; therefore, lack of access to the grievance process or unjustified rejection of appeals by CDCR staff often receive the most attention from Intake Unit staff.

When Intake Unit staff finds potential misconduct or policy violations after reviewing complaints and corresponding CDCR documents, those cases are presented at a meeting every two weeks with the Inspector General for consideration of referral to OIG regional field staff. In the field, OIG staff make recommendations to CDCR administrators to remedy identified issues, usually resulting in simple, informal fixes, such as the training of staff, the initiation of inquiries, or use-of-force reviews to determine whether misconduct may have occurred. If CDCR initiates a formal investigation, OIG regional staff monitors the case in accordance with the OIG's normal discipline monitoring activities and reports the findings in the Semi-Annual Report.

Complaints alleging theft, fraud, or waste of State resources concerning CDCR are also

presented to the Inspector General for consideration of referral to the California State Auditor.

In 2016, the OIG's Intake Unit received 2,851 general complaints submitted by inmates, parolees, families, CDCR employees, and advocacy groups, including 32 complaints the Office of the Governor assigned the OIG to review. Intake Unit staff conducted additional research into matters or requested clarifying documentation from CDCR institutions for 1,409 of these complaints.

The OIG's Intake Unit received 321 complaints alleging inappropriate healthcare, lack of access to healthcare, or both. OIG Intake or medical staff conducted additional analysis of these medical, dental, and mental health complaints. The OIG referred 7 of the 321 complaints to CDCR's Division of Correctional Health Care Services or CDCR (institutions with delegated authority for medical operations) for remedy where the OIG determined potential violations of medical policies or procedures occurred.

Field Inquiries

Since its inception, the OIG has provided a process by which inmates, CDCR staff, and the public can report misconduct. The OIG examines complaints received and assigns staff to conduct field inquiries regarding the complaints at the institutions. In 2016, the OIG referred 70 field inquiries to the OIG's regional operations teams to bring the matters to the attention of the specific institutions and to monitor departmental response at the local level. The results of CDCR's response to OIG's inquiries are included in the OIG's Semi-Annual report. OIG's inquiries are limited to finding out if the hiring authority is aware of the problem, and to recommend appropriate action. OIG staff do not conduct investigative activities.

CDCR Oversight Activities

Retaliation Claims

California Penal Code sections 6128 and 6129 authorize the OIG to receive and review complaints of retaliation levied against members of CDCR management by CDCR employees. The OIG's Legal Services Unit analyzes the allegations of each complaint to determine whether the complaint states a prima facie case of retaliation. If the complaint meets this initial legal threshold, the OIG initiates an investigation into the allegations and determines whether retaliation occurred. If the OIG determines a CDCR employee was subjected to unlawful retaliation, the OIG provides a report of its findings to CDCR along with a recommendation for appropriate corrective action.

At the beginning of 2016, there were two complaints and one investigation pending from 2015. The OIG concluded the investigation and completed its review of those two complaints, neither of which stated a prima facie case of retaliation. In 2016, the OIG received nine new retaliation complaints. The Legal Services Unit completed analyses of seven complaints and determined none stated a prima facie case of retaliation. Two complaints are still pending.

Sexual Abuse in Detention Elimination Act Ombudsperson Claims (also referred to as Prison Rape Elimination Act claims)

California Penal Code Section 2641 directs the OIG to act as the ombudsperson for complaints related to sexual abuse in detention. The OIG is tasked with reviewing allegations of mishandled sexual abuse investigations within correctional institutions, maintaining the confidentiality of sexual abuse victims, and ensuring

impartial resolution of inmate and ward sexual abuse complaints.

CDCR notified the OIG of 396 sexual abuse allegations during 2016, including 252 with a staff member as the alleged perpetrator, and 144 with an inmate as the alleged perpetrator. The OIG monitors CDCR's handling of all sexual abuse allegations and all subsequent investigations of alleged staff involvement.

In order to fulfill the independent role of SADEA ombudsperson, the OIG supplies informational posters to all the adult institutions, Division of Juvenile Justice (DJJ) facilities, and parole offices explaining how to report SADEA allegations. As a result, the OIG SADEA Ombudsperson received and reviewed 167 complaints directly from inmates, family members, and third parties. Most, but not all, of these allegations were also included in the allegation notifications from CDCR listed above.

Seventeen of those contacts requested general SADEA information which was provided, and 13 complaints alleged inadequate investigation by CDCR. Twenty-seven of the complaints were referred to the OIG regional offices to follow up and make recommendations for resolution.

The complainant first notified the OIG of 16 allegations of sexual abuse or sexual harassment which the OIG referred directly to CDCR to conduct an initial investigation or inquiry. This third-party reporting process increases transparency and provides another reporting method for inmates who are concerned with reporting the alleged abuse or harassment directly to CDCR staff.

Monitoring Activities

The OIG's Discipline Monitoring Unit provides contemporaneous oversight of CDCR's internal affairs investigations and employee discipline process. The OIG also oversees CDCR's response to critical incidents within the institutions and monitors the department's contraband surveillance watch process and use-of-force reviews.

Internal Affairs and Employee Discipline Monitoring

The OIG's monitoring of CDCR's internal affairs and employee discipline cases includes the OIA allegation intake process, the investigative phase by CDCR's Office of Internal Affairs, the decision-making process by the hiring authorities, and the handling of the matter by the CDCR Employment Advocacy and Prosecution Team attorneys (referred to as "vertical advocates"). Monitoring includes all case activity, up to and including State Personnel Board proceedings, if necessary. The Semi-Annual Reports document the department's adherence to its operating rules and procedures as well as the quality of the investigation and legal representation regarding employee discipline. In 2016, the OIG opened 679 employee discipline cases for monitoring. California Penal Code Section 6133(b)(1) mandates the OIG publish a Semi-Annual Report of its oversight of CDCR.

Closed discipline cases are reported in Volume I of the OIG's Semi-Annual Report: www.oig.ca.gov/pages/reports.php

Critical Incident Monitoring

The OIG maintains regional on-call staff who can respond on site 24-hours-per-day to critical incidents reported to the OIG from any of the State's correctional institutions. In 2016, the OIG monitored 204 critical incidents.

The OIG monitors a critical 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. If the facts appear to show neglect or misconduct, OIG staff will recommend, and subsequently monitor, any investigation. The OIG may recommend policy changes to prevent future occurrences and conform to best practices. In some instances, the OIG has identified systemic issues and made recommendations statewide or at a specific institution.

Critical incident case summaries are reported in Volume II of the OIG's Semi-Annual Report, available at: www.oig.ca.gov/pages/reports.php

Contraband Surveillance Watch

The OIG monitors the department's contraband surveillance watch process to ensure it is conducted within departmental policy and not used for punitive purposes.

Department staff notify the OIG any time an inmate is placed on contraband surveillance watch. The OIG reviews all relevant data regarding the use of contraband surveillance watch. Additionally, whenever the department keeps an inmate on contraband surveillance watch longer than 72 hours, the OIG goes on scene to inspect the inmate's condition, and ensures the department is following its policies. This on-scene process continues every 72 hours until the department removes the inmate from contraband surveillance watch. The OIG immediately discusses serious breaches of policy with institution managers.

In 2016, the OIG was notified of 238 contraband surveillance watch cases, 70 fewer than in 2015. Of the 238 notifications in 2016, the OIG monitored 72 cases that extended beyond 72 hours, as compared to 101 cases extending beyond 72 hours in 2015. The continued decrease in the need and length of contraband surveillance watch is a positive trend.

Contraband surveillance watch reports are found in Volume II of the OIG's Semi-Annual Report, at: www.oig.ca.gov/pages/reports.php

Use-of-Force Monitoring

The OIG continues to monitor the department's use-of-force review process. The OIG attended 1,512 Executive Review Committee meetings and reviewed 6,434 of the 7,349 use of force incidents. The OIG developed a new use-of-force monitoring tool to allow more in-depth analysis of each use-of-force incident, and allow collection of data identifying those officers who use force most often and those inmates against whom force is used most often. The new tool will also allow identification of "hot spots" where force is used within a prison. The new tool was deployed on January 1, 2016. The data collected is shared with the department each month. The OIG also participates as a non-voting member of the CDCR Deadly Force Review Board.

Use-of-Force monitoring reports are found in Volume II of the OIG's Semi-Annual Report, at: www.oig.ca.gov/pages/reports.php

Medical Inspections

Pursuant to Penal Code Section 6126(f) the OIG conducts an objective, clinically appropriate, and metric-oriented medical inspection program to review delivery of medical care at each of the adult institutions in California.

During 2016, the OIG completed the fieldwork for the remaining 26 Cycle 4 medical inspections. Related to those inspections, the OIG issued 18 final public reports. As of December 31, 2016, the OIG

had also issued five draft reports to external stakeholders. The following nine institutions received delegations back to the department from the Receiver in 2016:

- Folsom State Prison
- Correctional Training Facility
- Chuckawalla Valley State Prison
- California Correctional Institution
- Pelican Bay State Prison
- California State Prison, Centinela
- Sierra Conservation Center
- California Institution for Men
- Avenal State Prison

The Cycle 4 medical inspection includes qualitative reviews and compliance testing conducted by teams staffed with OIG clinicians and registered nurses, who used 16 quality indicators of health care to assess each institution. The OIG plans to complete the Cycle 5 inspections over a period of approximately 12 months. In December 2016, the OIG issued three job start letters for Cycle 5 medical inspections to Valley State Prison, California Medical Facility, and Ironwood State Prison in preparation for starting fieldwork for these institutions in 2017.

OIG Cycle 4 Medical Inspections Final Reports Issued During 2016

Institution Inspected	Issue Date	Rating
CCI	January 2016	Adequate
CEN	February 2016	Adequate
PBSP	February 2016	Adequate
VSP	February 2016	Inadequate
SCC	March 2016	Adequate
WSP	April 2016	Inadequate
CIM	April 2016	Adequate
MCSP	May 2016	Inadequate
ISP	May 2016	Inadequate
SQ	July 2016	Adequate
ASP	August 2016	Adequate
CIW	September 2016	Adequate
CMF	September 2016	Inadequate
CAL	September 2016	Adequate
COR	November 2016	Inadequate
SVSP	November 2016	Inadequate
HDSP	December 2016	Adequate
CMC	December 2016	Adequate

Medical Inspection reports are available on the OIG's website at: www.oig.ca.gov/pages/reports.php

Warden/Superintendent Vetting

Penal Code Section 6126.6 requires that the OIG evaluate the qualifications of every candidate whom the Governor nominates for appointment as a warden or a youth correctional facility superintendent, and report the recommendation in confidence to the Governor within 90 days of the request to evaluate the candidate. Candidates have typically been acting wardens for at least three months before the OIG process begins. The OIG is keenly aware of the need for stability in management and, therefore, strives to complete its part of the vetting process as expeditiously as possible.

The OIG uses a three-phase vetting process with an internal completion goal of 60 days. This year, eleven vettings were completed with an average completion time of 61 days. In addition to conducting a background investigation of the candidate and surveying designated stakeholders, the first phase consists of a site visit conducted by a team of inspectors, who provide the OIG with an overview of the institution's operations. During the second phase, the Inspector General personally consults with outside stakeholders, conducts a management review, and tours the facility with the candidate. In the final phase, the Inspector General reviews all of the information gathered during the vetting process and evaluates the candidate's suitability for the position of warden or superintendent after a one-on-one interview. The Inspector

General then submits a confidential recommendation to the Governor.

Given the high rate of turnover due to retirement within CDCR management, the OIG anticipates a continued demand for warden vetting in 2017.

As of December 31, 2016, the following adult and youth institutions were without permanent wardens or superintendents:

- California City Correctional Facility
- California Correctional Center
- California Correctional Institution
- Central California Women's Facility
- California Institution for Women
- California Training Facility
- California State Prison, Sacramento
- Wasco State Prison
- N.A. Chaderjian Youth Correctional Facility and O.H. Close Youth Correctional Facility and,
- Ventura Youth Correctional Facility

Blueprint Monitoring

In 2012, the Legislature passed and the Governor signed legislation mandating the OIG periodically review delivery of the reforms identified in *The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight and Improve the Prison System* (the *Blueprint*).

The OIG monitored the department's progress implementing five key goals:

- Establish and adhere to the standardized staffing model at each institution;
- Establish and adhere to the new inmate classification score system;
- Implement and adhere to the comprehensive housing plan;
- Increase the percentage of inmates served in rehabilitative programs to 70 percent of the target population prior to the inmate's release; and
- Establish and adhere to the new prison gang management system.

The department continued to show progress in implementing the goals of the *Blueprint* in 2016. Two of the reforms contained in the initial *Blueprint*, standardized staffing and the inmate classification score system have been completed. Also, many of the housing plans outlined in the *Blueprint* have been completed, or are nearing completion, and the department is housing inmates at *Blueprint*-prescribed levels.

As a result of the settlement agreement reached in January 2016 for *Todd Ashker, et al., v. Governor of the State of California, et al,* the department agreed to change its policies and practices for placing, housing, managing, and retaining inmates who have been validated as prison gang members and associates, as well as the conditions in each of its four Security Housing Unit (SHU) institutions. The department also expedited its review of inmates in the Step-Down Program (SDP) to determine eligibility for release from the SHU and transfer to a general population facility.

In January 2016, the department issued *An Update to the Future of California Corrections*, which provides a summary of the goals identified and progress made since the initial *Blueprint*, as well as the department's future vision for rehabilitative programming and safety and security. The OIG will monitor the department's remaining goals from the initial *Blueprint* including rehabilitative programming and SHU inmate status.

Blueprint monitoring reports are available on the OIG's website at:
www.oig.ca.gov/pages/reports.php

California Rehabilitation Oversight Board

The Public Safety and Offender Rehabilitation Services Act of 2007 (AB 900) established the 11-member California Rehabilitation Oversight Board (C-ROB) Chaired by the Inspector General. California Rehabilitation Oversight Board meetings are conducted three times per year to examine CDCR's various mental health, substance abuse, education, and employment programs for inmates and parolees. The C-ROB report is published annually, on September 15.

In 2016, C-ROB staff, in collaboration with the OIG's *Blueprint* monitoring team, visited all 35 adult institutions to observe rehabilitation programs and identify successes and challenges in programming. C-ROB staff review a broad range of rehabilitative programs, services, and activity groups, including substance use treatment, academic education programs, career technical education programs, and volunteer rehabilitative programming.

Institution site visits revealed many positive changes occurring within the department, especially its efforts to expand reentry centers and substance abuse treatment programs to all 35 adult institutions. The department successfully increased the health benefit approval process for pre-release benefits, an important rehabilitative need. The department has also developed a comprehensive case management plan, and has addressed three of the four recommendations from the 2015 C-ROB report. The 2016 C-ROB report provides five additional recommendations.

California Rehabilitation Oversight Board reports are available on the OIG's website at: http://www.oig.ca.gov/pages/c-rob.php

Special Reviews

A special review process is codified in Penal Code Section 6126. Upon request of the Governor, the Speaker of the Assembly, or the Senate Rules Committee, the OIG will conduct a review of CDCR policies, practices, or procedures set forth in the review request. Upon completion of the review, the OIG reports its findings and recommendations to the authorizing entity and publishes a public report. In 2016, no special reviews were requested.

Special Reviews are available on the OIG's website at: www.oig.ca.gov/pages/reports.php

CDCR CORRECTIVE ACTION PLAN UPDATE

In 2016, the OIG published 25 formal reports containing 15 recommendations. The recommendations in these reports promote greater transparency, taxpayer savings, process improvements, increased accountability, and higher adherence to policies and constitutional standards.

Status of Recommendations Made to CDCR in 2016

The OIG made six recommendations to CDCR in the March 2016 Semi-Annual Report, and four more recommendations in the September 2016 Semi-Annual Report. The department has fully or substantially implemented one of the ten Semi-Annual Report recommendations and partially implemented two of the recommendations. Six of the recommendations have not been implemented, and the remaining one is currently being reviewed.

There were also five recommendations made in the California Rehabilitation Oversight Board (C-ROB) September 2016 annual report. C-ROB is an independent board, and, unlike the OIG, does not have authority to request specific responses to recommendations; however, the department has fully or substantially implemented one of the five C-ROB report recommendations and partially implemented one of the recommendations. One of the recommendations has not been implemented and the remaining two are being reviewed.

Status of Recommendations Made to CDCR in 2015

The OIG made eight recommendations to CDCR in the March 2015 Semi-Annual Report, and five more recommendations in the September 2015 Semi-Annual Report. The department has fully or substantially implemented six of the thirteen Semi-Annual Report recommendations and partially implemented four of the recommendations. Two of the recommendations have not been implemented, and the one remaining recommendation is currently being reviewed.

The OIG made 45 recommendations to the department in the December 2015 *Special Review: High Desert State Prison Susanville, CA*. The department has fully or substantially implemented 33 of the 45 recommendations and partially implemented three of the recommendations. Eight of the recommendations have not been implemented, and the one remaining recommendation is currently being reviewed.

There were also four recommendations made in the September 2015 C-ROB report. The department has fully or substantially implemented each of the four recommendations from the report.

The Medical Inspection Reports also contain institution-specific recommendations that are provided to the Receiver and the department, but due to the authority of the Receiver to implement corrections, the department does not submit a corrective action plan for the recommendations in the MIU reports.

APPENDIX: REPORTS RELEASED IN 2016

Annual Report

- 2015 OIG Annual Report (January 2016)

Semi-Annual Reports

- OIG Semi-Annual Report July–December 2015 Volume I (June 1, 2016)
- OIG Semi-Annual Report July–December 2015 Volume II (June 1, 2016)
- OIG Semi-Annual Report January–June 2016 Volume I (September 28, 2016)
- OIG Semi-Annual Report January–June 2016 Volume II (September 28, 2016)

Medical Inspection Reports

- California Correctional Institution Medical Inspection Results Cycle 4 (January 11, 2016)
- Pelican Bay State Prison Medical Inspection Results Cycle 4 (February 10, 2016)
- Valley State Prison Medical Inspection Results Cycle 4 (February 22, 2016)
- California State Prison, Centinela Medical Inspection Results Cycle 4 (February 26, 2016)
- Sierra Conservation Center Medical Inspection Results Cycle 4 (March 16, 2016)
- California Institution for Men Medical Inspection Results Cycle 4 (April 15, 2016)
- Wasco State Prison Medical Inspection Results Cycle 4 (April 15, 2016)
- Mule Creek State Prison Medical Inspection Results Cycle 4 (May 18, 2016)
- Ironwood State Prison Medical Inspection Results Cycle 4 (May 25, 2016)
- San Quentin State Prison Medical Inspection Results Cycle 4 (July 13, 2016)
- Avenal State Prison Medical Inspection Results Cycle 4 (August 3, 2016)
- California Institution for Women Medical Inspection Results Cycle 4 (September 12, 2016)
- California Medical Facility Medical Inspection Results Cycle 4 (September 19, 2016)
- Calipatria State Prison Medical Inspection Results Cycle 4 (September 19, 2016)
- Salinas Valley State Prison Medical Inspection Results Cycle 4 (November 1, 2016)
- California State Prison, Corcoran Medical Inspection Results Cycle 4 (November 16, 2016)
- High Desert State Prison Medical Inspection Results Cycle 4 (December 6, 2016)
- California Men's Colony Medical Inspection Results Cycle 4 (December 30, 2016)

California Rehabilitation Oversight Board (C-ROB) Report

- C-ROB September 15, 2016 Annual Report (September 15, 2016)

Blueprint Monitoring Reports

- Seventh Report on CDCR's Progress Implementing its Future of California Corrections *Blueprint* (March 23, 2016)

All Reports are available on the OIG's website at:
www.oig.ca.gov/pages/reports.php

2016 ANNUAL REPORT

OFFICE OF THE INSPECTOR GENERAL

Robert A. Barton
INSPECTOR GENERAL

Roy W. Wesley
CHIEF DEPUTY INSPECTOR GENERAL

STATE OF CALIFORNIA
February 2017