STATE *of* CALIFORNIA

OIG | OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley, *Inspector General*
Bryan B. Beyer, *Chief Deputy Inspector General*

Independent Prison Oversight

2017
Annual Report
Summary of Reports and Status of Recommendations

May 2018

Fairness ■ Integrity ■ Respect ■ Service ■ Transparency

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Map of California's Correctional and Rehabilitation Institutions

Map provided courtesy of the California Department of Corrections and Rehabilitation.

FOREWORD

Vision

The California prison system, by its very nature, operates almost entirely behind walls, both literal and figurative. The Office of the Inspector General (the OIG) exists to provide a window through which the citizens of the state can witness that system and be assured of its soundness. By statutory as well as judicial mandate, our agency oversees and reports on several operations of the California Department of Corrections and Rehabilitation (the department). We act as the eyes and ears of the public, measuring the department's adherence to its own policies and, when appropriate, recommending changes to improve operations.

Our objective is to create an oversight agency that provides outstanding service to our stakeholders, our government, and the people of the State of California. We do this through diligent monitoring, honest assessment, and dedication to improving the correctional system of our state. Our overriding concern is providing transparency to the correctional system so that lessons learned may be adopted as best practices.

Mission

Although the OIG's singular vision is to provide transparency, our mission encompasses multiple areas, and our staff serve in numerous roles overseeing distinct aspects of the department's operations, which include discipline monitoring, complaint intake, warden vetting, medical inspections, the California Rehabilitation Oversight Board (C-ROB), and a variety of special assignments.

Therefore, to safeguard the integrity of the state's correctional system, we work to provide oversight and transparency through monitoring, reporting, and recommending improvements on the policies and practices of the department.

— Roy W. Wesley
Inspector General

There is hereby created the independent Office of the Inspector General which shall not be a subdivision of any other governmental entity.

— State of California
Penal Code section 6125

ORGANIZATIONAL OVERVIEW AND FUNCTIONS

The Office of the Inspector General (OIG) is an independent agency of the State of California. First established by state statute in 1994 to conduct investigations, review policy, and conduct management review audits within California's correctional system, California Penal Code sections 2641 and 6125–6141 provide our agency's statutory authority in detail, outlining our establishment and operations.

The Governor appoints the Inspector General to a six-year term, subject to California State Senate confirmation. The Governor appointed our current Inspector General, Roy W. Wesley, on September 13, 2017; his term will expire in 2023.

The OIG is organized into a headquarters operation, which encompasses executive and administrative functions and is located in Sacramento, and three regional offices: north, central, and south. The northern regional office is located in Sacramento, the central regional office is in Bakersfield, and the southern regional office is in Rancho Cucamonga.

Our staff consist of a skilled team of professionals, including attorneys with expertise in internal investigations, criminal law, and employment law, as well as inspectors knowledgeable in correctional policy, operations, and investigations.

The OIG also employs a cadre of medical professionals, including doctors and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities, all of which are integral in achieving our mission.

The OIG performs a variety of oversight functions relative to the department, including the areas listed below:

- Medical inspections
- Warden/superintendent vetting
- Serving as the ombudsperson for, and monitor of, Sexual Abuse in Detention Elimination Act (SADEA)/Prison Rape Elimination Act (PREA) cases
- Reviewing and investigating retaliation complaints
- Coordinating and chairing the California Rehabilitation Oversight Board (C-ROB)
- Handling complaints filed directly with the OIG by inmates, employees, and other stakeholders regarding the department
- Special reviews authorized by the Legislature or the Governor's Office
- Monitoring of:
    - Internal investigations and litigation of employee disciplinary actions
    - Critical incidents, including inmate deaths, large-scale riots, hunger strikes, and so forth
    - Use of force
    - Contraband surveillance watch
    - Adherence to the *Blueprint* plan for the future of the department

REPORTS PUBLISHED IN 2017

In 2017, the OIG issued 30 public reports: 25 medical inspection reports, two semi-annual reports, the *Blueprint* report, the California Rehabilitation Oversight Board (C-ROB) report, and the annual report. Visit our website, **www.oig.ca.gov/pages/reports.php**, to view our public reports.

Semi-Annual Reports

Internal Investigations and Employee Discipline Monitoring

Our Discipline Monitoring Unit attorneys are responsible for the contemporaneous oversight of the department's internal investigations and employee discipline processes. The Discipline Monitoring Unit also oversees the department's response to critical incidents within its institutions.

To provide an accounting of our activities in monitoring internal investigations and the litigation of disciplinary actions on a regular basis, the OIG publishes semi-annual reports that document the department's adherence to its departmental operating rules and procedures. These reports also provide a record attesting to the quality of the investigation and legal representation regarding employee discipline. The OIG's attorneys monitor and assess the department's internal investigations that its Office of Internal Affairs' special agents conduct. In addition, we monitor and assess the performance of departmental attorneys throughout the disciplinary process, including any appeals.

In 2017, of the 2,004 cases departmental hiring authorities referred for investigation or approval for authorization to take direct disciplinary action, the Office of Internal Affairs opened 1,842 cases. Of these cases, the OIG monitored 490 (26 percent) for compliance with internal investigation and disciplinary policies. The OIG monitors the most sensitive internal investigations against staff members, including those involving allegations of dishonesty, sexual misconduct, unreasonable use of force, code of silence, abuse of authority, and criminal conduct. Of this group, 397 alleged administrative misconduct, 33 alleged criminal misconduct, and 39 were

use-of-deadly-force incidents. The OIG found that, from January through December 2017, the department generally performed well in the investigative and disciplinary phases. However, based on concerns we identified and our assessments, the OIG made recommendations for some changes. For example, in 2017, the OIG made recommendations to the department regarding the need to establish a deadline for completing internal investigations, to establish guidelines and exceptions to departmental cell entry policies for the Office of Internal Affairs' special agents, and to provide departmental attorneys with refresher training regarding how to properly assess the deadline for taking disciplinary actions against departmental employees (see Exhibit 1, pages 26–30).

Critical Incident Monitoring

Our agency maintains attorneys at headquarters and in the regional offices who are on call and can respond onsite 24 hours per day to critical incidents reported from any of the state's correctional institutions. Critical incidents are serious events that require the department to respond immediately, such as large-scale riots, inmate homicides, uses of deadly force, and unexpected inmate deaths. The OIG monitors critical incidents and any subsequent investigation, and emphasizes determining the event that led up to the incident, whether it was handled appropriately, and what, if any, recommended action should be taken afterward. If we find a reasonable belief of potential neglect or misconduct, OIG attorneys will recommend, and subsequently monitor, an investigation. In addition, we may recommend policy changes to avoid future occurrences and conform to best practices.

In 2017, the OIG opened and monitored 237 critical incidents at the state's institutions. This included incidents to which we responded on scene, as well as incidents we monitored remotely without an on-scene response. In addition, the OIG completed its review of and assessed 152 critical incident cases, some of which had been opened before 2017, but that were not completed until the 2017 reporting period ended. The OIG assessed these cases based on the department's actions before, during, and after the incident, assigning a separate assessment rating to all three of types of actions that occur in each case. Of these 152 closed critical incident cases, we found 78 of them, or 51 percent, insufficient in at least one of the three

assessment ratings; and 5 of them, or 3 percent, insufficient in all three assessments. For 74 of them, or 49 percent, we found all three assessments sufficient.

The OIG relies on the department to timely notify our staff of a critical incident, so we can respond appropriately, including immediately responding to the institution when warranted. Of the 152 critical incident cases we closed in 2017, the department timely notified us in 136 cases, or 90 percent. Departmental administration previously agreed to emphasize timely notification, and the department's performance in this area did improve in 2017.

Contraband Surveillance Watch Monitoring

The OIG monitors the department's contraband surveillance watch process to ensure its staff perform within departmental policy guidelines and that the process is not used for punitive purposes. Departmental staff notify us any time an inmate is placed on contraband surveillance watch. Whenever the department keeps an inmate on contraband surveillance watch longer than 72 hours or the department transports an inmate to an outside hospital during the contraband surveillance watch, the OIG responds to the scene to inspect the inmate's condition and to ensure the department is following its policies. This on-scene process continues every 72 hours until the department removes the inmate from contraband surveillance watch. OIG inspectors immediately discuss serious breaches of policy with institutional managers.

In 2017, the department notified the OIG concerning 248 contraband surveillance watch cases. Of these 248 notifications, the OIG monitored 73 cases. Of these 73 cases, the department found contraband in 54 cases, a 74-percent success rate. The most frequent types of contraband found were drugs and inmate notes, accounting for nearly 84 percent of all contraband found during 2017.

In October 2017, the department implemented a new procedure that requires institutions to consider placing inmates on contraband surveillance watch without the use of mechanical restraints when they do not pose an immediate risk to the safety and security of staff or the institution, or to themselves. The OIG monitored this new procedure during its pilot phase and will continue to monitor the program as it is deployed statewide.

Use-of-Force Monitoring

Another means by which the OIG fulfills its oversight mandate is by monitoring the department's review process for use-of-force incidents at institutional executive review committee meetings, departmental executive review committee meetings, and division force review committee meetings. The OIG utilizes a comprehensive database designed to more effectively allow our staff to examine the various circumstances surrounding occurrences of the department's use of force. This tool aggregates information concerning these types of incidents, allowing for an in-depth analysis of each use of force. We share some of the collected data with the department each month and continue to study how we can improve in sharing data on any trends we observe. The OIG also participates as a non-voting member of the department's Deadly Force Review Board.

During our 2017 reporting period, the OIG reviewed 7,573 use-of-force incidents. Of the incidents reviewed, often, multiple types of force were used in a single incident, with chemical agents used in 48 percent of those incidents, and physical force used in 37 percent of incidents.

In addition to the types of force used during the incidents reviewed, the OIG also reviews incidents in which the department's staff contributed to the need to use force. We reviewed 171 incidents in which staff:

- initiated force when there was no threat;
- failed to secure a cell door or food port; or
- opened the wrong cell door and allowed inmates access to unauthorized areas.

The department also identifies the use of force on inmates who participate in mental health programs, which the OIG also reviews. During the reporting period, of the incidents monitored, 40 percent of the use-of-force incidents involved one or more inmates participating in a mental health program.

During the 2017 reporting period, the OIG reported on use-of-force issues in which the department did not consistently follow policy for the use of spit hoods/masks, documentation of allegation inquires, decontamination after the use of chemical agents, and video-recorded interviews. The following listing offers more detail concerning these issues:

- The OIG found inconsistencies in the department's compliance with policy concerning the use of spit hoods/masks during uses of force. This policy directs institutional staff to use the spit hood/mask under specific conditions and not as a punitive measure, with parameters outlined. Exhibit 1, page 28, outlines this directive in greater detail. For example, the OIG inspectors identified various incidents that included the following:

    - Staff applied a spit hood/mask, despite the inmate having given no intent (verbal or physical) to contaminate others with spit or bodily fluids from the nose or mouth. In some cases, the spit hood/mask was applied to prevent contact with an inmate's blood emanating from parts of the body other than the nose and mouth (such as from a head wound or facial laceration). In other cases, the spit hood/mask was used to prevent further physical assaults to staff or due to the inmate displaying aggressive or bizarre behavior. These applications do not comply with departmental policy.

    - Staff applied a spit hood/mask, but did not maintain constant supervision while the inmate was wearing it. If an inmate begins to suffer from respiratory distress and cannot remove the hood/mask personally (e.g., due to restraints, loss of consciousness, or other incapacitating event), and no staff are available constantly supervising the use of the hood/mask, fatal consequences could ensue to the inmate. Therefore, the OIG recommended that the department provide its staff with training on the proper use of spit hoods/masks within the criteria set forth in its policy.

- The OIG found inconsistencies in the department's documentation of inmate allegations of unreasonable force. Departmental policy requires that staff document allegations concerning the unreasonable use of force when an inmate makes allegations during interviews or medical evaluations. The OIG recommended that the department establish clear guidelines for analyzing inmates' statements related to use-of-force incidents, and that departmental supervisors and

managers receive training to ensure inmate allegations are processed according to policy (see Exhibit 1, page 27).

- When staff use chemical agents in a use-of-force incident, policy requires that staff provide the inmate with clean clothes during the decontamination process. The OIG found that staff did not consistently document whether the department offered clean clothes to inmates after decontamination, and we also found inconsistencies among the institutions concerning the proper protocol on providing clean clothes. When the OIG raised this concern, the department did not agree with our position regarding staff needing to document that inmates were offered clean clothes after decontamination. In addition, some departmental executives did not believe policy requires staff to offer clean clothes to inmates who were taken for a medical examination or when an inmate was placed in administrative segregation, under the presumption that the institution's medical services or administrative segregation unit will not accept an inmate in contaminated clothing and will issue clean clothing as a matter of course. However, the department's records do not support this presumption, as these units do not document the issuance of an offer of clean clothes themselves. The OIG recommended the department clarify its policy regarding these issues (see Exhibit 1, page 27).

- The OIG found the department's compliance with policy regarding video-recorded interviews was inconsistent across institutions. The department's policy requires that its staff video-record any inmate who alleges unreasonable force or who sustains serious or great bodily injury possibly due to the use of force within 48 hours from the discovery of the allegation. In our semi-annual report issued March 2017, we found the department did not comply with policy for nearly 39 percent of the incidents reviewed in which policy required a video-recorded interview. Issues contributing to non-compliance involved staff failing to complete the interview in the time frame policy requires, interviewers failing to properly identify themselves or the inmate's injuries, failure to video-record the inmate refusing the interview, or failure to complete the interview at all.

The OIG maintains open communication with the department, including wardens at the institutions, to communicate use-of-force concerns and trends. The OIG provides wardens with regular reports that show the frequency of use-of-force incidents at specific locations and that involve specific staff. The purpose of these reports is to provide the wardens with feedback to help identify areas for improvement or risks as they relate to the use of force.

The reports also assist the OIG in identifying trends to communicate potential concerns and risks to the department. Furthermore, in 2017, supervisors from the OIG's Force Accountability and Compliance Team began holding regular meetings with departmental management to discuss issues specific to the use of force. These collaborations have proved beneficial in identifying policy concerns and inconsistencies in policy interpretation.

Cycle 5 Medical Inspection Reports

One of the critical responsibilities of the OIG is to conduct an objective, clinically appropriate, and metric-oriented medical inspection program. This program is directed toward reviewing the health care provided to patients housed at each of California's adult prisons.

During 2017, in addition to concluding the work for Cycle 4 and publishing its summary report, our staff began work on our fifth cycle of correctional institution medical inspections. We published 14 public reports for Cycle 5; 7 received *adequate* ratings, and 7 received *inadequate* ratings.

As of December 31, 2017, the OIG issued three additional draft reports to external stakeholders. Furthermore, the OIG began its fieldwork for the 18 remaining institutions in the cycle, and our staff will complete these inspections in 2018. In 2017, the federal receiver delegated the following prisons back to the department:

- San Quentin State Prison (January)
- California Institution for Women (March)
- Kern Valley State Prison (May)
- California City Correctional Facility (May)
- Pleasant Valley State Prison (July)
- Calipatria State Prison (December)

The Cycle 5 medical inspection process includes qualitative case reviews and compliance testing conducted by teams staffed with OIG doctors and nurses, who use 15 quality indicators of health care to assess care provided at each institution. The OIG expects to begin its Cycle 6 inspection in 2018, immediately following our completion of the remaining 21 inspection reports for Cycle 5.

For 2017, the following table lists the time frame of publication and the ratings for those institutions for which we have completed our Cycle 5 inspections and issued final reports:

Table 1. OIG Cycle 5 Medical Inspections: Final Reports Published in 2017

Institution Inspected	Publication Month	Overall Rating
Valley State Prison	June	*Adequate*
California Medical Facility	July	*Inadequate*
Ironwood State Prison	July	*Inadequate*
Wasco State Prison	August	*Adequate*
California State Prison, Los Angeles County	September	*Inadequate*
California State Prison, Solano	September	*Inadequate*
California State Prison, Corcoran	September	*Adequate*
California Correctional Center	October	*Adequate*
California Rehabilitation Center	October	*Inadequate*
North Kern State Prison	October	*Inadequate*
Salinas Valley State Prison	October	*Inadequate*
Richard J. Donovan Correctional Facility	November	*Adequate*
California Substance Abuse Treatment Facility at Corcoran	November	*Adequate*
California Correctional Institution	December	*Adequate*

The overall institutional ratings tightly correlated with the quality of provider performance. All seven prisons that passed their inspections demonstrated satisfactory provider performance, while six of the seven inadequate prisons suffered from weak provider performance.

OIG doctors and nurses ascertain provider performance quality within the context of an institution's systemic performance. The following table of health care indicators provides the summary distribution of results:

Table 2. OIG Cycle 5 Medical Inspections, 2017: Health Care Indicator Results

Health Care Indicator	Not Applicable	Number of Institutions		
		Proficient	*Adequate*	*Inadequate*
Access to Care	0	1	7	6
Diagnostic Services	0	1	9	4
Emergency Services	0	0	13	1
Health Information Management	0	0	6	8
Health Care Environment	0	0	4	10
Inter- and Intra-System Transfers	0	1	8	5
Pharmacy and Medication Management	0	0	2	12
Prenatal and Post-Delivery Services	14	0	0	0
Preventative Services	0	4	3	7
Quality of Nursing Performance	0	0	12	2
Quality of Provider Performance	0	0	8	6
Reception Center Arrivals	12	0	1	1
Specialized Medical Housing	0	1	9	4
Specialty Services	0	4	9	1
Administrative Operations (secondary)	0	5	7	2

Our doctors and nurses found that many institutions performed well in several areas of health care delivery; specifically, the indicators *Diagnostic Services*, *Emergency Services*, *Quality of Nursing Performance*, *Specialized Medical Housing*, and *Specialty Services* all received good ratings. For most institutions, however, two indicators were problematic: *Health Care*

Environment and *Pharmacy and Medication Management*. These two indicators revealed room for improvement at the institutional level.

OIG Cycle 5 Medical Inspections, 2017: Recommendations

The OIG offered 39 recommendations that our doctors and nurses believe will improve health care delivery within the institutions (see Exhibit 2, pages 31–36). While most of them were specific to the inspected institutions, the OIG repeated two recommendations for problems identified across multiple institutions:

- Beginning in 2016 and concluding in 2017, departmental institutions transitioned to a new electronic health record system (EHRS). Before transitioning to the EHRS, several institutions had not been scanning radiology reports into the older medical records database. This situation often inhibited providers from readily reviewing the results because at these institutions, staff instead entered these radiology reports into a separate database that was not the patients' primary health care record. Unfortunately, providers did not always check this separate, alternative database or even have access to it. The OIG recommended that institutions scan their radiology reports into the new EHRS. By the end of 2017, each departmental institution had transitioned to the new system, which appeared to have corrected this issue.

- Specialists' reports are essential documents that providers need to make correct medical decisions for their patients. Several institutions did not always retrieve specialists' reports from, or scan them into, patients' medical records, which meant that providers did not always review the reports promptly or carefully. The OIG made recommendations to several institutions to encourage timely retrieval and scanning of the specialty service reports into the patients' medical records, and for the providers to review these reports appropriately.

Cycle 4 Medical Inspection Summary Report

The Cycle 4 medical inspection summary report reviewed the delivery of health care examined in all 35 medical inspections during that cycle. The OIG determined the quality of medical care by examining 16 indicators (rather than the 15 examined during the present Cycle 5) and assigned overall ratings based on these indicators. We published 35 reports for Cycle 4: 2 institutions received ratings of *proficient*, 20 of *adequate*, and 13 of *inadequate*.

Institutions provided most services within required time frames, notably, in areas related to *Access to Care* and *Diagnostic Services*. Institutional staff responded timely to patient requests. For *Inter- and Intra-System Transfers* and *Specialized Medical Housing*, the majority of institutions received an *adequate* rating for completing intake screening forms and admission paperwork. Most of the institutions provided adequate clinical care, including in the areas of *Emergency Services*, *Quality of Nursing Performance*, *Quality of Provider Performance*, and *Specialty Services*. The following table lists the rating results returned during Cycle 4:

Table 3. Cycle 4 Medical Inspection Summary Report, 2017: Health Care Indicator Rating Results

Health Care Indicator	Number of Institutions		
	Proficient	***Adequate***	***Inadequate***
Access to Care	12	15	8
Diagnostic Services	9	15	11
Emergency Services	2	24	9
Health Information Management (Medical Records)	1	11	23
Health Care Environment	5	13	17
Inter- and Intra-System Transfers	4	24	7
Pharmacy and Medication Management	4	12	19
Prenatal and Post-Delivery	0	2	0
Preventive Services	9	11	15
Quality of Nursing Performance	0	28	7
Quality of Provider Performance	1	26	8
Reception Center Arrivals	0	4	2
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	4	21	7
Specialty Services	5	20	10
Internal Monitoring, Quality Improvement & Administrative	4	5	26
Job Performance, Training, Licensing & Certifications	12	7	16

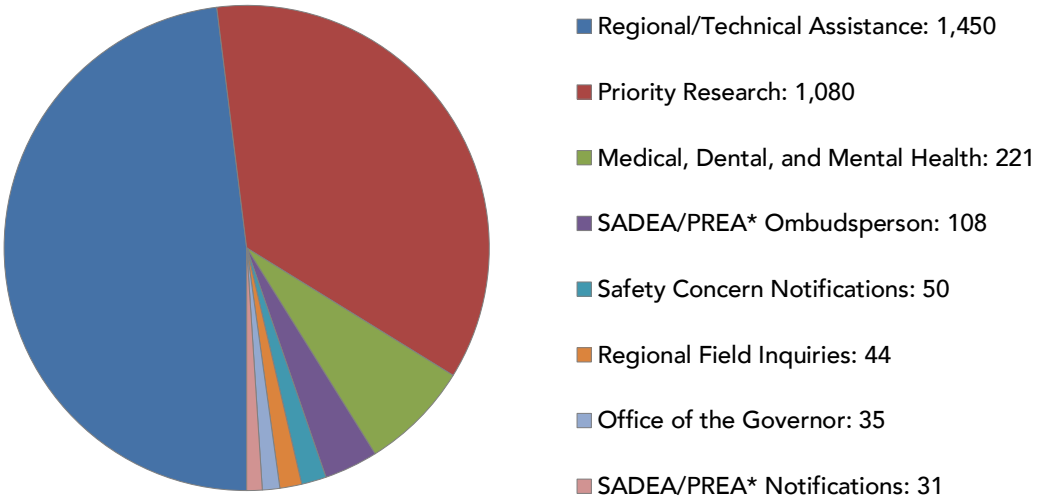
Complaint Intake

The OIG maintains a statewide complaint intake process to receive communications from any individual regarding allegations of improper activity within the department. Our staff notify the department concerning such complaints of misconduct. When the OIG receives a complaint, staff in our Intake Unit log, review, research, and respond. OIG staff screen all complaints within 24 hours of receipt to identify potential safety concerns involving departmental employees or inmates.

In 2017, the OIG received 3,019 complaints submitted by inmates, parolees, families, departmental employees, and advocacy groups. This is a slight increase from the 2,851 complaints submitted to the OIG in 2016. The 2017 figure includes 35 complaints initially submitted to the Office of the Governor, which were assigned to the OIG for our review. OIG staff conducted additional research into matters or requested clarifying documentation from departmental institutions for 1,080 of these complaints.

The OIG received 221 complaints alleging inappropriate health care, lack of access to health care, or both. Intake or medical staff from our agency conducted additional analyses of these medical, dental, and mental health complaints. The figure below lists the number and type of complaints our agency received in 2017:

Figure 1. Distribution of Complaints Received in 2017



* Sexual Abuse in Detention Elimination Act (SADEA)/Prison Rape Elimination Act (PREA).

During 2017, our staff contacted institutions on 50 occasions to recommend the investigation of potential safety concerns. These complaints described potentially unsafe conditions, such as enemy concerns, threatening behavior, suicidal thoughts, or other indicators noting safety or security risks that might be issues for either departmental staff or inmates. For instance, an inmate-patient alleged that he would take his own life or gravely injure himself and would not end his hunger strike without an investigation being conducted. The OIG notified both the department and California Correctional Health Care Services (CCHCS) staff to conduct an urgent mental health evaluation. Subsequently, CCHCS staff notified our agency that the inmate-patient's level of care within the Mental Health Services Delivery System had been increased to the enhanced outpatient program level, and he was subsequently referred for a mental health crisis bed placement.

In non-urgent matters, our staff directly contacted institutional personnel to resolve concerns that were eventually addressed informally by the department; for example, failures to accept an appeal, schedule a classification hearing, or schedule medical appointments. Furthermore, the OIG focused its staff resources on the most serious complaints according to a matrix of commonly occurring prison issues that receive priority attention. These include:

- Life-threatening situations or safety and security concerns
- Excessive or unnecessary use of force
- Lack of access to grievance processes and health care
- Allegations of staff misconduct
- Allegations of due process violations
- Allegations of sexual misconduct

Although the most serious complaints received priority attention, when our staff identified a trend of less egregious policy violations, we offered remedies for any potential systemic issues. In most instances, OIG staff encouraged complainants to use the department's grievance processes to resolve any issues before contacting our office. Therefore, a lack of access to the grievance process or an unjustified rejection of appeals by the department often received the most attention from OIG staff.

If we found potential misconduct or policy violations after reviewing complaints and corresponding documents, we then presented those cases to the Inspector General for review, who assigned the cases to regional staff. OIG staff made recommendations to the department's administrators, so they could remedy identified issues. This usually resulted in informal solutions, such as training staff, initiating inquiries, or reviewing the use of force to determine whether misconduct occurred. If the department initiated a formal investigation, our attorneys monitored the case in accordance with the OIG's normal discipline monitoring activities, and we reported or will report the findings in the OIG's semi-annual report.

Retaliation Claims

In addition to receiving complaints as described in the preceding paragraphs, our statutory authority directs the OIG to receive and review complaints of retaliation that departmental employees levy against members of their management. Our Legal Services Unit analyzes each complainant's allegations to determine whether the complaint presents the legally required elements of a claim of retaliation. If the complaint meets this initial legal threshold, our staff investigate the allegations to determine whether retaliation did occur. If the OIG determines the department's management subjected a departmental employee to unlawful retaliation, our office reports its findings to the department along with a recommendation for appropriate corrective action.

Due to public misperception regarding what constitutes whistleblower retaliation, few complaints present the legally required elements to state an actionable claim of retaliation. To counteract this misunderstanding, we engage with complainants to educate them regarding the elements of a retaliation claim, invite complainants to supplement their complaints with the necessary information, and correspond with complainants to clarify any questions we have regarding the information they submitted.

In 2017, the OIG received nine retaliation complaints. The Legal Services Unit completed analyses of seven complaints received in 2017 and two complaints that remained pending from 2016, determining none stated the legally required elements of a claim of retaliation. Two of the nine complaints received in 2017 remain pending.

Sexual Abuse in Detention Elimination Act Ombudsperson Claims

According to California Penal Code section 2641, the OIG is authorized to serve as the ombudsperson (a designated, impartial advocate) for complaints related to the Sexual Abuse in Detention Elimination Act (SADEA); these are also referred to as Prison Rape Elimination Act (PREA) claims. Acting in this capacity, the OIG reviews allegations of mishandled sexual abuse investigations within correctional institutions, maintains the confidentiality of sexual abuse victims, and ensures impartial resolution of inmate and ward sexual abuse complaints.

The department notified the OIG of 592 sexual abuse allegations during 2017, including 370 with a staff member as the alleged perpetrator and 222 with an inmate as the alleged perpetrator. This represents a 50 percent increase over the 396 sexual abuse allegations our agency received during 2016. The OIG monitors the department's handling of sexual misconduct allegations and subsequent investigations of alleged staff involvement.

In conjunction with our agency serving in the independent role of the SADEA ombudsperson, OIG staff supply informational posters to all adult institutions, Division of Juvenile Justice facilities, and parole offices explaining how to report SADEA allegations. As a result, the OIG received and reviewed 108 complaints directly from inmates, family members, and third parties. Most of these allegations were also included in the allegation notifications from the department listed in the preceding paragraph, with some measures in place to avoid double-counting. OIG staff from the Oversight, C-ROB, and Intake Unit (formerly: the Intake and Investigations Unit; name change effective 2-1-2018) reviewed and processed 101 of the 108 complaints, with the remaining 7 complaints referred to our staff in regional offices in Bakersfield and Rancho Cucamonga to review and for which to recommend appropriate resolutions.

In 31 instances, complainants first notified the OIG about allegations of sexual abuse or sexual harassment; the OIG referred these to the department for its staff to conduct initial investigations or inquiries. This third-party reporting process increases transparency and provides another reporting mode for inmates who are concerned with reporting the alleged abuse or harassment directly to departmental staff.

Warden/Superintendent Vetting

The OIG is also responsible for evaluating the qualifications of each candidate whom the Governor nominates for appointment as a warden at an adult institution or a superintendent at a juvenile facility, reporting the recommendation in confidence to the Governor within 90 days of the request. Typically, candidates have been serving as acting wardens or superintendents for at least three months before the OIG process begins. We are keenly aware of the need for stability in institutional management and, therefore, strive to complete our portion of the vetting process as expeditiously as possible.

Our staff use a three-phase vetting model, and we work toward an internal completion goal of 60 days. In 2017, the OIG completed seven warden and two superintendent vettings, with an average completion rate of 51 days, as depicted in the following listing:

Warden

- Wasco State Prison
- Correctional Training Facility
- California Institution for Women
- California Correctional Center
- Chuckawalla Valley State Prison
- California City Correctional Facility
- Deuel Vocational Institution

Superintendent

- Northern California Youth Correctional Center
- Ventura Youth Correctional Facility

In addition to conducting a background investigation of the candidate and surveying designated stakeholders, the first phase includes a team of OIG inspectors visiting the institutional site and then providing the Inspector General with an overview of the institution's operations. During the second phase, the Inspector General conducts interviews with members from the

institution's or facility's management team and also tours the institution or facility with the candidate. In the final phase, the Inspector General conducts a one-on-one interview with the candidate. The Inspector General next reviews all the information gathered during the vetting process and evaluates the candidate's suitability for the position of warden or superintendent. The Inspector General then submits a confidential recommendation to the Governor.

Due to the high turnover rate resulting from several retirements within departmental management, demand for warden vetting continues in 2018. On many occasions, experienced wardens mentor newer, less experienced administrators during their time as acting wardens prior to the OIG vetting process. As of December 31, 2017, the following adult institutions did not have permanent wardens assigned to their facilities:

- Central California Women's Facility
- Folsom State Prison/Folsom Women's Facility
- California State Prison, Solano
- Sierra Conservation Center
- Pelican Bay State Prison

The *Blueprint* Report

As part of our legislative mandate, the OIG periodically reviews 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*), published by the department in April 2012.

Toward that end, we monitored the department's progress in implementing five of its key goals:

- Establish and adhere to the standardized staffing model at each institution;
- Establish and adhere to the new inmate classification scoring system;

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

In January 2016, the department issued *An Update to the Future of California Corrections*, which provides a summary of the goals identified and progress achieved since the initial *Blueprint* was published four years earlier. It also lays out the department's future vision for rehabilitative programming, along with safety and security concerns.

On March 30, 2017, the OIG issued its *Eighth Report on the California Department of Corrections and Rehabilitation's Progress Implementing Its Future of California Corrections Blueprint and Update to the Blueprint*. Our report covered data we collected at all 35 adult institutions from December 2016 through March 2017, and was organized into two sections, which represented key areas that OIG staff monitored: rehabilitative programs, and classification and housing. Our staff analyzed data and performed fieldwork to determine the operational status of various programs at each institution during the 2016–17 fiscal year.

We found that the department continued to show substantial progress in implementing the goals outlined in its *Blueprint*. Its staff have completed four of the reforms proposed in the initial report, which included their establishing and adhering to the standardized staffing model, the inmate classification scoring system, and the prison gang management system; and implementing and adhering to the comprehensive housing plan.

Although the department implemented rehabilitation programs at all institutions, it has been unsuccessful in providing rehabilitative programs to 70 percent of its target population. Even had the department met this goal, the achievement would lack substance since its counting methodology considered an inmate's presence in a program for a single day as having had his or her needs partially met. To address this concern, on July 1, 2017, the department developed a new method for counting that will better track program information for all offenders. The department is now focused on

"meaningful participation," which it defines as enrollment in a program for a minimum of 30 calendar days.

This change may make it more difficult for the department to achieve its past target rate of 70 percent; however, it will allow its staff to more accurately evaluate its ability to address offenders' needs. The department anticipates analyzing and re-defining any prior goals related to offender participation or target populations.

We also determined that 82 percent of academic programs and 80 percent of career technical education programs were operational. For three remaining programs, 59 percent of the substance use disorder treatment slots were filled, 52 percent of the cognitive behavioral therapy slots were filled, and 60 percent of the pre-employment transitions' classes were operational. During the reporting period, 99 percent of offenders received the California Static Risk Assessment (CSRA) and 86 percent received the Core Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) needs assessment.

During the reporting period, the department initiated several efforts to address the growing sensitive needs yard population. The department developed new criteria by which it created two separate sensitive needs yard options (programming and non-programming) as well as worked to expedite transfers among yards and institutions. It also created four non-designated programming facilities, allowing inmates greater access to programs and privileges. In 2017, the department activated programming facilities at the following institutions:

- Richard J. Donovan Correctional Facility
- California Health Care Facility
- California State Prison, Los Angeles County
- Pelican Bay State Prison

California Rehabilitation Oversight Board Report

In 2007, the California Legislature established the 11-member California Rehabilitation Oversight Board (C-ROB) chaired by the Inspector General. Our agency convenes C-ROB meetings three times per year to examine the department's various mental health, substance abuse, educational, and employment programs for inmates and parolees. The C-ROB report is published annually, on September 15.

In 2017, C-ROB staff collaborated with the OIG's *Blueprint* monitoring team and visited all 35 adult institutions to observe rehabilitation programs, and to 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.

Rehabilitative programs have greatly expanded as a result of both Proposition 57 and innovative programming grants. Hundreds of inmate activity groups are now eligible for rehabilitative achievement credits, a process that has incentivized programming statewide. Re-entry programming at each institution combined with the rehabilitative case plan provided to both parole or post-release community supervision furthers transition efforts and is a noted progress point for successful re-entry. The following table offers additional details on rehabilitative program capacity from 2015 to 2017, as the department expanded its designation of "re-entry hubs" from an initial 13 institutions to all 35 adult institutions during the 2016–17 fiscal year:

Table 4. Adult Rehabilitative Program Capacity, 2017

Rehabilitative Program	Seats available in June		
	2015	2016	2017
Academic Education*	41,982	41,784	44,365
Career Technical Education	8,478	8,694	9,045
In-Prison Substance Use Disorder Treatment	6,072	7,747	11,645
In-Prison Employment Programs	6,885	7,380	21,553
In-Prison Cognitive Behavioral Treatment:			
Anger Management	3,840	4,176	8,208
Criminal Thinking	3,840	4,128	8,160
Family Relationships	1,684	2,272	4,312
Victim Impact	576	336	336
Post-Release Substance Use Disorder Treatment	5,020	4,020	8,926
Post-Release Employment	5,801	6,050	5,940
Post-Release Education	6,414	7,134	6,999
Total Capacity for All Programs	90,592	93,721	129,489

* Academic and career technical education report as a daily budgeted capacity. All other programs report the average number of times a program can be completed in one fiscal year (annualized).

Source: The department provides this data via its Division of Rehabilitative Programs as of June 2016 through July 2017; data are not validated by the OIG.

The department has greatly expanded its program capacity, making laudable progress with re-entry programming, case planning, and capacity. Institutional site visit successes were numerous during this reporting period, including increases in volunteer programs, credit-earning opportunities, and the expansion of face-to-face college programs in all 35 institutions.

The board commends the department for successfully increasing its rehabilitative program capacity for the fourth year in a row. Innovative grant funding for three-year support has expanded volunteer-led rehabilitative programming, and the department has provided additional support staff to assist with programming coordination.

Notably, the department extended its data-sharing agreement with the California Department of Health Care Services, allowing both departments

to continue exchanging Medi-Cal applications to improve benefit outcomes for the inmates served through the transitional case management program. In 2017, the department successfully screened 100 percent of inmates for health benefit eligibility and also successfully improved the health benefit approval process for pre-release benefits, resulting in a higher rate of authorization.

Program expansion has also posed some challenges as summarized in the summary of site visits. Other challenges noted were a less-than-50-percent completion rate for in-prison substance use treatment disorder programs, and the aftercare completion rate was also extremely low, averaging 29 percent for the prior fiscal year. Three categories of re-entry COMPAS assessments still reported a moderate to high need of approximately 50 percent for the paroling population, and 30 percent paroled without receiving a re-entry assessment. The board would like to see an increase in the substance use disorder treatment completion rates as well as a reduction in the high percentage of parolees released who are characterized by a moderate to high risk to re-offend.

As a result of site visits and the work of the board, the C-ROB report included two new recommendations offered to the department for 2017:

- The board recommended the department complete a training or issue a memorandum clarifying the use of split-shift programming for milestone, educational merit, or rehabilitative achievement credit-eligible programs, allowing eligible inmates to attend all credit-earning rehabilitative programs with a flexible work schedule (see Exhibit 3, page 37).
- The board recommended the department take the next steps to implement a data collection plan to document the effectiveness of current and future programming (see Exhibit 3, page 37). At this time, the Strategic Offender Management System (SOMS) has data that include the following for each inmate referred to at least one program:
    - Pre- and post-program risk assessment scores
    - Demographic information (age, ethnicity, and gender)
    - Educational level

- Criminal history
- Substance abuse history
- Prior treatment programs
- Times/hours of program attendance
- Absences (excused or not)
- Program start and graduation date
- Program completion or reason for dropping out

The board requests that the department work toward utilizing the SOMS data to identify program measures, such as institutional behavior, educational attainment, and individual offender progress in rehabilitation programming. Outcome measures, such as recidivism and other measurable goals that include housing after release, employment, income, transportation, family support, substance use, and educational attainment, should be collected for parolees after they are released into their communities (see Exhibit 3, page 37). The following table lists the distribution of program participation:

Table 5. Parolee Re-entry COMPAS Assessments

July 2016–June 2017		FY 2016–17 Paroling Population	Percentage of Parolee Population with a Re-entry COMPAS
Re-entry COMPAS Assessments Completed	28,776	40,854	70%
Source: The department provides this data via its Division of Rehabilitative Programs as of June 2016 through July 2017; data are not validated by the OIG.			

Special Reviews

Upon request of the Governor, the Speaker of the Assembly, or the Senate Rules Committee, and as part of our statutory mandate, the OIG will conduct a special review of departmental policies, practices, or procedures set forth in the review request as outlined by state statute. Upon completing the review, the OIG reports its findings and recommendations to the authorizing entity, and issues a public report. In 2017, no special reviews were requested.

CORRECTIVE ACTION PLAN UPDATES FOR THE DEPARTMENT

The OIG published 30 formal reports containing 11 recommendations in 2017. The recommendations in these reports promote greater transparency, process improvements, increased accountability, and higher adherence to policies and constitutional standards.

Status of Recommendations Made to the Department in 2017

The following exhibit outlines the 11 recommendations the OIG made in March and August 2017 as published in its semi-annual reports. The department has fully implemented two recommendations, partially implemented two recommendations, and not implemented seven recommendations.

Exhibit 1. Semi-Annual Report Recommendations, 2017

OIG *Semi-Annual Reports*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
Jan.–June 2017 (Issued Aug. 2017)	The OIG recommends that the department implement a policy change requiring investigations be completed within six months of assignment (renewal of a recommendation first published by the OIG in its March 2016 Semi-Annual Report, 2015-2, Vol. I).	The department continues to recognize the importance and value of completing investigations as quickly as possible. However, given the volume of cases processed by the Office of Internal Affairs (OIA) and the number of resources it has available to conduct investigations, it is not feasible to require all investigations to be completed within a six-month period. Moreover, many investigative timelines are dictated by the individual facts and circumstances of each investigation. Many OIA investigations are completed prior to six months after assignment to OIA, while others may take longer. Investigative times vary based on a myriad of factors, including but not limited to, OIA resources, investigation complexity, tolling factors, availability of witnesses and subjects, availability of stakeholders, prosecutorial reviews, follow-up investigative requests, and a host of other reasons. However, the department agrees that the faster an investigation is completed, the better it is for all involved in the process to include complainants, hiring authorities, subjects, and the public at large. Toward that end, the department has implemented changes to help speed up investigations and to increase the number of investigations completed, which will reduce caseloads of special agents and in turn allow them to complete future investigations in a timelier manner. These include the training of ISU staff on allegation inquiries, and development of 989 packages in order to receive thorough investigative requests and to resolve low-level misconduct issues with Direct Adverse Action whenever possible through a more critical review of cases in Central Intake. OIA has collaborated with stakeholders to conduct more timely interviews resulting in increases in monthly case completions on average. The department continues to explore a number of alternative solutions to reduce the length of time it takes to complete investigations, including but not limited to, reviewing how the department deals with low-level misconduct issues, engaging the department to review obstacles to supervisory functions and re-empower supervisors to deal with issues prior to their escalation. OIA is reviewing best practices at other agencies to include Education-Based Discipline, continues to review the OIA report to streamline report writing, and is recommending re-engaging unions on directed reports.	Not implemented

OIG *Semi-Annual Reports*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
Jan.–June 2017 (Issued Aug. 2017)	The OIG recommends that the department develop guidelines and exceptions to departmental cell entry policies and procedures for Office of Internal Affairs' special agents conducting criminal investigations to prevent the loss and destruction of evidence.	OIA disagrees with this this recommendation. Pursuant to departmental policy, absent an emergency situation all staff (including institutional staff) cannot enter an inmate's cell when the inmate refuses to exit. OIA agents are trained on industry standard tactical entry techniques, which are utilized outside institutional grounds in compliance with the law. However, cell entries in a secured facility, without the threat to human life, should be done in a controlled and safe manner. Cell entry techniques within the limited confines and available tools at a state prison are a specialty area that would require continued training and practice. Institutional personnel are in a better position to carry out this task within a state prison. Moving forward, OIA will endeavor to look at alternative ways to separate inmates from the ability to destroy evidence when conducting operations inside a state prison. This may include ruses for inmate movements or other industry standard tactics.	Not implemented
	The OIG recommends that the department provide training to all custody and medical staff regarding the removal of dead bodies without a coroner's authorization.	The department does not concur with the OIG's assessment of several of the cases cited within their report along with the recommendation for this particular item. The first case cited by the OIG identified that the Incident Commander did have the body moved without the coroner's approval, and corrective action would be appropriate in this particular case. However, in both the second and third cases cited, the onsite correctional officers initiated life-saving measures prior to the inmates being pronounced as deceased. The correctional officers' actions in these two other cases were in compliance with existing policy as a physician had not pronounced deaths prior to the staff initiating life-saving measures.	Not implemented
	The OIG recommends that the department establish clear guidelines for analyzing inmates' statements related to use-of-force incidents, including accepting an inmate's plain language complaint as a legitimate allegation of unreasonable force, to initiate a proper inquiry or investigation. The OIG also recommends the department provide training to all supervisors and managers to ensure inmate allegations are processed according to policy.	The department does not concur with the recommendation from the OIG. The "one" case cited wherein the IERC did not determine the inmate's statement to be an allegation was ultimately reviewed at a higher level. The department finds the existing policy regarding allegation reporting requirements is sufficient. Within the "one" case cited by the OIG, the DAI Directorate did not concur with the local IERC's decision on the matter and initiated appropriate follow-up of the inmate's allegation. The department does not find statewide training for supervisors is appropriate for one singular cited incident. The department will continue to monitor this process to maintain consistency. Additionally, a memo was generated from the DAI director, dated June 15, 2017, clarifying the department's policy and requiring training for all supervisors and managers (see attached). In this memo the department specifically identified the issues reported in the June-Dec. 2016 SAR and responded with direction from the DAI director. The current SAR evaluated departmental incidents from January to June 2017. This memo and the training were not completed and fully implemented until July 15, 2017. The department will continue to monitor this process and utilize progressive discipline for future areas of non-compliance with the policy.	Not implemented
	The OIG recommends that the department clarify its policy requiring staff members to document providing inmates with clean clothing as part of the chemical agent decontamination process and to document the time clothing is provided to the inmate.	The department concurs with the OIG that the existing policy language could provide clearer direction on documenting and reporting staff uses of force. The department is developing revisions to DOM, Section 51020.17.1, regarding staff reporting requirements. Additionally, the department is also looking at changes to Title 15, Sections 3268.1 through 3268.3. The regulatory and DOM approval processes are expected to be completed by April 2018, with associated lesson plan updates to be completed and implemented by June 2018.	Partially implemented

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OIG *Semi-Annual Reports*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG Status
Jan.–June 2017 (Issued Aug. 2017)	The OIG recommends that the department provide training to reinforce the importance of ensuring that the application of spit masks or hoods meets the criteria set forth in the Department Operations Manual. The OIG also recommends the department clarify criteria regarding the monitoring of inmates after a spit mask or hood has been applied.	The department has clarified the policy to require constant supervision of an inmate once a spit mask has been applied since application of a spit mask can cause respiratory distress regardless of other factors, such as pepper spray exposure.	Fully implemented
	The OIG recommends that the department attempt to obtain a secondary indicator, such as direct observation, failure to clear a metal detector, or contraband found during a cell search, before placing an inmate on contraband surveillance watch based only on a low-dose body scan.	The department's existing policy provides staff direction that when it becomes apparent through medical examination, direct observation, or there is reasonable suspicion that an inmate has concealed contraband in their body, the inmate may be placed on contraband surveillance watch. Ideally, the department would prefer to have multiple indicators prior to any CSW placement; however, this is not always an option. The department will not require an additional indicator when staff identifies possible contraband on an inmate using the low-dose scanner. The department finds that by implementing this recommendation it will result in staff being forced to allow contraband into the institution when there is not a secondary indicator present to justify CSW placement.	Not implemented
July–Dec. 2016 (Issued March 2017)	The OIG recommends that the department implement a policy change requiring investigations be completed within six months of assignment (renewal of a recommendation first published by the OIG in its March 2016 Semi-Annual Report, 2015-2, Vol. I).	The department continues to recognize the importance and value of completing investigations as quickly as possible. However, given the volume of cases processed by the Office of Internal Affairs (OIA) and the number of resources it has available to conduct investigations, it is not feasible to require all investigations to be completed within a six-month period. Many OIA investigations are completed prior to six months after assignment to OIA, while others may take longer. Investigative times vary based on a myriad of factors, including but not limited to, OIA resources, investigation complexity, tolling factors, availability of witnesses and subjects, availability of stakeholders, prosecutorial reviews, follow-up investigative requests, and a host of other reasons. However, the department agrees that the faster an investigation is completed, the better it is for all involved in the process to include complainants, hiring authorities, subjects, and the public at large. The department has implemented changes to help speed up investigations and to increase the number of investigations completed, which will reduce caseloads of special agents and in turn allow them to complete future investigations in a more timely manner. These include the training of ISU staff on allegation inquiries, and development of 989 packages in order to receive thorough investigative requests and to resolve low-level misconduct issues with DAA whenever possible through a more critical review of cases in Central Intake. OIA has collaborated with stakeholders to conduct more timely interviews resulting in increased timeliness. The department continues to explore a number of alternative solutions to reduce the length of time it takes to complete investigations, including but not limited to, reviewing how the department deals with low-level misconduct issues, engaging the department to review obstacles to supervisory functions and re-empower supervisors to deal with issues prior to their escalation. OIA is reviewing best practices at other agencies to include Education-Based Discipline, continues to review the OIA report to streamline report writing, and is recommending re-engaging unions on directed reports.	Not implemented

OIG *Semi-Annual Reports*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
July–Dec. 2016 (Issued March 2017)	The OIG recommends that the department provide its attorneys with refresher training on how to properly assess the deadline for taking disciplinary action and the requirements for documenting these assessments in the department's case management system.	The Office of Legal Affairs is in process of developing a training course on how to properly assess the deadline for taking disciplinary action and the requirements for documenting these assessments in the case management system. We anticipate training to be completed by August 2017. December 2017 Update: Training completed in September 2017.	Fully implemented
	The OIG recommends that the department develop procedures and implement better training for safe firearms handling, including addressing negligent discharges with appropriate follow-up to include training or discipline as appropriate.	Prior to the publication of this report, the department identified several areas of concern and made corrections or modifications to the training approach in an effort to mitigate negligent discharges. See changes outlined in Comments. DAI, DAPO, OCS, and OIA formed a workgroup to review several aspects of the department's use-of-force policies and regulations. Language regarding negligent and accidental discharges will be incorporated into this revision, which will include the appropriate follow-up to include training and discipline as appropriate. While the workgroup was established prior to the OIG's report, the negligent and unintended discharges are being reviewed within the workgroup. DAI will review the findings of the workgroup and determine if any changes relative to the use-of-force policy should be implemented. However, after reviewing the SAR, DAI does not concur with the OIG that institutions are failing to provide adequate follow-up when negligent discharges occur. For example, during the SAR review period, DAI hiring authorities referred approximately four negligent discharges for review through OIA's Central Intake Unit for Investigation/Direct Adverse Action. DAI will continue to review each incident on a case by case basis using the department's disciplinary matrix as appropriate. As pertains to DAPO, DAPO currently trains how to safely handle a weapon on a quarterly basis, which appears to be sufficient. In reviewing the SAR, similarly does not agree with the OIG that there is a failure to provide adequate follow-up when negligent discharges occur. For example, DAPO referred the one negligent discharge incident (OIG 15-1788-IR) of a firearm to the OIA. The employee in this case was disciplined utilizing the progressive discipline matrix. The department does take this matter very seriously and has done research into the issue, looking at other law enforcement agencies and their rates of accidental discharges. In one comparable example, the Los Angeles sheriff's department transitioned to the Smith & Wesson M&P semi-automatic handgun from the Beretta 92F in 2013. In 2015, the year that the M&P was substantially implemented in the patrol division, the department experienced 19 unintended discharges, accounting for approximately .17% of their total sworn peace officer staff. For the same approximate time period, during the transition to the Glock 22 semi-automatic handgun, the department experienced 16 unintended discharges, accounting for approximately .06% of the total peace officers trained in 2016. The department will continue to monitor incidents of negligent discharge to identify trends and potential areas of improvement.	Partially implemented

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OIG *Semi-Annual Reports*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
July–Dec. 2016 (Issued March 2017)	The OIG recommends that the department provide training to supervisors regarding the procedures and processes for obtaining timely and appropriate public safety statements.	The department has carefully reviewed each of the identified case examples and does not find that the examples are indicative of a systemic issue requiring additional training for custody supervisors. For example, OIG-16-1473-RO describes an incident that occurred during range training. A public safety statement is not required during firearms qualification or firearms training. Another example is OIG-16-1723-RO wherein the staff member fired three less-than-lethal rounds to stop an attack and one round struck the suspect in his facilia area. This incident did not require a public safety statement as deadly force was not utilized during the incident. Additionally, DAPO reviewed the cases identified in the SAR pertaining to DAPO and found that it only referenced one incident, OIG-15-2323-IR, where a public safety statement was not obtained. This one incident does not represent a systemic problem. The department believes existing regulations on the use of public safety statements are clear and the agency is committed to enforcing them through the progressive discipline process on a case-by-case basis. However, the department is committed to addressing any systemic issue through training and/or revision of existing policy and procedure, should the need arise.	Not implemented

The OIG offered 39 recommendations in its medical inspection reports to both CCHCS and the department. Currently, while the OIG does not formally follow up on responses or actions to these recommendations from either CCHCS or the department, we continue to observe and address prior recommendations from previous cycles.

Exhibit 2. Medical Inspection Recommendations, 2017

OIG *Medical Inspection Reports*	Institution	Description of Recommendation ("The OIG recommends that …")
(Issued 2017)	Ironwood State Prison	• ISP staff, prior to scanning specialist consultation reports, should check the documents for a provider's signature indicating review and, if the signature is missing, return the document to the provider for review. • ISP conduct OHU-specific audits and corresponding nurse training; that the audit assess both LVN and RN care on all shifts; that nursing supervisors also assess LVN and RN communication on the first and third shifts; and that ISP ensure open communication and thorough documentation; and that results be reported to the institution's quality management team. • ISP providers meet daily and discuss urgent and emergent patient care events and address chronic care and difficult patient management. These meetings will further develop an improved rapport and collegial atmosphere as the providers share and redefine patient care within the institution. • ISP conduct an assessment of its current population management practices. • ISP telemedicine services duplicate the scanning process of offsite specialty returns and scan specialist recommendations to the providers. This will allow ISP's providers to promptly review recommendations and implement orders.

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OIG *Medical Inspection Reports*	Institution	Description of Recommendation ("The OIG recommends that …")
(Issued 2017) (cont.)	California Medical Facility	• CCHCS revise its radiological report scanning policy and allow radiology reports to be scanned into the patient's electronic medical record (renewal of a previous recommendation from an earlier cycle). • CMF scan all future radiology reports into the electronic medical record. • CMF implement a local operating policy whereby specialty reports are required to be reviewed and signed by providers before they are scanned into the electronic medical record by medical records staff. • CCHCS further review the identified provider for at least six months. To ensure an objective peer review, the CME and CP&S should not be involved in this process. • CCHCS re-evaluate the process currently used to annually evaluate providers and that CMF leadership review the medical care of complex patients to effectively evaluate providers' abilities.
	Wasco State Prison	• WSP develop a process to improve access to all radiology reports that have not been scanned into the electronic health record since late 2015. • WSP leadership provide training for providers on spending adequate time reviewing the medical records of unfamiliar patients, even when caring for the patient for a brief time. This is especially important for the more complex patients in the CTC.
	California State Prison, Los Angeles County	• LAC implement training of all health care staff in how to use RIS-PACS to allow appropriate patient care, and to consider discipline, when appropriate, for staff who continue to miss timely report review in RIS-PACS. • LAC nursing administrators develop a process to implement the CCHCS policy requiring that administrators evaluate nursing assessments and nursing documentation.

OIG *Medical Inspection Reports*	Institution	Description of Recommendation ("The OIG recommends that …")
(Issued 2017) (cont.)	California State Prison, Solano	• SOL should not cancel and re-order invalid appointment orders. Instead, SOL should use the override function that still allows the institution to re-schedule invalid orders. By pursuing this strategy, compliance dates would not be lost, user error would be minimized, and the CCHCS Dashboard, the automatic medical care performance metrics, would better reflect SOL's true performance. • CCHCS audit a range of different laboratory report types to identify all data fields that are not transferring into the EHRS from the laboratory provider. Once identified, CCHCS should implement corrections to the EHRS to ensure that the critical information is available to health care staff. In the meantime, CCHCS should create an alternative workflow, for all institutions using the EHRS, to ensure missing information is retrieved timely and reviewed by providers. • CCHCS develop a set of electronic auditing tools that can identify diagnostic test results that providers have not reviewed and for which they have not generated patient letters. SOL management should then use the auditing tools to ensure all test results are reviewed timely and that providers notify patients of test results. • SOL and CCHCS modify the process currently used to cancel orders after a patient is absent from the institution for more than 48 hours. Since the vast majority of these are for outpatients, not all orders should be automatically canceled. SOL and CCHCS should consider subjecting only medication orders to the automatic cancellation process. • If the existing automatic cancellation process is not modified as recommended, then SOL will need to implement a process wherein all canceled orders are systematically reviewed for renewal when patients return to the institution. At the time of the onsite inspection, SOL providers were not aware of the automatic order cancellation process, their responsibility to review and renew those canceled orders, or a method of how to identify them.

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OIG *Medical Inspection Reports*	Institution	Description of Recommendation ("The OIG recommends that …")
(Issued 2017) (cont.)	California Correctional Center	• CCC re-examine and modify its diagnostic processes to ensure reliable test completion and diagnostic report retrieval. • CCC develop a local policy addressing provider and nursing responsibilities for patients in the OHU for less-than-24-hour observation. • At the time of a patient's discharge, the OHU nurse verbally communicate patient information to the assigned primary care clinic nurse and document in the OHU discharge nursing note that the nurse-to-nurse transfer of information occurred.
	California Rehabilitation Center	• CRC scan all future radiology reports into the patient's electronic medical record, and CCHCS revise its radiological report scanning policy (renewal of a previous recommendation from an earlier cycle). • CRC focus on improving communication during huddle meetings to share information on patients who were transferred. Both verbal and written communication templates could be developed to cover clinical details, such as the patient's vital signs and nursing assessment on the transferred patients. In addition, the provider reviewing the previous day's on-call work could use a comprehensive on-call provider note guide instead of a notepad to ensure all relevant information is covered. • Nursing leadership assess its current sick call audit selection process to include a nursing sick call triage to aid patients in the absence of nursing face-to-face encounters. • The medical leadership appropriately match the experience and skill of providers to the level of complexity of CRC's patient population. • The medical leadership provide additional provider training and monitoring for diabetic and opioid medication management.

OIG *Medical Inspection Reports*	Institution	Description of Recommendation ("The OIG recommends that …")
(Issued 2017) (cont.)	North Kern State Prison	• NKSP cross-train several nurses to work in the specialty clinic in the event that the regular specialty nurse is away from the institution. • NKSP develop a system to ensure specialty reports are retrieved from the offsite specialist in a timely manner.
	Salinas Valley State Prison	• SVSP leadership implement effective care management and care coordination processes for the institution's patients, so nurses can make appropriate interventions for their chronic care patients when needed. • SVSP provide training to nurses to improve their recognition of sick call requests requiring same-day evaluation, improve their quality of assessments, and improve the accuracy of their documentation.
	California Substance Abuse Treatment Facility and State Prison at Corcoran	• SATF provide training for health information management staff to ensure reports are reviewed and signed by providers prior to being scanned into medical records. When the EHRS is implemented, SATF should ensure that the health information management staff send reports to providers for their review and signature electronically. • SATF leadership deliver training to providers regarding careful review of medical records for complex patients, such as those cared for in the CTC. This is especially important for providers who are unfamiliar with the patients because the providers are on call or covering on weekends. In addition, SATF should train providers about the importance of careful record review for patients returning from outside hospitals to ensure that all diagnoses and management plans are appropriately addressed.

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OIG *Medical Inspection Reports*	Institution	Description of Recommendation ("The OIG recommends that …")
(Issued 2017) (cont.)	California Correctional Institution	• CCI arrange additional EHRS training for providers, supervisors, nurses, and ancillary staff, specifically targeting all staff involved with appointments, scheduling, specialty services, and utilization management. • CCI revise current nursing audits to include the electronic health record systems' processes and competencies. • CCI ensure the current SRN sick call audit process monitors the quality of all facets of the sick call process, including the initial nurse triage. • CCI implement audits on arriving and departing patients to ensure providers and nurses are notified of upcoming transfers as well as audit processes for specialty consults and follow-up appointments, to monitor timeliness. Audits should be ongoing, and findings reported directly to the Patient Safety Committee. • CCI audit the electronic records to determine if radiology information and electronic messages are being processed and received appropriately by each medical provider. During the OIG medical inspection, the CCI providers could not retrieve radiology information from the RIS-PACS and could not effectively cover each other's messages within the electronic health record system. • CCI implement OHU-specific continuous quality improvement programs that target communication processes among nursing staff on all shifts and also between OHU nurses and providers. CCI leadership should create a system to ensure unusual nursing occurrences are identified daily, documented, and communicated to the provider. This should be part of the daily huddle, but it was not occurring. While processes for communication did exist, CCI was not using them.

The OIG made two additional recommendations, and reiterated a concern, in the September 2017 C-ROB report as seen in the following exhibit. C-ROB is an independent board and, unlike the OIG, does not have the authority to request specific responses to recommendations; nonetheless, the department is reviewing both recommendations.

Exhibit 3. C-ROB Recommendations, 2017

OIG *C-ROB Annual Report*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
(Issued Sept. 2017)	The board recommends that the department issue a training or memorandum clarifying the use of split-shift programming for milestone, educational merit, or rehabilitative achievement credit-eligible programs, allowing eligible inmates to attend all credit-earning rehabilitative programs with a flexible work schedule.	The Division of Rehabilitative Programs (DRP) is in the process of developing a memorandum in coordination with the Division of Adult Institutions in regards to the split-shift flexible work schedule in order to ensure emphasize inmates are able to attend all credit-earning rehabilitative opportunities.	Pending
	The board recommends that the department take the next steps to implement a data collection plan to document the effectiveness of current and future programming. At this time, the Strategic Offender Management System (SOMS) has data that includes the following for each inmate referred to at least one program: pre- and post-program risk assessment scores; demographic information (age, ethnicity, and gender); educational level; criminal history; substance abuse history; prior treatment programs; times/hours of program attendance; absences (excused or not); program start and graduation date; and program completion or reason for dropping out.	The department's Strategic Offender Management System (SOMS) currently has the California Static Risk Assessment and COMPAS information, both static risk assessment tools. Additionally, there is in-classroom or face-to-face attendance that is taken, absence information, and program start and completion/assignment dates noted in SOMS, and program completion/exit reasons. DRP, in collaboration with the Office of Research, SOMS, and COMPSTAT divisions are planning to start workgroups beginning in January of 2018 to fully define business rules associated to the extraction of this data to ensure consistency within the department while identifying policy and program information issues that need resolution.	Pending
	The board would like to reiterate the importance of measuring program implementation and outcomes, and to the extent possible, longer-term outcomes after offenders have been released to the community. It would like to see the department work toward utilizing the SOMS data for program measures, such as institutional behavior, educational attainment, and individual offender progress in rehabilitation programming. Outcome measures, such as recidivism and other measurable goals that include housing after release, employment, income, transportation, family support, substance abuse, and educational attainment, should be collected for parolees after they parole to their communities.	DRP continues to build collaborative relationships including data sharing with the California Employment Development Department to assist in understanding post-release employment information for offenders. This is occurring at the departmental level through various divisions working with the California Workforce Development Board. Additionally, through the full implementation of the department's Automated Re-entry Management System and in collaboration with the Division of Adult Parole Operations, the department is continuing to look for opportunities to collect parolee information once inmates are released to their community. Conversations are ongoing.	Pending

APPENDIX: REPORTS RELEASED IN 2017

Annual Report

- 2016 OIG Annual Report (February 1, 2017)

Semi-Annual Reports

- OIG Semi-Annual Report, July–December 2016, Volume I (March 15, 2017)
- OIG Semi-Annual Report, July–December 2016, Volume II (March 15, 2017)
- OIG Semi-Annual Report, January–June 2017, Volume I (October 13, 2017)
- OIG Semi-Annual Report, January–June 2017, Volume II (October 13, 2017)

Medical Inspection Reports

- California State Prison, Los Angeles County Medical Inspection Results Cycle 4 (January 4, 2017)
- Deuel Vocational Institution Medical Inspection Results Cycle 4 (January 4, 2017)
- California City Correctional Facility Medical Inspection Results Cycle 4 (January 13, 2017)
- Substance Abuse Treatment Facility and State Prison at Corcoran Medical Inspection Results Cycle 4 (January 20, 2017)
- Richard J. Donovan Correctional Facility Medical Inspection Results Cycle 4 (January 20, 2017)

- Pleasant Valley State Prison Medical Inspection Results Cycle 4 (February 14, 2017)
- Central California Women's Facility Medical Inspection Results Cycle 4 (March 15, 2017)
- California State Prison, Sacramento Medical Inspection Results Cycle 4 (March 21, 2017)
- California Health Care Facility Medical Inspection Results Cycle 4 (April 19, 2017)
- Valley State Prison Medical Inspection Results Cycle 5 (June 21, 2017)
- Ironwood State Prison Medical Inspection Results Cycle 5 (July 7, 2017)
- California Medical Facility Medical Inspection Results Cycle 5 (July 26, 2017)
- Wasco State Prison Medical Inspection Results Cycle 5 (August 24, 2017)
- California State Prison, Los Angeles County Medical Inspection Results Cycle 5 (September 7, 2017)
- California State Prison, Solano Medical Inspection Results Cycle 5 (September 7, 2017)
- California State Prison, Corcoran Medical Inspection Results Cycle 5 (September 13, 2017)
- California Correctional Center Medical Inspection Results Cycle 5 (October 18, 2017)
- California Rehabilitation Center Medical Inspection Results Cycle 5 (October 24, 2017)
- North Kern State Prison Medical Inspection Results Cycle 5 (October 25, 2017)
- Salinas Valley State Prison Medical Inspection Results Cycle 5 (October 27, 2017)

- Richard J. Donovan Correctional Facility Medical Inspection Results Cycle 5 (November 1, 2017)
- California Substance Abuse Treatment Facility and State Prison at Corcoran Medical Inspection Results Cycle 5 (November 29, 2017)
- California Correctional Institution Medical Inspection Results Cycle 5 (December 7, 2017)

Medical Inspection Summary Report

- Cycle 4 Medical Inspection Summary Report (April 28, 2017)

Blueprint Monitoring Reports

- Eighth Report on the California Department of Corrections and Rehabilitation's Progress Implementing Its Future of California Corrections *Blueprint* and Update to the *Blueprint* (March 30, 2017)

California Rehabilitation Oversight Board (C-ROB) Report

- C-ROB September 15, 2017, Annual Report (September 14, 2017)

All reports are available on our website:
www.oig.ca.gov/pages/reports.php.

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Annual Report

OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
May 2018

OIG