OFFICE OF THE INSPECTOR GENERAL

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FOLLOW-UP REVIEW OF THE SPECIAL REVIEW INTO THE DEATH OF CORRECTIONAL OFFICER MANUEL A. GONZALEZ, JR. ON JANUARY 10, 2005 AT THE CALIFORNIA INSTITUTION FOR MEN

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STATE OF CALIFORNIA

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EXECUTIVE SUMMARY

The California Institution for Men has made significant progress in implementing recommendations presented in the Office of the Inspector General's March 2005 special review into the circumstances surrounding the stabbing death of a correctional officer on January 10, 2005, but the Department of Corrections and Rehabilitation's progress in addressing the recommendations for which it was responsible has been limited.

In March 2005, the Office of the Inspector General issued a special review into the circumstances surrounding the stabbing death of Correctional Officer Manuel Gonzalez, Jr. on January 10, 2005 at the California Institution for Men. The special review identified systemic procedural and policy deficiencies, procedural violations, and other factors that contributed to Officer Gonzalez's death. As a result of that special review, the Office of the Inspector General presented the following findings:

- The California Institution for Men had inappropriately housed the inmate who was charged with the officer's murder in a general population unit despite his history of violent behavior and other relevant factors.

- The accused inmate's reception center processing had been delayed due to complex case factors, severely limiting his options for transfer to another institution.

- The stabbing assault on the officer might have been prevented had officers on duty at the scene, including the victim, followed security protocols and additional security restrictions that had been recently imposed.

- Inmates were able to obtain and hide weapons because of lax tool controls, poor building maintenance, and the failure of the correctional staff to conduct required cell searches.

- Although the California Department of Corrections and Rehabilitation[1] procured and distributed protective vests to its institutions consistent with a budget change proposal and an agreement with the California Correctional Peace Officers Association, there were unwarranted delays in issuing vests at the California Institution for Men. Officer Gonzalez's vest was in the institution's warehouse when he was stabbed.

[1] As a result of reorganization in July 2005, the former Department of Corrections is now known as the Department of Corrections and Rehabilitation and all references to that department in this report are synonymous with references to the Department of Corrections in the Office of the Inspector General's March 2005 report.

- ♦ The institution's medical clinic where the victim was taken after the stabbing assault was poorly equipped and ill-prepared to handle the emergency.

- ♦ The institution's management had neither set up an Emergency Operations Center nor instituted an Emergency Operations Plan after the stabbing assault due to ambiguous protocols. There was resulting confusion in the chain of command, failure to implement emergency operations policies, contamination of the crime scene, and loss of critical evidence.

- ♦ The institution had failed to adequately address inmates' mental health needs.

- ♦ The inmate had been permitted to conduct a telephone conference with an attorney before being indicted for the officer's murder even though the attorney's request for the conference had not been properly submitted in writing.

The Office of the Inspector General submitted 42 recommendations to address these findings, directing 20 of them to the California Institution for Men and 22 of them to the Department of Corrections and Rehabilitation. Two of the recommendations directed to the department are no longer applicable.

The 2006 follow-up review revealed a distinct contrast between the institution's progress in implementing the Office of the Inspector General's recommendations and that of the department. While the institution fully implemented 75 percent (15 of 20) of the recommendations for which it is responsible, the department fully implemented only 50 percent (10 of 20) of the recommendations for which it is responsible. Similarly, while the institution achieved at least some degree of implementation on each of the 20 recommendations for which it is responsible, the department left 30 percent (6 of 20) of the recommendations for which it is responsible unimplemented.

The principal reasons the department cited for not implementing the Office of the Inspector General's recommendations were that it was either waiting to receive additional funding or needed to conduct further studies. The Office of the Inspector General notes, however, that the department has yet to complete these tasks, even though its own corrective action plan called for their completion by April 2006.

Among the most significant findings of this follow-up review are the following:

- ♦ The California Institution for Men has implemented a department directive requiring that any newly received inmate be placed in administrative segregation if that inmate's previous housing assignment or history of violence warrants such placement. The institution is also retrofitting certain cells for use as additional administrative segregation housing.

- ♦ While the institution's procedures and practices governing controls over tools have improved significantly, the Office of the Inspector General found that maintenance staff members were storing tools and equipment in three container exchange boxes (room-sized metal containers) located within the institution's

secure perimeter and were accessing tools from these locked units without conducting required daily inventories and without the knowledge of the institution's tool control officers. One of the boxes contained ladders of varying lengths, which could be deployed as escape aids.

- The institution has either issued protective vests or has otherwise made them available to custody staff.

- The institution has equipped its medical clinics in a manner consistent with the department's guidelines as they relate to the expected level of care for medical emergencies, which restricts the level of available care to cardiopulmonary resuscitation and basic first aid. Therefore, staff or inmates who suffer serious injury or trauma requiring treatment beyond basic first aid must rely on the prompt response of outside emergency medical care providers.

- The Department of Corrections and Rehabilitation still has not conducted the recommended evaluation of the scope and responsibility of institution investigative services units as the primary criminal investigation entities for securing crime scenes and for preserving and processing evidence. The department reports that it is waiting for funding approval for a pilot study to accomplish this, as well as for a review of all formal agreements between the institutions and the local law enforcement agencies that serve them.

- Institution security has been enhanced through the addition of a five-member security squad to its investigative services unit which is undergoing specialized training in securing crime scenes and preserving evidence.

- Although the Office of the Inspector General recommended that the department evaluate and modify regulations and policies governing confidential calls between inmates and attorneys, the department has still not modified its regulations. Similarly, the department reports that it continues to evaluate the need for additional procedures to improve communications among key staff with respect to dealing with external inquiries regarding inmates who require special handling.

As a result of the follow-up review, the Office of the Inspector General has issued the following recommendations:

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Institution for Men accomplish the following:

- **Discontinue the storage of tools within the secured perimeter unless they are placed under the supervision and control of the institution's tool control officer and subjected to standard inventory procedures.**

- **Conduct regular monthly meetings of the institution's emergency medical response review committee in conjunction with post-incident debriefings in which medical personnel involved in specific incidents participate.**

In addition, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation accomplish the following:

- **Continue efforts to develop appropriate emergency medical policy and procedures and a level of preparedness at all institutions consistent with community standards.**

- **Update section 55010 of the *California Department of Corrections and Rehabilitation Operations Manual* so that it both clarifies those circumstances dictating the implementation of an Emergency Operations Plan and incorporates any technological changes that have occurred since that section's last revision in 1989.**

- **Evaluate the need for a memorandum of understanding or protocols governing when an outside agency should assume primary responsibility for the criminal investigation of a crime committed against a staff member.**

- **Re-evaluate the scope and responsibility of the institutions' investigative services units as the primary criminal investigative entity, given their limitations in manpower, training, and resources.**

- **Clearly define the role and expectations of the institutions' investigative services units in identifying and securing potential crime scenes, identifying and preserving evidence, and, if they remain the primary investigative entities, properly processing the crime scene and collecting the resulting evidence.**

- **Evaluate the need for training at the correctional officer, sergeant, and investigative services unit levels relative to identifying, collecting, processing, and documenting physical evidence for potential forensic examination.**

- **Develop a "lessons learned" instructional curriculum for all institutions that addresses the appropriate or inappropriate handling of events leading up to and following the death of Officer Gonzalez and present it as formal training to custody staff at all institutions.**

- **Evaluate and possibly modify regulations governing "confidential calls" between inmates and their attorneys based on the advice of the department's legal counsel. Such modifications should deal with permitting verification through independent sources that the requesting attorney is licensed to practice, balancing an inmate's right to counsel with the institution's need to validate related telephone calls and its available resources to facilitate them.**

- **Develop procedures for wardens and chief deputy wardens to communicate with key institution staff members (such as the litigation coordinator and the public information officer) when inmates who require special handling enter their institutions. These communications should compel staff members to refer all external inquiries concerning these inmates to the attention of the warden or the warden's designee.**

BACKGROUND

On January 10, 2005, Correctional Officer Manuel A. Gonzalez, Jr. was fatally stabbed while on duty at the California Institution for Men in Chino. The suspected assailant was later identified by law enforcement as Jon Christopher Blaylock, an inmate who had been housed in the institution's reception center for more than six months while awaiting permanent institution placement.

The California Institution for Men is one of the state's 11 reception centers that serve as entry points into state prison for offenders newly sentenced to prison; parolees who have committed new crimes; parole violators being returned to custody; parolees-at-large extradited from other states; inmates scheduled for parole into the community from prisons throughout the state; and inmates enroute to other institutions or returning to prison from court.

Blaylock arrived at the institution in June 2004 to undergo reception center processing after receiving a 75-year prison sentence for the attempted murder of a police officer, a crime he committed shortly after his release on parole from an earlier prison term. At the time of his parole, he was serving an indeterminate term in the California State Prison, Corcoran security housing unit and was classified as a maximum security inmate. From the time of his arrival at the California Institution for Men on June 23, 2004 until his alleged stabbing assault on Correctional Officer Gonzalez in January 2005, Blaylock was assigned to general population housing, except for a seven-week period he spent in administrative segregation while being investigated for his involvement in an assault on another inmate.

The San Bernardino County Sheriff's Department conducted a criminal investigation into the death of Correctional Officer Gonzalez, resulting in charges of murder against Blaylock, who is awaiting trial.

Following Officer Gonzalez's death, the Office of the Inspector General conducted a special review into the circumstances surrounding the officer's death.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of this 2006 follow-up review was to assess the progress of the California Institution for Men and the Department of Corrections and Rehabilitation in implementing the 42 recommendations from the Office of the Inspector General's 2005 special review into the death of correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men.[2] The follow-up review was performed pursuant to California Penal Code section 6126, which assigns the Office of the Inspector General responsibility for oversight of the California Department of Corrections and Rehabilitation.

In response to the Office of the Inspector General's 2005 report, the California Institution for Men, in conjunction with the Department of Corrections and Rehabilitation, prepared a

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[2] This report is available on the Office of the Inspector General's web site at www.oig.ca.gov/reports/pdf/Review_03-17-05.pdf.

corrective action plan itemizing the procedures needed to address the Office of the Inspector General's recommendations. To conduct the 2006 follow-up review, the Office of the Inspector General evaluated the actions undertaken by the institution and the department since the March 2005 special review, examined documentation, and assessed the degree to which the department's and the institution's responses have addressed the Office of the Inspector General's recommendations.

As part of the follow-up review, the Office of the Inspector General visited the California Institution for Men in August 2005 and found continuing deficiencies in the housing of maximum security inmates, tool controls, and cell search procedures. The Office of the Inspector General alerted the Secretary of the Department of Corrections and Rehabilitation to these and other deficiencies in a December 9, 2005 letter. Based on findings made during the August 2005 visit to the institution, the Office of the Inspector General initiated a statewide review of the department's other reception center institutions to assess the potential for other instances of unsafely housed maximum security inmates and presented its findings in a March 2006 report, *Special Review: Improper Housing of Maximum Custody Inmates at California State Prison Reception Centers.*[3] The Office of the Inspector General found that despite new procedures initiated by the department, large numbers of potentially dangerous maximum custody inmates were still undetected by the screening process and were ending up in the general population. The March 2006 report on the processing of maximum custody inmates presented 13 recommendations to address the issue, in effect supplementing recommendations made by the Office of the Inspector General in Finding 1 of its March 2005 special review concerning the death of Officer Gonzalez at the California Institution for Men.

In May 2006, the Office of the Inspector General conducted additional fieldwork at the institution. During these visits, the audit team interviewed staff, reviewed logs and records, observed selected facility operations, and conducted tests needed to formulate conclusions regarding the implementation of the Office of the Inspector General's recommendations. After evaluating the results of the audit procedures, the Office of the Inspector General classified the progress of the department and the institution in implementing each recommendation into one of the following categories:

- **Fully implemented**: The recommendation has been implemented and no further corrective action is necessary.

- **Substantially implemented**: More than half of the corrective actions necessary to fulfill the recommendation have been implemented.

- **Partially implemented**: Half or fewer than half of the corrective actions necessary to fulfill the recommendation have been implemented.

- **Not implemented**: The recommendation has not been implemented.

[3] The March 2006 report is available on the Office of the Inspector General's web site at http://www.oig.ca.gov/reports/pdf/Improper_Housing.pdf.

- **Not applicable**: The recommendation is no longer applicable.

SUMMARY OF PREVIOUS FINDINGS

In its 2005 review, the Office of the Inspector General examined policies and procedures concerning safety and security, reception center housing and processing, inmate mental health care, emergency incident response, medical response, crime scene management, and distribution of protective vests.

The Office of the Inspector General presented the following findings as a result of that special review:

- The California Institution for Men inappropriately housed Blaylock in a general population unit despite his recent parole from a security housing unit and his demonstrated violence toward other inmates. Blaylock should have been placed in administrative segregation upon his arrival at the institution, consistent with department policy. Six weeks after his arrival, he was involved in a violent altercation with another inmate and was assigned to administrative segregation pending disciplinary action, but he was released to the general population seven weeks later and remained there until his alleged stabbing assault on Officer Gonzalez.

- Blaylock's reception center processing was delayed due to complex case factors that severely limited his options for transfer to another institution.

- The stabbing of Officer Gonzalez might have been prevented if officers on the second watch at Sycamore Hall, including the victim, had followed security protocols and additional security restrictions imposed in response to earlier incidents in the housing unit.

- Inmates were able to obtain and hide weapons because of lax tool controls, poor building maintenance, and the consistent failure of the correctional staff to conduct required cell searches. The institution's failure to adhere to department policy requiring consistent and accurate inventory counts of tools legitimately used by inmates hindered staff from detecting inmate theft of such tools and materials for use as weapons.

- The California Department of Corrections procured and distributed protective vests to the institutions consistent with a budget change proposal and an agreement with the California Correctional Peace Officers Association; however, delays in issuing vests at the California Institution for Men were unwarranted. Officer Gonzalez's vest was in the institution's warehouse when he was stabbed.

- The medical clinic at the California Institution for Men reception center where the victim was taken after the stabbing was poorly equipped and ill-prepared to handle the emergency. Although these deficiencies may not have contributed to

Officer Gonzalez's death, given the severity of his wounds, the level of care the staff was able to provide was nonetheless inadequate.

- ♦ Because of ambiguous protocols, the management of the California Institution for Men had not established an Emergency Operations Center or inaugurated an Emergency Operations Plan. Consequently, in the wake of the officer's stabbing, there was confusion in the chain of command, emergency operations policies were not implemented, the crime scene was contaminated, and an incident log was not initiated. Correctional officers regained control of the housing unit, however, and took the suspect-inmate into custody without further serious injury to staff.

- ♦ The California Institution for Men did not implement important emergency procedures in response to the incident, leading to contamination of the crime scene and the loss of important evidence. This loss of evidence will require that the case against the accused inmate rely more heavily on eyewitness accounts.

- ♦ The California Institution for Men failed to adequately address inmates' mental health needs.

- ♦ Blaylock was permitted to conduct a telephone conference with an attorney before he was indicted for the murder of Officer Gonzalez even though the attorney's request for the conference was not properly submitted in writing.

As a result of these findings, the Office of the Inspector General submitted 42 recommendations in its review, directing 20 of them to the California Institution for Men and 22 of them to the Department of Corrections and Rehabilitation.

RESULTS OF THE FOLLOW-UP REVIEW

The purpose of the Office of the Inspector General's 2006 follow-up review was to assess the progress of the California Institution for Men and the Department of Corrections and Rehabilitation in implementing the 42 recommendations from the 2005 special review.

The follow-up review determined that the California Institution for Men has made significant progress in addressing the 20 recommendations for which it was responsible. Fifteen of the 20 recommendations (75 percent) from the March 2005 special review have been fully implemented; three (15 percent) have been substantially implemented; and two (10 percent) have been partially implemented.

IMPLEMENTATION REPORT CARD CALIFORNIA INSTITUTION FOR MEN	
Previous recommendations still applicable	**20**
Fully implemented:	**15 (75%)**
Substantially implemented:	**3 (15%)**
Partially implemented:	**2 (10%)**
Not implemented:	**0 (0%)**

By contrast, the Department of Corrections and Rehabilitation has fully implemented only 10 of the 20 recommendations (50 percent) for which it was responsible; has partially implemented four (20 percent); and has not implemented six (30 percent). For four of the six recommendations it has not implemented, the department reported that it was either waiting for additional funding or gathering further information through other studies since release of the March 2005 report. Two of the recommendations directed to the department are no longer applicable.

IMPLEMENTATION REPORT CARD DEPARTMENT OF CORRECTIONS AND REHABILITATION	
Previous recommendations still applicable	**20**
Fully implemented:	**10 (50%)**
Partially implemented:	**4 (20%)**
Not implemented:	**6 (30%)**

The follow-up review noted the following achievements:

- The California Institution for Men has implemented a department policy requiring that all newly received inmates be placed in administrative segregation housing if the inmate paroled from a security housing unit or administrative segregation unit or if the inmate's history otherwise warrants such placement, pending review by the Institution Classification Committee. New inmate screening at the institution now takes place around the clock, enabling staff to identify potentially dangerous inmates upon their arrival.

- The California Department of Corrections and Rehabilitation has developed and implemented a protective vest policy. Vests have either been issued or are otherwise available to custody staff at the California Institution for Men, thereby reducing the possibility of inmate-inflicted injuries to its correctional officers.

- The institution has begun work to retrofit certain cells for additional administrative segregation housing and it estimates that the project will be

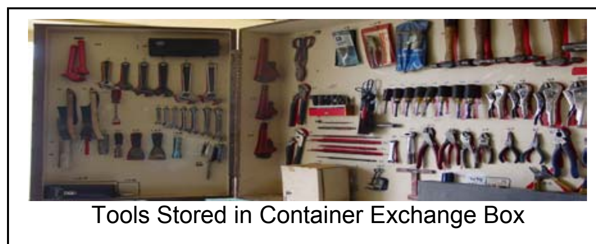
completed by January 30, 2007. These improvements should significantly enhance the safety of officers and other staff who must work with inmates in these units.

- A local operating procedure governing emergency medical care is in place at the institution and related training is being provided.

- The institution now has within its investigative services unit a five-member security squad undergoing specialized training that includes instruction in securing crime scenes and preserving evidence. The security squad also conducts cell searches and investigates crimes committed within the institution by inmates.

Nonetheless, the follow-up review revealed the following deficiencies:

- After complying with department-imposed emergency medical guidelines relative to the expected level of care provided in its clinics, the California Institution for Men has removed certain emergency equipment and replaced it with an emergency response bag, which has resulted in restricting the clinic's care level to cardio-pulmonary resuscitation and basic first aid. Consequently, staff or inmates who suffer serious traumatic injury requiring treatment beyond basic first aid must rely on a prompt response by outside emergency medical response teams to meet their medical needs. Meanwhile, apart from organizing a "focused improvement team" to collect information, the California Department of Corrections and Rehabilitation has made little progress in reviewing the emergency preparedness of its other institutions. The Office of the Inspector General made visits to seven other institutions after the department developed a corrective action plan in response to the Office of the Inspector General's March 2005 special review. Those visits, conducted in 2006, disclosed conditions similar to those at the California Institution for Men immediately following the death of Officer Gonzalez. For example, some institutions failed to provide one or more pieces of basic equipment in their emergency kits, such as oxygen tanks, suction devices, airways, or adjustable cervical collars. In addition, some emergency medical personnel at these institutions demonstrated limited knowledge of the proper use of such equipment.



Tools Stored in Container Exchange Box

- While there have been significant improvements in the institution's tool control procedures, the Office of the Inspector General found maintenance staff were storing tools in three container exchange boxes (room-sized metal containers) located behind the canteen warehouse within the minimum support facility's secured perimeter. The staff accessed tools from these storage units both without conducting required daily inventories and without the knowledge of the institution's tool control officers. One of the boxes, secured with a maintenance lock, housed ladders of varying lengths, which could be deployed for inmate escape. Once aware of this

situation, the institution's security squad members secured the storage units with their own locks and initiated steps to remove them from the secured perimeter.

Ladders Stored in Container Exchange Box

- ♦ The Department of Corrections and Rehabilitation still has not conducted the recommended evaluation of the scope and responsibility of the institutions' investigative services units as the primary criminal investigation entities for securing crime scenes and for preserving and processing evidence. The department reports that it is waiting for funding approval for a pilot study to do this, as well as for a review of all formal agreements between its institutions and the local law enforcement agencies that serve them.

- ♦ The department has still not modified its regulations governing confidential calls between inmates and attorneys. In addition, the department reports it is still evaluating the need for additional procedures to improve communications among its key staff with respect to dealing with external inquiries relative to inmates who require special handling.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General has issued 11 additional recommendations as a result of the follow-up review.

The Office of the Inspector General recommends that the California Institution for Men accomplish the following:

- ♦ **Discontinue the storage of tools within the secured perimeter unless they are placed under the supervision and control of the institution's tool control officer and subjected to standard inventory procedures.**

- ♦ **Conduct regular monthly meetings of the institution's emergency medical response review committee in conjunction with post-incident debriefings in which medical personnel involved in specific incidents participate.**

In addition, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation accomplish the following:

- ♦ **Continue efforts to develop appropriate emergency medical policy and procedures and a level of preparedness at all institutions consistent with community standards.**

- ♦ **Update section 55010 of the *California Department of Corrections and Rehabilitation Operations Manual* so that it both clarifies those circumstances dictating implementation of an Emergency Operations**

Plan and incorporates any technological changes that have occurred since that section's last revision in 1989.

- **Evaluate the need for a memorandum of understanding or protocols governing when an outside agency should assume primary responsibility for the criminal investigation of a crime committed against a staff member.**

- **Re-evaluate the scope and responsibility of the institutions' investigative services units as the primary criminal investigative entities, given their limitations in manpower, training, and resources.**

- **Clearly define the role and expectations of investigative services units in identifying and securing potential crime scenes, identifying and preserving evidence and, if they remain the primary investigative entities, properly processing the crime scene and collecting the resulting evidence.**

- **Evaluate the need for training at the correctional officer, sergeant, and investigative services unit levels relative to identifying, collecting, processing, and documenting physical evidence for potential forensic examination.**

- **Develop a "lessons learned" instructional curriculum for all institutions that addresses the appropriate or inappropriate handling of events leading up to and following the death of Officer Gonzalez and present it as formal training to custody staff at all institutions.**

- **Evaluate and possibly modify regulations governing "confidential calls" between inmates and their attorneys, depending upon the advice of the department's legal counsel. Such modifications could deal with: permitting verification through independent sources that the requesting attorney is licensed to practice, balancing an inmate's right to counsel with the institution's need to validate related telephone calls and its available resources to facilitate them.**

- **Develop procedures for wardens and chief deputy wardens to communicate with key institution staff members (such as the litigation coordinator and the public information officer) when inmates who require special handling enter their institutions. These communications should require staff members to refer all external inquiries concerning these inmates to the attention of the warden or the warden's designee.**

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1:

The Office of the Inspector General found that the California Institution for Men inappropriately housed Blaylock in a general population unit despite his recent parole from a security housing unit and his demonstrated violence toward other inmates.

ORIGINAL RECOMMENDATIONS:	STATUS	COMMENTS:
The Office of the Inspector General recommended that the California Institution for Men take the following actions:		
Use the Offender-Based Information System to carefully screen all incoming inmates and assign them to administrative segregation if the offender paroled from an indeterminate security housing unit term or if the offender's history otherwise merits such placement.	FULLY IMPLEMENTED	The California Institution for Men has implemented the provisions of an August 1, 2005 department directive requiring all newly received inmates to be placed in administrative segregation pending review by the Institution Classification Committee if the inmate paroled from a security housing unit or administrative segregation unit or if the inmate's history otherwise warrants such placement. In August 2005, the Office of the Inspector General visited the institution and found that even after the new department directive was in effect, there were inmates designated as "maximum custody" in the general population. One of these was an inmate with a history of violent behavior similar to that of the inmate who attacked Officer Gonzalez. As a result, the Office of the Inspector General conducted a statewide special review of reception center institutions and reported in March 2006 that despite the new procedures, potentially dangerous maximum custody inmates were still slipping through the screening process and ending up in general population. Accordingly, the Office of the Inspector General presented additional recommendations for screening potentially dangerous inmates at the department's reception centers. The Office of the Inspector General's follow up visit to the institution, conducted after release of the March 2006 special review, *Improper Housing of Maximum Custody Inmates at California State Prison Reception Centers*, found no instances of maximum custody inmates in the general population.

Continue the newly adopted practice of using an Offender-Based Information System terminal 24 hours per day in lieu of placing unscreened inmates into the general population.	**FULLY IMPLEMENTED**	The institution secured four office assistant positions to perform screening using the Offender-Based Information System (OBIS) on inmates received between 10:00 p.m. and 6:00 a.m., and on weekends and holidays. The California Institution for Men also reported that it has trained 20 designated custody staff in OBIS operation and posts a current listing of all trained staff in Reception Center-Central control and the security administration building. The Office of the Inspector General confirmed that OBIS log-in records verify that at least one of the employees on the designated user list uses the system on each shift.
Stress to line and supervisory staff the importance of carefully following prescribed classification regulations and procedures, including supervisory review of subordinates' work; use periodic audits by executive staff and progressive discipline to enforce compliance. Provide remedial training as necessary.	**FULLY IMPLEMENTED**	The California Institution for Men reported that it has trained staff members involved in the inmate classification process on relevant requirements of that process, and that it has initiated a weekly critique of compliance following each session.
Emphasize to all staff the need to charge inmates with the crimes the evidence demonstrates they committed while in custody and use periodic audits by executive staff and progressive discipline to enforce compliance. Provide remedial training as necessary.	**FULLY IMPLEMENTED**	The California Institution for Men reports that it trained chief disciplinary officers, captains, and hearing officers to administer the inmate disciplinary process. The institution also reports that it is initiating monthly reviews and critiques of its registers of inmate rules violations reports with its chief disciplinary officers.
In addition, the Office of the Inspector General recommended that the Department of Corrections take the following actions:		
Consider establishing a pre-parole designation that would allow parole regions and county	**NOT APPLICABLE**	The department reports that all of its reception centers for males are capable of housing inmates of all custody levels from minimum to maximum. In

jails to route parole violators with specific custody designations to the reception centers most suitably designed to handle them.		addition, the Office of the Inspector General's subsequent statewide review of the department's reception center institutions, *Special Review: Improper Housing of Maximum Custody Inmates at California State Prison Reception Centers*, released in March 2006, revealed the necessity for additional refinements to the process of screening potentially dangerous inmates who return to prison. Accordingly, this recommendation as originally presented is no longer applicable.
Work with the California Institution for Men to either phase out Sycamore Hall as a living unit for high-security inmates or upgrade it to meet safety and security standards. If the latter, prepare and submit a budget change proposal for the necessary funding.	**PARTIALLY IMPLEMENTED**	The Office of the Inspector General confirmed that the institution has begun physical modifications to Sycamore Hall, and that it estimates the modifications will be complete in January 2007.
Update the August 21, 1998 memorandum advising wardens that it is mandatory for them to chair Institutional Classification Committee meetings on a routine, rather than an exceptional, basis. Hold wardens accountable for doing so.	**FULLY IMPLEMENTED**	The Office of the Inspector General confirmed that a June 29, 2005 memorandum from a department director delineates the director's expectation that wardens routinely chair meetings.
Amend California Code of Regulations, Title 15, section 3341.5(c)(8) to mandate that when an inmate returns to prison either as a parole violator or as a new commitment having paroled from a security housing unit, the inmate be placed in administrative segregation pending an evaluation by the Institution Classification Committee.	**NOT APPLICABLE**	The Office of the Inspector General's subsequent statewide review of the department's reception center institutions, *Special Review: Improper Housing of Maximum Custody Inmates at California State Prison Reception Centers*, released in March 2006, disclosed the necessity for additional refinements to the process of screening potentially dangerous inmates who return to prison. Accordingly, this recommendation as originally presented is no longer applicable.

FOLLOW-UP RECOMMENDATIONS:

None.

ORIGINAL FINDING NUMBER 2:

The Office of the Inspector General found that Blaylock's reception center processing was delayed due to complex case factors that severely limited his options for transfer to another institution.

ORIGINAL RECOMMENDATION:	STATUS	COMMENTS:
The Office of the Inspector General recommended that the California Department of Corrections initiate a peer review audit with subject matter experts to identify any discrepancies in the processing of reception center inmates at the California Institution for Men.	FULLY IMPLEMENTED	The Office of the Inspector General found that the California Department of Corrections and Rehabilitation assigned a review team to conduct audits at the California Institution for Men. The team completed a review of reception center processing and submitted its findings and related recommendations to the warden and the southern regional administrator. The California Institution for Men responded by preparing a corrective action plan to address identified deficiencies and periodically reports its progress in implementing the corrective actions to department headquarters.

FOLLOW-UP RECOMMENDATIONS:

None

ORIGINAL FINDING NUMBER 3:

The Office of the Inspector General found that the stabbing of Officer Gonzalez might have been prevented if officers on the second watch at Sycamore Hall, including the victim, had followed security protocols and additional security restrictions imposed in response to earlier incidents in the housing unit.

ORIGINAL RECOMMENDATIONS:	STATUS	COMMENTS:
The Office of the Inspector General recommended that the management of the California Institution for Men take the following actions:		
Remind all custody staff of the importance of carefully reading and following post orders, including those requiring supervisory staff to monitor subordinates' work and to frequently inspect living units. Exercise progressive discipline to enforce compliance and provide remedial training as necessary.	FULLY IMPLEMENTED	The California Institution for Men distributed an April 20, 2005 directive to all custody staff advising them of the importance of reading and following post orders and directing supervisory and management staff to make frequent tours and inspections of their areas and document their findings. The California Institution for Men conducted security audits of all of its four facilities, prepared corrective action plans to address identified deficiencies, and instituted monthly status reports to document its progress in correcting the deficiencies. The Office of the Inspector General's tour of custody areas disclosed no material instances of non-compliance with the April 2005 directive.
Monitor adherence by custody supervisors to important security-related directives and post orders, holding supervisory staff accountable for compliance.	FULLY IMPLEMENTED	The institution reports that institution management is required to sign housing unit logs in red ink as evidence of reviewing post orders and inspecting work areas. The Office of the Inspector General confirmed evidence of management's regular visits to work sites by examining signatures in red ink on unit log books.
Ensure that all security-related directives are clear and specific to avoid misinterpretation by staff.	FULLY IMPLEMENTED	The California Institution for Men reported it performs a continuous review of all security related directives to ensure clarity and conciseness to the highest degree possible. It has initiated a process to review and clarify the program status reports at each morning meeting to address any misinterpretations.
The Office of the Inspector General further recommends that the director of the Department of Corrections and Rehabilitation hold the warden and his/her executive staff accountable for ensuring that they comply with the aforementioned recommendations.	FULLY IMPLEMENTED	The department reports that institution supervisors are required to sign housing unit logs in red ink as evidence of reviewing post orders and inspecting work areas. The Office of the Inspector General confirmed evidence of supervisors' and management's regular visits to work sites by examining signatures in red ink on unit log books.

FOLLOW-UP RECOMMENDATIONS:

None

ORIGINAL FINDING NUMBER 4:

The Office of the Inspector General found that Sycamore Hall inmates were able to obtain and hide weapons because of lax tool controls, poor building maintenance, and the consistent failure of the correctional staff to conduct required cell searches.

ORIGINAL RECOMMENDATIONS:	STATUS	COMMENTS:
The Office of the Inspector General recommended that the California Institution for Men require staff to timely and accurately complete tool maintenance inventories.	SUBSTANTIALLY IMPLEMENTED	The California Institution for Men distributed a directive on May 3, 2005 advising all staff of their responsibilities for effective tool control. It also issued a June 30, 2005 directive advising housing unit staff of their responsibilities to conduct required cell searches. The institution has completed security audits of each facility and developed corrective action plans for identified deficiencies. It also obtained approval for, and has filled, five security squad positions. The Office of the Inspector General's tour of housing units verified evidence of regular cell searches and confirmed that all tools were removed from the institution's Reception Center-Central. Further, the Office of the Inspector General found that tool control procedures within various maintenance shops had been improved and that tool inventories located in the inmate day labor boxes behind Reception Center-Central were current. The Office of the Inspector General also determined, however, that maintenance staff members were using three container exchange boxes for tool storage behind the canteen warehouse within the minimum support facility's secured perimeter. They were taking tools from these room-sized storage units both without conducting daily inventories and without the knowledge of tool control officers. One of these boxes, which had been secured with a maintenance lock, contained ladders of varying lengths that could facilitate an

		escape. Once aware of this situation, the institution's security squad members secured the storage units with their own locks and took steps to remove the boxes from the secured perimeter.
In addition, the Office of the Inspector General recommended that the California Department of Corrections assemble an experienced team and conduct a thorough inspection of the California Institution for Men. This inspection should identify all maintenance problems and result in a corrective action plan. In addition, the team should identify staffing requirements and resources necessary to complete the repairs and maintain the physical plant.	**FULLY IMPLEMENTED**	The Office of the Inspector General confirmed that the department had assembled a review team and completed an inspection of the institution that identified maintenance problems, staffing requirements, and resources necessary to complete repairs and maintain the physical plant. The institution prepared a corrective action plan addressing the maintenance issues and began monthly status reports to document the progress of the corrective actions submitted to department executives.

FOLLOW-UP RECOMMENDATIONS:

The Office of the Inspector General recommends that the California Institution for Men discontinue the storage of tools within the secured perimeter unless they are placed under the supervision and control of the institution's tool control officer and subjected to standard inventory procedures.

ORIGINAL FINDING NUMBER 5:

The Office of the Inspector General found that the California Department of Corrections procured and distributed protective vests to the institutions consistent with its budget change proposal and its agreement with the California Correctional Peace Officers Association; however, delays in issuing vests at the California Institution for Men were unwarranted.

ORIGINAL RECOMMENDATIONS:	**STATUS**	**COMMENTS:**
The Office of the Inspector General recommended that the California Department of Corrections do the following:		

Issue protective vests to correctional employees expeditiously upon arrival of the vests at the institution.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation distributed a June 2, 2005 directive to ensure that all institutions issue vests upon receipt, ideally the next business day, if possible. The Office of the Inspector General noted that inventory records at the institution comply with this directive.
Update *California Department of Corrections Operations Manual* section 33020.16 to address new policies and procedures for protective vests.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation has developed a protective vest policy in the *California Department of Corrections and Rehabilitation Operations Manual*, section 33020.16, which is further supplemented by the institution's *Operations Manual Supplement* in section 33020.17.
Require facilities to report quarterly vest inventory using CDC form 1405, and develop and implement an inventory tracking system to ensure all protective vests are adequately accounted for and replaced according to the manufacturer's standards.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation has implemented a policy requiring quarterly vest inventories. The Office of the Inspector General noted that the institution's inventory tracking and reporting procedures comply with the department's policies.

FOLLOW-UP RECOMMENDATIONS:

None

ORIGINAL FINDING NUMBER 6:

The Office of the Inspector General found that the medical clinic at the California Institution for Men reception center where the victim was taken after the stabbing was poorly equipped and ill-prepared to handle the emergency.

ORIGINAL RECOMMENDATIONS:	STATUS	COMMENTS:
The Office of the Inspector General recommended that the California Institution for Men take the following actions with respect to its central reception center clinic:		
Develop comprehensive procedures specific to the clinic that focus on delivery of emergency medical services.	FULLY IMPLEMENTED	The California Institution for Men has an urgent/emergent response local operating procedure approved by the department on July 8, 2005. The institution has trained all medical and custody staff on new procedures and will conduct emergency response drills semi-annually. The Office of the Inspector General noted that the institution's most recent drills were conducted in April and May 2006.
Assess the clinic's needs with respect to emergency medical supplies and equipment and assure that the clinic is adequately stocked with them. The chief medical officer should institute a practice of conducting regular inventories and inspections of these supplies and restock those that have been consumed or lost to spoilage or obsolescence.	FULLY IMPLEMENTED	The Office of the Inspector General found that the institution has exchanged emergency equipment inconsistent with the department's guidelines for the expected level of clinical care with a clinic emergency response bag containing equipment consistent with those guidelines. A daily checklist has been implemented to ensure that supplies are replaced as needed. All medical staff members have been trained to ensure their familiarity with the guidelines for the updated bag. The Office of the Inspector General noted, however, that the institution's conformance to the department's guidelines has resulted in reducing the expected level of care to cardio-pulmonary resuscitation and basic first aid.
Ensure that the emergency supplies are ready to use and are immediately accessible. A crash cart would address this purpose within the clinic, and could also be easily taken to any emergency in the facility served by the clinic.	SUBSTANTIALLY IMPLEMENTED	The institution reported that it maintains a crash cart in the standby emergency services area and an identical cart as backup in the general acute care hospital area. It has developed and implemented a checklist for the clinic emergency response bag at each outpatient medical clinic and has trained all medical staff to ensure their familiarity with the guidelines for the bags.

Provide specialized training in emergency medical procedures for clinic staff and other employees as appropriate. This may include courses leading to advanced cardiovascular life support certification. Further, management should conduct regular emergency drills for clinic staff. Management should provide additional training in medical charting and proper documentation of emergency medical incidents.	**Substantially Implemented**	The California Institution for Men reported that, where appropriate, it requires staff who work in the standby emergency services facility to acquire and maintain resuscitation skills. It has provided in-service and on-the-job training in medical charting, documentation, skills training, and report writing. All healthcare staff members are required to maintain current certifications in basic life support. Periodic training for all clinical staff will include orientation, emergency drills, debriefing after-action critiques, and skills labs where appropriate. The Office of the Inspector General noted that the institution initiated efforts in April 2006 to require that all physicians assigned to its standby emergency services facility become certified in advanced cardiac life support.
The institution's medical staff should engage in thorough debriefings following incidents of medical emergencies. California Evidence Code section 1157 encourages a frank evaluation of quality of care issues by prohibiting discovery of such information. The California Institution for Men should take full advantage of this statute by engaging in candid and complete self-assessments after significant medical events, whether involving inmates or employees.	**Partially Implemented**	The institution reported it has revised its local operating procedures for urgent/emergent response to include debriefing requirements and self-assessment guidelines after medical emergencies. It will conduct thorough reviews of all medical emergencies through the institution's and department's emergency medical response review committees. The institution has also provided training as directed by the emergency medical response review committee. Although the Office of the Inspector General found that the institution's emergency medical response review committee is conducting regular meetings, the committee did not meet between November 2005 and March 2006, resulting in a backlog of cases.
The institution should consider retaining the services of a consultant in emergency medicine to provide a comprehensive review of its policies, protocols, procedures, staffing, training, quality assurance/improvement program, supply and equipment requirements and to provide guidance on implementing improvements. The consultant should be knowledgeable and experienced in establishing	**Partially Implemented**	Although this recommendation was directed at the institution, the department has responded by reporting that it is in the process of negotiating an interagency agreement with the University of California, San Diego for consulting services for emergency medical policies, protocols, and procedures throughout its institutions, including the California Institution for Men.

and maintaining emergency medical clinics outside of a traditional hospital setting.		
In addition, the Department of Corrections should review the emergency preparedness of its other institutions to ensure that the deficiencies found at the California Institution for Men do not exist elsewhere.	**Partially Implemented**	The department has organized a focused improvement team to gather information on community standards for pre-hospital emergency medical services. The Office of the Inspector General found that the department's efforts are in their early stages and that, based on visits to six adult facilities and one juvenile correctional facility, substantial work remains relative to standardizing emergency medical procedures. For example, while the focused improvement team has amassed data on community standards for pre-hospital emergency services that have resulted in a draft emergency medical policy document, the department has failed to secure an agreement with an appropriate emergency medical services consultant. The Office of the Inspector General's visits to the hospitals and clinics of six adult facilities and one juvenile correctional medical facility revealed conditions similar to those described in its March 2005 report. For example, some institutions failed to provide one or more critical pieces of equipment in their emergency kits, including oxygen tanks, suction devices, airways, and adjustable cervical collars. In addition, some emergency medical personnel at these institutions demonstrated limited knowledge of the proper use of such equipment.

Follow-up Recommendations:

The Office of the Inspector General recommends that the California Institution for Men conduct regular monthly meetings of the emergency medical response review committee in conjunction with post-incident debriefings in which medical personnel involved in specific incidents participate.

In addition, the Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation continue its efforts to develop appropriate emergency medical policy and procedures and a level of preparedness at all of the institutions consistent with community standards.

ORIGINAL FINDING NUMBER 7:

The Office of the Inspector General found that the management of the California Institution for Men did not set up an Emergency Operations Center or institute an Emergency Operations Plan in the wake of Officer Gonzalez's stabbing due to ambiguous protocols. As a result, there was some confusion in the chain of command, emergency operations policies were not implemented, the crime scene was partially destroyed, and an incident log was not initiated.

ORIGINAL RECOMMENDATIONS:	STATUS	COMMENTS:
The Office of the Inspector General recommended that the Department of Corrections take the following actions:		
Reinforce with institutional executive staff the intent, objective, and purpose of implementing the Emergency Operations Plan when an inmate initiated disturbance significantly disrupts routine institutional operations or programs.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation issued a May 13, 2005 directive to all departmental executive staff regarding implementation of the Emergency Operations Plan in response to an inmate-initiated disturbance that significantly disrupts routine institutional operations. The department reported that it will provide continuing instruction to institutional executive and managerial staff.
Update section 55010 of the *California Department of Corrections Operations Manual* so that it (1) clarifies ambiguities such as the circumstances under which the Emergency Operations Plan should be implemented, and (2) incorporates changes in technology that have occurred since the manual's last revision in 1989.	NOT IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that it proposed to comprehensively revise its departmental emergency plan guidelines in compliance with a federal mandate to incorporate elements of the National Incident Management System. The department further reported that it had applied for grant funding from the Governor's Office of Homeland Security to accomplish this, but the application was denied on May 27, 2005. The Office of the Inspector General verified that the department's grant proposal requested over $200,000 to fund the cost of personnel and equipment to bring the emergency plan guidelines into compliance with federal mandates. While the Office of the Inspector General recognizes that the changes to be accomplished under the grant proposal might have addressed its

		recommendation, failure to secure grant funding does not constitute a significant impediment to the editing of its operations manual to clarify ambiguities, rectify references to outmoded technologies, and update text to reflect existing technologies.
In addition, the Office of the Inspector General recommends that the California Institution for Men reinforce, through training, the responsibility of supervisors and management to direct employees to provide leadership and direction in the face of emotionally devastating situations such as a staff murder to ensure that all objectives specified under the Emergency Operation Procedures are met. The objectives include, but are not limited to, consideration of crime scene preservation and evidence collection to enhance potential criminal prosecutions.	FULLY IMPLEMENTED	The California Institution for Men reported that it has revised its Emergency Operations Plan to incorporate the directive from the Department of Corrections and Rehabilitation regarding implementation of the Emergency Operations Plan in response to inmate disturbances that significantly disrupt routine institutional operations. The Office of the Inspector General corroborated that the institution has provided training to custody supervisors and managers to ensure they fully understand the department's expectations. The Office of the Inspector General also noted that the institution's newly revised emergency plan specifically includes guidance on crime scene preservation and that a designated room has been equipped with multiple telephone lines to function as a command center during emergencies.

FOLLOW-UP RECOMMENDATION:

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation update section 55010 of the *California Department of Corrections and Rehabilitation Operations Manual* so that it (1) clarifies ambiguities such as the circumstances under which the Emergency Operations Plan should be implemented, and (2) incorporates changes in technology that have occurred since that section's last revision in 1989.

ORIGINAL FINDING NUMBER 8:

The Office of the Inspector General found that the California Institution for Men did not implement important emergency procedures in response to the incident, leading to contamination of the crime scene and the loss of important evidence.

ORIGINAL RECOMMENDATIONS:	**STATUS**	**COMMENTS:**
The Office of the Inspector General recommended that the Department of Corrections take the following actions:		
Evaluate the need for a memorandum of understanding or protocols governing when an outside agency should take primary responsibility for the criminal investigation of a crime against a staff member. In doing so, consider the limited resources of institutional investigative units and the emotional impact that a crime against staff may have on the institution's ability to react properly.	**NOT IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that it is waiting for funding approval for a pilot study of Investigative Services Units at all institutions, as well as for a review of all formal agreements between institutions and local law enforcement agencies as part of a proposed reorganization of its Law Enforcement and Investigations Unit. Funding approval is expected during the 2006-07 fiscal year.
Reevaluate and assess the scope and responsibility of institutions' Investigative Services Units as the primary criminal investigative entity given their manpower, training, and resource limitations.	**NOT IMPLEMENTED**	See comments for first recommendation under this finding.
Clearly define the role and expectations of Investigative Services Units in identifying and securing potential crime scenes, identifying and preserving evidence and, if they remain the primary investigative entity, proper collection and processing of the crime scene and evidence.	**NOT IMPLEMENTED**	See comments for first recommendation under this finding.
Evaluate the need for training at the correctional officer, sergeant, and Investigative Services Unit levels regarding the	**NOT IMPLEMENTED**	See comments for first recommendation under this finding.

identification and collection of physical evidence with potential forensic examination in mind, including but not limited to the manner of collection, processing and documentation.		
Develop a "lessons learned" instructional curriculum by which all institutions can learn what went right and what went wrong in the events leading up to and following the death of Officer Gonzalez.	Not Implemented	The California Department of Corrections and Rehabilitation reported that it held a "lessons learned" discussion with the wardens from all institutions during a July 21, 2005 wardens' meeting. It also developed an executive-level report identifying "lessons learned" at the California Institution for Men and conducted a panel discussion at the wardens' meeting. These discussions, however, were presented to a limited audience. The Office of the Inspector General believes that presenting a more comprehensive instructional curriculum as formal training to custody staff at all institutions would maximize the benefit of such a curriculum.
In addition, the Office of the Inspector General recommended that the California Institution for Men take the following actions:		
Evaluate whether the "squad" concept of correctional officers specially trained in crime scene investigation and crime scene and evidence preservation is appropriate for the California Institution for Men under existing conditions.	Fully Implemented	The California Institution for Men was funded to hire an institution security squad of five correctional officers. The institution has scheduled specialized training for these officers and has arranged their work schedules to ensure that one of them is available to process crime scenes and preserve evidence on any given watch.
Using departmental policies and procedures, as well as the best practices of the law enforcement profession, develop better methods for processing, booking, and transferring evidence. These methods should include a "chain of custody" that will satisfy	Fully Implemented	The California Institution for Men reported that it has reviewed existing institutional policies and procedures for consistency with training provided by the department's Law Enforcement and Investigations Unit. It has met with representatives from the Chino Police Department and the San Bernardino County Sheriff's Office to review best practices and reports that it has incorporated these practices into its own policies.

legal and operational requirements of both the transferring and receiving entities.		

FOLLOW-UP RECOMMENDATIONS:

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation accomplish the following:

- **Evaluate the need for a memorandum of understanding or protocols governing when an outside agency should take primary responsibility for the criminal investigation of a crime against a staff member.**
- **Re-evaluate and assess the scope and responsibility of institutions' Investigative Services Units as the primary criminal investigative entity given their manpower, training, and resource limitations.**
- **Clearly define the role and expectations of Investigative Services Units in identifying and securing potential crime scenes, identifying and preserving evidence and, if they remain the primary investigative entity, proper processing of the crime scene and collection of evidence.**
- **Evaluate the need for training at the correctional officer, sergeant, and Investigative Services Unit levels regarding the identification and collection of physical evidence with potential forensic examination in mind, including but not limited to the manner of collection, processing, and documentation.**
- **Develop a "lessons learned" instructional curriculum by which all institutions can learn what went right and what went wrong in the events leading up to and following the death of Officer Gonzalez and present it as formal training to custody staff at all institutions.**

ORIGINAL FINDING NUMBER 9:

The Office of the Inspector General made confidential findings related to the adequacy of mental health care for inmates at the California Institution for Men.

The Office of the Inspector General found that the California Institution for Men failed to adequately assess and address particular inmates' mental health needs. However, due to state and federal medical privacy laws, those findings cannot be presented in a public document. Accordingly, the information in this section has been presented only to the Governor and the Department of Corrections and Rehabilitation.

The Office of the Inspector General made three recommendations to the California Institution for Men and two recommendations to the Department of Corrections and Rehabilitation related to those findings. All recommendations were fully implemented.

ORIGINAL FINDING NUMBER 10:

The Office of the Inspector General found that Blaylock was permitted to conduct a telephone conference with an attorney before he was indicted for the murder of Officer Gonzalez even though the attorney's request for the conference was not properly submitted in writing.

ORIGINAL RECOMMENDATIONS:	STATUS	COMMENTS:
The Office of the Inspector General recommended that the Department of Corrections take the following actions:		
Evaluate and, if necessary, modify regulations governing "confidential calls" between inmates and their attorneys. Such modifications may address (1) permitting verification through independent sources that the requesting attorney is licensed to practice, (2) verifying the attorney actually represents the inmate in question and (3) balancing	PARTIALLY IMPLEMENTED	The Department of Corrections and Rehabilitation reported that it has evaluated the regulation governing confidential calls between inmates and their attorneys to determine any need for clarification or revision. No modifications to the regulations have yet been made. The Office of the Inspector General has withdrawn from its recommendation the verification of an attorney-client relationship as a factor in considering attorney requests for telephone calls to inmates.

inmates' right to counsel with the institution's need to validate such calls and its resources available to facilitate them.		
Develop procedures for wardens and chief deputy wardens to communicate with key institutional staff members (such as the litigation coordinator and the public information officer) when inmates requiring special handling enter their institutions. Such communications should include instructions to staff that all external inquiries concerning these inmates be referred to the attention of the warden or the warden's designee.	PARTIALLY IMPLEMENTED	The Department of Corrections and Rehabilitation reported it has implemented a director's requirement that wardens hold daily meetings with staff. The department also reports that it is currently evaluating the need for additional procedures to improve communication between key institutional staff members. The Office of the Inspector General notes, however, that such an evaluation is unresponsive to the pressing need expressed within the recommendation itself—that is, to develop protocols for inquiries surrounding inmates who have generated a high level of public interest because they are involved in sensitive or potentially controversial matters.

FOLLOW-UP RECOMMENDATIONS:

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation:

- **Evaluate and, depending upon the advice of the department's legal counsel, modify regulations governing "confidential calls" between inmates and their attorneys. Such modifications may address permitting verification through independent sources that the requesting attorney is licensed to practice, balancing inmates' right to counsel with the institution's need to validate such calls and its resources available to facilitate them.**

- **Develop procedures for wardens and chief deputy wardens to communicate with key institutional staff members (such as the litigation coordinator and the public information officer) when inmates requiring special handling enter their institutions. Such communications should include instructions to staff that all external inquiries concerning these inmates be referred to the attention of the warden or the warden's designee.**