Office of the Inspector General

Matthew L. Cate, Inspector General

Management Review Audit

of the

N. A. Chaderjian Youth Correctional Facility

Stockton, California

May 2005

State of California

Matthew L. Cate, Inspector General

Office of the Inspector General

May 24, 2005

Steve Kruse, Superintendent
N. A. Chaderjian Youth Correctional Facility
7650 South Newcastle Road
Stockton, California 95213

Dear Superintendent Kruse:

Enclosed is the final report of the Office of the Inspector General's management review audit of the N. A. Chaderjian Youth Correctional Facility. Recognizing that you have been the Superintendent of the facility for a short time, the purpose of the audit was to provide a baseline assessment of the institution's performance in carrying out its essential functions.

The audit found a significant number of serious deficiencies at the institution, affecting counseling services, education, and mental health treatment. The deficiencies are significant enough to indicate that the facility is failing in its core mission of providing treatment and education services to wards.

The audit also found that the safety of staff and wards at the institution is jeopardized by the facility's structural and design defects, by poor management practices, and by the failure of the institution to comply with mandated security requirements.

The report presents 56 specific recommendations to remedy the deficiencies.

The written response to the audit from the California Youth Authority appears as an attachment to the report. We look forward to receiving by July 22, 2005 the department's comprehensive corrective action plan to address the audit findings.

Thank you for the cooperation extended to my staff during the course of the audit.

Sincerely,

Matthew L. Cate

MATTHEW L. CATE
Inspector General

Enclosure

cc: Roderick Q. Hickman, Secretary, Youth and Adult Correctional Agency
Walter Allen III, Director, California Youth Authority

MC:SC:lr

CONTENTS

EXECUTIVE SUMMARY

This report presents the results of a management review audit of the California Youth Authority's N.A. Chaderjian Youth Correctional Facility, which was conducted by the Office of the Inspector General between October 27, 2004 and April 29, 2005. The purpose of the audit was to provide a baseline assessment of the facility's performance in carrying out essential functions and to provide recommendations to correct deficiencies. The audit was performed under the authority provided to the Office of the Inspector General by California Penal Code section 6051.

The N.A. Chaderjian Youth Correctional Facility in Stockton, along with the Heman G. Stark Youth Correctional Facility in the southern part of the state, serves a ward population of generally older and more serious offenders than those of other California Youth Authority institutions. At the time of the audit, the facility held a population of 590 male wards between 17 and 24. The average age of the wards is 20, with 23 percent falling between ages 21 and 24. Some 68 percent are gang-affiliated. Many are serving long sentences for serious crimes such as murder, rape, armed robbery, and assault, and most have been sent to the facility because they have failed at other California Youth Authority institutions. A small number—eight at the time of the audit—have already served time in adult prisons and have been sent to the N.A. Chaderjian Youth Correctional Facility to finish out a California Youth Authority confinement term. All of the wards —except those who commit new offenses while in custody—must be released by age 25.

In short, most of the wards at the N.A. Chaderjian Youth Correctional Facility have run out of other options at the California Youth Authority. For these wards, the institution represents a last chance to avoid an adult life of crime. Yet the audit found the facility to be a troubled institution that fails to provide a safe environment for wards and staff and fails to provide wards with the education and programs that would give them the best opportunity to lead a crime-free life once they are released.

For example, the audit determined that the facility is not providing wards with the counseling and mental health care they are required to receive under state law. The youth correctional counselors, who are designated to provide most of the counseling, have almost no training in counseling and almost no time to counsel wards because they are busy with custody and security functions. The auditors found that the youth correctional counselors spend only about 10 percent of their time in counseling-related activities. The audit also determined that the institution is endangering wards by failing to consistently monitor those receiving psychotropic medications by administering baseline and follow-up laboratory tests and providing timely psychiatric evaluations. Finally, despite two suicides at California Youth Authority facilities last year, the institution is not complying with all department-mandated suicide prevention procedures.

Education services are similarly lacking. The audit found that special education wards at the facility—who represent 38 percent of the students enrolled at the facility's high school—are not receiving all of the special education service time they are mandated to receive. Moreover, the auditors found that the special education service providers at the facility have consistently over-

reported the amount of services provided. At the same time, more than a third of the academic classes scheduled at the high school end up being cancelled, mainly because teachers routinely fail to show up for class. Teachers at the facility take so much time off that the high school cannot provide enough substitutes to cover the absences.

The high number of cancelled classes contributes significantly to the school's low effectiveness rating, which measures actual, compared to potential, attendance and classes held. The effectiveness rating of the high school is 40 percent, meaning that wards are receiving only 40 percent of their assigned education programming. And even though department procedures require teachers and counselors to coordinate efforts to help wards by meeting in regularly scheduled case conference committees set up for each ward, the auditors found that the teachers seldom attend the case conferences. A review of a sample of 94 cases revealed that teachers failed to attend 86 percent of the meetings. Instead, many teachers take advantage of the half-day set aside each week for case conferences when no classes are scheduled by leaving the facility early.

The facility is also a dangerous place. The Office of the Inspector General found that the institution is not complying with numerous department-mandated security requirements and that the facility is riddled with structural and design defects that jeopardize the safety of wards and employees alike. For example, fences intended to separate recreation yards of different living units to keep rival gang members apart are too low and the flat panel razor wire on top is ineffective, *[Information pertaining to fences redacted for security reasons.]* The doors in one of the living units pop open unexpectedly when electrical motors overheat, and in some of the living units, surveillance cameras and video monitors are not working. The interior walls of the facility were supposed to have been constructed of solid concrete, but an engineering study found that *[information pertaining to interior walls redacted for security reasons.]* and wards have discovered that they can dig holes in the floors because at least in some places the concrete is less than two inches thick. The California Youth Authority has sought special repair funding for some of the problems identified in this report, but the Department of Finance has denied the requests.

Many of the employees at the facility fear for their safety every working day, and with reason—the facility recorded 12 physical, non-gassing,[1] assaults on staff in 2003 and 23 in 2004. Yet, staffing ratios at the institution are the same as those for other California Youth Authority facilities with younger wards exhibiting less violent behavior. Employee morale is reported to be low and the staff vacancy rate is high, with almost a third of the youth correctional counselor positions unfilled at the time of the audit.

One reason for these deficiencies is lack of leadership at the institution. The facility has had nine superintendents or acting superintendents in the last five years and the present superintendent has been on the job only since December 2004, although he has served as acting superintendent of the facility on three other occasions. Similarly, a high turnover among school administrators and consequent lack of oversight of the teaching staff has allowed teachers to abuse leave time and fail to participate in case conferences. Since 2002, the high school has had four principals in

[1] "Gassing" is the practice of throwing human excrement or bodily fluids.

either acting or permanent positions, and the present acting principal works concurrently at department headquarters in Sacramento and spends only about half his time at the facility.

The findings of this audit are consistent with those of the California Youth Authority Accountability Audit issued by the Office of the Inspector General in January 2005. That audit, which assessed the progress of the California Youth Authority in implementing recommendations from nine previous audits, concluded that the department is failing in its core mission of providing education, training, and treatment services to the youths in its care. As a result, the wards at the state's youth correctional institutions, including the wards at the N.A. Chaderjian Youth Correctional facility, have little chance to end the cycle of criminality.

The Office of the Inspector General has presented 56 specific recommendations to address the deficiencies identified in this audit. Those recommendations appear in the body of the report.

INTRODUCTION

California Penal Code section 6051 provides the Office of the Inspector General with authority to conduct a management review audit of any California Youth Authority superintendent. The purpose of a management review audit is to assess the superintendent's performance in carrying out the essential functions of the facility or to serve as a baseline for newly appointed superintendents. In areas where weaknesses are noted, the Office of the Inspector General makes recommendations to correct the deficiencies.

Pursuant to the provisions of *California Penal Code* section 6051, the Office of the Inspector General conducted a management review audit of the N.A. Chaderjian Youth Correctional Facility following a succession of nine changes in superintendents and acting superintendents dating back to March 2000. At the beginning of the audit, Steve Kruse had been the acting superintendent for one month. During the audit, the California Youth Authority appointed Mr. Kruse to the superintendent's position. This management review audit was performed between October 27, 2004 and April 29, 2005.

BACKGROUND

The N.A. Chaderjian Youth Correctional Facility (N.A. Chaderjian) is one of eight youth correctional institutions operated by the California Youth Authority. Along with O.H. Close and DeWitt Nelson, it is one of three youth correctional facilities comprising the Northern California Youth Correctional Center complex in Stockton. Constructed in 1991 with a design capacity of 600 beds, N.A. Chaderjian assists the California Youth Authority in pursuing its mission of providing educational, training, and treatment services for youthful offenders (wards) committed for confinement by the courts.

In addition to general population housing, N.A. Chaderjian has a variety of specialized programs for wards, including drug and alcohol abuse treatment, intensive medical and psychiatric treatment, parole violator programs, special counseling programs for wards who exhibit symptoms of mild to moderate mental illness, sex offender programs, and a special management program for violent and disruptive wards.

As of April 7, 2005 N.A. Chaderjian housed 590 wards. Many of the wards are among the most dangerous in the California Youth Authority's custody and are serving lengthy sentences for crimes such as murder, rape, armed robbery, and assault. Although the crimes were committed while the offenders were juveniles, nearly all wards at N.A. Chaderjian are between 18 and 25 years of age, with 23 percent over the age of 21. Most have transferred from other facilities, while others are parole violators. Still others have come from California Department of Corrections adult prisons. For example, one of the wards at the institution at the time of the audit had spent four years as an inmate in various adult prisons, including more than 14 months in administrative segregation units and more than three months in security housing units. He had been remanded to N.A. Chaderjian at the age of 24 to serve time remaining on his California Youth Authority confinement.

Not only are the wards older and more criminally sophisticated, but they are also disruptive and dangerous. Sixty-eight percent are affiliated with gangs that are active within the facility. Many

are in Phase I, the most restrictive phase of the facility's three-phase system of privileges. Accordingly, they have few privileges to lose by disrupting daily operations. Ward programming at the facility has diminished in the wake of large-scale fights and assaults on staff resulting in lockdowns of living units. In this environment, the institution has been attempting to implement an "open programming" model in response to the *Farrell v. Allen* agreement between the California Youth Authority and the Prison Law Office. Under this agreement, the facility is responsible for restoring safe general population programming and ensuring that wards are out of their rooms daily for educational, vocational, and treatment programming, as well as meals and recreation, by June 1, 2005.

For fiscal year 2004-05, N.A. Chaderjian has a budgeted staff of 352 personnel years and an operating budget of $30.5 million. Staff positions include administrators, administrative support personnel, youth correctional officers, and youth correctional counselors. In addition, the staff includes academic and vocational education instructors, administrators, and support staff, all of whom report to the California Youth Authority Education Services Branch, rather than to the superintendent. Employees performing medical, dental, mental health, and facility maintenance services report to the Northern California Youth Correctional Center.

Like other California Youth Authority institutions, N. A Chaderjian is subject to the "post-and-bid" provisions of the state's collective bargaining agreement with Bargaining Unit 6 of the California Correctional Peace Officers Association. Those provisions require 70 percent of post assignments to be governed by seniority and to be made through employee bidding. The 70-30 split allows the seniority-based preferences of staff to determine 70 percent of post appointments and allows management to determine 30 percent of the appointments.

There are six buildings on the facility grounds (Units I through VI), each housing two living units of 50 rooms. The living units are named for California rivers. A common wall separates the living units, and there is an elevated control tower at the top of the common wall. The control tower monitors ward activity in the central areas of the living units, which are known as day rooms, and controls the movement of wards into and out of the living units. In addition, the control tower maintains video surveillance of the outdoor recreation areas. Wards generally receive counseling services in their living units, but they leave the living units to participate in other programs at various locations on the institution grounds. The programs include attending the facility's N.A. Chaderjian High School and obtaining vocational training. Wards also leave their living units to obtain medical and dental services at the institution's clinic and to attend religious services.

Superintendent Steve Kruse. This is Superintendent Kruse's first assignment as a superintendent with the California Department of the Youth Authority, but he has served as an acting superintendent at N.A. Chaderjian on three occasions. Superintendent Kruse reported to N.A. Chaderjian in October 2004 for his last assignment as acting superintendent from his position as assistant superintendent of the DeWitt Nelson Youth Correctional Facility. The California Youth Authority appointed him to the superintendent's position in December 2004. A California Youth Authority employee for 29 years, Superintendent Kruse began his career with the department as a youth correctional officer. During his employment with the California Youth Authority, he has held increasingly responsible positions in various institutions and camps.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of the management review audit was to conduct a baseline evaluation of N.A. Chaderjian to identify areas of operation needing improvement. To that end, the Office of the Inspector General reviewed the following major functions: institution safety and security; ward treatment and mental health services; and academic education. Within these major functions, the audit team reviewed issues related to personnel, training, investigations, and budgeting.

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

- Interviewed Superintendent Kruse, members of his administrative staff, and various employees and wards at the institution to gain insight and perspective on various issues.
- Administered a survey questionnaire to N.A. Chaderjian staff regarding their areas of concern.
- Conducted on-site visits and inspections of living units and ward programming areas, including N.A. Chaderjian High School and administrative offices and facilities throughout the institution.
- Reviewed various laws, policies, and procedures and other documents related to key institution systems, functions, and processes.
- Gathered and reviewed institution logs, files, records, and transaction documents in various operational areas.
- Performed various analytical techniques, including sampling, to assess compliance with legal and procedural requirements.
- Formulated conclusions based on the audit methods cited above.

The audit team did not review the ward grievance process, the disciplinary decision-making system, or the facility's planning for and implementation of the *Farrell v. Allen* agreement.

FINDING 1

The Office of the Inspector General found that wards at N.A. Chaderjian are not receiving the counseling and other treatment services they are required to receive under state law.

Wards at N.A. Chaderjian are not receiving the fundamental assessments and specialized counseling services they are required to receive under state law and regulations.[2] The treatment services they do receive are of questionable quality, largely because the youth correctional counselors, who provide the bulk of the counseling, not only lack training, but spend only about 10 percent of their time counseling wards. The rest of their time is consumed by custody and security tasks, such as supervising meals and showers and working in the control tower. The failure of the institution to provide treatment services deprives the wards of the tools they need for successful reintegration into society and puts them at greater risk of committing future crimes.

Records reviewed by the Office of the Inspector General. To evaluate the institution's compliance with statutory and regulatory requirements governing treatment services, the Office of the Inspector General reviewed a sample of living unit files and other documents comprising the records of 94 wards in 9 of the facility's 12 living units—approximately 17 percent of the ward population. The review included the records of wards in four specialized program living units and five general population units. In addition, the audit team interviewed 26 youth correctional counselors and 26 wards regarding treatment services at the facility. Because the review determined that poor record-keeping in the living units made those records unreliable, the audit team also sought out and reviewed additional records, including counseling records, notes, and small group counseling summaries.

Results of the review. The Office of the Inspector General found that the living unit files failed to document that either general population wards or wards in specialized counseling programs had received the required amounts of counseling. The review of records and documents outside the living units, however, indicated that more counseling had occurred than had been documented in the living unit files. From those secondary records, the audit team determined that the specialized counseling programs had made available to wards more than the required amount of counseling, but that general population wards had received less than the required amount. Specifically, the audit team found the following:

- ***Living unit files did not document that wards had received required treatment***. Section 4050 of the *California Youth Authority Institutions and Camps Branch Manual* requires a formal, structured counseling program that includes planned, scheduled staff time for counseling and provides for a minimum of one hour of formal counseling (individual or small group) per ward per week. The review of the living unit records failed to document that

[2] The California *Welfare and Institutions Code* and Title 15, Division 4 of the *California Code of Regulations* require wards of the California Youth Authority to be provided with assessment, counseling, and training services. Accordingly, section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual* specifies the types and frequency of treatment services wards are to receive.

wards in the four specialized program units and in the five general population living units had received the required weekly formal, structured counseling sessions. Of the 58 ward living unit files reviewed in the four specialized program units, the documentation showed that only 30 (52 percent) of wards had received the required counseling. Of the general population living units, the documentation showed that only three of the 36 wards sampled (8 percent) had received the required one hour of weekly individual and small group counseling. Because the living unit file is the department's official record, these compliance rates would normally indicate significant non-compliance, but the Office of the Inspector General found that poor record keeping in both the specialized program living units and the general population living units rendered the information in the living unit files incomplete. Specifically:

- ✓ Youth correctional counselors' chronological notes frequently contained no records of small group counseling received by the ward.

- ✓ The youth correctional counselors often failed to update their counseling records each week; the audit team found instances in which counselors' chronological notes were two or more months in arrears.

- ✓ Rather than logging counseling sessions in the chronological notes section of the living unit file, youth correctional counselors frequently logged counseling notes in the facility's management information system known as the Ward Information Network 2000 without transferring them to the living unit files.

- ***Secondary records documented additional counseling.*** The Office of the Inspector General's review of counseling records and notes outside the living unit files confirmed that more counseling had occurred than had been documented in the living unit files. Accordingly, the audit team afforded counseling credit when possible, including giving credit for the General Population Outpatient Program. Given the difficulty of searching multiple locations for possible counseling information, however, the audit team could not rely on the accuracy of the compliance rate for the ward sample tested. Therefore, the Office of the Inspector General obtained and analyzed the small group counseling summaries for the facility's specialized program living units and general population living units for March 2004 through February 2005. These summaries document the counseling activity of each youth correctional counselor assigned to the living unit. From these records, the audit team determined that an average of 2.70 small group counseling sessions per counselor per week had taken place in the specialized counseling programs. The audit team concluded that that average made it possible for specialized program wards to receive more than the minimum of one hour of individual and small group counseling per week required by section 4050.

  However, the review determined that general population living units were making available less than the one small group session per week. The review found that an average of only .77 small group counseling sessions per counselor per week were made available in the general population living units, and that no general population living unit made available more than .85 sessions per counselor per week. With fewer than one small group counseling session per

counselor per week available to wards, formal individual counseling of no less than one hour's duration must occur to achieve compliance with section 4050. Yet, the Office of the Inspector General found—and staff confirmed—that formal, scheduled individual counseling rarely occurs in any of the living units.

Accordingly, the Office of the Inspector General concluded that the general population living units were not providing wards with the counseling services required by section 4050.

The counseling is of questionable quality. Even when provided, the quality of the counseling provided to wards is questionable. During the course of this management review audit, the Office of the Inspector General noted the following:

- ***Almost no individual counseling.*** Formal, scheduled individual counseling rarely occurs in any of the living units. Formal, scheduled individual counseling is designed to offer a private, confidential setting in which the counselor and ward can discuss sensitive matters not appropriate to a group setting. These matters include personal problems that, if discussed in a group setting, could subject the ward to ridicule or even physical harm. All 26 youth correctional counselors interviewed acknowledged that their individual counseling sessions with wards were almost always brief and informal and did not qualify as formal counseling under section 4050. These sessions generally lasted a few minutes and seldom exceeded 45 minutes.

- ***Frequent counselor turnover.*** Youth correctional counselor positions are subject to annual "post-and-bid" provisions of the state's collective bargaining agreement with Bargaining Unit 6 of the California Correctional Peace Officers Association, which requires 70 percent of post assignments to be governed by seniority and to be made through employee bidding. This results in frequent turnover in counselors, which in turn can hamper wards' progress by disrupting the continuity of established counselor-ward relationships. Moreover, the contractual "70-30" split means that the seniority-based preferences of staff determine 70 percent of the counselor appointments, while management can appoint only 30 percent based on institutional needs and the skills and abilities of employees. The 70-30 split applies to specialized program living units as well as to general population living units.

- ***Lack of training for counselors.*** Youth correctional counselors, who provide the bulk of the counseling to the wards, are not required to have advanced or even undergraduate degrees in counseling or any other field. Although the audit team did not review counselors' qualifications or all training records to verify statements, there is testimonial evidence that the counseling staff lacks training. The current superintendent and two past superintendents said the treatment staff is not well trained. Program managers, consultants, and even the youth correctional counselors themselves agreed. Of the 26 youth correctional counselors interviewed by the audit team, all said they had received little or no formal counseling training and 24 (92 percent) said they would like additional counseling training. Ten (38 percent) said they had not received even on-the-job training.

The audit team was able to document a significant training deficiency in the sex offender program. The program administrator said that 75 percent of the staff working in the sex offender program has no training in working with sex offenders. Furthermore, the parole agent and the casework specialist in this program commented on their small group audit sheets that only four of the eight youth correctional counselors who regularly work in the living unit had had training in the sex offender curriculum. The audit team reviewed the training records for all staff who worked in the sex offender living unit in February 2005 and found that 34 of the 42 staff members working directly with wards (81 percent) had received no sex offender training during the two-year period ended December 2004.

- ***Unavailability of interactive journals for small-group counseling.*** Interactive journals covering 15 specific topics are the primary treatment modality for small group counseling in the California Youth Authority. Wards use the journals to educate themselves about topics discussed in small groups to record what they have learned and to actively participate in the group's discussions. The Office of the Inspector General found, however, that the facility does not have enough interactive journals for small group counseling. The review determined that the facility had run out of the journals entitled V*ictims Awareness*, had never received the journals entitled *Responsible Thinking*, and was almost out of journals entitled *Substance Abuse*, *Handling Difficult Feelings, and Parole Planning*. The staff said administrators had attempted to acquire the journals from department headquarters, but that an administrator in headquarters told them there were no funds to purchase additional journals.

- ***Education staff rarely participates in ward case conference committees.*** Pursuant to *California Youth Authority Institutions and Camps Branch Manual* section 4025, superintendents are required to ensure that each living unit has a case conference committee consisting of the ward's youth correctional counselor, a parole agent, and an education representative. The requirement is intended to provide a coordinated effort among members of the treatment staff (teachers and counselors) to increase the wards' ability to succeed after release from custody. The audit determined, however, that this coordinated effort seldom occurs at the facility. The audit team found that in 86 percent of the cases reviewed (81 of 94), teachers failed to attend wards' case conferences, and interviews by the audit team with 26 youth correctional counselors confirmed that teachers rarely attend the case conferences.

- ***Initial and progress case conferences are not held within the required time limits***. To get wards into treatment promptly, the *California Youth Authority Institutions and Camps Branch Manual*, section 4030 requires the initial case conference to take place within five weeks of the ward's arrival at the institution. Yet the audit team found that 21 of the 93 initial case conferences held at the facility (23 percent) were conducted beyond the first five weeks of the ward's arrival.[3] Furthermore, to keep wards focused on short-term and long-term treatment program goals, section 4035 of the *California Youth Authority Institutions and Camps Branch Manual* provides that the case conference committee is to hold a progress case conference no more than 60 days following the initial case conference and at least every

[3] At the time of the fieldwork, one ward's initial case conference was not yet due.

120 days thereafter. Again, the facility failed to consistently meet that requirement. The audit team found that 26 of 82 files reviewed (32 percent) were late.[4]

- ***Wards' case files lack documentation that treatment was provided.*** The audit team found that wards' living unit files lacked sufficient documentation to demonstrate to management that policies and procedures are being followed, that wards' histories are current, and that the files provide the necessary information for treatment and parole recommendations. As noted earlier, the living unit files did not contain complete chronological notes on individual and small group counseling, which required the audit team to seek alternative sources to verify the extent of counseling taking place. In addition, the audit team found that ward case files lacked documentation that staff had performed the following five important steps in the treatment of wards:

  - ✓ ***Orientation on time-cut policy.*** Seventy-seven of the 94 case files reviewed (82 percent) did not have documentation that the wards had received orientation regarding the time-cut policy[5], as required by *California Youth Authority Institutions and Camps Branch Manual,* section 4003.5.

  - ✓ ***Assignment to an education, training, or work program within four days.*** Forty-four of the 94 case files reviewed (47 percent) did not have documentation that wards had been assigned to an academic school program, vocational training, work assignment, or any combination of these, within four working days of their arrival on the permanent living unit, as required by *California Youth Authority Institutions and Camps Branch Manual,* section 4010.4.

  - ✓ ***Interview by a casework supervisor within five days.*** Thirty-two of the 94 case files reviewed (34 percent) did not have documentation that wards had been interviewed within five working days of their arrival on the permanent living unit by the casework supervisor (parole agent), in order to establish rapport, continue orientation, and discuss the treatment program, as required by *California Youth Authority Institutions and Camps Branch Manual*, section 4010.2.

  - ✓ ***Orientation within 10 days of arrival.*** Twenty-seven of the 94 case files reviewed (29 percent) did not have documentation that wards had received orientation within 10 working days of their arrival at the institution, as required by *California Youth Authority Institutions and Camps Branch Manual,* section 4015.

  - ✓ ***Assignment to a counseling caseload within three working days.*** Twenty-six of the 94 case files (28 percent) did not have documentation that wards were assigned to a counseling caseload within three working days of their arrival on the permanent living unit, as required by *California Youth Authority Institutions and Camps Branch Manual,* section 4010.3.

[4] At the time of the audit, 12 wards had not been at the facility long enough to warrant a progress case conference.

[5] The "time-cut policy" refers to the ward's ability to have his time in custody reduced for good behavior.

The Office of the Inspector General identified the following factors as contributing to inadequate ward treatment services at the facility:

- ***Counseling staff members spend most of their time performing security functions.*** The audit team asked the 26 youth correctional counselors interviewed to estimate the amount of time they spend performing their various duties during the workweek. The results showed that the youth correctional counselors surveyed spend an average of 75 percent of their time performing daily activities associated with security and custody functions, such as supervising meals, showers, recreation, and school movement and working in the living unit control tower. They spend an average of 15 percent of their time performing administrative functions, such as casework documentation and writing behavior reports. They reported spending an average of only 10 percent of their time counseling wards. This 10 percent represents approximately one hour a week of small group counseling and three hours of "individual counseling," which they usually described as brief, informal interaction with wards and which does not meet the criteria for formal, scheduled individual counseling.

- ***Shortage of treatment staff in the general population living units.*** The audit determined that N.A. Chaderjian has fewer treatment staff members per general population ward than other facilities, even though the facility has older and more violent wards. The audit team reviewed treatment staffing levels for the general populations at each of the California Youth Authority facilities for the 2004-05 fiscal year, as reflected in the fiscal year 2005-06 Salaries and Wages Supplement to the Governor's Budget. The team compared that number to the facilities' ward populations as of June 30, 2004. The comparison revealed that N.A. Chaderjian has 4.0 wards per treatment staff member, which is higher than the department average of 3.8 wards. In comparison, the Southern Youth Correctional Reception Center and Clinic has a ratio of 1.4 wards per treatment staff member, and the El Paso de Robles Youth Correctional Facility has a ratio of 2.8 wards per treatment staff member. Even Heman G. Stark Youth Correctional Facility, which has a ward population comparable to that of N.A. Chaderjian, has a ratio of 3.5 wards per treatment staff member. If N.A. Chaderjian had the same ratio as the Heman G. Stark Youth Correctional Facility, it would have 16 more treatment positions. The shortage of treatment staff members affects counseling services, the documentation of casework services, and ward and staff safety.

- ***Ward counseling is scheduled to meet only the minimum requirements.*** The facility schedules wards in the general population living units for only the minimum amount of counseling effort required by the *California Youth Authority Institution and Camps Branch Manual*, section 4050—one small group per week. That practice does not allow for compliance with the counseling requirements of section 4050 when events such as ward-initiated disturbances, staff sick leave, and other staff absences prevent the small group from meeting. Even when regular counselors take scheduled vacations, the living units rarely receive substitute counselors who have developed the necessary rapport with the wards to effectively continue the treatment program. This scheduling problem has contributed significantly to the fact that during the period audited, the general population living units made available less than one (.77) small group counseling session per counselor per week. If

more time were scheduled for counseling each week, the general population living units might be able to meet the requirements for counseling frequency provided in section 4050.

- ***High vacancy rates in the counselor ranks.*** The facility has had difficulty filling youth correctional counselor and senior youth correctional counselor positions. As of November 2, 33 of the facility's 113 budgeted youth correctional counselor positions (29 percent) and 4 (29 percent) of the 14 senior youth correctional counselor positions, which supervise the youth correctional counselors, were vacant. To compound the problem, the audit team noted that in February 2005, there were only six youth correctional counselors in the relief pool of substitutes, a number insufficient to cover the 113 budgeted youth correctional counselor positions in the facility.

- ***Formal and informal training are inadequate.*** As noted earlier, the counseling staff readily admit that they lack training. An inadequate training budget and insufficient time to formally train staff apparently contribute to this problem. Informal, on-the-job training can augment formal training, yet it does not always take place. All of the 26 youth correctional counselors interviewed by the audit team said they had received little or no formal counseling training, and 10 (38 percent) also said they had never received on-the-job training. Furthermore, the facility does not regularly use internal resources such as the following staff for informal training:

  - ✓ ***Staff psychologists.*** Staff psychologists would be a valuable source of information and training to youth correctional counselors; but according to staff members interviewed, they spend little time helping counselors in the general population living units.

  - ✓ ***Staff experienced in using the Ward Information Network 2000 system.*** The audit team found that some counselors have not been adequately trained on how this system works and how it ties into documenting compliance with the counseling requirements of the *California Youth Authority Institutions and Camps Branch Manual.* Technically competent staff could help those less trained acquire necessary skills.

- ***Inadequate monitoring of casework.*** In February 2005, to his credit, the superintendent reinforced the need for program managers to audit the counseling staff's casework for compliance with the *California Youth Authority Institutions and Camps Branch Manual.* Given the multiple locations of information outside the living unit files, however, this task will be difficult until managers require and enforce strict adherence to the timely filing of all casework in the living unit file.

- ***Failure to hold teachers accountable for not attending case conferences.*** According to the staff, when the institution had education advisors assigned to the living units they participated more regularly in case conferences. Although the facility has done away with that approach, the high school administration has created a schedule that allows for teachers to attend case conferences in the living units. Yet, the administration is not holding teachers accountable for failing to attend. Administrators could note a teacher's failure to attend case

conferences in the annual performance appraisal, but as noted in Finding 2 of this report, at present, administrators do not conduct timely performance appraisals.

- ***Collective bargaining agreement provisions.*** The "post-and-bid" provisions of the state's collective bargaining agreement with Bargaining Unit 6 result in excessive turnover of youth correctional counselors by calling for an annual shuffling of counselor assignments. The contractual "70-30" requirement that management may appoint only 30 percent of the youth correctional counselors, while seniority drives the other 70 percent, limits the superintendent's ability to effectively address the treatment needs of wards.

- ***Lack of funding for interactive journals.*** As noted above, the facility does not have enough interactive journals for small group counseling. When facility administrators attempted to acquire the journals from department headquarters, a headquarters administrator told them there were no funds for more journals. Given that interactive journals are the primary treatment modality for small group counseling in the California Youth Authority, inadequate funding for such journals diminishes the effectiveness of the counseling function.

- ***No additional resources received for implementing Senate Bill 459.*** The passage of Senate Bill 459 (Chapter 4, Statutes of 2003) caused an increased workload for key treatment staff. Previously, wards appeared before the Youthful Offender Parole Board and if the board denied parole, it decided on the additional confinement period. The 2003 legislation eliminated the Youthful Offender Parole Board and replaced it with the Youth Authority Board. Wards now appear before the Youth Authority Board for parole consideration, and if denied parole, they must go before the facility's new Youth Authority Administrative Committee for a determination of additional confinement time. This new committee has added more paperwork and casework time to the parole agents' workload, and has added more responsibilities and work for the parole agent III who chairs the committee. Yet the facility received no new resources to handle the additional work.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and N.A. Chaderjian administrators jointly take the following actions to improve treatment services for wards:

- Provide adequate staffing to the facility's general population living units by evaluating the needs of the facility relative to the needs of other facilities and act accordingly. If necessary, redirect resources from other facilities.
- Fill staff vacancies by aggressively recruiting senior youth correctional counselors and youth correctional counselors for the facility. In addition, hire more staff for the counselor relief pool.

In addition, the Office of the Inspector General recommends that the management of N.A. Chaderjian take the following actions:

- As vacancies diminish and staffing levels increase, schedule more than one hour of formal counseling per week per general population ward and ensure that counseling for wards in all living units includes at least some formal, individual counseling of a least one hour duration.
- Assess the training needs of the facility's counseling staff, particularly those of the youth correctional counselors, and make available the funding and time necessary to upgrade their knowledge, skills, and ability through formal training. In addition, use in-house staff, such as psychologists, staff experienced in using the Ward Information Network 2000 system, and the best and most experienced treatment staff to provide structured on-the-job training on counseling techniques, living unit file documentation methods, and other relevant topics**.**
- Improve the monitoring of casework by ensuring that living unit files are organized and use progressive discipline to emphasize the importance of maintaining current, accurate information in these files.
- Regularly sample ward files for compliance with the treatment provisions of the *California Youth Authority Institutions and Camps Branch Manual*.
- Hold administrators, supervisors, parole agents, and counselors accountable for counseling wards through timely performance appraisals and progressive discipline.

Finally, the Office of the Inspector General recommends that the California Youth Authority take the following actions:

- Hold the facility's high school administrators responsible for ensuring that a teacher attends every case conference. Use performance appraisals and progressive discipline to enforce compliance.
- In future labor negotiations on behalf of the entire California Youth Authority, consider reducing or eliminating the "70-30" split for filling youth correctional counselor positions.
- Provide funding for interactive journals and similar items critical to the department's core functions of treatment and training.
- Evaluate the additional workload placed on treatment staff due to the passage and implementation of Senate Bill 459, and provide budget support for the facilities as necessary.

FINDING 2

The Office of the Inspector General found that education services provided to wards at N.A. Chaderjian are deficient.

Academic education and training for wards is integral to the California Youth Authority's mission of providing rehabilitation services to enable wards to return to society with the skills necessary to succeed and to discourage future criminal behavior. Yet the Office of the Inspector General found that the N.A. Chaderjian High School is not adequately fulfilling its responsibility to provide wards with education services. Special education wards, who make up 38 percent of the high school's enrolled students, are not receiving all of their individually mandated special education service time. Moreover, special education providers are consistently over-reporting the amount of service provided. At the same time, more than a third of the academic classes scheduled at the high school are routinely cancelled, mainly because teachers do not show up for class. Class cancellations contribute significantly to the school's low effectiveness rating, which measures actual—versus potential— attendance and classes held. The effectiveness rating of the high school is 40 percent, meaning that wards are receiving only 40 percent of their assigned education programming. Poor oversight by school administrators contributes to the problems. The school has had a succession of four principals since 2002 and the current acting principal works concurrently at department headquarters in Sacramento and spends only about half his time at the facility.

As a result of the deficiencies, wards' test scores are declining and fewer wards are graduating. The low academic achievement not only hampers the wards' development and chances for future success, but also jeopardizes the accreditation of N.A. Chaderjian High School. The Western Association of Schools and Colleges granted the high school candidacy accreditation in April 2003 for a period of two years and revisited the school on January 26, 2005 for the purpose of determining whether an extension of accreditation was warranted, and if so, for how long. As of the date of this report, the association had not announced its accreditation decision, but a report issued after its January 26, 2005 visit was critical of the school's limited progress in addressing the "critical areas of follow-up" identified in the April 2003 report. Among these critical areas were low staff morale; teachers working out of their areas of expertise; a lack of understanding of California academic standards; and a failure to integrate those standards into school curricula.

The Office of the Inspector General made the following specific findings as a result of the audit:

- ***Wards are not receiving the appropriate amount of special education service time.*** Special education wards at N.A. Chaderjian are receiving service far below the 90 percent threshold set by the California Youth Authority Education Services Branch**.** Furthermore, the Office of the Inspector General found that N.A. Chaderjian High School has been uniformly overstating the special education services provided to wards. A review by the audit team of three sample months in 2004 covering 40 reports prepared by service providers at the facility found that every single one overstated the service rates provided to wards. During those months, for example, N.A. Chaderjian High School reported an average compliance rate for resource specialists of 76 percent, meaning that 76 percent of the special education wards

received at least 90 percent of the required resource specialist service hours. A recalculation by the Office of the Inspector General of the data used to support the reported 76 percent compliance rate, however, yielded an actual compliance rate of 43 percent— meaning that the compliance rate had been overstated by 33 percentage points. Similarly, the audit team found that Special Day Classes compliance rates were overstated by five percentage points; Speech/Language Treatment compliance rates were overstated by four percentage points; and School Psychologist Therapy compliance rates were overstated by ten percentage points.

In summary, the audit team determined that during the three months sampled in 2004, the following percentages of special education wards obtained 90 percent or more of their individually mandated special education service time:

Resource Specialist Program .....43 percent
Special Day Classes.....11 percent
Speech/Language Treatment.....58 percent
School Psychologist Therapy.....56 percent

The failure to provide special education services at the required level and obscuring the issue by overstating special education statistics hampers decision-making for special education. The California Youth Authority's special education services historically have been under scrutiny by the courts, youth advocates, and legislators. The erroneous and misleading reports impair the department's efforts to identify shortcomings in special education services and develop appropriate corrective action.

- ***N.A. Chaderjian High School's standardized test scores have declined.*** The percentage of wards scoring below the 25th national percentile in Standardized Testing and Reporting (STAR) increased from 61 percent in 1998 to a high of 83 percent in 2004. This trend is also manifested in the disparity between N.A. Chaderjian wards and statewide STAR scores for public schools. While scores across the state improve, the wards at N.A. Chaderjian are failing to keep pace. In 1998 N.A. Chaderjian wards performed at a rate 3.7 percentage points below the statewide public school average. By 2003 the performance rate had plummeted to 10.8 percentage points below the statewide average. The 2004 scores continued the downward trend, with N.A. Chaderjian wards scoring 12.2 percentage points below the statewide average. Overall, the 2004 STAR scores at the N.A. Chaderjian High School ranked eighth worst among the eleven California Youth Authority institution and camp schools reporting.

- ***Fewer wards are graduating from N.A. Chaderjian High School.*** In 2004, N.A. Chaderjian High School graduated 41 wards, a significant decrease from 2003, when 72 wards graduated. While a drop in the ward population at N.A. Chaderjian High School from 2003 to 2004 contributed to the decline in the number of wards graduating, the population decrease was only 23 percent, while the decrease in the graduation rate was 43 percent. Earning a diploma from N.A. Chaderjian High School is difficult—a ward must earn 200 credits to graduate from the school. The Office of the Inspector General found that the average ward at N.A. Chaderjian has 134 credits, yet is earning only 13 credits per year. At that rate, the

average ward needs five years to earn a high school diploma at the facility; yet the average remaining confinement time of wards is slightly more than two years.

The audit team identified the following factors as contributing to the poor special education service rates and to the low academic achievement of wards at N.A. Chaderjian High School:

- ***Failure to assign properly credentialed teachers to special education.*** Education administrators at the facility have not managed the institution's resources effectively by assigning properly credentialed teachers to special education classes. The audit team identified two full-time teachers at N.A. Chaderjian High School who possess special education teaching certificates but who were not teaching special education classes. Another credentialed, part-time teacher who was hired in August 2004 to assist in providing special education services worked 112.25 hours from August through November 2004, yet provided only 29 special education service hours. And although N.A. Chaderjian High School had credentialed teachers available to provide special education classes, a teacher without special education credentials was providing special education Resource Specialist Program services.

- ***Inadequate oversight of special education by administrators.*** The overstated special education service rates are the result of a lack of meaningful supervisory review of the individual provider reports. The audit team found that administrators routinely signed monthly reports without checking for accuracy or logic in the numbers reported. For example, special education administrators approved reports containing illogical dates of service, including weekends, holidays, teachers' vacation days, and teachers' sick leave days. Teachers also reported service hours for wards who had already left the institution and for periods when classes had been cancelled.

- ***Classes are frequently cancelled.*** Perhaps helping to account for the declining STAR scores at N.A. Chaderjian High School, the Office of the Inspector General found that a significant amount of time is lost from academic and vocational education at the facility because classes are frequently cancelled due to teacher absences, security issues, or other facility-initiated purposes. A review by the audit team of a four-month period in 2004 found an average of 347 classes cancelled per month—34 percent of the total classes offered. The cancellations contribute significantly to the high school's relatively low effectiveness rating — the measure used by the California Youth Authority Education Services Branch to compare actual ward attendance and classes held to potential ward attendance and classes held. In fiscal year 2003-04, the effectiveness rating of N. A. Chaderjian High School was 40 percent, meaning that wards received on average only 40 percent of their assigned educational programming.

  The class cancellations at the facility can be attributed to the following:

  - ✓ ***Teacher abuse of leave time.*** Sixty-three percent of class cancellations at the high school occur because teachers are absent and because teachers' use of leave time at the facility is so high that it exceeds the institution's ability to provide substitute coverage. The Office of the Inspector General found that teacher-induced class cancellations occur every day

of the school week and for a variety of reported reasons, including medical and dental appointments, personal and family sick leave, training, meetings, and personal business. Yet, the audit team found that teachers frequently did not charge their leave balances when taking time off for medical and dental appointments, personal and family sick leave, or personal business.

The ability of California Youth Authority teachers to take time off without charging their leave balances is rooted in a section of the California State Employees Association Bargaining Unit 3 contract that designates teachers as "exempt" and therefore excluded from the Federal Fair Labor Standards Act. This designation allows teachers to take partial days off for legitimate purposes without deducting hours from their sick leave or vacation leave balances provided they meet their weekly performance objectives. Yet, the very nature of scheduled classroom instruction precludes teachers from making up lost time if they cancel a class; therefore, they cannot meet their performance objectives during any week in which they cancel classes.

The bargaining unit contract specifically calls for teachers to try to schedule time off during non-class hours—which at N.A. Chaderjian would be before 8:20 a.m., after 3 p.m., or during the half-hour lunch period. Nonetheless, the Office of the Inspector General found that some teachers at the facility take advantage of the exempt status contract provision by abusing leave time. The audit team found that in July 2004, 15 teachers out of the 43 teachers at the facility took an average of 1.8 days of uncharged leave that resulted in class cancellations. In the worst example, one teacher took an average of 5.3 days of uncharged sick leave per month over a three-month period in 2004. During one of those months, that teacher took off half-days on 11 of the 21 school days available for instruction.

- ✓ ***Poor oversight of teachers by education administrators.*** Poor oversight by school administrators allows teachers to abuse leave time, contributing to the high number of class cancellations. One cause of the poor oversight, in turn, is high turnover among administrators. Since 2002, N.A. Chaderjian has had four principals in either acting or permanent appointments. The present acting principal of the facility's high school works concurrently at the Education Services Branch headquarters in Sacramento, and the audit team observed that he spends only about half his time at the facility. The lack of continuity and disengagement of school administrators contributes to low morale among members of the teaching staff. High turnover at headquarters has also contributed to lack of direction from the Education Services Branch, which has had four different superintendents in the past year alone and has numerous vacancies in key management positions.

  Poor supervision of teachers is illustrated by the following:

  - ***Performance appraisals are not completed on time.*** The audit determined that school administrators do not consistently complete teacher performance evaluations on time, and that the number of overdue evaluations increased during the course of 2004. The

audit team found 16 past-due performance appraisals for the month of January 2004 and 57 overdue evaluations for December 2004. The teachers' labor contract provides management with the authority to enforce performance objectives, which could lessen abuse of leave time, but to do so requires timely performance appraisals.

- ***Teachers fail to attend case conferences.*** The failure of teachers to attend wards' case conferences, described in Finding 1, is further evidence of poor supervision by school administrators. N.A. Chaderjian High School sets aside one-half day each week as a time when no classes are scheduled, specifically to allow teachers to attend case conferences in the living units and provide feedback to the treatment teams concerning each ward's educational programming. The auditors found, however, that teachers rarely attend case conferences. A review of wards' treatment files from December 2004 through March 2005, showed that teachers attended the case conferences only 14 percent of the time. Instead of attending afternoon case conferences, many of the teachers simply took advantage of the half-day break in the class schedule to leave the institution early. To address the problem, administrators began scheduling meetings during the case conference time as a way of keeping teachers on the grounds. That measure may have served the purpose of keeping teachers from leaving the facility, but directly undermined the goal of having teachers attend case conferences.

✓ ***Security factors contribute to class cancellations.*** According to the N.A. Chaderjian High School Student Ward Attendance Tracking system, safety and security considerations accounted for 18 percent of class closures during the period June through September 2004.

✓ ***Teacher training and development.*** Classes are also occasionally closed for teacher training and development and administrative meetings. According to the N.A. Chaderjian High School Student Ward Attendance Tracking system, teacher development accounted for 17 percent of class closures during the period June through September 2004.

- ***Ward absenteeism has increased.*** In addition to class cancellations and failure to provide appropriate special education services, ward absenteeism has contributed to declining STAR scores and the low effectiveness rating of N.A. Chaderjian High School. The four-year downward trend in STAR scores at the institution mirrors an upward trend in ward absenteeism. The Office of the Inspector General found that in fiscal year 2003-04, ward absenteeism averaged 23 percent—up from 18.5 percent the previous year and nearly double the fiscal year 1999-00 ward absenteeism average of 12 percent.

  Numerous factors have contributed to the heightened absenteeism, including several beyond the control of the wards. For example:

  ✓ ***Counselors keep wards out of class.*** The Bargaining Unit 6 contract allows counselors to withhold wards from school during scheduled education time to attend small group

counseling sessions—a clash of priorities that demonstrates the lack of coordination between treatment services and education.

- ✓ ***Long class periods discourage attendance.*** In response to violence that has often accompanied the movement of wards to classes and to reduce the number of movements, the N.A. Chaderjian High School has instituted a schedule of two 140-minute classroom periods per day. Although this schedule meets the minimum required instructional minutes over a two-week period, most teachers interviewed told the audit team that the wards' attention spans diminish significantly after one hour, with the result that more than half the class period is not productive. In addition, the long periods magnify the impact of absences and cancellations. When a teacher arrives late, his or her class is canceled for the entire 140-minute period, resulting in a loss of half the normal school day. Wards held from school for small group sessions or other activities similarly lose a half day of school, or even a full day, depending on the ward's class schedule. If the school schedule consisted of four shorter periods per day, only 25 percent of the school day would be lost when a teacher arrives late or a ward is held out for a counseling session or other reason.

- ✓ ***Wards lack motivation to complete coursework.*** Because wards at the facility often have had negative education experiences both inside and outside the California Youth Authority, many of them believe earning a high school diploma is beyond their ability; yet California Youth Authority policy requires wards to make "satisfactory progress" toward high school graduation to be considered for parole. As a result, many wards enroll in classes solely for that reason and lack the motivation to complete the courses. Wards who might be more interested in learning a trade, meanwhile, are often denied that opportunity because the number of vocational education programs at the facility has shrunk from 13 to six since 1996 because of budget cuts.

- ✓ ***Gang segregation limits educational opportunities.*** Current policy at N.A. Chaderjian High School requires segregation of students by gang affiliation. As a result, many wards are assigned to school for only one period and, consequently, one subject. But because not all classes required for graduation are offered in both morning and afternoon sessions, wards may be unable to complete graduation requirements. The Office of the Inspector General identified one ward, for example, who needs only 5.5 credits to graduate, but the two classes he needs are offered only in the morning, and his gang affiliation permits him to attend class only in the afternoon.

RECOMMENDATIONS

To improve educational achievement at N.A. Chaderjian, the Office of the Inspector General recommends that the California Youth Authority take the following actions:

- Expedite the appointment of a superintendent of education.

- During the next Bargaining Unit 3 negotiations, bargain for removal of the exempt status of teachers.

- During the next Bargaining Unit 6 negotiations, bargain to eliminate the authority of counselors to keep wards from attending the high school classes.

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

- Expedite the appointment of a permanent principal for N.A. Chaderjian High School.

- Use performance appraisals and progressive discipline to hold teachers and administrators accountable for their performance, including attending case conferences, meeting performance objectives, and accurately reporting special education services and attendance.

- Reduce class cancellations by working with the facility superintendent to improve scheduling and coordination between the facility staff and the high school administration. As part of this joint effort, eliminate the scheduling conflict between small group counseling and wards' attendance in school.

- For wards 18 years of age and older, consider developing alternatives to obtaining a high school diploma as a criterion for parole consideration. While obtaining a high school diploma should remain the primary goal for the majority of wards, alternatives such as adult basic education and vocational programs should be considered as appropriate options for educating wards and earning parole consideration.

- If teachers' attendance at case conferences does not improve, eliminate the half-day reserved for case conferences and require teachers to provide timely progress reports to the wards' youth correctional counselors.

- Adjust the school schedule to provide for at least four class periods per day.

- Study ways to lessen the negative effects of gang segregation within the high school in order to provide all wards with equal educational opportunities.

- Comply with all recommendations of the Western Association of Schools and Colleges in order to obtain full accreditation for N.A. Chaderjian High School.

- Use existing special education staff to provide special education services and ensure that only properly credentialed special education staff are providing the services.

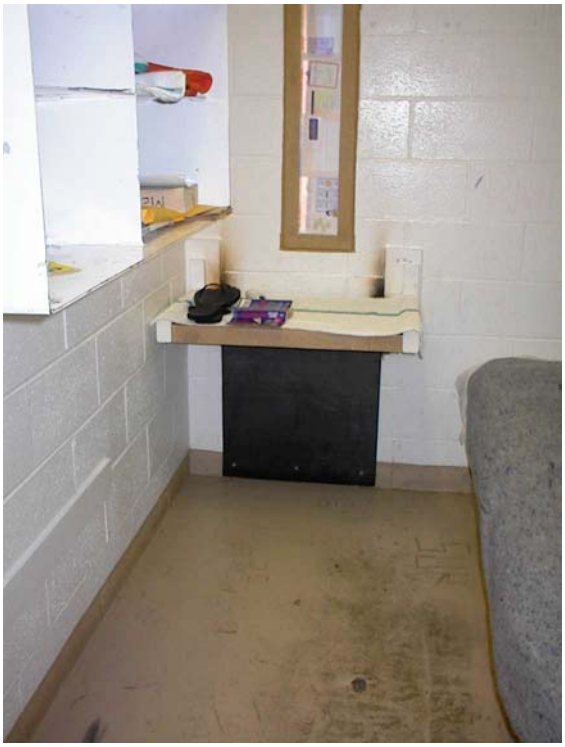
FINDING 3

The Office of the Inspector General found that structural defects, maintenance problems, and deficient management practices at N.A. Chaderjian jeopardize the safety of employees, wards, and visitors.

The Office of the Inspector General found that N.A. Chaderjian has significant structural deficiencies and that the institution is not complying with numerous security policies and procedures required by the *California Youth Authority Institutions and Camps Branch Manual.* These deficiencies, combined with maintenance problems and deficient management practices, jeopardize the safety of staff, wards, and visitors to a degree that exceeds even the normal risks inherent in a correctional setting.

Building deficiencies compromise security. According to the plant operations staff for the Northern California Youth Correctional Center complex, the institution has been plagued by structural defects since the day it opened in 1991. As an example, according to the Facilities Planning Branch of the California Youth Authority, the construction plans for the facility called for walls to be "solid grouted" — meaning that cement blocks were to be filled with concrete — but the facility staff discovered that some of the walls had hollow areas. In response to that discovery, the department contracted with a geotechnical engineering firm to conduct an independent study of the facility. *[Information pertaining to interior walls redacted for security reasons.]* The study identified other structural deficiencies, including inadequate bracing, and recommended that further testing be conducted. The plant operations staff has found numerous other deficiencies, including improperly installed floor tiles, gaps in the doors and food tray slots of the wards' rooms, and failure to properly ground water lines and electrical panels. The California Youth Authority has sought special repair funding for some of the problems identified in this report, but the Department of Finance has denied the requests.

Picture provided by California Youth Authority staff illustrating a hollow area within a wall in one of the rooms in the Kern living unit. These cement blocks were not filled with concrete. This hole had been repaired prior to the initiation of the audit.



Metal plate installed over a hole in a room in the Kern living unit.

The Office of the Inspector General confirmed the existence of numerous structural deficiencies at the institution and noted that wards are able to exploit the deficiencies, endangering staff and other wards. For instance, section 1802 of the *California Youth Authority Institutions and Camps Branch Manual* requires that doors to wards' rooms be constructed to withstand damage. It also requires that doorjambs and locks be constructed to be as secure and indestructible as practicable. The section also requires plumbing and electrical fixtures in the wards' rooms to have limited potential for damage by wards and that rooms be designed to lessen the possibility of escape, suicide, and passing contraband.

Yet the Office of the Inspector General found that the institution does not consistently meet these standards. For example:

- ***The doors to ward rooms are in poor repair and are not secure.*** The Office of the Inspector General found that construction of the doors to the wards' rooms in at least five living units is such that wards are able to jam the doors and prevent them from being locked by placing objects in the doorjamb. The torsion springs in some of the doors are weak, allowing wards to prop open doors with string or wire. The staff reported that replacement parts are hard to find, making repairs difficult.
- ***Doors to ward rooms can pop open.*** All of the doors in the Kern living unit are electrically operated and have undersized motors that tend to overheat. This can cause the doors to open unexpectedly when the motor cools and the computer memory executes the most recent command. Doors in the other living units are manually operated and therefore do not have this deficiency.
- ***Gaps between doors and doorjambs allow wards to assault staff.*** Gaps between the doors and the doorjambs and along the food tray slots in the doors provides an opportunity for wards to "gas" employees— intentionally throw human excrement or body fluids on them. In 2003, there were 43 gassing incidents at the institution, and in 2004, there were 25 gassing incidents. Gassing incidents usually require testing victims and perpetrators for hepatitis and tuberculosis at state expense.

A door in the Kern living unit showing gaps next to the food tray slot that provides an opportunity for gassing assaults.

Food tray slot altered by the plant operations staff to prevent gassing assaults.

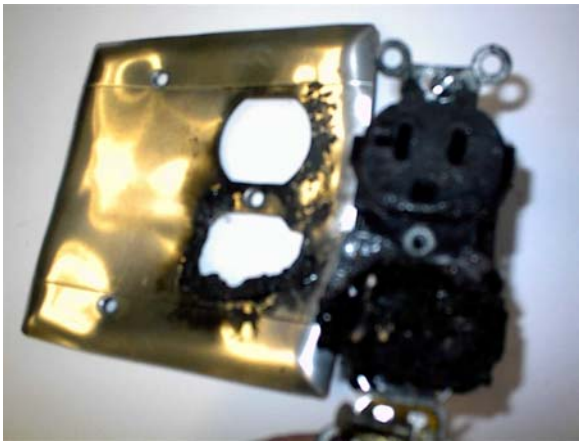
- ***Holes in the floor.*** Wards have been able to dig through the cement floor of some of the rooms into the underlying soil, revealing that the floor in some places is less than two inches thick and raising questions about its structural integrity. The maintenance staff patches the holes as they are discovered.

Picture provided by California Youth Authority staff illustrating a hole dug by a ward in the floor of a room in the Sacramento living unit. This hole had been repaired prior to the initiation of the audit.

A hole in the floor of the Sacramento living unit after it was patched by plant operations.

- ***Wards are able to tamper with electrical fixtures.*** Some of the rooms are without power for radios and television sets because wards have tampered with the electrical outlets. Because

the rooms continue to be used so long as the lights are working, wards sometimes remove electrical outlet plates in adjoining rooms and tamper with those outlets to divert electricity to rooms without power. This practice, referred to as "juicing," involves tying a wire to a plug, attaching it to metal shelving, and transferring the power to the adjacent room. Wards camouflage the small wires with toothpaste blended to match the wall color. Other forms of tampering involve altering light switches or light ballasts. Some of the tampering incidents have caused plugs to conduct 220 volts instead of 110 volts, tripped circuit breakers, and caused computers to fail. Wards sometimes divert electricity to deliberately cause electrical shocks to the staff, and a number of staff members have received electrical shocks while working in the rooms. Wards who are unaware of the dangers of the tampering are also at risk of electrical shock.



An electrical outlet that was burned out due to electrical tampering by wards.

- ***Broken electrical and plumbing fixtures have rendered many rooms unusable***. Many of the rooms in the living units are unusable because wards have damaged or destroyed plumbing and electrical fixtures and repairs have not been made. The review found that 13 (26 percent) of the 50 rooms in the Kern living unit, for example, were unusable because of unrepaired plumbing, doors, or electrical fixtures.
- ***Wards are able to flood dayrooms.*** Because the floors in ground-level ward rooms are at the same level as the floors in the central dayrooms, when wards flood their rooms, they also flood the dayrooms, disrupting the programming activity of all wards in the area. The flooding, together with the fact that the tiles were not properly installed, has damaged the tiles and left them loose and in poor condition, resulting in broken pieces of tile that can be used as weapons.

Broken floor tiles in the dayroom of the Pajaro living unit. Pieces of tile can be used as weapons or to manufacture weapons.

The Office of the Inspector General found numerous other building deficiencies at the facility that endanger staff and wards. Examples include the following:

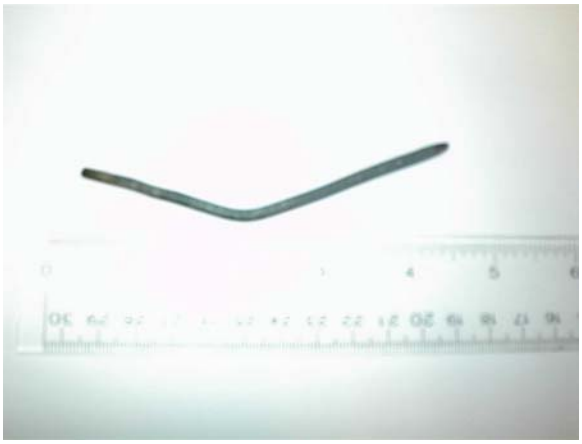
- ***Control panels, monitoring devices, and lights are out or malfunctioning.*** In some living units, the door status lights in the control tower electrical panel mistakenly indicate that a door is locked when it is not, or that it is open when it is not. In addition, some of the surveillance cameras, as well as some of the video monitors in the control towers, are not fully functioning. For example, the audit team found that three of the nine screens of a surveillance monitor in one control tower were blacked out, and the staff reported that they were unaware that a surveillance camera on the recreation yard was broken until a staff member was assaulted on the yard. In addition, in some of the living units, lights in the wards' rooms and in the dayrooms have been out for as long as a week, making it difficult to conduct counts or provide regular programs. Evening programs in at least one living unit have been cut short because of inadequate lighting.

Surveillance monitor in the control tower over the Owens and Pajaro living units showing three of the nine screens blacked out.

- ***Fences between recreation yards are inadequate.*** Fences separating the recreation yards of different living units are too low and the flat panel razor wire on top does not sufficiently discourage climbing. *[Information pertaining to fences redacted for security reasons.]*

- ***Outdoor caged areas are in disrepair.*** Some of the outdoor caged areas used by the Sacramento and Kern living units to provide wards in the lockup unit and the special management program with large-muscle exercise are in disrepair because of damage by wards. *[Information pertaining to cages redacted for security reasons.]* The maintenance staff reported they are unable to keep up with the necessary repairs, and some of the cages are continually unusable.

Picture taken during the audit depicting a large cage used as an individual recreation area outside the Kern living unit with a hole probably created by wards either to obtain material for weapons or to break through the fence.



A piece of metal more than 4" long that was found on 03/08/05 behind the Sacramento living unit. The metal appears to be broken off a fence. One of the ends appears to have been sharpened. Because of its location, it was likely broken off from the large cages used as individual recreation areas.

- ***Electronic entry/exit tracking system is not reliable.*** Sections 1915 and 1920 of the *California Youth Authority Institutions and Camps Branch Manual* require the use of the electronic entry/exit system to identify all employees and certain visitors and to alert the staff when those checking into the institution have not departed at the expected time. The Office of the Inspector General found, however, that the bio-scan electronic entry system was not operating properly at the time of the review. *[Information pertaining to bio-scan electronic entry system redacted for security reasons.]* Those who attempted to use it often found that the system would neither register their access card nor recognize their fingerprint. The institution does use a manual system to identify those entering and leaving the institution, but unlike an electronic system, that system cannot automatically alert staff when employees or

visitors fail to leave the facility at the expected time and instead relies on the staff to monitor departure times.

- ***The main entrance of the facility lacks a stationary metal-detector.*** Section 1805 of the *California Youth Authority Institutions and Camps Branch Manual* requires a stationary metal-detection device to be in place for screening incoming staff and visitors for contraband such as firearms or knives. *[Information pertaining to metal detector removed for security reasons.]* Although hand held metal-detection devices are available, the Office of the Inspector General never saw them being used. The audit team did observe that stationary metal-detection devices in the school and visiting areas were operational.

- ***Youth correctional counselor stations provide minimal protection.*** Section 1820 of the *California Youth Authority Institutions and Camps Branch Manual* requires every facility to design youth correctional stations in living units so as to provide protection from wards during emergencies. Whenever possible, these stations are to be enclosed with locking doors and secure from intrusion. The audit team found, however, that the youth correctional counselor stations on the floors of the 12 living units at the institution are open and unsecured. While the stations can serve as a barrier from a thrown object, they provide no protection from physical assaults.

- ***Intercom system does not serve all areas.*** Intercoms are essential to enabling the security staff to monitor ward activity and respond to emergencies. Section 1810 of the *California Youth Authority Institutions and Camps Branch Manual* requires institutions to "have an intercom system linking school classrooms with security staff and having an all-call capability." While the Office of the Inspector General found that most of the academic classrooms and vocational education shops at the institution had operable intercom systems, two of the vocational shops in which classes are being held (auto mechanics and building maintenance) did not.

- ***Perimeter security is deficient.*** Section 1813 of the *California Youth Authority Institutions and Camps Branch Manual* requires all buildings that form part of the institution perimeter to include specified features and to conform to structural specifications for fences, fence poles, cameras, fence alarms, and other equipment necessary to secure the perimeter and prevent escapes. Section 1813 also requires that "sallyports shall be provided with an electronic overide lock system operable from a security control station."

  The Office of the Inspector General found that the institution's one vehicle entry/exit sallyport does include an electronic override lock system operable from the control tower. But the audit revealed deficiencies in both the perimeter fence at the institution and in security procedures at the entry gate. The bottom of the perimeter fence is not set in concrete and the fence poles are of insufficient diameter, with the result that the fence is unstable and sways in the wind. *[Information pertaining to perimeter security redacted for security reasons.]* Although fence lighting is adequate, some of the fence cameras are not operating and those that are operating are not useful in foggy conditions. Also, the signs identifying the fence "zones" are so small that the staff is obliged to memorize the zone locations to be able

to respond to alarms. *[Information pertaining to perimeter security redacted for security reasons.]*

- ***Radio equipment is outdated and needs a replacement schedule.*** Section 1814 of the *California Youth Authority Institutions and Camps Branch Manual* requires that radios needed to provide secure communication and sensitive information be placed on a replacement schedule and budgeted for accordingly. *[Information pertaining to radio equipment redacted for security reasons.]*

- The Office of the Inspector General also found that the institution is not complying with numerous other department-mandated security policies and procedures. The *California Youth Authority Institutions and Camps Branch Manual* requires the state's youth correctional institutions and camps to comply with specific policies and procedures intended to provide for the safe and secure operation of California Youth Authority facilities. Policies and procedures affecting ward, employee, and visitor safety include those found in sections 1800 through 1848 (safety and security standards); sections 1915 through 1947 (entry-exit systems); sections 5000 through 5030 (contraband and searches); and sections 5050 through 5075 (searches of employees and visitors).

The importance placed by the California Youth Authority on compliance with sections 1800 through 1848 is demonstrated by a department requirement that the superintendent of every institution and camp conduct an annual evaluation of the entity's compliance with those sections. Superintendents are required to report the results of the evaluations each November to the deputy director of the department's Institutions and Camps Branch. Non-compliance with any provision requires the superintendent to submit a plan and expected date for achieving compliance. In addition to reviewing the annual compliance reports, the deputy director is responsible for assembling a review team to visit every camp and institution each year to conduct a security audit of compliance with the safety and security requirements.

Despite the importance placed by the department on compliance with safety and security requirements, the Office of the Inspector General found numerous deficiencies in N.A. Chaderjian's compliance with the requirements, as well as with the department's monitoring of that compliance. The Office of the Inspector General found the following:

Security evaluations do not identify all problems and do little to achieve change. Problems affecting the safety and security of staff, wards, visitors, or the general public should be identified and addressed by the institution's annual security audit, as required by section 1800. The Office of the Inspector General's review of N.A. Chaderjian's 2002, 2003, and 2004 section 1800 security evaluation reports, however, revealed the following:

- ***Areas of non-compliance were missed.*** The evaluations overlooked significant areas of non-compliance and did not result in correction of the non-compliance they did identify. As itemized below, the Office of the Inspector General identified non-compliance with 17 of the sections contained in sections 1800 through 1848 of the *California Youth Authority Institutions and Camps Branch Manual* pertaining to security policies and procedures. According to staff interviews and facility records, many of the issues of non-compliance have

existed for years; yet the facility's 2002 report identified problems with only seven sections. Furthermore, while the 2003 report identified problems with 11 sections, 7 were the same problems identified the previous year. And although the 2004 report identified compliance deficiencies with 14 sections, 11 of those were the same problems identified in the previous year, meaning that problems identified earlier had not been resolved.

- ***Report errors reflect careless work and minimal effort.*** In the 2004 report, only two items of non-compliance included the required estimated completion date, and both of the estimated completion dates given were nonsensical because they had already expired —one by 12 months and the other by 11 months. The audit team noted that the staff person who prepared the 2004 report appeared to have copied the previous years' reports and neglected to update the estimated completion dates. The auditors also found that the document the reviewer used to conduct the compliance evaluation had not been updated to reflect changes in sections 1800 through 1848. For example, in August 2002, section 1815 of the manual was changed from "restraint devices" to "ward accountability." All three reports indicate that the institution was in compliance with that section, but no evidence was provided to show that ward accountability was evaluated. Also, the 2004 report addressed section 1835 ("room extraction"), even though that section has not been part of the manual since at least March 2003.

The Institutions and Camps Branch has not conducted required security audits of the facility. The Office of the Inspector General found that the Institutions and Camps Branch has not conducted security audits of the facility as required by section 1800 for at least the past three years. In December 2002, the department's compliance review unit did conduct a three-day management review audit at the facility that included a security component, but a three-day review is much more limited than an in-depth review. It is noteworthy that the management review audit criticized the Institutions and Camps Branch for neglecting to act on the facility's section 1800 reports, saying the reports were routinely filed without comment. Furthermore, the errors in the institution's section 1800 reports identified above indicate that the branch does not review the reports or assess compliance. The failure of the Institutions and Camps Branch to conduct required security audits and its inaction on section 1800 reports is clearly inconsistent with the security needs of the California Youth Authority.

The Office of the Inspector General also found numerous other security deficiencies related to the management of the institution. For example:

- ***Ward movement practices are deficient.*** Section 1804 of the *California Youth Authority Institutions and Camps Branch Manual* requires that each institution develop "controls and written procedures for ward movement" and that the controls "be based on a system which provides for advance communication of the movement and observation and accountability for all wards." According to the staff, any ward leaving a unit is issued a pass.

  The Office of the Inspector General observed the following practices in ward movements at the institution that compromise safety and security:

- ✓ Wards were allowed to leave the culinary arts program without a pass or a phone call to notify school security. Wards also left the administration building without a pass.
- ✓ Staff personnel allowed ward workers in the living units to continually communicate with wards who were secured in their rooms.
- ✓ Staff personnel also allowed wards to go behind the youth correctional counselor station in the living units and go unescorted into an area of the Kern living unit that is not readily visible.

- ***Multi-hazard emergency plan is outdated.*** Section 1807 of the *California Youth Authority Institutions and Camps Branch Manual* requires the institution to update its multi-hazard emergency plan annually and to meet annually with local law enforcement officials to plan for any emergency, such as a disturbance or an escape. The Office of the Inspector General found, however, that the institution's multi-hazard emergency plan was outdated and was told by a staff member that the 1996 version was being revised. The 2003 and the 2004 security audits both found the plan to be outdated, and both reported that the anticipated rewrite would be completed in January 2004.

- ***Hostage training is not conducted.*** Section 1809 of the *California Youth Authority Institutions and Camps Branch Manual* requires that each institution implement procedures for handling hostage situations and that appropriate employees be trained for handling those situations. But the Office of the Inspector General found that the institution has not provided hostage training. The superintendent said he was the most recently trained hostage negotiator. The security major said the institution would rely on local law enforcement to handle any hostage situation, but the Office of the Inspector General found no written agreement or memorandum of understanding with a local law enforcement agency to provide for such assistance. According to the security major, an agreement with a local law enforcement agency to provide mutual aid was recently completed, but the agreement does not include a formal hostage protocol. The major reported that the Youth and Adult Correctional Agency is developing a hostage protocol for both youth and adult correctional institutions.

- ***Key controls are deficient.*** Section 1811 of the *California Youth Authority Institutions and Camps Branch Manual* requires the institution to establish a key control committee, but the institution has not done so. Also, the facility locksmith reported that some teachers and other staff have keys that allow them to enter the living units without going through the main doors. This is a safety hazard because security personnel are often unaware that staff who enter this way are inside the living units.

- ***Ward accountability practices are deficient.*** Section 1815 of the *California Youth Authority Institutions and Camps Branch Manual* requires that each institution "develop and maintain a ward accountability system that ensures accurate counts for all wards assigned to the facility," and provides that the "system shall include written procedures that require a minimum of six daily major counts of all wards." The institution complies with the requirements in this section by conducting six official counts of all wards throughout the day and by conducting room checks and logging the counts at each living unit. The institution does not have written procedures, for handling erroneous counts, however. Also, a review of

living unit logs by the Office of the Inspector General revealed that ward movements are not documented consistently. For example, the review team noted that a count of wards taken from the unit to attend education classes was documented in the living unit logbook, but there was no count documented when the wards returned to the living unit, and not all the wards returned at the same time. The logbook is the primary document for recording activity in the living unit. As such, it should accurately record the egress and ingress of wards in each living unit.

- ***Institution operations manual is outdated.*** Section 1816 of the *California Youth Authority Institutions and Camps Branch Manual* requires each facility to have an updated operations manual detailing institution safety and security policies and procedures. However, the operations manual at the institution is outdated, with many sections written in March 1999. The section 1800 security audit noted this problem in each of the last three years, reporting each time that a committee has been established to update the manual. As currently written, some sections of the operations manual simply define a subject, but provide no procedures. For example, section 1185, covering "hostile work environment," defines the subject in one sentence and defines "sexual harassment" in another, but provides no guidance on how to handle or report those issues. The manual's index also lists sections that are not included in the manual.

- ***Personal alarm system and procedures are deficient.*** Section 1817 of the *California Youth Authority Institutions and Camps Branch Manual* requires employees working in the security area of the institution to be trained in the use of the personal alarm system and to carry an alarm or a two-way radio. Only volunteers or visitors escorted or supervised by staff are not required to carry an alarm. Section 1817 also requires alarm signals to terminate in the security control center and requires procedures to ensure timely replacement of batteries in the personal alarms and two-way radios.

  With the exception of one staff member, the employees questioned during the Office of the Inspector General's review reported that security staff respond to personal alarms immediately, but the audit team noted that the personal alarm system is outdated. The section 1800 security audit reports completed in November 2003 and November 2004 reported that a new system was being installed and was expected to be on line by December 2003. At the completion of the Office of the Inspector General's fieldwork, the new system had still not been implemented. *[Information pertaining to personal alarms redacted for security reasons.]* The audit team found there are often not enough alarms to provide to visitors, and the staff reported that maintenance personnel who come from the central complex to perform services on the institution grounds are not provided with personal alarms.

- ***Annual orientation on escape procedures is not provided.*** Section 1818 of the *California Youth Authority Institutions and Camps Branch Manual* requires every facility to establish escape prevention procedures and to monitor ward behavior that might signal escape tendencies. The procedures are to be included in the operations manual and every employee is to be provided with annual orientation on those procedures. However, the Office of the Inspector General found that the institution is not providing employees with the required

annual orientation. The major of security told the Office of the Inspector General that the last training on escape procedures was "probably in 2002."

- ***Ward visiting room practices are deficient.*** Section 1830 of the *California Youth Authority Institutions and Camps Branch Manual* requires ingress and egress to visiting areas to be controlled so that visitors are identified before they enter the area and that they submit to a metal detector scan and have their property searched for contraband. The Office of the Inspector General found that the institution does control ingress and egress to the ward visiting area, which is inside the administration building, and that employees screen, search, and subject visitors to a metal detector scan. Visiting is normally monitored by two youth correctional officers on the floor and one in the visiting tower. But the audit team noted that the tower officer also acts as the gate-keeper for wards arriving or departing and must walk away from the visiting area to open the doors, thereby compromising surveillance of the visiting room. Several staff members told the Office of the Inspector General that most of the drug contraband enters the institution from the visiting section. The audit team also found that the duty lieutenant was unaware of a recent policy change that allows wards to leave their seats without seeking permission from staff to use the vending machines or to retrieve table games.

- ***Post orders are not always available at work sites or included in personnel files.*** Section 1836 of the *California Youth Authority Institutions and Camps Branch Manual* requires that all peace officers have current and signed duty statements and post orders on file. The section also requires post orders to be updated annually and to be placed in each peace officer's personnel file, in the supervisor's work file, and at each work site. The Office of the Inspector General found, however, that post orders were not available at every post and that some post orders were outdated. A review of a sample of personnel files also revealed that some did not contain updated post orders and duty statements.

- ***Communication with employees is inadequate.*** Section 1844 of the *California Youth Authority Institutions and Camps Branch Manual* requires that superintendents ensure that pertinent information is disseminated to all appropriate employees and requires a "read-and-initial" system. A "read-and-initial" system is necessary because access to computers is limited at the institution and only a few employees in the living units have ready access to computers to retrieve electronic mail. The Office of the Inspector General found, however, that the institution does not appear to be using the read-and-initial system effectively to communicate with employees. In some instances, lists of employees needing pertinent information appear to be incomplete and out of date, and confirmation that employees have read the information is not always timely. For example:

  - ✓ A July 8, 2004, memorandum notifying employees to discontinue the use of water rounds as a restraint option had been initialed as read by 70 employees, but nine members of the security staff had written their names on the list because they had been omitted, and 24 other names had not been initialed.

  - ✓ In the case of the same July 8, 2004 memorandum, 23 of the 70 initials were signed in November 2004, more than four months later. In another instance, an April 26, 2004

memorandum concerning emergency staff accountability procedures was supposed to have been read by employees by May 3, 2004, yet 12 of 84 initials had been signed in November 2004, more than six months after the due date.

- ***Search practices are deficient.*** Sections 5065 and 5070 of the *California Youth Authority Institutions and Camps Branch Manual* allow for the search of employees' and visitors' persons, property, and vehicles as a condition of entering the facility. Section 5066 requires searches to be conducted by at least two staff members unless a metal-detection device is used and requires each search to be recorded with the person's name, time, and date of search, search results, and significant comments. The section also requires that if random searches are conducted on groups, those who are searched are to be advised of the reasons the others were not searched.

  At the beginning of this audit, the Office of the Inspector General observed commercial and state vehicles entering and leaving the facility without being searched. This is an especially serious problem because the audit team also observed that personnel at the main gate of the complex also were not searching vehicles. After the audit team reported that vehicles were not being searched, the facility began searching vehicles.

  The Office of the Inspector General did not see the property of any employee being searched as employees entered the institution and many of the facility staff members interviewed said they had never been searched. The major of security provided a report listing and quantifying searches of employees for the period January 2004 to March 2005, however. The report records the dates of the searches and the number of employees searched by civil-service classification, but not by name. Although the property of the Office of the Inspector General's staff was searched, the audit team saw no searches of individuals who were not visiting wards. The major's report identified only two occasions on which visitors were searched in the period covered by the report.

- ***Conflict of interest in conducting inquiries.*** The Office of the Inspector General's review of staff fact-finding inquiries found an instance of conflict of interest. In the inquiry in question, an employee in the chain of command directly under the major of security was assigned to conduct an inquiry in which the major of security was both the complainant and primary witness to the incident other than the subject employee. Such conflict in job assignments compromises the integrity of the inquiry and engenders mistrust of management by line staff. With trained staff available at neighboring facilities, it would be prudent to refer inquiries involving management staff to them.

- ***The workplace violence prevention program is almost non-existent.*** Failure to provide a workplace violence prevention program to staff in an environment like N.A. Chaderjian eliminates a tool that staff can use to help provide a safe workplace. Sections 5250 through 5255 of the *California Youth Authority Administrative Manual* require managers to ensure that employees are trained in the workplace violence prevention program and that a manager or supervisor complete the workplace violence worksheet within 24 hours of a reported incident. The local administrator is required to forward the worksheet to the department coordinator within 24 hours of completion of the form. The Office of the Inspector General

found that only four incidents of workplace violence have been reported to the coordinator in the last 3½ years, and that all were reported between July 23 and September 30, 2004. None of the forms were forwarded within the appropriate time period; instead one was forwarded within 7 days, another in 19 days, and two in 23 days. Several staff members, including union representatives, said in interviews that they were unaware of the program and did not know the identity of the local administrator. A review of the facility's operation manual found only one sentence referring to workplace violence — which defined it as "hostile work environment"— and no procedures to implement the program.

Employees claim that management policies and practices compromise safety. Members of the institution's custody and living unit staff complained particularly of management policies and practices they said cause unsafe conditions at the facility. Line staff consistently said that the institution management does not communicate with or provide leadership in a way that promotes safe and secure operations and that changes in department policies have put the staff and wards at risk. Employees said that as a result they have become hesitant to perform simple functions or to respond to incidents for fear that if an incident arises, they could be accused of wrongdoing. Examples cited by the staff include the following:

- ✓ ***Disciplinary sanctions have been eliminated and alternatives have not been provided.*** The staff said that the loss of disciplinary sanctions that were formerly available puts them at risk in dealing with the violence-prone wards at the facility, particularly because sufficient alternatives have not been provided. As part of reforms being implemented at California Youth Authority institutions, programs that staff utilized to provide disciplinary sanctions for disruptive wards, such as the 23-and-1 program and temporary detention, are being eliminated, but have not been replaced by other disciplinary or incentive measures. Forms of discipline such as loss of privileges are ineffective with Phase I wards, who have few privileges left to suspend. Similarly, wards whose specified commitment time already extends to their 25th birthday, after which they can no longer be held by the California Youth Authority, realize that their commitment time will not increase as a result of bad behavior and therefore have less incentive to avoid trouble. The changes have left the staff with few disciplinary options or positive incentives that will convince wards to curtail disruptive or assaultive behavior. In 2003, there were 12 physical, non-gassing, assaults on the staff at the facility, and in 2004, there were 23 such assaults. Assaults on other wards also endanger staff, who must quell the incident.

- ✓ ***Staffing ratios compromise safety.*** Required staffing levels are based on ward population and do not take into account the ages and violent histories of wards at N.A. Chaderjian or the configuration of the living units at the facility. Sections 24.04 (b) and (c) of the collective bargaining unit agreement between the State of California and the California Correctional Peace Officers Association specifies the required staffing ratios for California Youth Authority facilities, taking into account the differences between single-room living units and open-dorm living units. To provide the same level of safety, a living unit primarily housing wards over age 18 who have committed violent offenses and who have consistently displayed poor in-custody behavior would appear to justify a higher staffing ratio than a living unit with younger wards with less-violent histories. Yet,

at N.A. Chaderjian, the living units have a lower staffing ratio than other facilities because one of the living unit posts in each of the six buildings is actually assigned to the control tower shared by two adjacent living units and is not available on the floor of either unit. As a result, although one living unit can put all three of its staff members on the living unit floor to provide additional security and ward supervision, the adjacent living unit, with the same staffing level has only two staff members on the floor with a third staff member manning the control tower shared with the adjacent unit.

- ✓ ***Staff is uncertain what use-of-force policy is in effect.*** The California Youth Authority is revising its use-of-force policy, but has not made clear to the staff whether the old or the new policy is now in effect. The department provided training on the proposed policy to employees throughout the California Youth Authority in May 2004 and promised to provide staff with the new policy when it became final, but has not yet done so. Department administrators advised the Office of the Inspector General that the new policy is not yet in final form. In the meantime, however, facility staff are uncertain which policy is in effect.

RECOMMENDATIONS

The Office of the Inspector General recommends that the institution management take the following actions to improve security operations and safety at the facility:

- In conjunction with the plant operations staff of the Northern California Youth Correctional Center, develop and implement a comprehensive plan to identify, prioritize, and correct all building deficiencies that create security and safety risks. The plan should specifically address the deficiencies identified in this report and should have cost estimates and a schedule with target dates for completion. The California Youth Authority headquarters should assist the facility with the plan.
- Take steps to secure the recreation yard fences. In so doing, consider "climb-resistant" fences and using wire of the appropriate gauge to lessen the possibility of wards ripping or breaking through the fence.
- Until a properly functioning electronic entry/exit system is installed, security staff at the main entrance should track visitors and staff on an electronic spreadsheet. The spreadsheet should be structured so that it can easily be sorted by estimated exit time to track the names of individuals whose anticipated exit time has passed.
- Hold the security major accountable for improving the thoroughness and overall quality of the facility's annual Section 1800 security audits. The facility should ensure that unresolved deficiencies are resolved promptly.
- Improve ward accountability and movement by requiring that movement of wards to and from the living units be recorded in the unit logbooks. Recorded information should include the time of arrival and departure for each ward and his name and identification number. Staff from each sending area should be required to provide prior notification to staff at the receiving area that ward movement is about to occur,

and the receiving area should be required to confirm receipt of the wards by notifying the sending area when ward movement is completed. Staff should ensure that all wards carry a pass during movement.

- Develop procedures for handling erroneous ward counts, including recording each occurrence and identifying the responsible staff member to determine whether additional training, discipline, or procedural changes are needed.
- Update the multi-hazard emergency plan and provide training and notification of changes to appropriate staff as necessary.
- Update and formalize hostage procedures and provide hostage training as necessary.
- Require all staff entering the living units to notify the living unit control tower so that security personnel are aware of their presence.
- Set the bottom of the perimeter fence in concrete and, if necessary, replace fence poles with poles of a larger diameter.
- In conjunction with California Youth Authority headquarters, develop and implement a radio replacement schedule and dedicate funding for that function in order to supply facility personnel with adequate communication devices.
- Update the facility's operations manual and post orders. Provide post orders for every watch on every post. Provide training on procedures requiring major changes. Use the read-and-initial system to ensure that staff personnel receive copies of important procedural changes and confirm receipt within a reasonable time.
- Update escape procedures and provide training annually.
- Improve security related to the ward visiting area by providing uninterrupted visual coverage. Consider adding another staff person to the visiting tower so that one person can continually monitor the visiting area while the other can operate the doors for wards entering and leaving.
- Augment electronic mail and the read-and-initial system by conducting quarterly meetings involving line staff and management to enhance communication and provide a forum to discuss issues affecting the work environment. Ensure that meeting times are rotated so that staff from different shifts can attend.
- Conduct more random searches of both employees and visitors and record searches by identifying the names of those searched, the time and date of the search, and the results of the search. Ensure that searches occur on a random and unpredictable schedule.
- Refer inquiries involving a management employee as a subject, complainant, or primary witness to a neighboring institution to improve the integrity of the inquiry and its findings.

- Develop policies and procedures to implement a workplace violence prevention program. Train or orient staff on the program as necessary. Ensure that the policies and procedures comply with the required time limits.

In addition, the Office of the Inspector General recommends that the California Youth Authority take the following actions:

- Before committing resources to implement the facility's comprehensive plan cited above, contract for a thorough, independent study that tests the structural integrity of the buildings in the facility. If the contractor finds that structural deficiencies exist, the contractor should include in the study the estimated costs to fix them. The director should use the test results to recommend to the administration and the Legislature whether to make the repairs and keep the facility open or close it and find a suitable alternative for housing the wards.
- Require the Institutions and Camps Branch to perform the annual security audit of the N.A. Chaderjian Youth Correctional Facility and other facilities as required by section 1800 of the *California Youth Authority Institutions and Camps Branch Manual*.
- Evaluate staffing ratios and work requirements for each living unit to determine whether the current staffing ratios are appropriate given the types of resident wards, the physical design of the units, and the job requirements of staff. Based on the results, propose to the California Correctional Peace Officers Association realignment of the staffing ratios of the living units. (This recommendation is partially addressed in finding one, which discusses staffing in the general population living units.)
- Explore and evaluate disciplinary measures and positive reinforcement options that can be used with wards as disincentives to poor behavior and incentives for good behavior. Give consideration to the fact that many wards cannot have time added to their commitments.
- Provide department staff with the status of the revised use-of-force policy and advise staff on what policy to follow until the new policy is final.

FINDING 4

The Office of the Inspector General found that N.A. Chaderjian is not consistently complying with department policies and procedures governing the use of psychotropic medications and suicide prevention, assessment, and response.

Providing mental health treatment, including the appropriate use of psychotropic medication for wards diagnosed with mental disorders, and instituting effective suicide prevention measures are fundamental responsibilities of the California Youth Authority. To accomplish those objectives the department has adopted specific policies and procedures to govern the use of psychotropic medication and to reduce the possibility of suicide by wards. Suicide prevention, assessment, and response is critically important in California Youth Authority facilities, where suicide risk is generally high. Since January 2004, there have been two suicides in other California Youth Authority institutions.

The Office of the Inspector General found, however, that the suicide prevention, assessment, and response program at N.A. Chaderjian is severely deficient. The audit also determined that wards at the facility are receiving psychotropic medications without proper testing and monitoring. As a result, the facility is jeopardizing the health of wards receiving psychotropic medications and is not taking adequate measures to protect wards from suicide. The failure of the institution to comply with required policies and procedures also exposes the department to potential lawsuits resulting from death or injury to wards.

Psychotropic medication practices. The Office of the Inspector General found the following deficiencies in the administration of psychotropic medication at the facility.

- ***Wards on psychotropic medication are not consistently tested.*** Because some psychotropic medications may cause liver toxicity or other organic damage, *California Youth Authority Institutions and Camps Branch Manual* section 6275 requires that wards receiving psychotropic medications undergo appropriate laboratory tests and be monitored regularly. Consistent with that provision, the chief medical officer of the Northern California Youth Correctional Center told the Office of the Inspector General that wards should receive a baseline laboratory test before starting psychotropic medications and should undergo follow-up tests at least every three months. Pharmaceutical manufacturers also recommend testing. Yet, the audit found that psychiatrists at N.A. Chaderjian do not consistently order laboratory tests before and after dispensing psychotropic medications to wards.

  At the time of the management review audit, approximately 58 wards were receiving psychotropic medications at the facility. To determine whether wards had received baseline and follow-up tests, the Office of the Inspector General reviewed the unified health records of 28 wards who had a total of 52 prescriptions for psychotropic medications. The 28 wards included all of the 13 wards in the general population who were taking psychotropic medications and a random sample of 15 wards from two specialized program living units. The review determined that wards did not undergo baseline laboratory tests for 34 of the 52 prescriptions (65 percent). Furthermore, of the 30 prescriptions that were at least three

months old, the auditors found that wards had received both baseline and follow-up testing in only 23 percent of the cases—seven of the 30 prescriptions. In the other 23 prescriptions (representing 77 percent of the 30 prescriptions), wards did not receive all of the testing. In seven prescriptions, wards received neither baseline nor follow-up testing. In four prescriptions, wards received a baseline test, but no follow-up tests. In the case of 12 prescriptions, wards underwent follow-up tests, but had never received a baseline test. It should be noted that follow-up tests are of limited value without baseline data to identify trends or progress. Baseline data is also critical for wards who arrive at the California Youth Authority with existing prescriptions if the sending entity does not provide the data.

- ***General population wards receive psychotropic medications without an evaluation.*** *California Code of Regulations*, Title 15, section 4746(b) requires wards to receive a Special Program Assessment Needs evaluation before receiving psychotropic medication. That assessment is important because it identifies mental health disorders and directs wards toward treatment, including possible placement in an intensive treatment program or specialized counseling program. Yet the Office of the Inspector General found that four (31 percent) of the 13 general population wards at the facility who were taking psychotropic medication prescribed by staff psychiatrists had not been given a Special Program Assessment Needs evaluation before receiving the medication.

- ***General population wards are not receiving timely follow-up psychiatric evaluations.*** General population wards using psychotropic medications are not meeting with the psychiatrists for evaluations as often as required by the California Youth Authority Health Care Services Division. The *California Youth Authority Institutions and Camps Branch Manual* section 6275 requires an evaluation of wards placed on psychotropic medications at regular intervals consistent with good medical practice. The acting chief of the California Youth Authority Health Care Services Division advised the audit team that the standard for monitoring wards is a minimum of every 30 days. The Office of the Inspector General found that six (60 percent) of the 10 general population wards who had been receiving psychotropic medications for more than 30 days were not being seen by a psychiatrist every 30 days. For example, of five general population wards receiving Bupropion (an anti-depressant medication), four received an evaluation an average of every 60 days, while the fifth had not received an evaluation for five months. In contrast, two wards in the specialized counseling program and two wards in the intensive treatment program who also were taking Bupropion received psychiatric evaluations an average of every 17 days.

- ***Treatment plans are not prepared for wards receiving psychotropic medications.*** *California Youth Authority Institutions and Camps Branch Manual* section 6206 requires a treatment plan to be prepared for wards undergoing psychiatric treatment. While section 6206 does not define treatment plans in detail, a study conducted for the department in 2001 by Stanford University described the role of treatment planning as follows:

  > *The process would result in a treatment plan which is as specific as possible, delineating not just global malfunctions and symptoms, but also specifying which domains of functioning are disturbed, appropriate treatments for these dysfunctions and when one*

can expect them to resolve, along with a date for re-assessment which will then determine further level of care.[6]

In addition, Section 6275 of the *California Youth Authority Institutions and Camps Branch Manual* specifically requires that the administration of psychotropic medications be linked to a diagnosis and statement of the desired benefit and approximate length of treatment time expected. A review of the files of the 28 wards receiving psychotropic medications for this specific information, however, determined that none included a notation of the desired benefit or the approximate length of time expected to achieve a desired effect. The audit also determined that 26 (93 percent) of the 28 wards reviewed who were receiving psychotropic medications did not have a treatment plan in their unified health records. The absence of a treatment plan, a statement of the desired benefit, and approximate length of time expected for the outcome, deprives the medical and mental health treatment team of the information needed to ensure proper treatment and monitoring.

- ***Incoming parole violators are not receiving Treatment Needs Assessments.*** *California Youth Authority Institutions and Camps Branch Manual*, section 6260 requires all wards, including returning parole violators, to receive a Treatment Needs Assessment within three weeks of admission to the California Youth Authority to identify those needing treatment for problems such as depression, anxiety, anger, or thought disorders at the time of admission. The absence of the assessment deprives mental health and medical personnel of complete information about the ward and could lead to misdiagnosis, improper treatment, or lack of treatment. The Office of the Inspector General reviewed the unified health records of 10 parole violators to determine whether they had received Treatment Needs Assessments within three weeks of arrival and found that none had received the assessment at all, even though they had been at the facility for between five to ten weeks.

- ***Unified health records do not document informed consent.*** Section 6178 of the *California Youth Authority Institutions and Camps Branch Manual* requires the facility to obtain informed consent for the administration of psychotropic medication. To obtain consent, the physician or psychiatrist must obtain signed consent after disclosing to the patient the nature and seriousness of the illness or disorder, the reason for treatment, the nature of the procedures, the probable degree and duration of improvement or remission, potential side effects, any division of opinion concerning the proposed treatment, reasonable treatment alternatives, and the fact that the ward has the right to accept or refuse the treatment. The absence of signed informed consent exposes the department and the institution to possible liability should a ward suffer adverse effects from the medication. A review by the Office of the Inspector General found that the unified health records of eight (29 percent) of the 28 unified health records for wards on psychotropic medication did not include a signed consent form.

[6] "The Assessment of the Mental Health System of the California Youth Authority: Report to Governor Gray Davis," prepared by Principal Investigator: Hans Steiner, M. D., Co-Principal Investigator: Keith Humphreys, PhD., and Project Manager, Allison Redlich, PhD., Department of Psychiatry, Stanford University School of Medicine, December 31, 2001.

Suicide prevention and response. The *California Youth Authority Institutions and Camps Branch Manual* requires the institution to have a comprehensive suicide prevention, assessment, and response program to lessen the potential for suicides. Sections 6263 through 6272 of the manual describe the program and lay out specific requirements. The requirements include: establishing a multi-disciplinary suicide prevention, assessment, and response committee to oversee the program; maintaining suicide risk lists in the living units; maintaining cut-down tools to minimize the potential for suicide by hanging; and assessing and maintaining the physical safety of living areas.

The Office of the Inspector General found the institution's suicide prevention, assessment, and response program to be deficient**.** The audit determined that cut-down tools were available in all living units, but that overall deficiencies in the program amount to significant non-compliance with program requirements. Specifically:

- ***The program lacks leadership.*** Section 6263 of the *California Youth Authority Institutions and Camps Branch Manual* requires the superintendent to designate a manager at the program administrator level or above to serve as the facility's risk management officer. That person is also to serve as chairman of the suicide prevention, assessment, and response committee. At N.A. Chaderjian, however, responsibility for the suicide prevention, assessment, and response program is divided between the risk management officer and a senior psychologist—neither of whom are program administrators. The responsibilities of the committee chairman, which include ensuring that the committee analyzes and reports on "lessons learned" about suicides, suicide attempts, and other suicidal behavior, have been assigned to the senior psychologist, who has no line authority over the living unit staff. Like the senior psychologist, the risk management officer also has no line authority over living unit staff. Furthermore, the responsibilities of the risk management officer, which include tracking wards on suicide watch and ensuring that they receive mandated services, are presently not being fulfilled because the position has been vacant since February 2005. Moreover, the two most recent risk management officers—an associate governmental program analyst and a lieutenant —told the audit team they did not perform the tracking and monitoring duties assigned to the risk management officer.

- ***Committee meetings have been sporadic and poorly attended.*** The suicide prevention, assessment, and response committee, which is comprised of staff members from various disciplines inside the facility, has not consistently held quarterly meetings as required by section 6263 of the *California Youth Authority Institutions and Camps Branch Manual*. The committee did not meet at all for a period of more than 19 months from March 21, 2003 to October 27, 2004. When meetings are held, committee members frequently fail to attend. For example, only five of the committee's 12 members attended the October 2004 meeting. At the completion of the audit fieldwork, the most recent committee meeting had been held on January 25, 2005 and only seven members attended.

- ***Suicide risk lists were neither appropriately displayed nor routinely initialed.*** Section 6269 of the *California Youth Authority Institutions and Camps Branch Manual* requires that living unit suicide risk lists be displayed in the living unit control center in a manner that provides

ready access to and easy review by staff, but does not allow wards to see them. The manual also requires every member of the living unit staff to initial the list as evidence that they reviewed it. The audit found, however, that living units were not consistently displaying the lists and that staff members are not consistently reviewing them. The audit team found that 10 of the 12 living units (83 percent) did not have the unit's suicide risk list appropriately displayed and nine of the 12 (75 percent) could not verify that the staff reviewed and initialed the suicide risk list daily as required.

- ***Committee has not conducted annual room inspections.*** Section 6263 of the *California Youth Authority Institutions and Camps Branch Manual* requires the suicide prevention, assessment, and response committee to conduct an annual inspection of all living unit rooms to identify problems with configuration, equipment, and supplies that could facilitate a ward's suicide. However, the chairman of the committee told the Office of the Inspector General that the committee has not conducted these living unit inspections for more than two years, since April 2003.

- ***Staff members have not received training.*** Some staff members who have routine contact with wards have not received the suicide prevention, assessment, and response refresher training required by section 6263 of the *California Youth Authority Institutions and Camps Branch Manual*. The Office of the Inspector General found that of a sample of 31 staff members in routine contact with wards, only 11 (35 percent) had received the required training annually between January 1, 2000 and February 8, 2005.

The Office of the Inspector General found that the following factors have contributed to the facility's failure to administer and monitor psychotropic medications consistently and to comply with required suicide prevention, assessment, and response program procedures:

- ***Psychiatrist positions are not fully staffed.*** According to the staff at the California Youth Authority, the facility is budgeted for two full-time psychiatrists, which equates to 80 hours per week, but the facility is currently staffed only with two part-time psychiatrists who provide a combined total of approximately 18 hours per week of psychiatric services, or 23 percent of the total budgeted hours. Of the 18 hours, approximately 8 hours per week are dedicated to general population wards and 10 hours per week are dedicated to wards in the intensive treatment and specialized counseling programs. The chief medical officer informed the Office of the Inspector General that he is working with the department's Health Care Services Division to fill these vacancies.

- ***Psychotropic medication protocol has not been developed.*** The chief medical officer has not developed and maintained a psychotropic medication protocol that identifies each step of the process for prescribing, dispensing, and administering the medications. Without that protocol, the facility lacks standardized policies and procedures for baseline testing, follow-up testing, monitoring, and related functions.

- ***Insufficient oversight by the chief medical officer.*** The chief medical officer has not provided sufficient oversight to ensure that his staff appropriately performs the following functions:

    - ✓ Consistently administer baseline and follow-up tests to wards to monitor psychotropic medications.

    - ✓ Provide Special Program Assessment Needs evaluations of wards before prescribing psychotropic medications.

    - ✓ Conduct timely follow-up psychiatric evaluations for general population wards.

    - ✓ Describe the desired benefit of psychotropic medications to wards and properly documents informed consent in wards' unified health records.

    - ✓ Develop treatment plans for each ward.

    - ✓ Conduct Treatment Needs Assessments for parole violators.

- ***Insufficient priority given to suicide prevention and response.*** The institution management has given insufficient priority to the suicide prevention, assessment, and response program. The lack of priority has manifested itself in various ways. Specifically, management has not emphasized to staff the importance of the suicide prevention, assessment, and response committee and has not monitored attendance at the committee's meetings. In addition, management has not ensured that pertinent staff members receive required training. Management also has not appointed a risk management officer at the appropriate level or monitored that person's work to ensure that the required duties, including ensuring that suicide risk lists are properly posted and reviewed by the living unit staff, are performed.

RECOMMENDATIONS

To improve the administration and monitoring of psychotropic medications and the suicide prevention, assessment, and response program, the Office of the Inspector General recommends the following:

- The chief medical officer should continue to work with the department's Health Care Services Division to fill vacancies in psychiatrist positions at the facility.

- The chief medical officer should develop a psychotropic medication protocol and forward a copy to the chief of the department's Health Care Services Division for review and approval.

- The chief medical officer should more closely monitor the work of employees to ensure that they comply with California Youth Authority policies and procedures and best professional practices. When employees are not doing work correctly, the chief

medical officer should provide on-the-job training and formal training as necessary. The chief medical officer should provide timely feedback to employees through accurate performance appraisals and hold staff accountable for their work through progressive discipline.

- The chief medical officer should develop a checklist for the unified health record that itemizes all the requirements to be met by mental health staff before administering psychotropic medications. These requirements should include fulfilling requirements for mental health testing and psychiatric evaluations; written informed consent; developing treatment plans; and statements of duration of prescription time and desired clinical effect, and performing laboratory tests.

- The chief medical officer should ensure that incoming parole violators receive Treatment Needs Assessments.

- The superintendent should assign a higher priority to the suicide prevention, assessment, and response program by emphasizing to all staff the program's importance. The superintendent also should stress to the members of the suicide prevention, assessment, and response committee the importance of its duties by the following:

  - ✓ Monitoring attendance at the committee meetings and reviewing the committee's quarterly reports.

  - ✓ Appointing a committee chairman and a risk management officer at the program administrator level or above and holding those individuals accountable for the positions' duties, including ensuring that suicide risk lists are properly posted and reviewed by the living unit staff.

  - ✓ Ensuring that the committee conducts annual room inspections and reports on conclusions and recommendations as required by section 6263 of the *California Youth Authority Institutions and Camps Branch Manual.*

  - ✓ Ensuring that all staff members who have routine contact with wards receive the training required by section 6263 of the *California Youth Authority Institutions and Camps Branch Manual.*

RESPONSE FROM THE CALIFORNIA YOUTH AUTHORITY

STATE OF CALIFORNIA

Arnold Schwarzenegger, *Governor*

YOUTH AND ADULT CORRECTIONAL AGENCY
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May 20, 2005

Matthew Cate
Inspector General
P.O. Box 348780
Sacramento, CA 95834
Attention: Sam Cochrane

Dear Mr. Cate:

The California Youth Authority (CYA) and the Youth and Adult Correctional Agency appreciate the opportunity to respond to the draft report of the Office of the Inspector General's May 2005 Management Review Audit of the N.A. Chaderjian Youth Correctional Facility, Stockton, California. The purpose of the audit was to provide a baseline assessment of the facility's performance in carrying out essential functions and to provide recommendations to correct deficiencies.

We agree that there are deficiencies that must be addressed. Accordingly, the CYA will develop a comprehensive plan, including specific timelines for implementation, to address the deficiencies identified in your Management Review Audit. The plan will be submitted to you by July 22, 2005.

Sincerely,

[original signed by Undersecretary G. Kevin Carruth for Roderick Q. Hickman]

RODERICK Q. HICKMAN
Secretary
Youth and Adult Correctional Agency

cc: G. Kevin Carruth
Walter Allen