Office of the Inspector General

Matthew L. Cate, Inspector General

Folsom State Prison
Quadrennial and Warden Audit

January 2008

State of California

Matthew L. Cate, Inspector General

Office of the Inspector General

January 23, 2008

James E. Tilton, Secretary
California Department of Corrections and Rehabilitation
1515 S Street, Room 502 South
Sacramento, California 95814

Dear Mr. Tilton:

Enclosed is the Office of the Inspector General's audit report concerning Folsom State Prison (FSP) and the performance of its warden. The purpose of the audit was to satisfy our statutory requirement to audit each warden one year after appointment and to audit each adult correctional institution at least once every four years.

The report finds that Warden Matthew Kramer has proven himself as both an effective leader and an advocate for inmate rehabilitation. Both the staff and inmates view him as an experienced administrator, and supervisors credit him for improving staff morale, and for supporting inmate rehabilitation programs. For example, he has revised policies to ensure inmates can attend classes after their work shifts and take the GED test during lockdowns, and he also helped establish charity benefits and self-help programs. Overall, the prison runs smoothly under his management.

The report also contains the results of our review of FSP's operations and programs and presents three findings and 11 recommendations. Specifically, cells in some housing units were not being searched as frequently as required, and many inmates were not required to stand for the "standing count." We also found that in the medical area, inexperienced nurses and a shortage of qualified nurse supervisors contributed to practices that compromise institutional safety and security. The federal court-appointed receiver for California's prison medical care system received a copy of this report, and the receiver's response is included as part of this report.

Thank you for the courtesy and cooperation extended to my staff during the audit. Please call Bill Shepherd, Deputy Inspector General, In-Charge, at (916) 830-3621 if you have any questions.

Sincerely,

Matthew L. Cate

MATTHEW L. CATE
Inspector General

cc: Matthew Kramer, Warden, FSP
Scott Kernan, Chief Deputy Secretary, Adult Operations

Suzan Hubbard, Director, Adult Institutions
Carole Hood, Chief Deputy Secretary, Adult Programs
Robert Sillen, Receiver's Office
Kim Holt, External Audits Coordinator

Enclosure

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Executive Summary

This report presents the results of an audit by the Office of the Inspector General (OIG) concerning the operations of Folsom State Prison and the performance of its warden. The audit was performed under California Penal Code section 6126, which requires the OIG to audit each warden of an institution one year after his or her appointment, and to audit each correctional institution at least once every four years. The OIG performed the audit work between March 28, 2007, and November 30, 2007.

Our team of inspectors examined Folsom State Prison's operations and programs to identify problem areas and recommend workable solutions. The prison, which houses nearly twice as many inmates as it was designed for, gave our inspectors full access to its records, logs, and reports. Site visits allowed us to observe the prison's day-to-day operations and witness the unique physical plant challenges inherent in a prison built in the late 1870s. We also interviewed various staff members and inmates, and we sent surveys to three distinct groups: managers at the institution and at the California Department of Corrections and Rehabilitation, institution employees, and key external stakeholders. In all, our inspectors made three audit findings and 11 recommendations, which are detailed in Chapter 2 of this report.

Overall, Warden Kramer is an experienced, effective leader. As detailed in Chapter 1 of this report, our inspectors used surveys and personal interviews along with our audit results to evaluate Warden Matthew C. Kramer's performance. During this first year of his appointment at Folsom State Prison, Kramer faced challenges requiring adverse personnel actions against members of his management team. However, he confronted these challenges and took action to restructure and rebuild the team. After an initial period of disruption, the institution's staff relations and general morale improved, and staff members credit Kramer's actions for this turnaround in morale.

Staff members praised Kramer's leadership skills and dedication to inmate rehabilitation and programming opportunities, but some members of the custody staff criticized him for prioritizing inmate programming at the possible expense of institutional safety and security. Nevertheless, survey results indicate that staff members believe Kramer to be a "very good" warden, and our audit work demonstrates that he is moving Folsom State Prison in the right direction, especially in inmate programming.

Folsom State Prison needs to address safety and security concerns. While our evaluation of the warden's performance was mostly positive, our audit of Folsom State Prison uncovered several safety and security concerns. One area of concern involves the work of the institution's licensed vocational nurses (LVNs). Most of Folsom State Prison's 22 LVNs were hired between March and June 2007 and

had never before worked in a prison setting. However, they were unsupervised during that four-month period for more than one-third of the time in which medications are distributed and when most patient care occurs. As a result, some new LVNs unintentionally compromised the safety of staff members and inmates on many occasions by inadvertently allowing inmates access to controlled medications and syringes.

Our inspectors also found that some members of Folsom State Prison's custody staff do not conduct the minimum number of daily cell searches required by department policy, which calls for random searches of three cells daily for both the second and third watches. In examining cell search logs for several months, we found that significantly fewer searches were conducted than required by policy. Without adequate cell searches, hidden weapons and contraband go undetected, endangering the safety of staff members and inmates.

Moreover, our inspectors found that the custody staff does not require inmates to stand during the daily standing count. Section 3274 of the California Code of Regulations, Title 15, requires each institution to conduct a physical count of all inmates under its jurisdiction at least four times daily, one of which must be a standing count during which inmates are required to stand. However, our inspectors observed custody staff members allowing many inmates to sit or lie on their bunks, some covered with blankets, during the prison's daily standing count—potentially preventing ill, injured, or escaped inmates from being detected.

Finally, we found that locating a substance abuse treatment program for parolees at the Folsom Transitional Treatment Facility—a facility that also houses a substance abuse treatment program for inmates—exposes inconsistencies between the policies governing the security level for inmates housed at the facility and the policies governing eligibility for participation in the parolee program conducted there. These inconsistencies include the potential for housing at the facility parolees formerly classified as "maximum custody." The Parolee Substance Abuse Program is a drug treatment program under the custodial jurisdiction of Folsom State Prison and its warden, but the department's Division of Addiction and Recovery Services (DARS) evaluates parolees' eligibility for the program. In doing so, DARS does not use the same criteria as the institution uses to assign appropriate housing to inmates. Thus, the Folsom Transitional Treatment Facility may house parolees participating in the substance abuse program whose presence is technically prohibited by facility operational procedures.

Institution Overview

Folsom State Prison is one of the California Department of Corrections and Rehabilitation's 33 adult institutions. Opened on July 26, 1880, Folsom State Prison is the department's second-oldest adult institution. The prison has a design capacity of 2,236 beds and, as of September 30, 2007, it housed 4,059 inmates. Folsom State Prison accommodates two levels of medium-security inmates (levels II and III) within its four general population cellblocks and its administrative segregation unit. The prison also operates a minimum-security unit and a transitional treatment facility within its 40-acre site.

Substance Abuse Treatment

The Folsom Transitional Treatment Facility was activated in March 2004. The facility offers two supervised, intensive substance abuse treatment programs. The first program is for inmates scheduled for parole and lasts 120 days. The second program is for parolees who have violated their parole terms through certain drug-related violations. Participants in the Parolee Substance Abuse Program may elect to participate in a 90-day substance abuse treatment program instead of returning to prison. Both programs strive to help participants understand substance abuse and recovery. As of September 30, 2007, the transitional treatment facility housed 287 participants combined from both programs.

Vocational and Educational Opportunities

Folsom State Prison inmates may participate in various vocational and educational programs. For example, the Prison Industry Authority (PIA) operates one of the state's best-known enterprises at Folsom, the license plate factory. The PIA also operates a sign shop and metal fabrication, furniture manufacturing, and maintenance enterprises at the prison. Inmates may participate in other vocational programs, such as building maintenance, janitorial, and landscape gardening. Inmates interested in pursing educational opportunities may enroll in adult basic education (ABE), high school, general education development (GED), literacy, and computer-assisted instruction programs. Finally, inmates may also participate in community service crews, a youth diversion program, religious programs, the Folsom Project for the Visually Impaired, and the Arts in Corrections program.

Physical Plant Challenges

Built in the late 1870s, Folsom State Prison features unique structural characteristics, such as five-tiered housing units equipped with manually operated

doors. As such, Folsom State Prison poses both physical and security challenges. The institution's age necessitates frequent inspection, preventive maintenance, and renovation to keep it running smoothly.

Many inmates must move unescorted throughout the institution. For example, during our review, inmates housed in Units 1, 4, and 5 had to walk through Unit 2 to access the medical clinic, posing potential security risks for both the inmates and staff. In addition, many staff members must walk through Unit 2 to reach their assigned work areas. Because of the institution's physical layout, inmate movement throughout the institution can appear to be, as one correctional officer described it, "controlled chaos."

Health Care

Folsom State Prison's unique structural characteristics also challenge the institution's health care team. According to the health care manager and the chief medical officer, inadequate space to conduct the institution's medical program when compared to community standards is the health care team's number one concern.

Despite the prison's physical plant challenges, the health care team provides inmates with several important services. For instance, the health care team operates a medical and dental clinic, as well as a triage area, pharmacy, and radiology area. The prison's physicians treat about 25 to 45 patients each day, while the triage nurses evaluate 100 to 125 patients each day. In addition, the pharmacy staff administers 400 to 500 prescriptions daily. The institution does not have enough space to provide inpatient hospital care; thus, the health care team refers inmates who require hospitalization to the adjacent California State Prison, Sacramento, or to outside hospitals as needed.

Folsom State Prison also operates a mental health unit that provides treatment for inmates who participate in the Correctional Clinical Case Management System (CCCMS). CCCMS is an outpatient program designed to maintain or improve functioning of mentally disordered inmates. Approximately 800 inmates participate in Folsom's CCCMS program. The mental health unit refers inmates requiring 24-hour inpatient psychiatric attention to California State Prison, Sacramento, or to outside hospitals as needed.

On April 17, 2006, a federal court-appointed receiver assumed control of the California Department of Corrections and Rehabilitation's medical system. One of the receiver's duties is to ensure that the quality of medical services in California prisons meets constitutional standards. To that end, the receiver implemented several changes throughout the department, many of which affected Folsom State Prison. For example, the receiver replaced all medical technical assistants with licensed vocational nurses in late 2006. More recently, in May

2007, Folsom State Prison became the first of the department's 33 institutions to implement the receiver's new pharmacy operating procedures.[1]

Budget and Staffing

For fiscal year 2006–07, Warden Matthew C. Kramer manages an operating budget of $114.9 million, which includes 1,078 budgeted positions, of which 654 positions (61 percent) are custody staff. The table below summarizes Folsom State Prison's budgeted and filled positions as of September 30, 2007. As shown in the table, almost 94 percent of the authorized positions were filled.

Staffing Levels at Folsom State Prison*

Position	Filled Positions	Budgeted Positions	Percent Filled
Custody	635	654	97.1%
Support	130	149	87.2%
Medical	101	122	82.8%
Trades	90	97	92.8%
Education	44	45	97.8%
Management	10	11	90.9%
Total	**1,010**	**1,078**	**93.7%**

Source: California Department of Corrections and Rehabilitation, COMPSTAT, 3rd Quarter 2007 (as of September 30, 2007), Folsom State Prison.
** Unaudited data.*

[1] The Maxor National Pharmacy Services Corporation provides pharmacy management consulting services to the receiver.

Chapter 1:
One-Year Evaluation of Warden Matthew C. Kramer

California Penal Code section 6126(a)(2) requires the OIG to audit each warden one year after his or her appointment, and to audit each correctional institution at least once every four years. To satisfy this requirement, our inspectors audited the warden's performance and the institution's operations simultaneously.

Objectives, Scope, and Methodology

To understand how the staff and other stakeholders view the warden's performance, we surveyed three distinct groups. Specifically, we sent surveys to 19 officials at the California Department of Corrections and Rehabilitation and at Folsom State Prison. Of those surveys, we received 11 responses. We also delivered surveys to 204 institution employees and received 54 responses. Finally, we sent surveys to 15 key stakeholders, including certain members of the Legislature, representatives of unions and associations, a local district attorney, and a court-appointed special master. However, we received only one response.

Our inspectors toured Folsom State Prison to gain insight into the environment where the warden must perform. We also interviewed key staff members and reviewed the prison's records in the following areas:

- health care
- inmate appeals
- inmate discipline
- investigative services
- litigation
- labor relations
- inmate records
- plant operations
- educational and vocational programs
- inmate visiting
- receiving and release
- personnel assignment
- perimeter security
- armory
- procurement
- housing units

We also toured the Folsom Transitional Treatment Facility and the grounds operated by the Prison Industry Authority (PIA). During our site visits, we asked 54 individuals throughout the institution to rate the warden's performance. These individuals included custody staff members, executive management team members, union representatives, education and health care professionals, and representatives from the Inmate Advisory Council and the Citizen's Advisory Committee. We also reviewed relevant logs, reports, and other documents related to the warden's performance over the past year, including the results of our institutional audit contained in Chapter 2.

Background of Warden

Folsom State Prison represents Warden Matthew C. Kramer's second appointment as a warden for the California Department of Corrections and Rehabilitation. Kramer served as the warden of the Sierra Conservation Center from March 1996 through June 2005, where he managed the institution and its 22 conservation camps. From February 1994 through March 1995, Kramer served as the acting warden of the California Correctional Center in Susanville while he assisted with the activation of High Desert State Prison. Governor Schwarzenegger appointed him as Folsom State Prison's warden on May 5, 2006.

Discussion of Warden's Strengths

Kramer has improved staff morale, according to staff interviews. During his first year of appointment at Folsom State Prison, Kramer faced challenges requiring adverse personnel actions against members of his management team. He confronted these challenges and took action to restructure and rebuild the team. After an initial period of disruption, the institution's general morale and relations among staff members improved, according to staff interviews. Staff members felt the institution was better off, and they generally approved of Kramer's actions. One unit supervisor said that Kramer was instrumental in rebuilding morale, while another unit supervisor said that institution communication and morale is the best in ten years.

Kramer has significant experience as a warden. Having served as acting warden and warden since February 1994, Kramer has a significant amount of warden experience. Kramer was a warden for nine years at the Sierra Conservation Center before being appointed as warden at Folsom State Prison.

Kramer is viewed as an effective administrator. Staff members we surveyed and interviewed described Kramer as an effective administrator who follows sound correctional practices, listens to others' opinions, and makes thoughtful decisions. Others described him as an advocate for inmate programming who also supports the medical functions at the prison**.** Staff members who interact directly with Kramer said that he is personable and expresses himself well. In addition, many mentioned his open-door policy and willingness to meet with staff members. The local chapter representatives of two staff labor organizations also commented favorably about Kramer's overall performance.

Supportive of the institution's medical function, Kramer assigned the associate warden of health care services to attend all meetings on health care issues for which the institution's chief medical officer requested her assistance. Kramer also rearranged the schedules of the correctional officers who escort inmates to

medical appointments to coincide with medical clinic hours and thus increase operational efficiency. Previously, those officers' schedules differed from the clinic's hours of operation and from medical staff schedules, which created conflicts for both custody and medical personnel.

Kramer supports inmate programming. Kramer has also worked to improve inmate programming. He changed institution policy so that the inmate assignment office now provides "priority ducats," or passes for inmates to move between locations, instead of general ducats to inmates scheduled to take the GED test. Priority ducats ensure that inmates are not prevented from taking the test by lockdowns or modified programs. Further, Kramer extended inmate visiting hours so they start on Friday afternoon, instead of limiting visiting to weekends. Kramer also arranged for inmates assigned to PIA jobs to attend education classes in upstairs classrooms in PIA work areas after the regular work shift, and in doing so, alleviated conflicts between inmates' work and school schedules. Moreover, representatives from the Inmate Advisory Council rated Kramer "outstanding," saying that Kramer made many improvements, such as helping to establish self-help programs and food sale events benefiting outside charity groups. Staff members reported that Kramer emphasizes inmate programming and has supported the use of volunteer veterans groups in inmate programs.

Kramer received a favorable overall rating from the staff and management. Of the 54 individuals we asked to rate the warden's performance, 31 provided an overall rating for Kramer. The remaining 23 had no direct interaction with him and did not provide a rating. Twenty-three of 31 respondents (74 percent) rated the warden as either "outstanding" or "very good."

Warden's Overall Performance Rating

Rating	Respondents	Percentage
Outstanding	11	35%
Very Good	12	39%
Satisfactory	7	23%
Improvement Needed	0	0%
Unacceptable	1	3%
Total	**31**	**100%**

Survey results also indicate a favorable overall rating for Kramer's management skills in six rating categories based on the following 1-to-5 scale, with 1 being the highest: "outstanding," "very good," "satisfactory," "improvement needed," and "unacceptable." The survey respondents' average rating of 2.18 corresponds most closely with a qualitative rating of "very good."

Warden Rating of Management Skills and Qualities: Rating on a Scale of 1 to 5

Category	Average Response
Leadership	2.27
Communication	2.09
Decision Making	2.45
Organization/Planning	2.00
Relationships with Others	2.27
Personal Characteristics/Traits	2.27
Overall Rating: Very Good	**2.18**

Discussion of Criticisms

The warden needs to hold staff members accountable for critical safety and security procedures. As discussed in Chapter 2 of this report, our audit disclosed that some custody staff members are not conducting the minimum number of cell searches required by department standards, and they are failing to require inmates to stand during the institution's daily standing count. The importance of these procedures is unquestioned, and as the individual responsible for the overall safety and security of the institution, the warden must hold the staff accountable for following these procedures.

Some custody staff members criticize the warden's stance on safety and security. Staff surveys and interviews highlight the sometimes conflicting concerns between the need to maintain institution safety and security versus the need to provide inmate programming and rehabilitation. Staff members in the areas of health care, education, vocational trades, and the PIA generally gave high marks to Kramer for being supportive of inmate programming and their respective areas.

In contrast, some custody staff members responding to the survey felt that the warden initiates too few lockdowns and that the length of lockdowns is too short. Lockdowns are implemented to gain control of dangerous conditions, such as disruptive inmate behavior. While lockdowns are important to the institution's investigative process, they also interrupt inmate programming by keeping inmates from their work assignments, educational classes, vocational training, and rehabilitative activities. On the other hand, releasing inmates from lockdowns too soon may lead to more disruptive behavior.

We note, however, that Kramer's emphasis on inmate programming parallels the department's emphasis on rehabilitation. Further, statistical data maintained by the department shows that Folsom State Prison's incidents of inmate violence and disruptive behavior are no more frequent than at other institutions to which the department compares it for analysis. Without objective supporting evidence, criticisms of the warden's handling of inmate lockdowns should not negatively affect him.

Warden's Response to Criticisms

In his December 21, 2007, interview with the Inspector General, Kramer acknowledged the importance that cell searches and standing counts play in maintaining Folsom State Prison's safety and security. Kramer further stated that he is committed to ensuring that his staff consistently follows department standards, adding that, to replace the various methods currently in practice, all housing units in the institution will adopt a uniform method of documenting cell searches.

Kramer also responded that when lockdowns become necessary, releasing inmates is a risk-filled process that must consider many factors—including factors that are at odds with each other. He noted that he carefully considers each lockdown and weighs the risks by balancing his overall responsibility for institutional safety and security against his need to provide rehabilitative programming for the inmate population.

Summary Discussion

Kramer has over 20 years of experience with the California Department of Corrections and Rehabilitation, including nine years as warden at the Sierra Conservation Center before becoming warden at Folsom State Prison. Staff members describe him as an experienced warden and an effective administrator who has improved staff morale. The non-custody staff praises him for being supportive of inmate programming, while some custody staff members criticize him for prioritizing inmate programming at the possible expense of institution safety and security. We found that he must improve staff performance in the areas of cell searches and standing counts to ensure the safety of the staff and inmates.

Nevertheless, Kramer continues to be a strong advocate of the department's emphasis on inmate rehabilitation by providing inmates with programming opportunities. On average, Kramer scored qualitative ratings of "very good" based on staff interviews and surveys.

In summary, Warden Matthew C. Kramer is performing his duties well, and we are confident that he is moving the institution forward as warden at Folsom State Prison.

Chapter 2:
Quadrennial Audit Findings and Recommendations

Objectives, Scope, and Methodology

We gained an understanding of Folsom State Prison's mission and safety and security concerns by reviewing applicable laws and regulations, department and institution policies and procedures, and other criteria related to key facility functions. As detailed in Chapter 1, we also visited the institution and observed its general operations, sent surveys to staff members and key officials, and interviewed various employees and inmates. In addition, we reviewed prior audit reports and various statistical data reports that concern the institution.

After assessing the institution's operations and the survey results, we focused our audit work on the institution's efforts to maintain a safe and secure environment. These efforts include

- holding inmates and employees accountable for their actions and behavior;
- preventing contraband from entering the institution through visiting;
- ensuring custody staff properly conduct the daily standing count of inmates;
- conducting the daily minimum number of cell searches;
- ensuring a secure perimeter;
- supervising new nursing staff.

We also assessed awareness of methods to minimize inmate and staff exposure to the Methicillin-resistant *Staphylococcus aureus*, commonly referred to as MRSA, and the process for determining eligibility for the Parolee Substance Abuse Program, an area of particular concern to the warden. In addition, we reviewed the institution's process for identifying and referring inmates needing mental health services. Finally, we assessed whether the institution accurately reports certain statistics to the department's COMPSTAT[2] unit.

In conducting our work, we performed the following procedures:

- To determine whether new nursing staff members are adequately oriented in dealing with inmates and supervised to ensure their safety and the safety of others in the institution, we studied applicable department and institution policies and procedures, and we interviewed members of the

[2] Short for Comparative Statistics, COMPSTAT tracks organizational data to determine increases or decreases in performance in the areas of safety, security, programs, finance, and operations.

custody staff, nurses, and other medical staff members. We also reviewed nurse supervisor time sheets, various memorandums and reports of incidents involving nursing staff, executive staff meeting minutes, and employment applications for licensed vocational nurses. In addition, we observed procedures at the nursing stations within the institution. Our findings and recommendations in this area are discussed in Finding 1.

- To determine whether the institution conducts the minimum required number of cell searches, we studied applicable regulations and department policies, unit activity logs, and daily cell search logs, and we interviewed members of the custody staff. Finding 2 discusses our findings and recommendations in this area.

- To determine whether inmates are required to stand during the institution's daily standing count, we observed the standing count as it occurred in four of the institution's five celled housing units. Finding 2 discusses our findings and recommendations in this area.

- To assess the process for admitting parolees to the Parolee Substance Abuse Program at the Folsom Transitional Treatment Facility, we familiarized ourselves with the program assignment process. We also interviewed parole staff, parole management, custody staff, and union representatives. In addition, we reviewed reports containing specific information system queries from the department's Distributed Data Processing System. Our findings and recommendations are discussed in Finding 3.

We also performed the following procedures; however, no significant issues came to our attention in these areas.

- To determine whether inmates are held accountable for their actions and behavior, we reviewed a sample of disciplinary logs, rules violation reports, and inmate central files.

- To determine whether employees are held accountable for their actions and behavior, we reviewed a sample of inmate appeals against employees, the outcomes of the related inquiries and investigations, and the subsequent disciplinary actions, when applicable.

- To assess the institution's compliance with inmate visiting procedures, we reviewed applicable post orders, interviewed visiting staff, and observed visiting operations.

- To assess the adequacy of the institution's awareness concerning methods to minimize staff and inmate exposure to MRSA infection, we interviewed the institution's chief medical officer and an official at Cal/OSHA, and we

attended an institutional staff meeting on MRSA in correctional settings. We found that the institution and the department understand how the infection is transmitted and are aware of the methods to prevent its spread among the inmates and staff.

- To determine whether significant weaknesses in the institution's security perimeter exist, we reviewed applicable department policies and toured the security perimeter.

- To understand and evaluate the adequacy of the process used to identify incoming inmates who have mental health problems, we interviewed the institution's senior psychologist, the receiving and release sergeant, the triage registered nurse assigned to the receiving and release unit, and living unit staff. We also reviewed various records, forms, and documents related to the identification process, including inmate unit health records. Lastly, we reviewed the latest corrective action plan and other correspondence related to the *Coleman*[3] class action lawsuit.

- To determine the institution's compliance with the *Armstrong* [4] class action lawsuit, we attended a meeting on the institution's compliance status with *Armstrong*, and we toured the institution with the *Armstrong* monitor.

- To understand and evaluate the adequacy of the process used to compile selected data reported to the department for inclusion in its quarterly COMPSTAT report, we interviewed institution employees. We evaluated the accuracy of the data reported by reviewing source documentation for a select period.

Finally, we summarized the results of our work and developed our conclusions.

[3] In *Coleman v. Wilson*, a federal court found that the department's mental health system was unconstitutional and that institution officials were intentionally indifferent to the needs of mentally ill inmates. All California Department of Corrections and Rehabilitation institutions are now being monitored by a court-appointed special master to assess compliance with the federal court's order.

[4] In *Armstrong v. Wilson,* a federal court issued an injunction to improve program access for inmates with disabilities after ruling that the department's prisons and parole facilities violated the Americans with Disabilities Act and the Rehabilitation Act.

Finding 1

Poor implementation of the changeover from medical technical assistants to licensed vocational nurses left the nurses unsupervised and ill prepared to work in a prison setting.

With a court order stemming from the *Plata v. Schwarzenegger*[5] litigation, the federal court-appointed receiver replaced medical technical assistants (MTAs) with licensed vocational nurses (LVNs) at prisons statewide. The timing of the MTAs' replacement was intended to ensure the LVNs were adequately trained before the MTAs left. However, when most of the LVNs began working at Folsom State Prison, most of the MTAs were gone. In addition, the LVNs' on-the-job training did not make up for the lack of mentoring the MTAs could have provided because too few experienced nurses were available to provide adequate training. Consequently, the LVNs were ill prepared to function in a prison environment where safety and security consciousness is paramount given the criminal nature of the patient population. Moreover, in their first few months of employment, the LVNs went unsupervised for more than one-third of the daily hours during which medications are distributed and when most patient care occurs. As a result, LVNs inadvertently allowed inmates access to medications and medical supplies.

Background. The receiver implemented a significant change to each institution's nursing department by replacing MTAs with LVNs. The MTAs were correctional officers who also were licensed vocational nurses or registered nurses; they assisted in the medical care of inmates, as well as maintained order and supervised inmates, much like the correctional officers. According to the receiver, MTAs served primarily as LVNs in the prison medical system, but their dual role as both correctional officer and nurse caused confusion in the workplace, divided loyalties, and made recruitment of registered nurses difficult. The institution's MTA-to-LVN conversion began in September 2006, and all MTA positions at Folsom State Prison were vacated by June 1, 2007.

Initially, the receiver allowed institutions to hire LVNs into temporary buffer positions or into vacant MTA positions to create a foundation of trained LVNs prior to and during the MTAs' departures. At Folsom State Prison, however, the foundation of trained LVNs did not materialize before the MTAs left. Although the prison began the hiring process soon after receiving authorization and interviewed applicants in October and November 2006, out of eight job offers only two LVNs were hired. Folsom State Prison continued to have difficulty hiring LVNs during the first few months of 2007; by

[5] In this class action lawsuit, inmates alleged that California Department of Corrections and Rehabilitation officials inflicted cruel and unusual punishment by being intentionally indifferent to inmates' medical needs. A 2002 settlement agreement required the department to overhaul its medical care policies and procedures, as well as ensure prompt access to adequate medical care. However, in May 2005, federal court reports showed continued medical malpractice and neglect. Consequently, in October 2005, the judge ordered that the department's medical care system be placed under the control of a court-appointed receiver.

mid-February 2007, only nine of the 21 MTAs working at the start of the conversion remained at the prison, and only five permanent LVNs had started work. Between March and June 2007, the prison eventually succeeded in hiring 17 additional LVNs. Three of the new employees were already working at the prison as registry contract nurses, but nine others started working between mid-May and June, leaving little or no time to benefit from the experience of the seven MTAs who remained in their positions until May 30, 2007.

Folsom State Prison used medical registry contracts[6] to fill its nursing vacancies during the transition. In fact, until the positions were permanently filled, they were temporarily filled by 22 different registry contract LVNs. To compound the matter, six permanent LVNs resigned before the end of June, and the resulting vacancies were once again temporarily filled by registry nurses. Ultimately, most of the permanent LVNs were hired too late to benefit from working with and learning from the experienced MTAs.

In addition, in May 2007, the receiver's pharmacy management consultant, Maxor National Pharmacy Services Corporation, implemented a new pharmacy operating system at Folsom State Prison while the nursing department was still undergoing the MTA-to-LVN transition. As a result, according to a nurse supervisor at the institution, the confusion that employees typically experience when a new system is implemented was exacerbated by frequent procedural changes in response to unanticipated problems, coupled with inexperienced LVNs adjusting to those changes while being reassigned to meet additional staffing needs.

Folsom State Prison's LVNs distribute and administer medications to about 2,400 inmates in designated housing units throughout the prison. The LVNs must ensure that inmates receive accurate doses of prescribed medication, and they must also safeguard the medications and syringes in their work areas. For the LVNs, morning and evening medication distribution begins with diabetic inmates lining up for insulin injections that, in most cases, inmates are allowed to self-administer. Next in line are inmates with prescriptions for medications that require administration by licensed health care staff. For example, for drug types such as narcotics and tuberculosis medications, the nurse must observe the inmate take the medication and verify that the medication is swallowed by completing a visual mouth inspection and viewing the empty water cup. When inmates receive medications, the LVNs also are required to verify the inmate's identity, verify that he has an active prescription, and document in the inmate's medical record that the medication was given.

Most of the recently hired licensed vocational nurses lacked prior correctional experience. For 16 of Folsom State Prison's 22 LVNs, their previous nursing experience was limited to caring for patients in community hospitals or skilled nursing facilities. In contrast, the patients in a prison setting are convicted criminals, many with histories of violence or drug abuse, who move about unrestricted areas of the prison. Moreover, the culture of prison life may also induce inmates to seek drugs or syringes

[6] A medical registry coordinates the availability of temporary medical staff when the prison needs such services.

for abuse or sale, or to seek unsecured items to use as weapons. In comparison to working in a community hospital, working in a prison requires new LVNs to be more aware of their surroundings and potential dangers that can jeopardize safety and security.

An awareness of prison culture and the development of strong security practices are critical to the safety of the inmates and staff. Well-trained nurses in a prison environment should know that many inmates take advantage of situations in which staff members are inattentive or easily manipulated. For instance, the department's Inmate Medical Services Program Policies and Procedures manual requires licensed health care staff to record the administered medication in the inmate's medical record. But the nurses do not always record the information immediately after administering the medication. Consequently, if an inmate claims that he has not received his medication, the nurse dispensing the medication has no evidence to indicate otherwise and risks giving the inmate additional doses.

In one instance, nurses reported missing five tablets of Oxycodone, a narcotic typically used for pain relief, after conducting a count of remaining medications following the morning distribution. Folsom State Prison's head pharmacist told us he received a report that the LVN dispensing the narcotics had unknowingly given an inmate with terminal cancer a double dose of medication. After receiving his prescribed dose of five Oxycodone tablets, the inmate got back into the pill line. When later seen by a doctor, the inmate admitted that he had noticed that the LVN had not recorded giving him the five tablets, and he stepped back into the line hoping that she would not recall seeing him and would give him another five tablets. The LVN apparently did not recall seeing the inmate earlier that morning and, because she had not promptly recorded that he had already received five tablets, she had no way to verify that fact and gave the inmate another five tablets.

The nurses must also be diligent when observing inmates placing their used syringes into biohazardous waste containers after self-injecting insulin. It is imperative that syringes be properly disposed of so they are inaccessible to inmates; otherwise, the syringes are sought by inmates to engage in illegal drug activity. For example, officers found syringes in the cells of two inmates who recently died of suspected drug overdoses. In June 2007, a correctional officer witnessed one LVN turn his back while an inmate injected himself with insulin. According to the officer, rather than dispose of the used syringe, the inmate put it in his pocket after realizing that the nurse was not watching. When questioned by the LVN, the inmate told the LVN that he had already placed the syringe in the disposal container. Had the officer not been observant, prompting the inmate to dispose of the syringe, the inmate could have later used the syringe to administer illegal drugs himself, or passed it to another inmate. In a similar example, another LVN reported missing nine syringes in March 2007 after she briefly turned around while handing out medications in a housing unit. According to the minutes of an April 2, 2007, warden's executive staff meeting, the nurse reported that when she turned back around, she saw an inmate place an empty syringe box back inside the window where the box had been sitting. Although the nurse was able to

identify the inmate, who was subsequently placed into the administrative segregation unit, staff members were unable to immediately find the syringes. Seven of the syringes were later found in a garbage can in the housing unit.

Other lapses of security procedures have also occurred in the housing unit clinics. For example, in June 2007, a medical security sergeant reported the padlock to the medication locker missing. Although we found no evidence that an inmate took the padlock, inmates have been known to insert padlocks into socks and use them as weapons by swinging the weighted sock. As discussed in the following section, a more experienced nurse providing on-the-job training might have noticed that the nurses were not adequately safeguarding the padlock once they had removed it from the medication locker—a routine precaution that they might not have had to consider until they began working in the security-conscious environment of a prison.

LVNs did not promptly attend new employee orientation. The California Department of Corrections and Rehabilitation requires all new employees to attend a 40-hour orientation course within the first 30 days of appointment. At Folsom State Prison, this new employee orientation course covers 22 topics, including two topics that are relevant to maintaining safety and security: one hour of training on inmate/staff relations and one hour on escape prevention and key and tool control. Despite this requirement, as of July 9, 2007, four LVNs at Folsom State Prison—all of whom had been working for at least one month and had no prior experience working in a correctional setting—had not attended the two sessions related to safety: inmate/staff relations and key and tool control. Another three LVNs who had been working since April or May 2007 had attended only one of the sessions. By not receiving the safety and security training, these nurses were less aware of necessary safeguards that heighten their safety and the safety of others.

Besides the prison's 40-hour orientation course, the nursing department has its own new employee orientation program that also covers various topics, including overfamiliarity with inmates and key control. Moreover, the orientation manual provided to medical personnel states that "keeping a safe and secure environment will require that you become aware of things that can jeopardize the safety and security of the institution." According to Folsom State Prison's staff development nurse, the nurses' orientation course consists of two days of classroom instruction followed by eight days of on-the-job training with a more experienced nurse. The training records indicate that all the new LVNs received the two days of classroom instruction. However, the on-the-job training the LVNs received was ineffective because not enough experienced nurses were available to provide the training after the MTAs left.

The information presented in either of these new employee orientation sessions should raise an employee's level of awareness of the correctional setting. Still, orientation is cursory by nature, and attendance at the sessions is not enough by itself to ensure that new employees learn how to handle inmates and what special precautions they must consider—topics more effectively learned through on-the-job training and experience. On-the-job training under direct supervision—when nurses encounter actual

situations—is a necessary part of their orientation that ensures they are adequately prepared to handle inmates and understand the special precautions inmates require.

The existing supervisory staff is unable to adequately monitor and train the new licensed vocational nurses. Nursing activities generally occur 16 hours each day during the second and third watches. Thus, depending on whether a month has 30 or 31 days, either 480 or 496 monthly hours are available for nursing supervisors to answer questions from the nursing staff, communicate new information, model appropriate behaviors, observe and correct unsafe work habits, and inspect syringe and key control logs. We analyzed the nursing supervisors' time sheets for April through June 2007 and found that nursing supervisors were unavailable for a significant number of hours. This condition diminished the supervisors' ability to observe and monitor the new LVNs.

After accounting for factors such as sick leave, vacation leave, and training days, the total supervising hours available was reduced by an average 168 hours each month, or about the equivalent of a full-time employee. In addition, on many weekends during this time, a nurse supervisor was at the prison on only one of the days. And except for an on-call supervisor, no supervisors worked on holidays even though the prison's urgent care clinic, called the Triage and Treatment Area, is open and LVNs still distribute medications in the housing units on those days. Consequently, as shown in the following table, from April through June 2007 there was no nurse supervisor at the prison for 36 to 45 percent of the daily hours starting from 5:00 a.m. and ending at 10:00 p.m., which is when medications are distributed and most patient care occurs. For at least 25 percent of those hours, there was only one nurse supervisor at the prison.

Percentage of Patient Care Hours with Inadequate Supervisory Coverage: April through June 2007

	April	May	June
Percentage of patient care hours with no supervisor available	36%	45%	40%
Percentage of patient care hours with one supervisor available	30%	25%	27%

No specific policy requires supervisory coverage. However, given the unique environment of a prison and the number of inexperienced LVNs, it is not unreasonable to expect that the LVNs be under close supervision during peak patient care hours until supervisors are satisfied that the LVNs understand and follow procedures.

Time spent performing other duties further reduces the available hours for direct supervision and on-the-job training of the new nursing staff. For example, nursing supervisors must approve subordinates' time sheets, prepare employee work schedules, ensure positions are covered, handle employee disciplinary actions, interview applicants for nurse positions, attend meetings, and work on special

assignments. Supervising nurses told us that scheduling the nursing staff and ensuring that enough LVNs are available to cover the housing unit medication lines is a priority, but scheduling remains a chronic problem. The supervising nurses also explained that scheduling problems were caused by the new pharmacy services process and high turnover of LVN staff.

To compound the problem, Maxor decided to move the process for distributing medication to inmates living in Units 3 and 5 out of Unit 2 and into the respective housing units—a change that increased the number of inmate medication lines and thus required more LVNs to cover the two shifts in each of the two units. Further, LVN turnover—both permanent and temporary—and the sudden manner in which many LVNs quit or are asked to leave also complicates scheduling. For example, one nurse supervisor told us about a contract LVN who had called her at home the previous night to tell her she had accepted another position and would not be at work the following day. This same supervisor also told us that a contract LVN was asked to leave the same day because he repeatedly displayed a poor attitude.

Some controls designed for safekeeping medication and syringes are not adequate, while other controls are not followed. Drugs, syringes, and other medical tools kept in the Triage and Treatment Area are stored in lockable cabinets within a locked storage room. The cabinets are equipped with padlocks, and signs posted on the cabinets indicate they are to be kept locked. However, we observed several instances in which the cabinets were left unsecured. We also learned that inmates performing janitorial duties are allowed access to the storage room where, if supervised by an inexperienced nurse, they could possibly open an unlocked cabinet, steal medications and syringes, and later either take the medication or sell it to another inmate. Moreover, several staff members, including some who are not assigned to the Triage and Treatment Area, have keys to the storage room, which undermines the supervisors' ability to hold staff members accountable when medications and syringes disappear.

In addition to not locking the cabinets, we found in a review of logs that the Triage and Treatment Area nursing staff do not always count the needles and syringes twice daily, as required by Folsom State Prison's operational procedures. The procedures state that the two oncoming second watch staff members must count all needles and syringes. Another count must be completed later in the day by one of the second watch nursing staff members and the oncoming third watch nurse. In one example, a nurse reported that 64 needles and syringes were missing after several consecutive counts had not been conducted.

The court-appointed receiver's observations parallel those of the Office of the Inspector General. The receiver's sixth quarterly report to the U.S. District Court, dated September 26, 2007, discussed ongoing projects, including implementation of Maxor's new pharmacy operating system at Folsom State Prison. In his report, the receiver acknowledged that implementation of the new pharmacy software system did not go as smoothly as expected, and that the resulting problems had repercussions

beyond the pharmacy walls and affected the medication delivery process to inmates. The receiver's report further explained that staff members were not trained in advance to operate under the new system. This lack of training, coupled with the prison's space constraints, limited the nurses' ability to deliver medications safely to inmates. The receiver further acknowledged that these problems were compounded by implementing the new pharmacy system "in the midst of the nursing staff's transition from Medical Technical Assistant positions to new LVN positions, resulting in a large number of new LVNs at Folsom State Prison who were still being trained to perform medication administration functions." Furthermore, the receiver stated, "These new LVNs were not prepared to handle prisoner/patients who were irate over not receiving their scheduled medications." However, the receiver's report did not address the security concerns that we raised in this finding.

Recommendations

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

- **Evaluating the adequacy of nursing supervision coverage at all institutions, especially before implementing significant changes, such as the new medication management system, and adding nursing supervisor positions when warranted.**

- **Restricting access to Folsom State Prison's Triage and Treatment Area medication storage room to only those staff members responsible for maintaining the counts and inventory. Staff members who have authorized access should be held accountable when they fail to lock all medical cabinets in the medication storage room after use.**

- **Ensuring that members of Folsom State Prison's nursing staff attend institution new employee orientation sessions relevant to safety and security within the time frame established by the department or the receiver. The orientation sessions should be expanded to include role-playing using actual examples of unsafe and safe practices.**

- **Ensuring that members of Folsom State Prison's nursing staff count needles and syringes twice daily, in accordance with Triage and Treatment Area procedures. Supervising nurses should be held accountable for ensuring this requirement is enforced.**

Finding 2

Folsom State Prison's custody staff does not consistently follow critical safety and security procedures.

Among the most important procedures followed in a prison's housing units are daily random cell searches and daily standing counts. These procedures inhibit inmates' possession of potentially dangerous contraband and confirm inmates' presence and physical welfare. However, some custody staff members at Folsom State Prison do not consistently follow these procedures, as required by department policy. As a result, they compromise public safety and the safety of inmates and other staff members.

The number of daily cell searches does not meet department standards, potentially allowing weapons and contraband to remain hidden. Some custody staff members at Folsom State Prison are not conducting the minimum number of daily cell searches, as required by section 52050.18 of the department Operations Manual. The policy calls for daily searches of three cells, rooms, dormitories, or living areas in each housing unit during both the second and third watches, for a minimum of six searches a day. By not following this policy, the staff's interdiction of contraband in the housing units may suffer.

In examining housing unit cell search records, we found that Units 3 and 5 documented considerably fewer cell searches in the months we examined than were required, as shown in the following table.

Housing Unit	Month	Minimum Cell Searches Required (six each day)	No. of Cell Searches Recorded	Shortage
3	March 2007	186	60	126
5	March 2007	192 (includes Feb. 28)	166	26
5	April 2007	180	26	154
5	May 2007	186	8	178

Conducting searches in Unit 3 is crucial because most of the inmates housed in Unit 3 are assigned to the Prison Industry Authority (PIA), and thus they have access to potentially dangerous materials, such as tools and material scraps commonly used by inmates to make weapons. Unit 3 also houses newly arrived inmates who may pose potential threats because their behaviors or histories are less likely to be known to the custody staff.

We recognize that correctional officers may be required to escort inmates to programs, transport inmates to outside medical appointments, respond to emergency incidents, write inmate disciplinary actions, and respond to inmate appeals. Despite these other duties that officers must perform, detection of hidden

contraband is critical to improving safety and security for the prison's staff, as well as in helping to reduce or prevent illicit inmate activity. For example, in May 2007, a cell search in Folsom State Prison's administrative segregation unit disclosed two weapons made from razor blades. Also, in June 2007, a correctional officer conducted a cell search and discovered a green leafy substance suspected to be marijuana. During this same search, the officer also discovered a cellular phone charger and noticed one of the cell's occupants holding a cellular phone.

Cell searches in Folsom State Prison's housing units are inconsistently recorded. The method for documenting cell searches varies not only among housing units, but also among different shifts on the same housing unit. For example, Unit 3's second and third watch staff members document their cell searches on a shared document, instead of using separate cell search logs, while Unit 4 uses two separate formats unlike any used in other housing units. For instance, Unit 4's second watch staff records cell searches by cell number, while its third watch staff records cell searches by the day of the month. The Unit 5 staff, meanwhile, uses two logs concurrently, one arranged by cell number and the other by date.

While there is no officially mandated form or format for documenting cell searches, recordkeeping inconsistencies make it difficult for institution managers and supervisors to determine whether the custody staff is performing these duties in accordance with department policy.

Although Unit 5 was deficient in the number of cell searches performed for the months we tested, Unit 5's method of documenting cell searches appears to be particularly useful as a management tool. By using two parallel cell search logs, users can determine not only that the minimum daily number of searches is conducted, but they can also analyze the distribution of searches among cells, thus avoiding inadvertently ignoring certain cells or focusing unnecessary attention on others.

The custody staff allows many inmates to sit or lie on their bunks, some covered with blankets, during the institution's daily standing count, potentially allowing ill or injured inmates from being detected. Contrary to state regulations, the custody staff at Folsom State Prison does not require inmates to stand during the daily standing count. As a result, staff members may fail to notice safety and security problems, such as missing inmates, evidence of criminal activity, or inmates with serious illnesses or injuries.

During one of our site visits, we observed a standing count conducted by the custody staff. We noted that in three of four celled housing units visited many inmates were allowed to sit or lie on their bunks, or they stood at the rear of their cells, partially obscured behind their bunks. Section 3274 of the California Code of Regulations, Title 15, requires each institution to conduct a physical count of

all inmates under its jurisdiction at least four times daily, one of which must be a standing count during which inmates are required to stand.

The intent of a standing count is to demonstrate that an inmate is present and that the correctional officer performing the count can see that the inmate is alive, well enough to stand, and free of obvious injuries or illnesses. The standing count thus allows staff members to assess each inmate's general welfare and identify serious incidents, such as escapes and inmate violence.

The failure to require inmates to stand is, as one correctional sergeant explained, a matter of expediency. The sergeant told us that the count numbers must be reported in a timely manner, and asking inmates to stand would be time consuming, especially considering the nearly 1,200 inmates in Unit 1. Thus, some correctional officers are willing to accept verbal or physical acknowledgement from inmates that they are well.

However, standing counts are required for a good reason. When inmates are allowed to lie down or sit on their bunks during the standing count, as they did during our observation, the custody staff might not notice serious injuries and potentially miss detecting evidence of a serious incident. For example, on September 6, 2005, at Pelican Bay State Prison, a correctional officer found an inmate unresponsive in his cell during an institutional count. The inmate, whose cellmate was suspected of his murder, had suffered serious facial injuries and was pronounced dead. Further examination determined that the inmate had been dead for about three days, undiscovered by custody staff. Had the custody staff required the inmate to stand during the designated standing count, the inmate's condition and any evidence concerning the incident would have been discovered sooner.

Recommendations

The Office of the Inspector General recommends that the management staff at Folsom State Prison:

- **Enforce the department's Operations Manual requirements for daily cell searches and ensure that supervisors monitor staff compliance with those requirements.**

- **Develop uniform procedures throughout the institution for documenting cell searches. The method should allow officers to easily identify the cells searched, the date and watch of the search, and the staff members conducting the search. The method currently employed by Unit 5, involving the use of parallel logs, satisfies these elements.**

- **Hold custody staff accountable for conducting the daily standing count, as required by section 3274 of the California Code of Regulations, Title 15.**

- **Use the inmate disciplinary system as necessary to require inmate cooperation during the daily standing count.**

Finding 3

Housing certain parolees and inmates together in the same treatment facility exposes classification policy conflicts and violates department procedure.

Background. Originally built in the late 1980s as a community correctional facility operated by the City of Folsom, the 380-bed Folsom Transitional Treatment Facility is a lower-security facility appropriate for inmates who can be housed in its dormitory-style setting.

The facility operates under the jurisdiction of Folsom State Prison and its warden, and it houses two separate substance abuse treatment programs. One is a pre-release program for Folsom State Prison inmates, and the other program, known as the Parolee Substance Abuse Program, serves parolees and is under the authority of the Division of Addiction and Recovery Services (DARS). Both programs operate autonomously on separate yards at the facility. Inmates and parolees, however, can be present concurrently in the facility's administrative area for activities such as medical treatment.

Parolees who have violated their parole terms because of actions related to drug or alcohol dependency may participate in the substance abuse program in lieu of parole revocation. The program reflects the department's effort to provide rehabilitative treatment services, and it provides an alternative to reincarcerating these parolees. While parole violators participating in the Parolee Substance Abuse Program retain their status as parolees, they wear the same clothing as inmates and are restricted to the facility during the 90-day program under the provisions of section 11561 of the Health and Safety Code.

Department policies for housing inmates in state institutions, including the Folsom Transitional Treatment Facility, involve a classification process. The classification process assesses inmates' security risks and assigns them to institutions capable of dealing with those risks. In addition, the department considers the inmates' degree of custody, a measure of the amount of supervision inmates must have.

Before receiving permanent housing assignments, inmates typically undergo a classification review in which the department considers the inmate's background, criminal history, and incarceration history to calculate a classification score under guidelines outlined in section 3375.3 of the California Code of Regulations, Title 15. The resulting classification score determines the security level of the institution to which the inmate may be permanently assigned and housed. The following table summarizes the department's classification scores and the corresponding security levels.

Classification Score Title 15, § 3375.1	Facility Security Level Title 15, § 3375.1	Facility Description Title 15, § 3377
0 – 18	Level I	Open dormitories with a low-security perimeter
19 – 27	Level II	Open dormitories with a secure perimeter and optional armed coverage
28 – 51	Level III	Secure perimeter, armed coverage, and celled housing units
52 and above	Level IV	Secure perimeter, armed coverage, and cells non-adjacent to exterior walls

The Folsom Transitional Treatment Facility, with its open dormitories and low-security perimeter, most closely resembles a level I or level II facility.

As the authority responsible for the safety and security of the treatment facility, the warden is guided by Folsom State Prison's local operating procedures, which prohibit admitting level III and level IV inmates to the Folsom Transitional Treatment Facility. Specifically, Operational Procedure 30 requires that parolees received for placement in the Parolee Substance Abuse Program meet the same placement criteria used for placing inmates in a community correctional facility. Those standards, in turn, incorporate a policy memorandum dated May 11, 1998, from the California Department of Corrections' deputy director of institutions, which states, "Effective immediately, inmates with a classification score of 28 or greater shall not be endorsed or transferred to a [community correctional facility]."

Besides prohibiting level III and level IV inmates, inmates labeled as "maximum custody"[7] are prohibited from direct placement in the treatment facility. Instead, such inmates are initially segregated from the general population until further assessment by a team of custody officials.

DARS does not focus on departmental housing criteria in determining parolees' eligibility to participate in the Parolee Substance Abuse Program. Program participants currently on parole status are not subject to classification reviews to determine their housing placement. Nonetheless, program participants' histories are addressed by a parole agent II who screens parolees against various eligibility criteria. For example, parolees cannot participate in the program if they have histories of escape attempts, current gang affiliations, or convictions for certain violent or sexually related crimes. Further, DARS prohibits program entry to those who paroled from a security housing unit or a psychiatric services unit. If

[7] The degree of custody reflects an inmate's behavior while in custody along with other factors and determines the amount of supervision an inmate must be assigned. For example, maximum custody inmates must be housed in a cell in an approved segregated housing unit and be under the direct and constant supervision of custody staff. In contrast, minimum custody inmates may be housed in either cells or dormitories and require only supervision of their location adequate to ensure their presence. Inmates may be designated as maximum custody irrespective of their assigned institution's security level.

the parole agent II finds the parolee eligible, the parolee is referred to the Board of Parole Hearings for final approval.

Locating the Parolee Substance Abuse Program at the Folsom Transitional Treatment Facility violates operational procedure and creates safety problems. Because DARS' program participation rules do not focus on participants' past custody classifications in the same way that the treatment facility's housing rules do, and because the warden has no authority over the Parolee Substance Abuse Program, it is possible for DARS to place participants who do not conform to the facility's housing rules into the Parolee Substance Abuse Program. In fact, treatment facility staff members advised Folsom State Prison's management that the transitional treatment facility has held program participants who would be considered "maximum custody" if they were inmates, and that this violates the provisions of Operational Procedure 30. The staff also expressed concerns that this situation presents a potential safety issue.

We examined records of Parolee Substance Abuse Program participants for a 13-month period from August 2006 through August 2007 and found nine program participants whose former custody scores placed them in levels III and IV, as well as four who were formerly designated as "maximum custody." While we confirmed that no violent incidents involving such parolees occurred at the facility during the period we examined, their presence at the Folsom Transitional Treatment Facility violates the provisions of Operational Procedure 30.

Another problem presented by locating the Parolee Substance Abuse Program in a state correctional facility is the differing use-of-force policies applicable to inmates versus those applicable to parolees. The department's use-of-force policy authorizes the use of deadly force to prevent an escape by an inmate. However, the department's Office of Legal Affairs confirmed that "normal escape procedures cannot be employed during an escape or attempted escape of a parolee participant in PSAP [Parolee Substance Abuse Program]." This opinion presents the custody staff with a dilemma in the event of an escape attempt from the Folsom Transitional Treatment Facility because inmates and parolees wear identical clothing—leaving officers with no means to visually distinguish between an escaping inmate and an escaping parolee. An officer would have to consider that failure to use deadly force on an inmate could result in harm to the public, but the use of deadly force on a parolee is prohibited.

Recommendations

Because of the unique issues surrounding the Folsom Transitional Treatment Facility, the Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation consider using the facility exclusively for one of the two treatment programs it currently houses—either

the pre-release inmate substance abuse program or the Parolee Substance Abuse Program.

Alternatively, if the department decides to keep inmates and parolees at the facility simultaneously, the Office of the Inspector General recommends that the department:

- **Modify Operational Procedure 30 to eliminate current conflicts with housing parolees at the Folsom Transitional Treatment Facility, giving consideration to custodial safety and security needs while advancing the department's goals of providing rehabilitative services to inmates and parolees.**

- **Consider issuing Parolee Substance Abuse Program participants distinctive clothing to enable custody staff to distinguish them from inmates.**

California Department of Corrections and Rehabilitation's Response

Memorandum

Date : January 18, 2008

To : Matthew L. Cate
Inspector General
Office of the Inspector General
P.O. Box 348780
Sacramento, CA 95834-8780

Subject: **RESPONSE TO THE OFFICE OF THE INSPECTOR GENERAL'S DRAFT REPORT ENTITLED *FOLSOM STATE PRISON QUADRENNIAL AND WARDEN AUDIT***

The California Department of Corrections and Rehabilitation (CDCR) is pleased to provide this response to the Office of the Inspector General's (OIG) draft report entitled ***Folsom State Prison's Quadrennial and Warden Audit.*** Warden Matthew Kramer, Folsom State Prison (FSP), has been praised for his leadership skills and dedication to inmate rehabilitation and programming opportunities. The OIG's acknowledgement of Warden Kramer's strengths is not only appreciated, but reiterated by CDCR. Although deficient areas were identified and require remedial action, the overall report is positive in nature.

FSP continues to take proactive steps in meeting the Department's goals to expand inmate rehabilitation and programming opportunities, while striving to meet the challenges of a changing medical mission. During the quadrennial review period associated with this audit, FSP has been confronted with a variety of inherent problems related to the operation of a 120-year-old institution, as well as the restructuring of the institutional management team.

The identification of deficiencies by the OIG is of great value to CDCR and crucial changes are already underway at FSP. To address the more vital issues, FSP has initiated the following steps:

- Measures have been taken to reiterate the expectations to all custody supervisors regarding their responsibilities for completing and properly documenting daily cell searches in accordance with the Department Operations Manual, Section 52050.18. Procedures are being put into place to ensure uniformity in the documentation of the cell searches, which will include a mechanism for a supervisory and management compliance review.

- Documentation has been provided to all staff and inmates reiterating the requirement to perform a mandatory standing count at 1630 hours each day. Custody supervisors have also been directed to routinely monitor the process of standing counts and take corrective actions to ensure staff adheres to the conditions of the California Code of Regulations, Title 15, Section 3274. Custody staff will be provided training on the above listed policies and procedures, and the disciplinary process will be utilized when inmates do not comply with the requirement during the daily standing count.

- Division of Addiction and Recovery Services will review the recommendation to consider operating the Folsom Transitional Treatment Facility as either an inmate Pre-Release Substance Abuse Program or a Parolee Substance Abuse Program (PSAP). Consideration was previously given to issuing PSAP participants distinctive clothing to distinguish parolees

from inmates; however, it was determined this option would create additional operational and security difficulties.

- FSP consulted with CDCR's Office of Legal Affairs to provide an opinion regarding the use of force that is authorized during the escape of a parolee. FSP has developed an addendum to the institution escape pursuit plan, which we believe addresses these concerns. Training will be provided to all staff on these procedures.

Although CDCR is concerned about the issues relative to the delivery of medical services statewide, improvements are under the auspices of the Office of the California Prison Health Care Receivership and many projects are underway to improve the court-ordered quality of care standard. The Receiver was provided a copy of the OIG's report and has responded independently to the medical deficiencies identified in this report. FSP staff will continue to work with health care personnel to provide new employee orientation training to ensure awareness with custodial policies and procedures.

All deficiencies identified by the OIG in this audit will be addressed in corrective action plans submitted to CDCR's Office of Audits and Compliance (OAC) for follow-up and monitoring. In addition, OAC will be conducting a peer review of FSP in late 2008.

CDCR would like to thank the OIG for its continued professionalism and guidance in CDCR's efforts to improve its operations. Our commitment is evident and significant progress and improvements are being made. If you should have any questions or concerns, please call my office at 323-6001.

JAMES E. TILTON
Secretary
California Department of Corrections and Rehabilitation

cc: Matthew Kramer, Warden, Folsom State Prison
Robert Sillen, Receiver, California Prison Health Care Receivership
Richard Krupp, Assistant Secretary, Office of Audits and Compliance

Receiver's Response

CALIFORNIA
PRISON HEALTH CARE
RECEIVERSHIP CORP.

Robert Sillen
Receiver

January 11, 2008

Matthew Cate
Inspector General
Office of the Inspector General
P.O Box 348780
Sacramento, CA 95834-8780

Dear Mr. Cate:

I appreciate the opportunity to review and comment on the Office of Inspector General's (OIG) draft "Audit of Folsom State Prison (FSP) and Warden", conducted between March 28, 2007 and November 30, 2007. The OIG report further affirms the November 2007 iteration of the Receiver's Plan of Action that focuses on 22 major initiatives over the next 34 months, including two of the top clinical initiatives:

1) the new healthcare-employee orientation (POA Objective A.8.1 & 8.5.) and;
2) the nursing medication delivery process improvement (POA Objective B.8.).

The following comments relate to the OIG Report recommendation resulting from Finding 1.

Evaluating the adequacy of nursing supervision coverage at all institutions, especially before implementing significant changes, such as the new medication management systems, and adding nursing supervisor positions when warranted.

- The adequacy of nursing supervision was evaluated and completed by the Receiver's Nursing Executive Management team in approximately April 2007. A staffing assessment of the availability of 24/7 coverage by Supervising Registered Nurse (SRN) II/III at each institution was completed. It was determined that seven (7) institutions (including FSP) did not have an SRN III, and that multiple institutions had severely inadequate SRN II coverage. In the May 2007 budget revise process, California Department of Corrections and Rehabilitation (CDCR) requested seven (7) SRN III positions that were allocated to those institutions including FSP. CDCR has added two (2) new SRN II positions to FSP to provide additional PM shift coverage. Despite this addition, the number is still inadequate to provide 24/7 SRN II coverage. The Executive Nursing Management team has created a "service line-based staffing model" for SRN II positions. Based on this model, the specific number of SRN II that are minimally required to adequately supervise at each institution has been determined. Implementation of this model program is in process and is being evaluated at this time. To complement the increase in direct line supervision, Nurse Consultants have been hired to support the

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facilities in implementing pilots, revising polices, establishing improved processes, and mentoring supervisors. In response to the difficulties identified with the implementation of the Guardian Pharmacy program at FSP, four Nurse Consultants were assigned to support the facility. As a result of these efforts, new polices were developed, implemented, and evaluated resulting in a pharmacy system that is operating successfully.

Restricting access to the Triage and Treatment Area medication storage room to only those staff members responsible for maintaining the counts and inventory. Hold staff who have authorized access accountable when they fail to lock all medical cabinets in the medication storage room after use.

- As part of the nursing medication delivery process improvement initiative, the Director of Nursing (DON) at FSP has addressed this issue with the SRNs and staff nurses by implementing the following practices:

  1) The SRN assigned to the Triage and Treatment Area (TTA) is responsible to monitor and to ensure that the medication cabinets and storage rooms are secured, logged, and checked on a daily basis.
  2) The DON expects the SRN's to hold line staff accountable for compliance. SRN's hold regular staff meetings to address these issues. New locks were placed on the door to the medication room to eliminate non-nursing staff from accessing the medication room. Monitoring activities were initiated to track compliance and reports are sent to the Pharmacist in Charge, the DON, and the HCM for regular evaluation and continuous quality improvement.

Ensuring that nursing staff attend institution new employee orientation sessions relevant to safety and security within the timeframe established by the Department or the Receiver. Consider expanding the orientation sessions to include role playing using actual examples of unsafe and safe practices.

- The Receivers POA new healthcare-employee orientation (NEO) includes a competency-based nursing orientation and a customized preceptor program. The NEO pilot is being conducted at selected sites and will be implemented more broadly once finalized. In the interim, the Regional DON's are ensuring that all new Licensed Vocational Nurse (LVN)'s are attending the institutional orientation. The LVN's are provided an experienced nurse as a resource person to address clinical and procedural questions immediately as a supplement to institutional orientation. In addition, all nurses including registry staff are required to attend the institutional orientation. This effort will establish a baseline of core competency in all nurses that will be complemented by the NEO program.

- We are collaborating with custody to ensure that safety issues are covered in the new healthcare orientation.

Ensuring that nursing staff count needles and syringes twice daily, in accordance with the Triage and Treatment Area procedures. Supervising nurses should be held accountable for ensuring this requirement is enforced.

- Monitoring activities are in place to ensure compliance with the policy that narcotics are to be counted by two licensed healthcare staff at change of shift.

If you have question regarding the Receiver's comments related to nursing operations, please contact Betsy Chang Ha, Chief Nurse Executive, 408-203-3075.

Sincerely,

Robert Sillen
Receiver

cc: John Hagar, Chief of Staff, CPR
Betsy Chang Ha, Chief Nurse Executive, CPR
Dave Runnels, Undersecretary, CDCR
Matthew Kramer, Warden, FSP