Roy W. Wesley, Inspector General

Bryan B. Beyer, Chief Deputy Inspector General

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

May 2020

2019 Annual Report

Summary of Reports and Status of Recommendations

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at 916-255-1131.

May 20, 2020

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California

Dear Governor and Legislative Leaders:

This annual report summarizes the work the Office of the Inspector General completed during 2019. In 2019, we issued 12 public reports that detailed our oversight of the California Department of Corrections and Rehabilitation, which comprised the following: five reports on medical inspection results; two reports concerning monitoring the department's internal investigations and its employee disciplinary process; one report on monitoring the department's use of force; one special review; one report concerning the status of the *Blueprint*; one report on the California Rehabilitation Oversight Board; and the OIG's annual report for 2018.

This report also enumerates the recommendations we made to the California Department of Corrections and Rehabilitation in 2019, as well as, when required, the department's responses and its action plans to address our recommendations.

Respectfully submitted,

Roy W. Wesley
Inspector General

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Vision

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

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

Mission

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

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

— Roy W. Wesley
Inspector General

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

— *State of California*
Penal Code section 6125

Organizational Overview and Functions

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

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

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

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

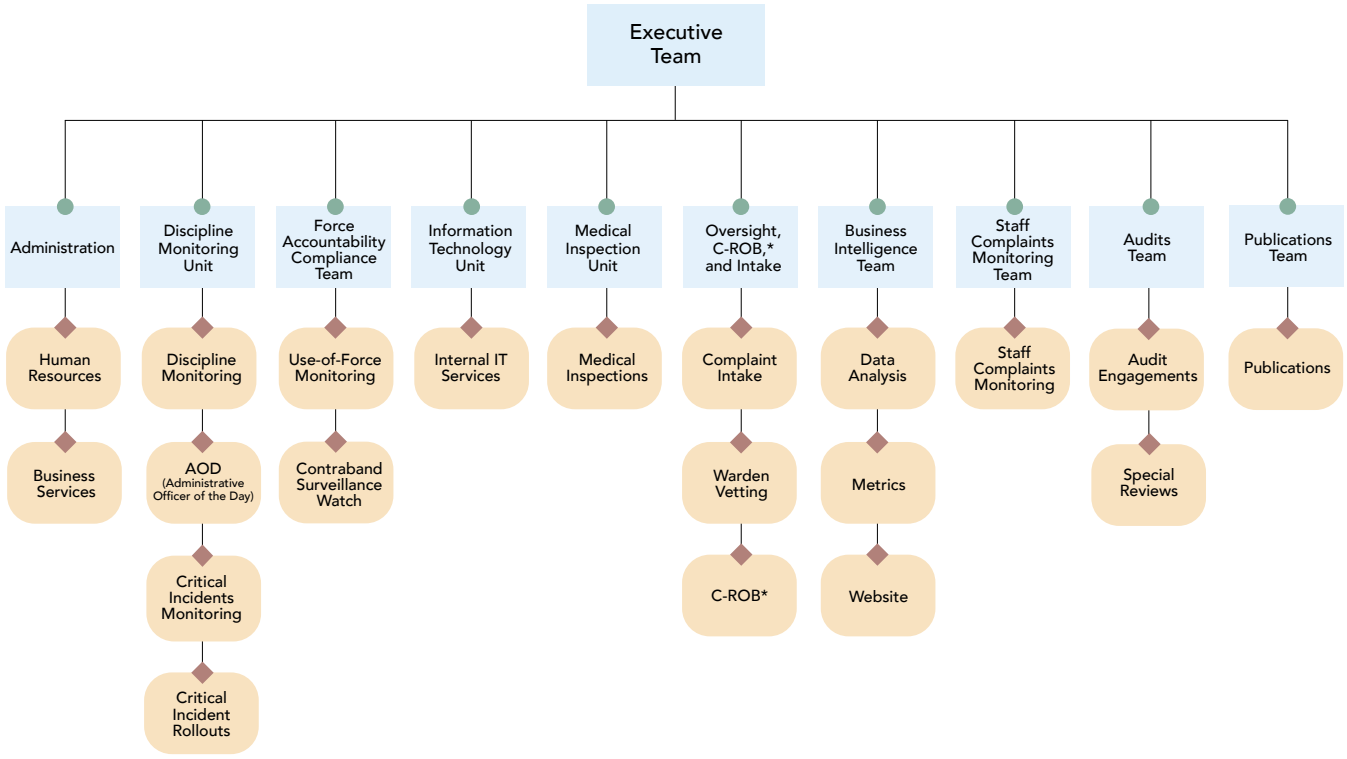
The OIG also employs a cadre of medical professionals, including doctors and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities,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

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

- Medical inspections
- Audits and authorized special reviews
- Complaint hotline and intake
- Reviewing and investigating retaliation complaints

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

Figure 1. Office of the Inspector General Organizational Chart, 2020



* C-ROB is the abbreviation for the California Rehabilitation Oversight Board.

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Reports Published in 2019

In 2019, we issued 12 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: five reports on medical inspection results; two reports on monitoring the department's internal investigations and employee disciplinary process; one report on monitoring the department's use of force; one special review; one report on the status of the *Blueprint*; one report on the California Rehabilitation Oversight Board; and our 2018 annual report. Visit our website, **www.oig.ca.gov**, to view our public reports.

Internal Investigations and Employee Discipline Monitoring

OIG attorneys are responsible for the contemporaneous oversight of the department's internal investigations and employee disciplinary process. We account for our monitoring of these activities twice annually when we publish our discipline monitoring reports. These reports document our assessment of the quality of the department's internal investigations and its handling of the employee disciplinary process, as well our evaluation of the department's adherence to its own rules and procedures when performing these activities. Our attorneys monitor and assess the work of the Office of Internal Affairs' special agents who conduct the department's internal investigations, the hiring authorities who make decisions concerning employee disciplinary actions, and the performance of department attorneys throughout the disciplinary and appeals processes.

As part of our monitoring process, we monitored the Office of Internal Affairs' weekly central intake meetings pursuant to which the Office of Internal Affairs made decisions concerning employee misconduct referrals it received from the hiring authorities. In 2019, the Office of Internal Affairs addressed and made decisions concerning 2,161 referrals for investigation or for authorization to take direct disciplinary action. Of these, the Office of Internal Affairs approved 2,033 referrals; and the OIG identified 352 of these as cases to monitor. We identified for monitoring the most serious and sensitive internal investigations, including those involving allegations of dishonesty, sexual misconduct, use of deadly force, code of silence, abuse of authority, and criminal conduct.

In addition, we monitored and closed 328 cases in 2019. Of those cases, 269 involved administrative allegations, and 59 cases involved alleged criminal activity by departmental staff members. Furthermore, of the 328 cases, we monitored and closed 23 administrative investigations and 11 criminal investigations, all of which involved the use of deadly force.

In 2019, the OIG implemented a new method for assessing the department's internal investigations and employee disciplinary process in which we categorized our assessments into six separate phases, or indicators. The OIG assessed how well the hiring authorities discovered alleged employee misconduct and referred the allegations to the Office of Internal Affairs; how well the Office of Internal Affairs processed and analyzed the referrals; the performance of the Office of Internal Affairs in investigating the allegations; the performance of the hiring authorities in making findings concerning the investigations and the alleged misconduct and processing the misconduct cases; the performance of the department attorneys in providing legal advice to the Office of Internal Affairs; and how well the department advocates (either department attorneys or employee relations officers) represented the department in employee misconduct litigation.

When assessing a case, the OIG attorney answered a series of compliance- and performance-related questions and, depending on the answers, assigned a rating of *superior*, *satisfactory*, or *poor* to each of the six indicators, in addition to providing an overall rating for each case. To monitor and track this data, we assigned a numerical point value to each of the individual indicator ratings and to the overall rating for each case. The OIG assigned four points for a *superior* rating, three points for a *satisfactory* rating, and two points for a *poor* rating. We then added the assigned points for each indicator and divided the total by the number of points possible to arrive at a weighted average score. We assigned a rating of *superior* to weighted averages that fell between 100 percent and 80 percent, *satisfactory* to weighted averages that fell between 79 percent and 70 percent, and *poor* to weighted averages that fell between 69 percent and 50 percent.

Using the above methodology, we found that, from January through December 2019, overall the department's performance was *satisfactory* in conducting internal investigations and handling the employee disciplinary process. However, hiring authorities' overall performance was *poor* in processing the employee discipline cases, and the department attorneys' performance was *poor* in providing legal representation during litigation.

The OIG also identified and made recommendations regarding specific issues concerning the department's internal investigations and employee disciplinary process. The OIG recommended that the Office of Internal Affairs eliminate the practice of identifying allegations at the beginning of and during investigations, and instead allow the hiring authority to determine the appropriate allegations at the conclusion of investigations. In addition, the OIG noted that, in 2019, the Office of Internal Affairs returned 1,184 cases to hiring authorities without interviewing the employee suspected of misconduct. In many of those cases, the department had no statement from the employee who allegedly committed misconduct and was unaware of the employee's side of the story until after discipline had already been imposed. We recommended that the Office of Internal Affairs conduct interviews of employees suspected of misconduct in all cases.

The Office of Internal Affairs also returned some referrals to hiring authorities and requested that the hiring authorities conduct further inquiry. The OIG noted that the department does not have a system or methodology to track these cases. We recommended that the department develop a method for noting in its case-management system which cases the Office of Internal Affairs rejected because there was no reasonable belief that misconduct had occurred and which cases it rejected and then returned to the hiring authority to conduct further inquiry. The OIG also recommended that the Office of Internal Affairs develop a method for tracking the cases it returns to the hiring authority for inquiry to ensure that those further inquiries are actually conducted and are completed in a timely manner.

Finally, the OIG recommended that the department clarify its policy establishing a specific time frame in which a hiring authority must conduct an investigative and disciplinary findings conference, and by requiring that the conference be held within a specific number of days after a hiring authority receives an investigative report or notice of approval for direct action from the Office of Internal Affairs. Furthermore, to prevent delays in processing disciplinary actions, the OIG recommended that the department implement a policy requiring that department attorneys and employee relations officers compose disciplinary actions within a specific number of days of the investigative and disciplinary findings conference. This step would help ensure that employees receive timely service of disciplinary actions and assist in reducing unnecessary costs the department incurs while, in some cases, it waits for a department attorney or employee relations officer to compose a disciplinary action.

Use-of-Force Monitoring

Another means by which we fulfill our oversight mandate is by monitoring the department's process for reviewing use-of-force incidents at institutional executive review committee meetings, departmental executive review committee meetings, and division force review committee meetings. We use a comprehensive database designed for our staff to effectively examine the various circumstances surrounding uses of force by departmental staff. This tool aggregates information and allows for an in-depth analysis of use-of-force incidents. We meet quarterly with departmental executives to share information related to trends we observe. The OIG also participates as a nonvoting member of the department's Deadly Force Review Board.

In June 2019, we published *Monitoring the Use of Force: The California Department of Corrections and Rehabilitation Continues to Perform Well in Self-Assessing Its Use-of Force Incidents, but Has Shown Little Improvement in Its Overall Compliance With Policies and Procedures*. This report covered use-of-force incidents for which the department completed reviews during the period from January 1, 2018, through December 31, 2018. Carrying out our monitoring process, OIG inspectors visited every adult and juvenile institution and departmental headquarters, and both the northern and southern parole regions to attend 1,294 of the 1,764 executive review committee meetings (73 percent). During this one-year review period, our inspectors reviewed and analyzed 6,426 separate use-of-force incidents. Inmates alleged unreasonable force in 660 of the 6,426 incidents we monitored.

Statistics Regarding the Use of Force From January 1, 2018, Through December 31, 2018

- The OIG monitored 6,426 use-of-force incidents by attending 1,294 of the department's 1,764 executive review committee meetings (73 percent).
- Approximately 93 percent of the use-of-force incidents (5,996 of 6,426) occurred at State prisons and contract facilities housing adult inmates, with the remainder involving juvenile facilities (359), parole regions (57), and the Office of Correctional Safety (14).

- Approximately one-third of the incidents we reviewed occurred at only five State prisons: Salinas Valley State Prison (500); California State Prison, Sacramento (495); Kern Valley State Prison (484); California State Prison, Los Angeles County (421); and California State Prison, Corcoran (420).
- We monitored 6,426 incidents that involved 19,527 *applications* of force. An incident may involve more than one application of force. For example, two baton strikes count as two applications during a single incident. Chemical agents accounted for 9,736 (50 percent) of the total applications, while physical strength and holds accounted for 5,995 (31 percent). The remaining 19 percent of applications comprised force options such as less-lethal projectiles, baton strikes, tasers, and firearms.

Highlights of Our Use-of-Force Monitoring

The department continued to perform well in reviewing incidents; however, staff were fully compliant with departmental policies in only 55 percent of the use-of-force incidents. The department subjects its use-of-force incidents to several levels of review, which culminate with an executive review committee determining compliance with use-of-force policies and procedures. This process has proven effective in self-identifying instances of noncompliance. For example, while the department found that 55 percent of the incidents occurring during this period fully met policy standards, it identified its staff committed policy violations in 45 percent (2,883 of 6,426) of the incidents we monitored during this one-year period. We agreed with the vast majority of the department's compliance determinations, yet we also identified several instances of noncompliance that the department's review committees did not address.

The department's policy for the use of immediate force requires officers to provide justification for using force by articulating their reasoning in reports. For example, an officer may use force in response to a threat against the life of another person or to prevent great bodily injury or escape. Despite this standard and policy requirement, we concluded that officers did not adequately articulate an imminent threat in 95 of the 6,426 incidents (1.5 percent) we monitored during this one-year period, leading us to question whether the use of force was justified in those cases.

The department continues to garner low compliance with its procedures for video-recorded interviews required of inmates in use-of-force cases. Departmental policy requires that staff conduct video-recorded interviews with inmates who allege unnecessary or excessive use of force, or who sustain serious or great bodily injury, possibly from the use of force. The policy requires that staff record these interviews within 48 hours of discovering the injury or inmate allegation and that staff video-record any visible or alleged injuries. We noted the department's compliance rate with its own standards was only 51 percent during 2018. Despite the department's repeated attempts to provide additional training and direction to its staff regarding the requirements, the compliance rate remained low throughout this reporting period.

In controlled use-of-force incidents, the department's noncompliance rate also remained high, with at least one violation in 65 percent of incidents. The department requires institutional staff to follow "controlled force" procedures when an inmate's presence or conduct poses a threat, even if the inmate is located in an area that can be controlled or isolated. These procedures require advance planning and organization by custody, medical, and mental health staff. In addition, institutional staff must video-record the incident. Of the 100 controlled use-of-force incidents we monitored during the one-year review period, the department's executive review committees found that staff violated one or more of the department's controlled-force policies in 65 incidents (65 out of 100). Most of these violations occurred not in the application of the force itself, but rather in complying with the requirements for planning and organization prior to the actual force. While this showed progress compared with the compliance rate noted in our last report (a 75 percent noncompliance rate), there remains room for improvement.

Cycle 5 Medical Inspection Reports

Pursuant to Penal Code Section 6126 (f), the OIG conducts a medical inspection program for the purpose of reviewing the delivery of medical care at each of California's 35 adult institutions. Our clinicians perform objective, clinically appropriate, and metric-oriented medical inspections that offer insight into the quality of the medical care the department provides to its patients.

Table 1. OIG Cycle 5 Medical Inspections: Final Reports Published in 2019

Institution Inspected	Publication Month	Overall Rating
California Health Care Facility	April	*Inadequate*
Pleasant Valley State Prison	April	*Adequate*
San Quentin State Prison	February	*Inadequate*
California Institution for Men	January	*Inadequate*
Deuel Vocational Institution	January	*Inadequate*

Source: The Office of the Inspector General medical inspection results.

In 2019, the OIG completed its fifth cycle of medical inspections and published five reports for the following institutions: Deuel Vocational Institution, California Institution for Men, San Quentin State Prison, Pleasant Valley State Prison, and California Health Care Facility, Stockton. The ratings for these five institutions resulted in one *adequate* and four *inadequate*, as set forth in Table 1 above.

The table lists the institutions for which we completed our Cycle 5 inspections and issued final reports, the month each report was published, and the rating we assigned to each institution. Through those reports, the OIG made 27 recommendations to the department to further improve the delivery of medical care to its patients.

We also commenced our sixth cycle of medical inspections in 2019. To date, the OIG completed inspections of the following five institutions: Valley State Prison; Wasco State Prison; California State Prison, Los Angeles County; California Correctional Center; and California State Prison, Solano. We anticipate publishing these inspection reports in 2020.[1]

1. At the time of this report's publication, the world is enduring a novel coronavirus disease pandemic (COVID-19), which has resulted in severe economic and societal disruptions on a global scale. As a result, delays in carrying out our medical inspections in 2020 may occur.

Retaliation Claims

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

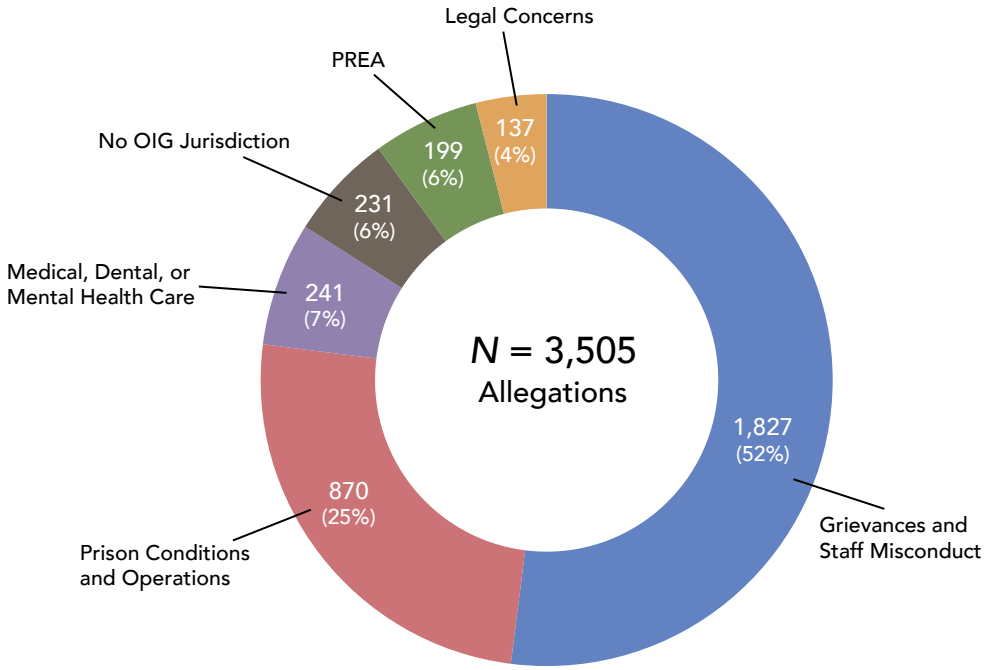
Due to public misperception regarding what constitutes whistleblower retaliation, few complaints present the legally required elements to state an actionable claim of retaliation. To counteract this misunderstanding, we engage with complainants to educate them on the elements of a retaliation claim,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

In 2019, the OIG received 14 retaliation complaints, and our Legal Services Unit completed analyses of 11 of them. We also completed analyses of two complaints that had been pending from 2018. We determined that none fulfilled the legally required elements of a claim of retaliation. Three of the 14 complaints received in 2019 remain pending.

Complaint Intake

The OIG maintains a statewide complaint intake process that provides anyone a point of contact for expressing allegations of improper activity within the department. We receive complaints from inmates, parolees, families, departmental employees, and advocacy groups. Individuals submit complaints by sending us letters, calling our toll-free phone line, calling our main telephone number, or emailing us through our website. We screen all complaints within 24 hours of receipt to identify potential safety concerns involving departmental employees or inmates.

Figure 2. Types of Allegations Received in 2019



Source: The Office of the Inspector General.

In 2019, the OIG received 3,505 allegations of improper governmental activities, as shown as Figure 2 above. Based on these allegations, we opened 3,200 cases.[2] After we reviewed each complaint, we provided a written response to the complainant. Our office does not have the authority to conduct investigations; however, our staff conducted inquiries by reviewing the department's policies and procedures, by requesting relevant documentation from the institution, or by visiting the institution to observe and make recommendations to departmental administrators.

In 231 of the 3,200 cases, we determined that we did not have jurisdiction because the allegations pertained to county jails, federal prisons, or local law enforcement. In these cases, we referred the complainant to the most appropriate entity. Our office conducted either a preliminary inquiry or a field inquiry into the remaining 2,969 cases to assist the complainant or look into the alleged improper activity.

2. The reduction in the number of allegations received versus cases opened resulted from a complainant submitting a subsequent complaint involving the same allegation; these multiple allegations were merged into a single case.

We performed a preliminary inquiry for 2,924 cases wherein our staff analyzed the alleged activity, reviewed departmental policies and procedures, reviewed the inmate's case file, and requested additional documentation from the department, as needed. In the vast majority of the cases, our inquiry resulted in our providing the complainants with advice on how to address their concerns with the department. Common examples of such advice include instructions on how to request services or navigate the department's appeals process, disciplinary process, and visiting process. On occasion, our advice included instructions on how to contact specific departmental divisions and offices for services or additional help.

In the following paragraphs, we discuss a sampling of the preliminary inquiries that we completed in 2019. These inquiry summaries exemplify the assistance we provided to complainants regarding both the department's appeals process and the process for requesting an investigation. Each of these complainants had been unsuccessful in their initial attempts to remedy these situations with departmental staff.

In one complaint, an inmate alleged that appeals staff were not responding to his appeals. The inmate alleged that a correctional officer transferred him to a new institution and incorrectly housed him in an upper bunk despite his having a medical condition requiring a lower bunk. The inmate stated that while housed at the new institution, he fell out of his upper bunk and sustained injuries.

We reviewed documents the inmate submitted, which included medical documents and responses from the appeals office initially returning his appeal for corrections and subsequently canceling the appeal. The OIG found the inmate had made multiple allegations within a submitted appeal and that the department's response requesting clarification was appropriate. The department requires that appeals issues be derived from a single event and may be rejected if they involve multiple issues that are not directly related to one event. The OIG also found the inmate subsequently requested that the department's appeals staff withdraw the appeal after writing our office. During our review of the department's records, we found conflicting records in its computer systems regarding the inmate's approval and need for lower bunk housing. Subsequent to the initial complaint, the department corrected these errors, updated the inmate's medical records for lower bunk housing, and housed the inmate in a lower bunk.

In another complaint, an inmate alleged that he was involved in a use-of-force incident with two correctional officers, after the inmate did not receive his vegetarian meal. The inmate alleged that, while employing a use of force, one of the officers lost his smartwatch inside the inmate's cell. The watch included the officer's personal information, which the inmate described in the complaint. The inmate alleged that due to his refusal to return the smartwatch to custody staff, his subsequent meals were withheld from him, and one officer stated, "You'll get to eat when you give up [return] the watch." The inmate stated he had not submitted a Form 602 "Inmate/Parolee Appeal" to departmental staff, but instead contacted our office, along with inmate advocacy groups and federal authorities.

Our office met with the inmate and explained that our authority precludes us from investigating his allegation. However, with the inmate's signed approval, we shared his complaint with the department to conduct an inquiry and determine whether an investigation was recommended. The hiring authority subsequently requested that the Office of Internal Affairs conduct an investigation of the involved officers.

Some preliminary inquiries involved safety and security threats or mental health conditions, which resulted in our immediate referral to the department. Our staff contacted institutions on 37 occasions to recommend that departmental staff conduct checks on an inmate's safety or mental health condition.

In one complaint, an inmate alleged that he was in fear for his life from other inmates and staff, due to a book he authored that was published in 2017, which included details about his past involvement with a security threat group.

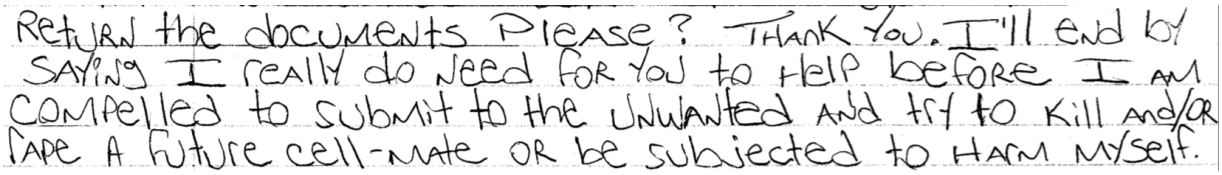
We reviewed documents the inmate submitted, which included an excerpt from his book, appeals forms, and committee documents regarding his pending transfer endorsement to another prison.

Our review of departmental records identified information that supported some of the inmate's allegations, for example, that he was scheduled to transfer to the same institution and housing yard of an inmate whom he had identified in his book. We found the inmate who authored the book did not have a separation alert (used to identify confidential and nonconfidential enemy concerns) with the inmate he cited in the book, which may have precluded a transfer to the same institution and housing location. We notified the hiring authority and members of the committee at the inmate's current prison who were to conduct a transfer review to ensure

that this inmate's safety would not be jeopardized due to his transfer to another institution.

However, we found that the inmate had transferred to the new institution eight days after we contacted the prior institution regarding his potential safety concern. The inmate he cited in the complaint was not initially housed on the same yard, but was later housed on the same yard with him for more than two months. After the inmate who authored the book had been housed at the institution for approximately two months, the department conducted a review of his alleged safety concerns, and the inmate notified departmental staff he had no safety concerns and that some inmates were "looking out for him." The inmate later returned to his initial institution by the end of 2019 due to being charged with an assault of a noninmate and battery on a peace officer.

Some inquiries require further contact and follow-up with hiring authorities or site visits to the institution: we call these *field inquiries*. During 2019, we reviewed 45 field inquiries. In one of the field inquiries, we received a complaint from an inmate claiming he should remain single-celled, as he had not had a cellmate for more than 14 years. The inmate stated the department was forcing him to be double-celled as his appeals to remain single-celled had been denied. His statement is reproduced below:


Return the documents Please? Thank You. I'll end by saying I really do need for You to Help before I am compelled to submit to the unwanted and try to Kill and/or rape A future cell-mate or be subjected to Harm Myself.

Source: Inmate complaint submitted to the OIG's intake unit.

Our office notified the prison's Chief of Mental Health about the inmate's concerns and of the potential danger concerning both the inmate and a potential cellmate. Upon review and assessment of the inquiry, mental health staff indicated that departmental staff should use caution before *double celling* (the practice of placing two inmates into a single cell) this inmate, but also cited that it ultimately would not be a decision made by mental health staff. Subsequently, a Unit Classification Committee, which is typically chaired by staff at the level of facility captain or correctional captain, changed the inmate's status from single-cell to double-

cell. The decision to double-cell this inmate was affirmed by the hiring authority at the institution.

The OIG then recommended that the associate director (an individual with responsibility over several prisons within a particular mission, such as high-security institutions) reconsider whether this inmate should be double-celled based on the concerns cited above. The associate director concurred with the hiring authority's decision to double-cell this inmate, and the inmate was subsequently double-celled.

At 3:00 a.m., within 48 hours of being housed with an inmate deemed to be compatible, the inmate attacked his new cellmate while he was asleep. The inmate subsequently wrote to our office describing the attack, stating he first hit his new cellmate in the head with a ***hot pot*** (an appliance used to heat water) and then struck him with a portable fan. Our office found the victim sustained a three-centimeter laceration on his right temple and a two-centimeter laceration on his left temple, with no loss of consciousness. On the day after the in-cell fight, the inmate who had written to our office was approved for single-cell status for a period of observation and at the time of this report, remains single-celled due to his continuing threats to kill a cellmate if given one.

Another field inquiry complaint concerned a lack of resources for inmate advisory councils. In 2019, our office met with most of the inmate councils statewide to share information about our office and allow representatives to share their concerns in a confidential setting. A third party wrote on behalf of one of the inmates who had met with our representatives at one of these meetings. It was alleged that custody staff were no longer allowing the council sufficient time to meet and had removed supplies from the council's assigned area.

Our office met with the hiring authority to share these concerns, and investigative staff initiated an inquiry into the allegations. The inquiry included interviews of four inmates who were members of the inmate advisory council. Some of the inmates confirmed delays in receiving supplies such as paper, pens, and appeals forms, and confirmed that the inmate advisory council was without a permanent office. The inquiry also revealed that a sergeant assigned to assist in providing office supplies and office space had been on long-term leave. This resulted in a period of time during which the council representatives experienced delays in receiving supplies. Our office recommended that the inquiry include all council members who had met with our office's representative.

However, the hiring authority disagreed and did not conduct any additional interviews. Because the hiring authority declined to interview a percipient witness, our office did not agree that an adequate inquiry was conducted.

Sexual Abuse in Detention Elimination Act Ombudsperson Claims

According to California Penal Code section 2641, the OIG is authorized to serve as the ombudsperson (designated, impartial advocate) for complaints related to the Sexual Abuse in Detention Elimination Act (SADEA).[3] Acting in this capacity, we review allegations of mishandled sexual abuse investigations within correctional institutions, maintain the confidentiality of sexual abuse victims, and ensure an impartial resolution of inmate and ward sexual abuse complaints. Our staff supplies informational posters to all adult institutions, Division of Juvenile Justice facilities, and parole offices that explain how to report these allegations through our toll-free phone line or by mail. By acting as an external reporting mechanism, we increase transparency and provide another option to inmates who are concerned with reporting alleged abuse or harassment directly to departmental staff.

In 2019, the department notified the OIG through sexual incident reports or critical incident notifications of sexual harassment or sexual misconduct allegations, commonly referred to as Prison Rape Elimination Act or *PREA* allegations. As seen in Table 2 on the next page, we received 967 sexual incident reports, which is a slight increase from the 943 we received the prior year. The department also notified us of 284 critical incidents related to sexual misconduct or sexual harassment allegations made against a departmental staff member. This is a substantial decrease of 127 critical incidents (or 45 percent), compared with 411 incidents reported in 2018.

According to departmental policy, an inmate may report an allegation of sexual violence, sexual misconduct, or sexual harassment to any staff member, verbally or in writing, through the inmate appeals process, the sexual assault hotline, or a third party. In addition, an inmate may report these allegations

3. The federal Prison Rape Elimination Act (PREA) of 2003 provided national standards to eliminate sexual abuse in detention facilities. In 2005, California enacted Assembly Bill 550, the Sexual Abuse in Detention Elimination Act (SADEA), which provides the Office of the Inspector General with the authority to investigate reports of the mishandling of sexual abuse incidents.

Table 2. Sexual Misconduct Allegations

Type	Incident	Sexual Incident Report	Critical Incident Notification
Inmate-on-Inmate	Nonconsensual Sexual Acts	229	3*
	Abusive Sexual Acts	164	0
	Sexual Harassment	87	0
	Subtotal	**480**	**3**
Staff-on-Inmate	Sexual Misconduct	332	216
	Sexual Harassment	155	65
	Subtotal	**487**	**281**
Total Sexual Misconduct Allegations		**967**	**284**

* The OIG does not require sending critical incident notifications for inmate-on-inmate allegations to our administrative officer, as they are reported separately via sexual incident reports. Furthermore, three inmates could not identify whether the alleged suspect was an inmate or staff member.

Source: The Office of the Inspector General Tracking and Reporting System.

directly to the OIG's ombudsperson for sexual abuse in detention elimination. Any departmental employee who observes an incident or is provided with a report by a victim must complete the required reports, including a sexual incident report.[4] Allegations must be investigated by a trained departmental investigator and reviewed by the institution's hiring authority.

In 2019, our staff also reviewed 199 complaints received directly from inmates, family members, and third parties alleging sexual misconduct or sexual harassment policy violations. In 32 instances, our office referred these allegations to the department for its staff to conduct an initial investigation or inquiry.

One allegation involved an inmate who reported being a victim of a staff-on-inmate sexual misconduct incident, stating that during a clothed body search, he

> would lean into her [correctional officer] & she in me so she would snick [*sic*] in a quick lick & kiss on the back or side of my neck. I feel & she felt we can trust each other & I can keep my mouth shot [*sic*] & "not kiss & tell" anyone about us . . . so she felt good & comfortable & trusted me & felt safe cause I had her back on the yard & she had mine.

4. The Survey of Sexual Violence (SSV) form is part of the U.S. Department of Justice, Bureau of Justice Statistics National Prison Rape Statistics Program, which gathers mandated data of sexual assault in correctional facilities, under the Prison Rape Elimination Act (PREA) of 2003.

We reported the allegation to the institution's PREA compliance manager, who confirmed this allegation had not been reported to departmental staff.

Our staff reviewed the inquiry and found that the alleged victim was interviewed by a locally designated investigator on the same day our office reported the allegation to the institution's PREA compliance manager. During the interview, the inmate confirmed he made the PREA allegation to our office and stated that he had a relationship with this officer for a period of two years. The inmate alleged that the officer would deliberately conduct clothed body searches of him while he was on the recreational yard, and stated that she would lick and kiss his neck and grab his crotch area during these searches. The inmate initially stated this behavior occurred from 2016 through 2018, but later clarified these incidents actually ended in (November or December) 2017. The locally designated investigator identified discrepancies between the reported allegation dates, and determined there was a lack of corroborating evidence and witnesses to support any of the allegations. As a result, departmental staff concluded that the PREA allegation was unfounded.

In another allegation, an inmate also reported being a victim of a staff-on-inmate sexual misconduct incident, stating that a mental health employee was "paying me cash money to masturbate for her for a few months giving me her address/phone # to keep in contact with her" upon his release from prison. Our office met with the inmate, and we explained that our authority did not include the ability to investigate these allegations. However, with the inmate's signed approval, we shared his complaint with the department to conduct an inquiry and determine whether an investigation is recommended. We also reported the allegation to the institution's PREA compliance manager, who confirmed this allegation had not been reported to departmental staff.

Departmental staff initiated a PREA inquiry into this allegation, along with an inquiry into the safety of the California Correctional Health Care Services mental health employee. On the same day, the inmate received a rules violation report for indecent exposure as witnessed by the same mental health employee. A few weeks after the inmate's allegation, the inmate was found in possession of the mental health employee's confidential personal information. Departmental investigative staff issued a staff separation alert (staff safety concern) to ensure the mental health employee and inmate had no further contact, along with a cease-and-desist notice to the inmate directing all forms of communication to end. Departmental staff conducted an inquiry and referred the

allegation to the Office of Internal Affairs. The Office of Internal Affairs accepted this case for an investigation, which remains pending as of the date of publishing this report.

Special Reviews

The Office of the Inspector General completed one special review in 2019. In January 2018, the secretary of the department and attorneys from the Prison Law Office requested that the OIG assess the effectiveness of Salinas Valley State Prison's (Salinas Valley) process of handling inmate allegations of staff misconduct, commonly referred to as staff complaints.[5] The prison conducts staff complaint inquiries—a precursor to a formal investigation—to address such allegations. A staff complaint inquiry includes the gathering of evidence, through interviews and document collection, and can evolve into a formal investigation if the prison suspects staff misconduct serious enough to warrant disciplinary action. This special review encompassed two periods: a retrospective review of 61 staff complaint inquiries that the prison completed between December 1, 2017, and February 28, 2018, and an on-site monitoring review of 127 staff complaint inquiries that the prison initiated between March 1, 2018, and May 31, 2018. The special review also included our assessment of nine additional staff complaints that the Prison Law Office submitted to the department. We published our report on January 25, 2019.

When inmates believe they have been the victim of staff mistreatment or abuse, inmates may file a staff complaint, which the prison calls an appeal. The prison may reject the appeal, request an investigation by the Office of Internal Affairs, or conduct a staff complaint inquiry. A supervisor—typically a sergeant or a lieutenant—is assigned to work on the staff complaint inquiry, in addition to all other regular duties. That supervisor, referred to as a *reviewer* for the purposes of this process, collects evidence and conducts interviews of the inmate appellant, of inmate witnesses and staff witnesses, and of the staff member who is the subject of the complaint. The reviewer then provides a written report to the hiring authority based on

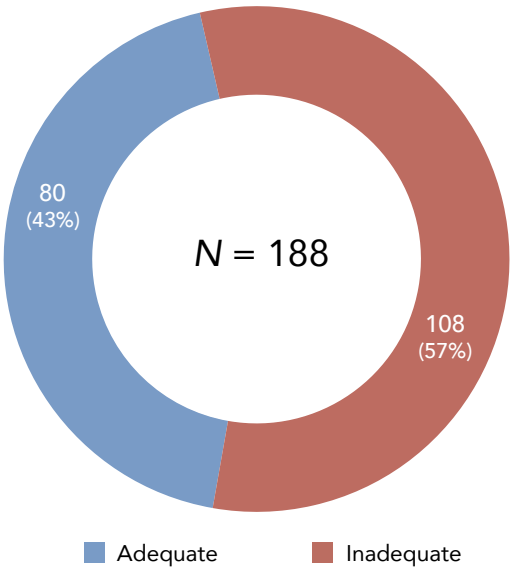
5. This assessment comprised a *review*. We differentiate this term from the term *investigation* in two primary respects. First, a review focuses on the adequacy of a *process*, whereas an investigation focuses on the appropriateness of an individual's *behavior*. Second, a review's intended outcome is fundamentally different from that of an investigation: a review may result in recommendations regarding policies and procedures, whereas an investigation may result in disciplinary or criminal action against individuals due to their behavior, if warranted.

the results of the interviews, along with any reports and analysis completed, and evidence the reviewer received during the inquiry.

Of the 188 staff complaint inquiries we reviewed, the prison determined that its staff did not violate policy in 183 of them (97 percent). However, we found that the dependability of the staff complaint inquiries was significantly marred by reviewers' inadequate investigative skills—notably, their deficiencies in interviewing, collecting evidence, and writing reports. These inadequacies resulted in final reports that were often incomplete or inaccurate, or both incomplete and inaccurate. Based on these overall procedural deficiencies, we determined that prison staff completed more than half of the staff complaint inquiries inadequately, which meant the hiring authority was deprived of adequate investigative results to make determinations. The hiring authority found that staff had violated policy in five cases, took corrective action in four cases, and determined corrective action was not possible in the fifth case. Furthermore, the hiring authority determined that, of the four, only one case warranted a formal investigation.

Our conclusions, however, were not meant to convey whether the hiring authority's decisions were correct or incorrect, or whether accused staff members were responsible for committing the alleged misconduct; rather, we pointed out that the hiring authority made decisions based on inadequate investigative work. We found at least one significant deficiency in 173 of the 188 staff complaint inquiries (92 percent); for example, the work across all ranks of reviewers lacked quality; reviewers failed to ask relevant questions in interviews, failed to collect relevant evidence, compromised the confidentiality of the process, and displayed bias against inmates; and none of the reviewers received meaningful training in the inquiry-related techniques of interviewing, collecting evidence, or writing reports. On the next page, Figure 3 (reproduced from the special review) shows the distribution.

Figure 3. Quality of the Staff Complaint Inquiry Reports



Source: Data and analysis by the Office of the Inspector General.

Although this special review reported only on Salinas Valley, the process we reviewed prevails at prisons statewide. Therefore, the conditions we found may also exist to some degree at other institutions. To that end, we offered the department the following recommendations:

- Reassign the responsibility for conducting staff complaint inquiries to an entity outside the prison's command structure;
- Adopt a regionalized monitoring model for staffing purposes as is done with the Office of Internal Affairs;
- Provide comprehensive, ongoing training for all staff who perform inquiries. Consider requiring staff who perform inquiries to obtain certification from the California Commission on Peace Officer Standards and Training. Assign inquiries only to staff who have completed the required training;
- Require audio recording of all subjects and witnesses;

- Consider redefining an inquiry so that it is not considered less laborious or inferior to an investigation;
- Require reviewers to report all evidence they uncover and prohibit them from stating their personal opinions, drawing conclusions, or making recommendations in reports. In other words, they should just report the facts;
- Evaluate its notification procedures so that it promptly notifies appellants when reviewers need additional time to complete the staff complaint process beyond the regulatory time frame; and
- Ensure that staff receive the corrective or adverse actions that the hiring authority orders when policy violations occur. Complete routine audits in a timely manner, and report the results publicly.

In response to the special review, the department created a new section in the Office of Internal Affairs called the Allegation Inquiry Management Section (AIMS). The department assigned a chief deputy, six captains, and 36 lieutenants to the section. The section will conduct inquiries of some allegations of staff misconduct.

Over the past year, the California Legislature enacted legislation that established new mandates for the OIG. In July 2019, the California Legislature allocated an additional 3.5 million dollars to the OIG's annual budget, and in October 2019, the Legislature enacted legislation requiring the OIG to monitor inmate complaints regarding departmental staff. The new legislation also assigns the OIG authority to conduct audits of departmental programs and operations. To utilize the additional funding and accommodate the new legislative mandates, the OIG began to establish new units within its office.

The OIG is in the process of establishing a new unit dedicated to monitoring staff complaints submitted by inmates. Our staff complaints monitoring team will consist of four inspectors and a supervisor who will monitor select departmental staff complaint inquiries conducted by AIMS. The OIG is developing policies and procedures, and a process for accepting and monitoring staff complaint inquiries from the department. We will publish an annual report of our monitoring results, findings, and recommendations. We anticipate issuing our first report in 2021.

Corrective Action Plan Updates for the Department

The OIG published 12 formal reports that contained recommendations in 2019. The recommendations in these reports promote greater transparency, process improvements, increased accountability, and higher adherence to policies and constitutional standards.

Status of Recommendations Made to the Department in 2019

The following exhibit outlines the nine recommendations we made in June and November 2019 as published in our two monitoring reports relating to investigation and disciplinary processes. The department has fully implemented one recommendation and has not implemented eight recommendations.

Exhibit 1. Status of Recommendations on Monitoring Internal Investigations and the Employee Disciplinary Process, 2019

OIG *Investigation and Disciplinary Process Reports*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
Jan.–June 2019 (Issued Nov. 2019)	The OIG recommended that the Office of Internal Affairs eliminate the practice of special agents identifying allegations at the beginning of and during investigations, and instead allow the hiring authority to determine the appropriate allegations upon the conclusion of the investigation.	The department is in the process of identifying an expert to review the *Madrid* reforms and make recommendations regarding the stakeholder's role and processes.	Not implemented
	The OIG recommended the Office of Internal Affairs conduct interviews of employees suspected of misconduct in all cases.	The department does not intend to interview employees suspected of misconduct in all cases.	Not implemented
	The OIG recommended that the Office of Internal Affairs develop a mechanism in its case management system to differentiate between hiring authority employee misconduct referrals it rejects because there is no reasonable belief of employee misconduct and those it rejects for the hiring authority to conduct further inquiry, and to develop a procedure to track the cases the Office of Internal Affairs returns to hiring authorities for further inquiry.	The Office of Internal Affairs has implemented a plan to hold cases as inquiries during the Central Intake Process when more information is needed to make a decision. The Office of Internal Affairs will reject cases when there is no reasonable belief that misconduct occurred.	Not implemented
	The OIG recommended that the department develop a precise policy setting the specific time frame in which a hiring authority must conduct investigative and disciplinary findings conferences and make findings at the conference after receiving the referred case from the Office of Internal Affairs.	The Office of Legal Affairs is in the process of revising Article 22 and drafting a regulation that will set forth the time frame for hiring authorities to conduct investigative and disciplinary findings conferences.	Not implemented
	The OIG recommended that the department implement a policy requiring department attorneys and employee relations officers to provide all disciplinary actions to the hiring authority within a specific number of days after the investigative and disciplinary findings conference to ensure timely service of disciplinary actions and reduce unnecessary costs.	The Office of Legal Affairs is drafting a revision to Article 22 and regulations and will consider this recommendation during the revision process.	Not implemented

Continued on next page.

Exhibit 1. Status of Recommendations on Monitoring Internal Investigations and the Employee Disciplinary Process, 2019 (continued)

OIG *Investigation and Disciplinary Process Reports*	Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
July–Dec. 2018 (Issued June 2019)	The OIG recommended that the Office of Internal Affairs submit criminal cases to the prosecuting agency prior to the deadline to file misdemeanor charges unless the prosecuting agency indicates that it will not consider filing misdemeanor charges.	The Office of Internal Affairs will continue to submit both misdemeanor and felony investigations within the applicable statutes and as soon as operationally possible.	Not implemented
	The OIG recommended the Office of Internal Affairs consult with prosecuting agencies at the beginning of criminal investigations to determine whether the prosecuting agency objects to the department conducting a concurrent administrative investigation.	The Office of Internal Affairs will continue to submit both misdemeanor and felony investigations within the applicable statutes and as soon as operationally possible.	Not implemented
	The OIG recommended the department reassess its internal review process so that it can detect and prevent delays in processing disciplinary actions.	The Employment Advocacy and Prosecution Team (EAPT) will attempt to implement this recommendation in the revisions of Article 22 or the new CMS 4.0 system.	Not implemented
	The OIG recommended the department rescind the prior chief counsel's directive regarding service of disciplinary actions.	EAPT rescinded the prior chief counsel's directive and now requires that the department serve disciplinary actions within 30 days of the proposed decision made at the findings and penalty conference.	Implemented

The following exhibit outlines the four recommendations we made in June 2019 as published in the report on monitoring the use of force. The department has fully implemented one recommendation and has partially implemented three recommendations.

Exhibit 2. Status of Recommendations on Monitoring the Use of Force, 2019

Description of Recommendation	Departmental Unit	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
Ensure that the department validates the data collected in the new tracking system for accuracy and evaluates the data for monitoring use-of-force trends.	Division of Adult Institutions (DAI)	DAI will research ways to validate data collected in the new Incident Report Tracking (IRT) component of the Strategic Offender Management System (SOMS) when it comes online. DAI will evaluate the data collected in IRT for trends in use of force (UOF).	Partially Implemented: The department implemented its new Incident Report Tracking (IRT) on January 1, 2020; however, due to the recent implementation, the department has not demonstrated how the data collected will assist in tracking use-of-force trends. We will continue to monitor the department's implementation progress for this recommendation.
	Division of Adult Parole Operations (DAPO)	The SOMS IRT is a comprehensive tool that allows the department to track and report incidents and will provide aggregate statistical information statewide. Upon IRT implementation, the Fidelity Assurance and Outcomes Unit (FAOU) will be responsible for maintaining all DAPO UOF data and statistical reports related to UOF incidents for the purposes of monitoring trends, detecting patterns, and reporting data to the DAPO executive staff.	Partially implemented: The department stated that it replaced its previous Incident Report Tracking System (IRTS) with a new IRT to be implemented January 2020. However, the department has not demonstrated that the implementation was completed and currently in use. We will continue to monitor the department's implementation progress for this recommendation.
	DJJ Headquarters	The AGPA analyzes, tracks, and monitors the UOF trends and reports it in the Quarterly Report. The Captain reviews the Quarterly Report and provides a report.	Partially implemented: The department stated it is implementing a component in the IRT to track and validate data specific to compliance of policies and procedures. However, the IRT deployment is currently pending approval of related training materials. We will continue to monitor the department's implementation progress for this recommendation.
Ensure that managers hold staff accountable for deficiencies in the video-recorded interview process.	Division of Adult Institutions (DAI)	Managers and supervisors will use corrective action to hold their staff accountable for policy violations in the allegation video-recorded interview process.	Partially implemented: The department stated it will use corrective action to hold staff accountable for policy violations specific to the video-recorded interview process. However, the department has not demonstrated how hiring authorities can use this information in real time, when making decisions on compliance issues prior to or during committee meetings. We will continue to monitor the department's implementation progress for this recommendation.
	DJJ Headquarters	The UOF Captain will follow up with manager(s) to ensure that corrective actions taken against supervisors are being carried out and documented in their files and that the 844s are being sent to the Stockton Training Center for tracking. If the manager(s) are not doing the above, the following will take place: 1) Providing a copy of the policy for review 2) Training 3) Work Improvement Discussion (WID) 4) Adverse action	Fully implemented

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Exhibit 2. Status of Recommendations on Monitoring the Use of Force, 2019 (continued)

Description of Recommendation	Departmental Unit	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
Ensure that managers hold staff accountable for violations of policy related to controlled use-of-force incidents.	Division of Adult Institutions (DAI)	Managers and supervisors will use corrective action to hold staff accountable for policy violations related to controlled UOF incidents.	Partially implemented: The department stated it will use corrective action to hold staff accountable for policy violations specific to the video-recorded interview process. However, the department has not demonstrated how hiring authorities can use this information in real time when making decisions on compliance issues prior to or during committee meetings. We will continue to monitor the department's implementation progress for this recommendation.
	DJJ Headquarters	The UOF Captain will follow up with manager(s) to ensure that corrective actions taken against supervisors are being carried out and documented in their files and that the 844s are being sent to the Stockton Training Center for tracking. If the manager(s) are not doing the above, the following actions will take place: 1) Providing a copy of the policy for review 2) Training 3) Work Improvement Discussion (WID) 4) Adverse action	Fully implemented
Require all staff at contract facilities to attend use-of-force training to ensure compliance with the department's use-of-force policy.	Division of Adult Institutions (DAI)	All contract staff are required to attend training in the California Department of Corrections and Rehabilitation UOF policy. Staff are provided initial training during new employee orientation, as well as annual refresher training.	Fully implemented

We offered 27 recommendations in our medical inspection reports to both California Correctional Health Care Services and the department. Currently, while we do not formally follow up on responses or actions to these recommendations from either California Correctional Health Care Services or the department, we continue to observe and address the concerns expressed in prior recommendations from previous cycles.

Exhibit 3. Medical Inspection Recommendations, 2019

Institution	Description of Recommendations
California Health Care Facility, Stockton (CHCF)	The chief executive officer (CEO) and the chief support executive (CSE) should ensure that all CHCF providers have access to and show proficiency using the radiology information system (RIS) to retrieve and review off-site radiology reports. Alternatively, CHCF can scan off-site radiology reports directly into the patient's electronic health record, which would be a more efficient method of enabling providers to review off-site reports. During this inspection, we found that the majority of CHCF providers did not review off-site radiology reports because they were inaccessible. The CEO and the CSE should identify and fix the processes we identified during this inspection that resulted in delayed or incomplete X-rays and laboratory tests. The CSE and the chief nurse executive (CNE) should rectify the problems we found whereby standby emergency medical services (SEMS) nurses did not consistently collect and process laboratory specimens when they performed tests during weekends. All CHCF executives should analyze why the processing of diagnostic and specialty reports was delayed and attempt to correct the issue. We found delays in both the initial retrieval and the providers' review of those reports. The CNE should train and improve the clinical performance of nurses in multiple areas. The training should focus on making thorough assessments, recording complete documentation, and administering all medications correctly. We found errors in these areas throughout the institution. The CEO, the CNE, and the pharmacist in charge should analyze why problems occurred with pharmacy and nursing processes, and adjust these processes to correct problems we found with medication administration and continuity. The chief medical executive (CME) should improve hiring, training, and monitoring processes to ensure sufficient provider quality. We found serious problems with providers' assessments, misdiagnoses, patient record reviews, and chronic care performance. Most CHCF staff attributed these problems to severe provider understaffing during this review period. The CEO and the CNE should adjust scheduling processes to ensure that patients who require urgent or short-interval specialty follow-ups receive them. During this inspection, we found that delayed specialty follow-ups occurred more frequently with urgent or expedited follow-up orders.
Pleasant Valley State Prison (PVSP)	The chief executive officer (CEO) should correct the review process of the Emergency Medical Response Review Committee (EMRRC): the EMRRC failed to identify problems with the institution's emergency response and care provided by providers and nurses in the triage and treatment area (TTA). PVSP needs a properly functioning EMRRC to identify and correct the institution's various lapses in emergency care. The CEO should address the numerous problems related to medications at PVSP by first improving the pharmacy's staffing levels. The pharmacist in charge and the chief nursing executive (CNE) should then implement quality improvement measures to address the numerous problems we found with medication management during this inspection. The CNE and the pharmacist in charge should correct and then monitor the medication transfer process to ensure medication continuity for patients transferring into and out of PVSP or returning from an outside hospital. During our inspection, we found serious problems with medication continuity in all transfer processes. The CNE should provide training to, and monitor, nurses in the receiving and release (R&R) and the TTA, as these nurses are the primary staff responsible for coordinating and ensuring the continuity of care for patients in these areas. During our inspection, nurses in the R&R and the TTA did not fulfill their responsibilities sufficiently. The CEO should revamp the specialty services processes to ensure that PVSP staff coordinate their efforts to deliver appropriate specialty care. During our inspection, we found a lack of coordination, resulting in poor tracking of specialty appointments and sporadic performance retrieving specialty reports at PVSP. The CEO and the CNE should also develop and implement a process to ensure the institution's staff refer those patients who refuse specialty services back to the primary provider for further evaluation. The chief medical executive (CME) should refine the current methods used to evaluate provider performance, as we found problems with providers' performance in the emergency setting and with their superficial reviews of medical records.

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Exhibit 3. Medical Inspection Recommendations, 2019 (continued)

Institution	Description of Recommendations
San Quentin State Prison (SQ)	The chief nursing executive (CNE) should implement a comprehensive quality improvement program to improve the institution's delivery of reception center services, as we found problems with nursing performance and provider appointments during this inspection. The CNE and the pharmacist in charge should implement quality improvement measures to ensure proper medication continuity for patients returning from off-site hospitals, arriving from county jails, and receiving chronic care medications. We found room for improvement in these areas during this inspection.
California Institution for Men (CIM)	The chief medical executive (CME) should audit the records of patients returning from the hospital, an emergency department, or a specialty consultation to ensure that providers address all their patients' diagnoses, medications, and recommendations. The CME should also consider designating the chief physician and surgeon (CP&S) or another provider to review each of these records to ensure that the institution implements any urgent recommendations. We found serious lapses in care due to poor provider performance in this area. The CME should revamp the methods the institution uses to appraise provider performance. Although we found serious provider quality problems during this inspection, the CME was unaware of any provider performance issues. The chief nursing executive (CNE) should also inspect the records of patients returning from a hospital or emergency department to ensure that the nurses thoroughly review the discharge summaries, perform complete assessments, and implement essential recommendations. The CNE and the pharmacist in charge should launch a quality improvement program to increase medication continuity for patients who return from an outside emergency room or hospital. We found serious problems with medication continuity for these patients during our inspection. The CME should instruct providers to specify the appropriate clinical time frames for specialty services within electronic health record system orders. The CNE should instruct the specialty department to schedule services according to those time frames. These changes should help ensure that the institution schedules specialty appointments within clinically appropriate time frames. California Correctional Health Care Services (CCHCS) should modify the specialty access policy by eliminating both "routine" and "urgent" priority time frames. Instead, CCHCS should monitor specialty access by measuring the ability of each institution to provide specialty services within the time frame specified in each electronic health record system order.
Deuel Vocational Institution (DVI)	The chief executive officer (CEO) should ensure that all providers and nurses have access to any images and reports stored in the radiology information system–picture archive and communication system (RIS–PACS). During our inspection, we found that most of DVI's staff members were unable to access this important information. The pharmacist in charge and the chief nursing executive (CNE) should implement quality improvement processes to correct the numerous medication continuity problems we found during this inspection, including issues with chronic care, hospital, reception center, and other transfer medications. The CNE should evaluate and improve DVI's current nursing sick call process due to the prevalence and severity of errors we found during this inspection. The CNE should consider assigning clinic nurses, rather than triage and treatment area (TTA) nurses, responsibility for reviewing their own sick call requests and making their own triage decisions. The CNE should also consider having staff review sick call requests at a time other than the middle of the night, when patients are reluctant to awaken for a medical evaluation. We have found the best sick call practices occur when sick call nurses review requests before the clinic day begins. In this way, sick call nurses can prioritize their own appointments accordingly and have an opportunity to discuss the requests during huddles. Furthermore, patients are more likely to come to an evaluation during normal daytime hours. The CNE should also expand improvement efforts to advance the quality of nursing assessments and interventions in several areas, including sick call requests, transfers-in, transfers-out, and hospital returns. These efforts should include additional nurse training and monitoring. The CNE should implement additional training and monitoring for first medical responders and TTA nurses to ensure they accurately record the time and sequence of their assessments and interventions in accordance with the actual event.

The following exhibit outlines the four recommendations we made in June 2019 as published in our tenth report on *The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight, and Improve the Prison System*. The department has fully implemented three recommendations and is in the process of implementing one other.

Exhibit 4. Status of *Blueprint* Recommendations, 2019

Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
The Office of the Inspector General recommended that the department take the following actions to meet its staffing level goals for rehabilitative programming:		
Promptly advertise and recruit for all statewide vacant academic and career technical education teacher positions and utilize the "Substitute Academic Teacher (Correctional Facility)" job classification. We found that the department has 101 courses that are not operational, primarily due to teacher vacancies.	On a monthly basis, the department's Division of Rehabilitative Programs (DRP) personnel team is to compare reported vacancies with job ads posted on California Human Resources' (CalHR) VPOS website and reach out to institution Personnel Officers (IPO) for status of any vacancies not currently posted. DRP will continue to generate interest in educational opportunities through local hiring forums and focused recruitment. Also, DRP is exploring the use of the Substitute Academic Teacher (SAT) classification. DRP has previously attempted to use this classification, but this practice was suspended pending outcome of arbitration with Service Employees International Union (SEIU) and fiscal availability.	Fully implemented
Prioritize its recruitment and filling of both the longest-running (over one year, over six months, etc.) and the highest number of teacher vacancies. Determine whether these types of vacant positions at each prison are critical to the department, and if so, determine if the positions should be transferred to another prison with a greater need or ability to fill the position.	DRP tracks academic and career technical vacancies monthly (including the length of the vacancy), and DRP Headquarters Personnel engage in a semimonthly call identifying those institutions with vacancy issues and troubleshooting and engaging in the hiring process to assist. DRP is preparing a comprehensive report of current program space. Once available space, offender needs, and teacher availability have been assessed, DRP will consider moving vacant teacher positions to locations with higher needs while assessing the criminogenic needs of the population.	Fully implemented
Establish an experienced worker program to identify a pool of experienced former teachers who would be willing to come back to work as retired annuitants. These teachers could be utilized to fill vacancies at their most recent prisons of employment or at other prisons with vacancies.	DRP is working with the Office of Personnel Services (OPS) to facilitate the hiring of retired annuitants using the CalHR "boomerang" site, on which retired state employees can register and departments can search for qualified applicants. OPS will request a statewide exemption from CalHR to allow teachers at the department's institutions to return as retired annuitants in less than the required 180-day postretirement period. During the Statewide Principal's Call, DRP will instruct principals to discuss the retired annuitant classifications with teachers who are retiring and provide them with information on how to return as a retired annuitant.	Partially implemented
Require monthly updates from each supervisor of correctional education programs (principal) for courses that are not operational for which a teacher is assigned, but who is unable to provide instruction. Consider other alternative duties, such as providing support to other teachers by providing educational services to assigned/enrolled students.	Institutional principals are required to update a position control spreadsheet on a weekly basis. This spreadsheet identifies all vacancies, as well as all teachers who have been hired, but are unable to deliver programming. The Office of Correctional Education has outlined expectations or alternate duties for those teachers who are unable to deliver assigned programs.	Fully implemented

We made one additional recommendation in the September 2019 C-ROB report, as seen in the following exhibit. C-ROB is an independent board and, unlike the OIG, does not have the authority to request specific responses to recommendations; nonetheless, the department is reviewing the recommendation.

Exhibit 5. Status of C-ROB Recommendations, 2019

Description of Recommendation	The Department's Proposed Action Plan	Implementation Status as Determined by the OIG
The Board recommends the department create baseline metrics, where possible, for its In-Prison Integrated Substance Use Disorder Treatment (ISUDT) program. This collaboration between CDCR and California Correctional Health Care Services (CCHCS) implements a new program to address the needs of inmates with substance use disorders. The department is developing a short-term goal to identify inmates at highest risk for SUD-related harms and to provide treatment that reduces the number of fatalities. The long-term goals include building a program that can recognize and treat the chronic illness of SUD at all levels of clinical need and optimizing rehabilitative potential for all inmates. Further, full implementation of the ISUDT is expected to result in the following: • Reduction in both SUD-related morbidity and mortality; • Creation of a rehabilitative environment which improves safety for inmates and CDCR staff; • Successful reintegration of individuals into their community at time of release; and • Improved public safety by promoting healthy families and communities. The Board emphasizes the importance of measuring program implementation and outcomes and, to the extent possible, the long-term outcomes after offenders have been released to the community. Outcome measures, such as successful integration of individuals into their community upon release (housing, employment, income, and substance use), should be collected for parolees after they parole. The Board requests the department provide future updates on its progress with implementation of the SUDT program.	The ISUDT Program, like all health care operations, has been impacted by the current international health care emergency, and the anticipated schedule for ISUDT Program implementation will be altered as health care staff address the most immediate threat to patient safety posed by the COVID-19 pandemic. Because performance measures are implemented in the same phased approach as program operations (the department cannot measure processes until they are put into place), the same delays to program implementation due to COVID-19 will also impact the availability of performance data. The department has compiled a preliminary catalog of 73 proposed measures to support monitoring and improvement for the new joint California Correctional Health Care Services and department ISUDT program. These measures cover the following program areas: Program Access; Treatment & Monitoring; Release to Community; and Population Outcomes and Other Trends. The department proposes semiannual updates to the Board, with the first to take effect in June 2020.	Partially implemented

Appendix: Reports Released in 2019

Annual and Semiannual Reports

- *2018 Annual Report: Summary of Reports and Status of Recommendations* (May 1, 2019)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, July–December 2018* (June 6, 2019)
- *Monitoring the Use of Force: The California Department of Corrections and Rehabilitation Continues to Perform Well in Self-Assessing Its Use-of-Force Incidents, but Has Shown Little Improvement in Its Overall Compliance with Policies and Procedures* (June 24, 2019)
- *Monitoring the Internal Investigations and Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, January–June 2019* (November 25, 2019)

Medical Inspection Reports: Cycle 5 Results

- California Institution for Men (January 1, 2019)
- Deuel Vocational Institution (January 1, 2019)
- San Quentin State Prison (February 14, 2019)
- Pleasant Valley State Prison (April 12, 2019)
- California Health Care Facility (April 14, 2019)

Special Reviews

- *Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct* (January 6, 2019)

Blueprint Monitoring Report

- *Tenth Report on the OIG's Monitoring of the Delivery of the Reforms Identified by the California Department of Corrections and Rehabilitation in Its Report Titled* The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight, and Improve the Prison System and Its Update (June 28, 2019)

California Rehabilitation Oversight Board (C-ROB) Report

- *C-ROB September 15, 2019, Annual Report* (September 14, 2019)

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2019
Annual Report

Summary of Reports and Status of Recommendations

OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
May 2020

OIG