Roy W. Wesley, Inspector General

Bryan B. Beyer, Chief Deputy Inspector General

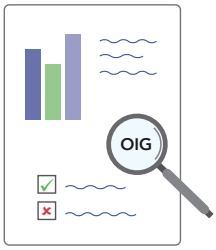
OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

April 2021

2020 Annual Report

A Summary of Reports



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STATE *of* CALIFORNIA
OIG | OFFICE *of the* INSPECTOR GENERAL

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

Independent Prison Oversight

Regional Offices

Sacramento
Bakersfield
Rancho Cucamonga

April 2, 2021

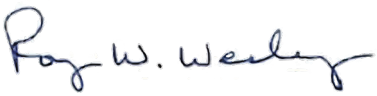
The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California

Dear Governor and Legislative Leaders:

This annual report summarizes the work the Office of the Inspector General completed during 2020. In 2020, we issued 22 public reports that detailed our oversight of the California Department of Corrections and Rehabilitation, which comprised the following publications: six reports on medical inspection results; two semiannual reports and four sentinel cases concerning monitoring the department's internal investigations and its employee disciplinary process; two reports from a three-part review series concerning the pandemic spread of the novel coronavirus disease (COVID-19) throughout the State's prison system; one report concerning monitoring the department's use of force; one report on complaint intake and field inquiry; one report concerning the status of the *Blueprint*; one report on the California Rehabilitation Oversight Board; three special reviews or reports; and the OIG's annual report for 2019.

This report also introduces our dashboard that displays the recommendations we made to the California Department of Corrections and Rehabilitation in 2020, as well as the status of their implementation.

Respectfully submitted,



Roy W. Wesley
Inspector General

***Gavin Newsom**, Governor*

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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 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.

The OIG serves as an oversight agency known to provide 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 providing oversight and transparency concerning 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 (the 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.

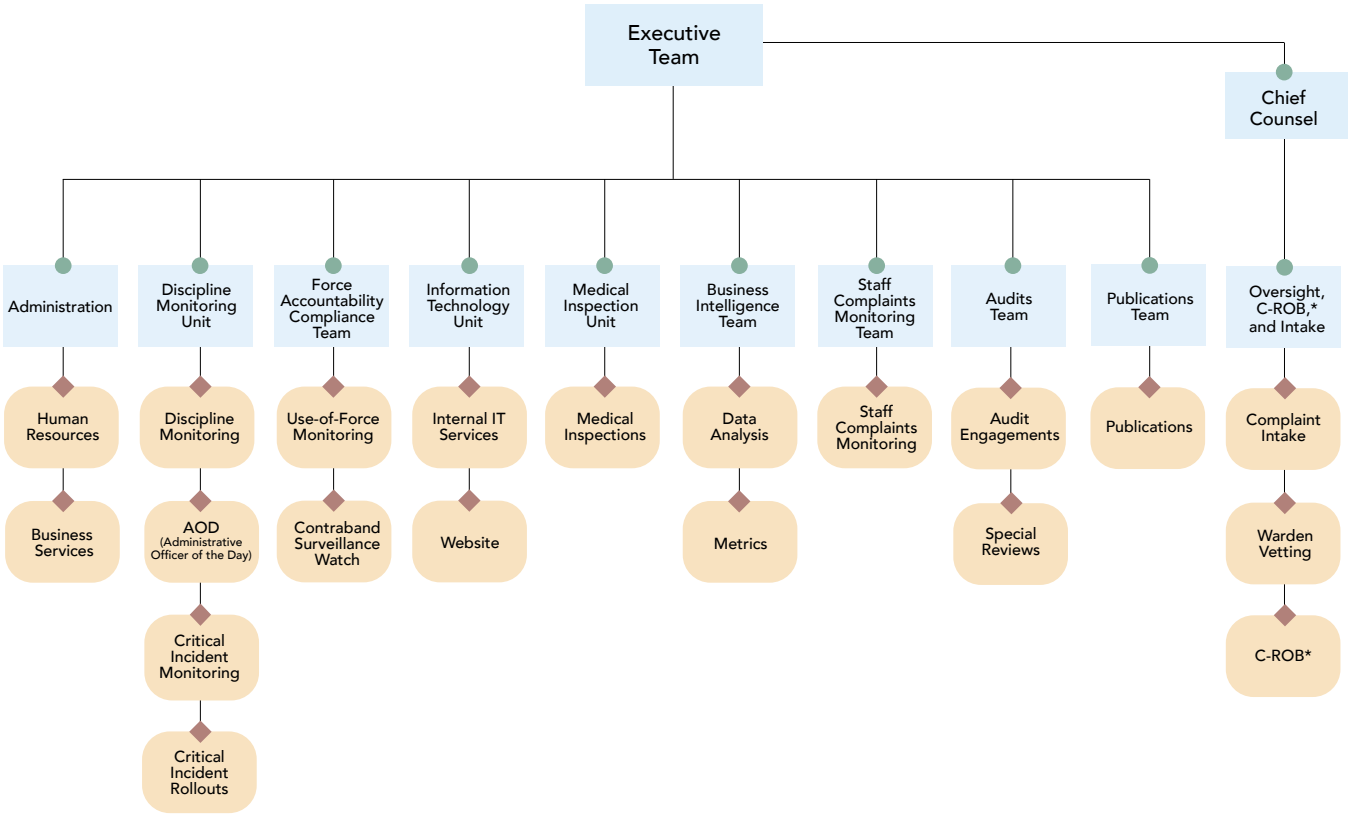
The OIG also employs a cadre of medical professionals, including physicians and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities,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

Staff in our office perform a variety of oversight functions relative to the department, including those listed below:

- Conduct medical inspections
- Carry out audits and authorized special reviews
- Staff the complaint hotline and intake unit
- Review, and when appropriate, investigate whistleblower retaliation complaints

- Handle complaints filed directly with the OIG by incarcerated persons, employees, and other stakeholders regarding the department
- Conduct special reviews authorized by the Legislature or the Governor's Office
- As ombudsperson, monitor Sexual Abuse in Detention Elimination Act (SADEA)/Prison Rape Elimination Act (PREA) cases
- Coordinate and chair the California Rehabilitation Oversight Board (C-ROB)
- Conduct warden and superintendent vettings
- Monitor the following:
    - Internal investigations and litigation of employee disciplinary actions
    - Critical incidents, including deaths of incarcerated persons, large-scale riots, hunger strikes, and so forth
    - Staff complaint grievances filed by incarcerated persons
    - Adherence to the *Blueprint* plan for the future of the department
    - Uses of force
    - Contraband surveillance watches

Figure 1. The Office of the Inspector General Organizational Chart, 2021



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

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Reports Published in 2020

In 2020, we issued 22 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: six reports on medical inspection results; two reports and four sentinel cases concerning monitoring the department's internal investigations and employee disciplinary process; one report on complaint intake and field inquiries; one report on monitoring the department's use of force; one special review comprising the first two parts of our three-part series concerning the pandemic spread of the novel coronavirus disease (COVID-19) throughout the State's prison system; three special reviews or reports; one report on the status of the *Blueprint*; one report on the California Rehabilitation Oversight Board; and our 2019 annual report. Visit our website, **www.oig.ca.gov**, to view our public reports.

Internal Investigations and Employee Discipline Monitoring

A cadre of 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 as 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 performance of the hiring authorities who make decisions concerning employee disciplinary actions, and the performance of department attorneys throughout the disciplinary, litigation, and appeals processes.

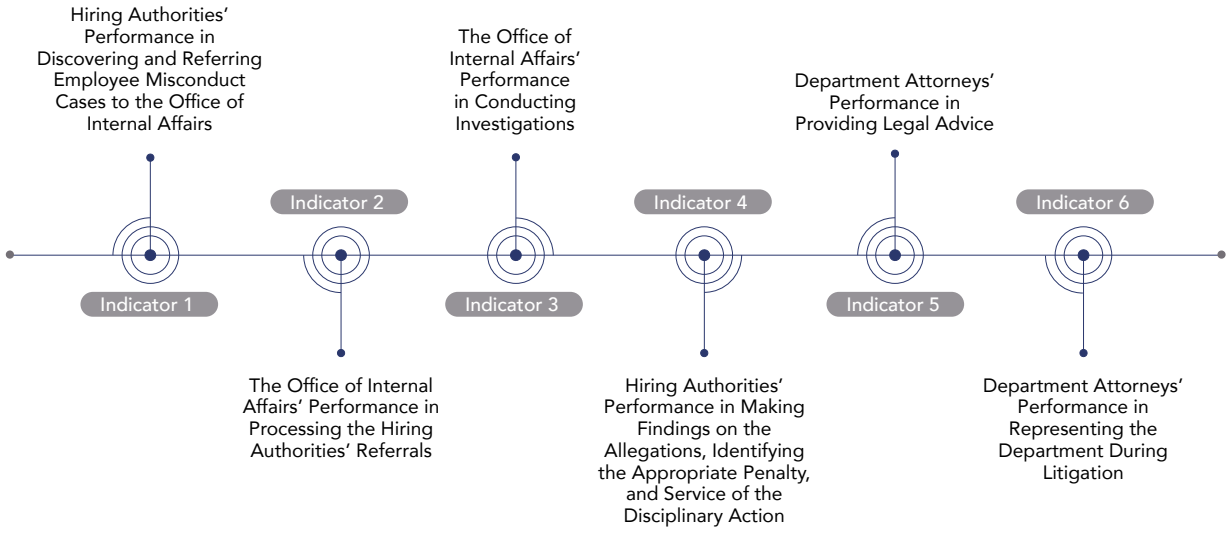
As part of our monitoring process, we monitored the Office of Internal Affairs' weekly central intake meetings pursuant to which the Office of Internal Affairs made decisions concerning employee misconduct referrals it received from the hiring authorities. In 2020, the Office of Internal Affairs addressed and made decisions concerning 2,061 referrals for investigation or for authorization to take direct disciplinary action. Of these, the Office of Internal Affairs approved 2,002 referrals, and the OIG identified 283 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 292 cases in 2020. Of those cases, 252 involved administrative allegations, and 40 cases involved alleged criminal activity by departmental staff members. Furthermore, of the 292 cases we monitored and closed, 12 administrative investigations and seven criminal investigations involved the use of deadly force.

Applying the methodology we used last year, 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 of 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

Figure 2. The Six Indicators We Used to Assess the Department's Internal Investigations and Employee Disciplinary Process in Determining Our Overall Ratings of Departmental Performance



Source: The Office of the Inspector General.

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 2020, 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. We recommended the department develop and implement a policy for the Office of Internal Affairs to concurrently open an administrative case in those instances in which a corresponding criminal investigation is also pending and that it not wait until the conclusion of the criminal investigation to actively conduct the administrative investigation. The OIG also recommended the policy specify that although the Office of Internal Affairs will consult with a prosecuting agency (such as a district attorney's office) concerning whether to conduct investigative work on an administrative case in those instances in which there is also a corresponding criminal investigation, the Office of Internal Affairs not relegate its decision to the prosecuting agency.

Furthermore, the OIG recommended the department formulate a policy concerning how it will manage employees who are subject to domestic violence restraining orders, including whether and in which instances such employees will be nonpunitively dismissed,

redirected to another post, or placed on administrative time off from work, and the time frames in which hiring authorities should make such decisions.

Finally, the OIG recommended the department modify its executive review policy to restrict a department attorney's ability to elevate or invoke executive review of a hiring authority's decision in employee discipline cases to cases in which one of the following criteria is met:

- A hiring authority clearly ignored critical evidence and was not able to logically explain the finding he or she made; or
- No reasonable person could have made the investigative or disciplinary finding the hiring authority made; or
- The department attorney has a reasonable belief that the hiring authority is acting contrary to departmental policy or the law.

We further recommended the department attorney be required to declare which of the above factor(s) forms the basis for the executive review; to inform the hiring authority, the OIG, and the hiring authority's supervisor of that basis; and to provide a written analysis supporting the invocation of executive review. To address the situation in which some department attorneys hold a position vehemently opposed to a hiring authority's decision to move forward with discipline—and have posited during executive reviews that they do not believe in a case; that there is no chance or minimal chance the department will prevail before the State Personnel Board; and that, after the case is lost, the department will be responsible for back pay—we recommended the department immediately reassign the case to another department attorney, one who will advocate for the hiring authority's position to the State Personnel Board.

In addition to publishing semiannual discipline monitoring reports, the OIG may issue a separate public report regarding some cases, called *Sentinel Cases*. The OIG issues Sentinel Cases when it has determined the department's handling of a case was particularly *poor*. In 2020, the OIG issued four Sentinel Cases, including one case that involved departmental executives refusing to take disciplinary action against an officer who punched his girlfriend and then slammed a truck door on her hand, completely severing a portion of her thumb at the first joint.

Use-of-Force Monitoring

Another means by which we fulfilled our oversight mandate was by monitoring the department's process for reviewing use-of-force incidents at institutional executive review committee meetings and division force review committee meetings. We used a monitoring methodology to assess whether departmental staff complied with the department's use-of-force policies and procedures prior to, during, and following each incident we monitored. Our methodology consisted of 11 units of measure we call *performance indicators*. We developed a series of compliance-related questions for each indicator, and based on the collective answers, we assigned a rating of ***superior***, ***satisfactory***, or ***poor*** to each indicator as well as to the overall incident. This tool aggregates information that allows for an in-depth analysis of incidents and the identification of problematic trends. We met regularly with departmental executives to share information related to trends we observed.

In July 2020, we published *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation*. This report covered use-of-force incidents we monitored that occurred during the period from January 1, 2019, through December 31, 2019.

Use-of-Force Statistics, January 1, 2019, Through December 31, 2019

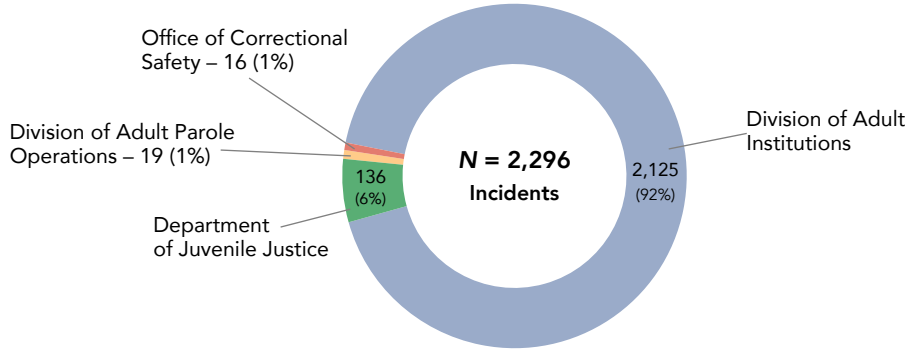
The list below offers details concerning the department's uses of force; Figure 3 on the next page shows the distribution of the incidents.

- The OIG monitored 2,296 of the 9,692 use-of-force incidents that occurred (24 percent).
- The OIG attended 973 of the 1,861 review committee meetings (52 percent).
- More than 92 percent of the use-of-force incidents we monitored (2,125 of 2,296) occurred at the adult prisons and contract facilities housing adult incarcerated persons, with the remainder involving use-of-force incidents at juvenile facilities (136), or involving parole staff (19) or Office of Correctional Safety staff (16).
- Approximately 35 percent of the incidents we reviewed occurred at only five prisons: Salinas Valley State Prison (215);

California State Prison, Sacramento (206); Kern Valley State Prison (190); High Desert State Prison (104); and California State Prison, Corcoran (89).

- The 2,296 incidents we monitored involved 7,717 applications of force. An incident may have involved more than one application of force. For example, two baton strikes count as two applications of force during a single incident. Chemical agents accounted for 3,511 of the total applications (45 percent), while physical strength and holds accounted for 2,713 (35 percent). The remaining 20 percent of force applications consisted of force options available to departmental staff such as less-lethal projectiles, baton strikes, tasers, and firearms.

Figure 3. Distribution of the 2,296 Use-of-Force Incidents the Office of the Inspector General Monitored by Division and Other Entities



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

Highlights of Our Use-of-Force Monitoring

We monitored 2,296 of the 9,692 use-of-force incidents that occurred in 2019, and concluded that the department's performance was overall *satisfactory.* We assessed the department's performance as *superior* in 24 incidents, *satisfactory* in 2,063 incidents, and *poor* in 209 incidents. In the 24 incidents in which we assessed the department's performance as *superior*, the staff performed exceptionally well in multiple areas, such as in attempting to de-escalate the situation prior to using force, decontaminating involved incarcerated persons and the exposed area following the use of chemical agents, and describing in the required reports the force used and observed. In the 209 incidents in which we assessed the department's overall performance as *poor*, we identified multiple failures, such as not following

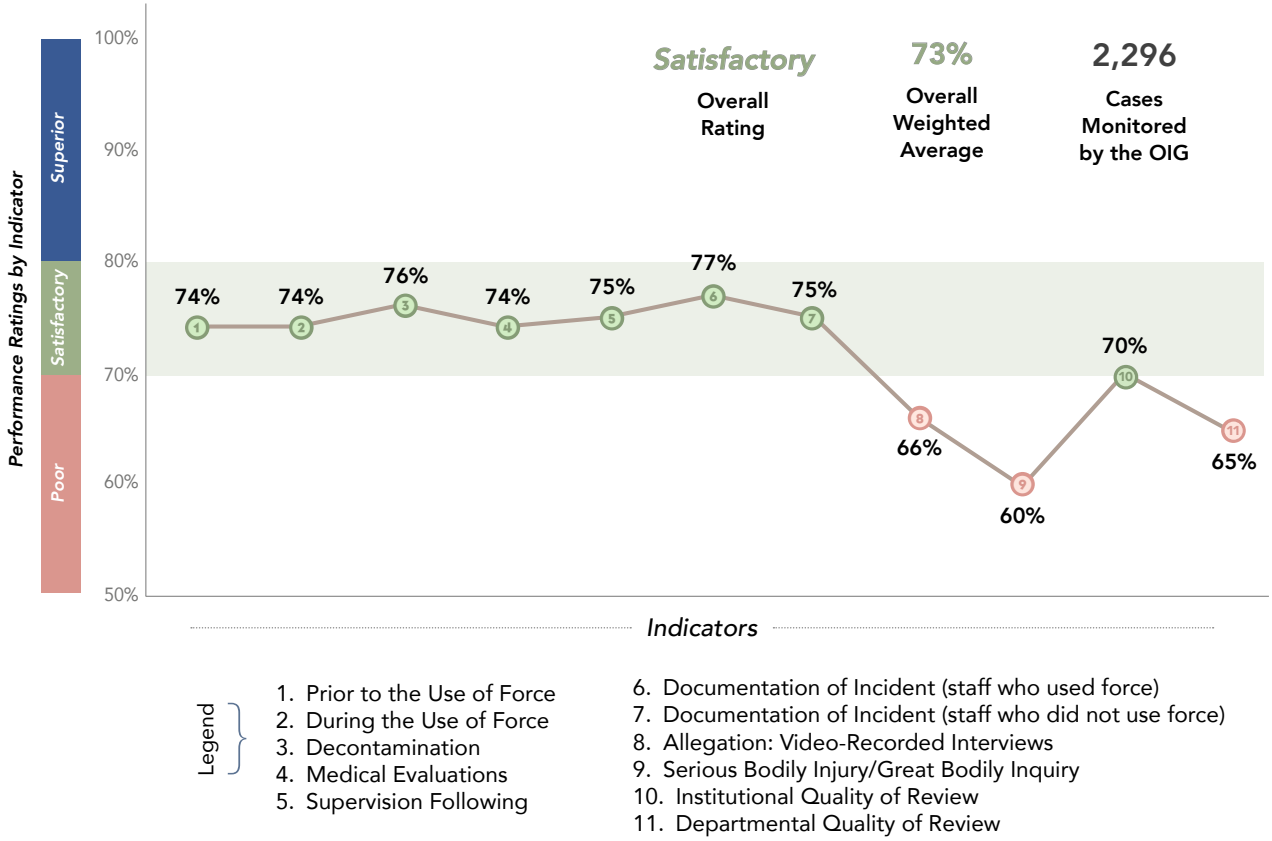
decontamination protocols after using chemical agents, medical staff not evaluating incarcerated persons as soon as practical following an incident, and the levels of review failing to identify and address policy deviations. The incidents in which we assessed the department's performance as *poor* also included incidents in which we identified a single violation that was particularly egregious, such as officers using unnecessary force or staff failing to recognize and address an incarcerated person's allegation of unreasonable force.

The department performed satisfactorily prior to the use of force. However, we identified two areas of concern regarding the officer's actions prior to force being used. Departmental policy requires officers to use verbal persuasion to mitigate the need for force whenever possible. We identified 23 instances in which officers had the opportunity, but did not attempt to de-escalate a potentially dangerous situation prior to using force; we rated those incidents as *poor*. In addition, we identified 74 instances in which an officer's actions (or failure to act) unnecessarily contributed to the need to use force; we also rated those instances as *poor*.

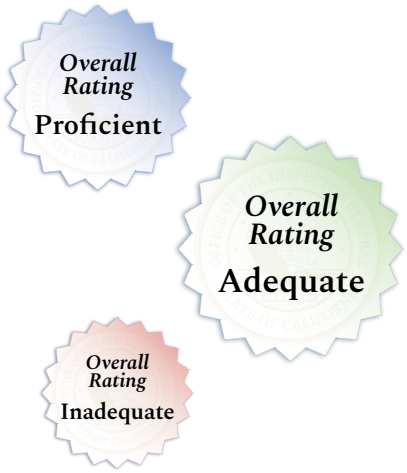
We found that, overall, the department performed satisfactorily during the actual force. We identified one key area of concern regarding the force used. In some instances, officers failed to describe an imminent threat to justify the force used, leading us to conclude that the force was unnecessary. The department's policy for the use of immediate force requires officers to provide justification for using force by articulating their reasoning in reports. Despite this requirement, we concluded that officers did not adequately articulate an imminent threat in 51 of the 2,296 incidents, and we rated those 51 incidents as *poor*. Figure 4 on the next page is reproduced from the report, and it outlines the ratings and indicators in detail.

We assessed the department's performance in several areas following the use of force. While the department performed satisfactorily in most areas, one area of concern we identified was the quality of the reviews conducted by supervisors and managers at the prisons. Following a use-of-force incident, the review process involved a minimum of five levels of review, during which each reviewer was required to review and evaluate staffs' actions and identify policy deviations. Of the 2,296 incidents we monitored, we identified 799 incidents in which one or more reviewer did not identify a deficiency, leading us to question whether the supervisors and managers required additional training or whether they merely neglected their duty to make a good faith effort to review each incident thoroughly.

Figure 4. The Office of the Inspector General's Overall Rating of the Department's Handling of Its Use-of-Force Incidents



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



New styling for the rating seals used in MIU reports as introduced for Cycle 6

Cycle 6 Medical Inspection Reports

In 2020, the OIG continued its sixth cycle of medical inspections and published a report for each of the following prisons: California State Prison, Los Angeles County; Wasco State Prison; Valley State Prison; California State Prison, Solano; California Correctional Center; and California Rehabilitation Center. The ratings for these six prisons were *adequate*, as set forth in Table 1 on the following page. The table lists the prisons for which we completed our Cycle 6 inspections and issued final reports, the month each report was published, and the rating we assigned to each prison. Through those reports, the OIG made several recommendations to the department to further improve the delivery of medical care to its patients.

In 2020, the OIG also completed inspections of the following seven prisons: Corcoran State Prison, California Medical Facility, North Kern State Prison, Salinas Valley State Prison, Richard J. Donovan Correctional Facility, California Substance Abuse Treatment Facility, and Folsom State Prison. We anticipate publishing inspection reports for the above prisons in 2021.

Table 1. The Office of the Inspector General Cycle 6 Medical Inspections: Final Reports Published in 2020

Institution Inspected	Publication Month	Overall Rating
California State Prison, Los Angeles County	July	*Adequate*
Wasco State Prison	August	*Adequate*
Valley State Prison	August	*Adequate*
California State Prison, Solano	September	*Adequate*
California Correctional Center	September	*Adequate*
California Rehabilitation Center	December	*Adequate*

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

Whistleblower Retaliation Claims

In addition to receiving complaints as described in the preceding paragraphs, our statutory authority directs us to receive and review complaints of whistleblower retaliation that departmental employees levy against members of departmental management. The OIG analyzed each complaint to determine whether it presented the legally required elements of a claim of whistleblower retaliation—that the complainant *blew the whistle* (reported improper governmental activity or refused to obey an illegal order)—and that the complainant was thereafter subjected to an adverse employment action because he or she blew the whistle. If the complaint met this initial legal threshold, our staff investigated the allegations to determine whether whistleblower retaliation occurred. If the OIG determined the department's management subjected a departmental employee to unlawful retaliation, our office reported its findings to the department along with a recommendation for appropriate action.

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

In 2020, the OIG received 25 whistleblower retaliation complaints. The OIG completed analyses of 21 of these complaints and determined that 20 did not state the legally required elements of a claim of whistleblower retaliation. Regarding the one complaint that stated a *prima facie* case of whistleblower retaliation, we determined that the department had already opened an investigation into the complaint; we are monitoring the department's investigation. The OIG received additional information throughout 2019 regarding a previously closed 2018 complaint that is still being reviewed. We completed our analysis of one complaint pending from 2019, determining that it did not state the legally required elements of a claim of whistleblower retaliation. Two complaints received in 2019 and four received in 2020 are still pending.

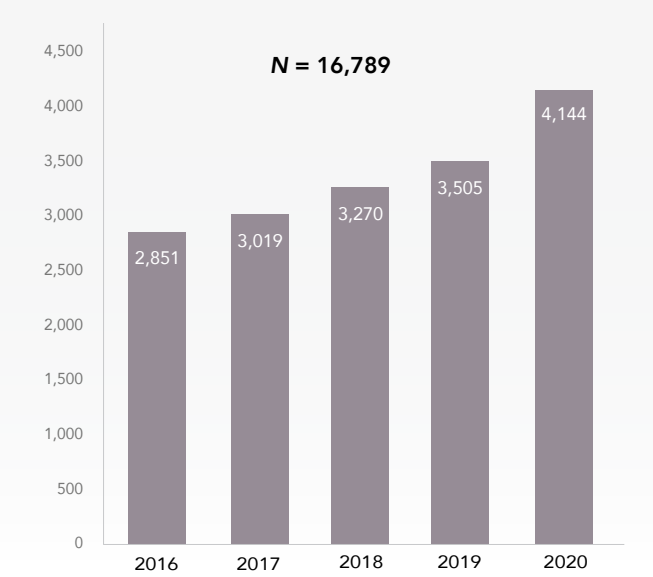
Complaint Intake

The OIG maintains a statewide complaint intake process that provides a point of contact for communicating allegations of improper activity within the department. We receive complaints from incarcerated persons and parolees, their families, departmental employees, and advocacy groups, among others. 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 and promptly address potential safety concerns involving departmental employees or incarcerated persons, mental health or medical concerns, or reports of sexual abuse.

In this section, we discuss the type of work we performed regarding these complaints. Starting on page 26, we present a summary of a report we issued in response to 6,009 complaints we received during the two-year period between July 1, 2017, and June 30, 2019.

In 2020, the OIG received 4,144 complaints, an increase of approximately 30 percent from 2019. For each complaint, OIG intake staff created a case, or a numbered record of the complaint, and noted our response. We reviewed and assessed the complaints by accessing information from various departmental databases, reviewing the department's policies and procedures, or by requesting relevant documentation from a specific prison or facility. In most cases, we provided a written response to the complainant after conducting our review. Our staff conducted nine field reviews and assessments in 2020. These reviews differ from preliminary reviews and assessments in that we visited the prison or facility to observe and make recommendations to departmental administrators.

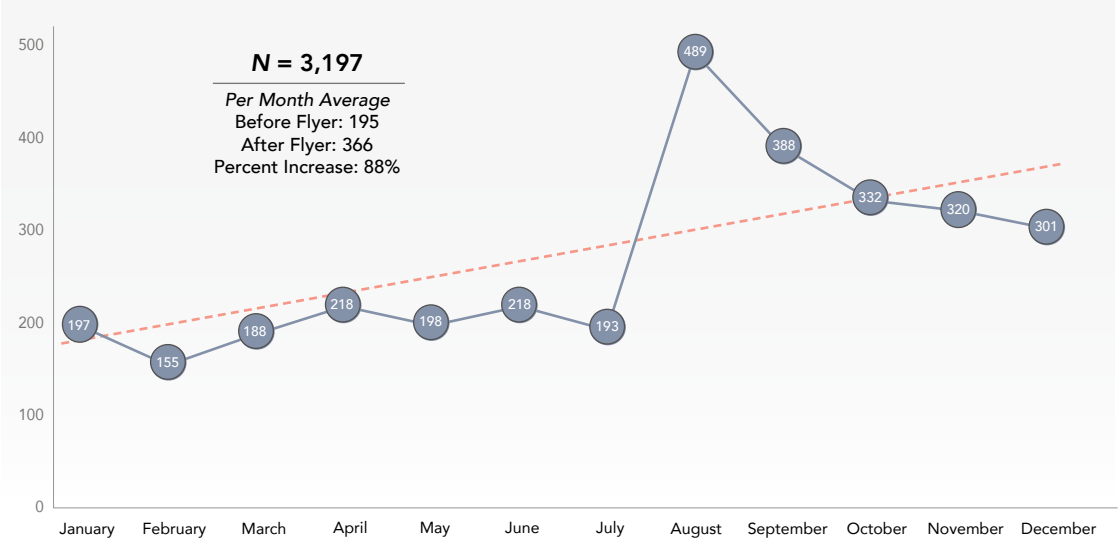
Figure 5. Total Complaints the Office of the Inspector General Received Over the Past Five Years, From 2016 Through 2020



Source: The Office of the Inspector General.

As the novel coronavirus disease (COVID-19) began to spread across California, the number of mail complaints began to increase as well, starting in March 2020. In August 2020, the OIG delivered a pamphlet to all incarcerated persons outlining the process for filing a complaint with our office. Before we distributed this pamphlet, the OIG received an average of 195 mail complaints per month. After we distributed it throughout the prison system, the number of complaints we received increased to an average of 366 mail complaints per month, an increase of 88 percent for the remainder of the year.

Figure 6. Total Number of Mail Complaints the Office of the Inspector General Received Each Month During 2020

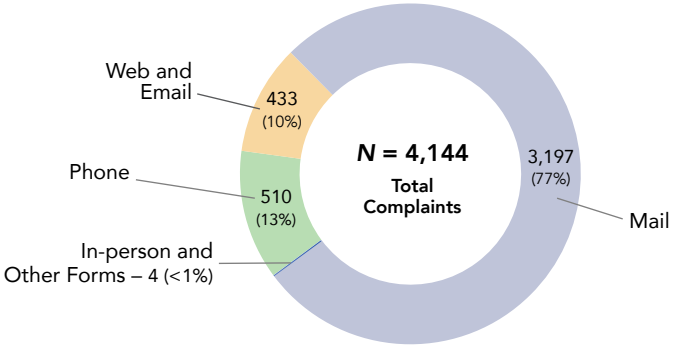


Source: The Office of the Inspector General.

Data

Approximately 83 percent of all complaints—a total of 3,459—came from adult incarcerated persons across the state. Citizen complainants made up approximately 14 percent of cases or 587 complaints. We received the remaining complaints from departmental employees, anonymous complainants, parolees, Department of Juvenile Justice wards, or other individuals. Mail comprised more than 77 percent of the complaints we received, in the form of 3,197 letters. The OIG received the remaining complaints through telephone calls (510), web complaints (433), and in-person discussions. This number does not include voicemails that arrived in which the caller either hung up before speaking or made unintelligible noises.

Figure 7. Distribution of the Methods People Used to Submit Complaints to the Office of the Inspector General



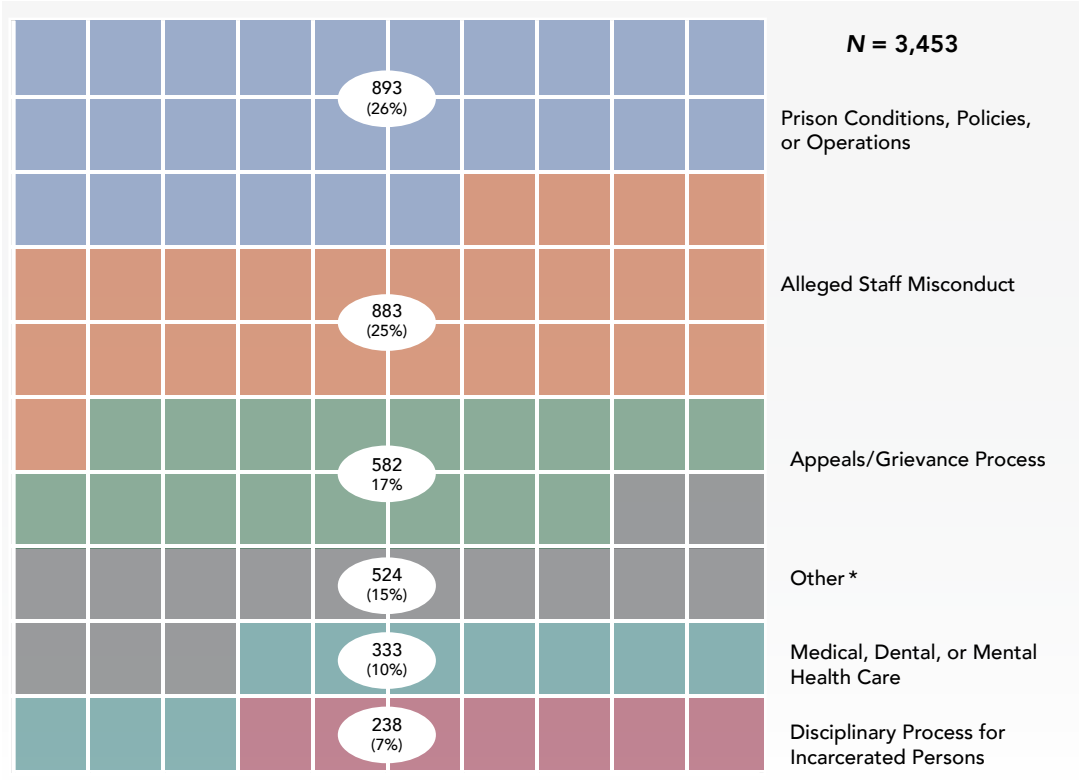
Source: The Office of the Inspector General Tracking and Reporting System.

Of the 4,144 complaints received, we did not have the authority to review 230 of them because the allegations pertained to county jails, federal prisons, local law enforcement, criminal courts, or other concerns beyond our jurisdiction. In 473 cases, the complainant repeated a complaint previously filed with our office. (A small subset of these complaints fell into both categories; 3,453 is our best approximation of the total number we reviewed.)

Accordingly, approximately 17 percent of the complaints the OIG received were either repeated complaints or ones over which we had no jurisdiction to review. Of the remaining 3,453 complaints, we conducted a preliminary review and assessment to assist the complainant or reviewed the alleged improper activity.

The remaining complaints fell into several categories; the five most common were prison conditions, policies, or operations (893); alleged staff misconduct (883); appeals/grievance process (582); medical, dental, or mental health care (333); and the department's disciplinary process for incarcerated persons (238). Below, Figure 8 offers a visual representation of this distribution.

Figure 8. Distribution of Amounts and Types of Complaint Allegations the Office of the Inspector General Received in 2020



* Includes the following categories: Legal Concerns and Public Records Requests (4%), Prison Rape Elimination Act (PREA) Allegations or Investigations (4%), Safety Concerns (4%), Employee Issues (1%), Board of Parole Hearings/Parole Hearings (1%), Visiting (.4%), and Parole (.2%).

Source: The Office of the Inspector General.

The OIG received complaints regarding all 35 adult institutions. Below, Table 2 lists the number of complaints received for each institution. The remaining allegations pertained to other departmental entities or locations, including Board of Parole hearings, parole regions, community correctional facilities, and departmental headquarters. For some allegations, the complainant did not provide a location; therefore, the specific institution was not known. Finally, some individuals submitted complaints that did not fall within the jurisdiction of the OIG.

Table 2. Number of Complaints the Office of the Inspector General Received in 2020 by Institution

Prison	Total
Avenal State Prison	50
California City Correctional Facility	17
Calipatria State Prison	69
California Correctional Center	61
California Correctional Institution	117
California Central Women's Facility	64
Centinela State Prison	34
California Health Care Facility	261
California Institution for Men	71
California Institution for Women	46
California Men's Colony	117
California Medical Facility	193
California State Prison, Corcoran	187
California Rehabilitation Center	72
Correctional Training Facility	165
Chuckawalla Valley State Prison	36
Deuel Vocational Institution	59
Folsom State Prison & Women's Prison	40
High Desert State Prison	180
Ironwood State Prison	37
Kern Valley State Prison	202
Calif. State Prison, Los Angeles Co.	280
Mule Creek State Prison	294
North Kern State Prison	29
Pelican Bay State Prison	91
Pleasant Valley State Prison	38
Richard J. Donovan State Prison	187
California State Prison, Sacramento	159
California Substance Abuse Treatment Facility and State Prison, Corcoran	203
Sierra Conservation Center	69
California State Prison, Solano	67
San Quentin State Prison	53
Salinas Valley State Prison	154
Valley State Prison	63
Wasco State Prison	37

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

We performed a preliminary review and assessment for these 3,453 complaints wherein we analyzed the alleged activity, reviewed departmental policies and procedures, reviewed the incarcerated person's case file, or requested additional documentation from the department, as needed. For most cases, our review and assessment resulted in our providing the complainants with advice on how to address their concerns with the department. Common examples of such advice included instructions on how to request services or navigate the department's grievance, disciplinary, and visiting processes. Occasionally, our advice included instructions on how to contact specific departmental divisions and offices for services or additional help.

Complaint Examples

In the following paragraphs, we discuss a sampling of the preliminary reviews and assessments we completed in 2020. These summaries exemplify the most typical allegations we received. They also demonstrate the assistance we provided to complainants or the steps we took to address their concerns with the department.

Vague or Unintelligible Complaints

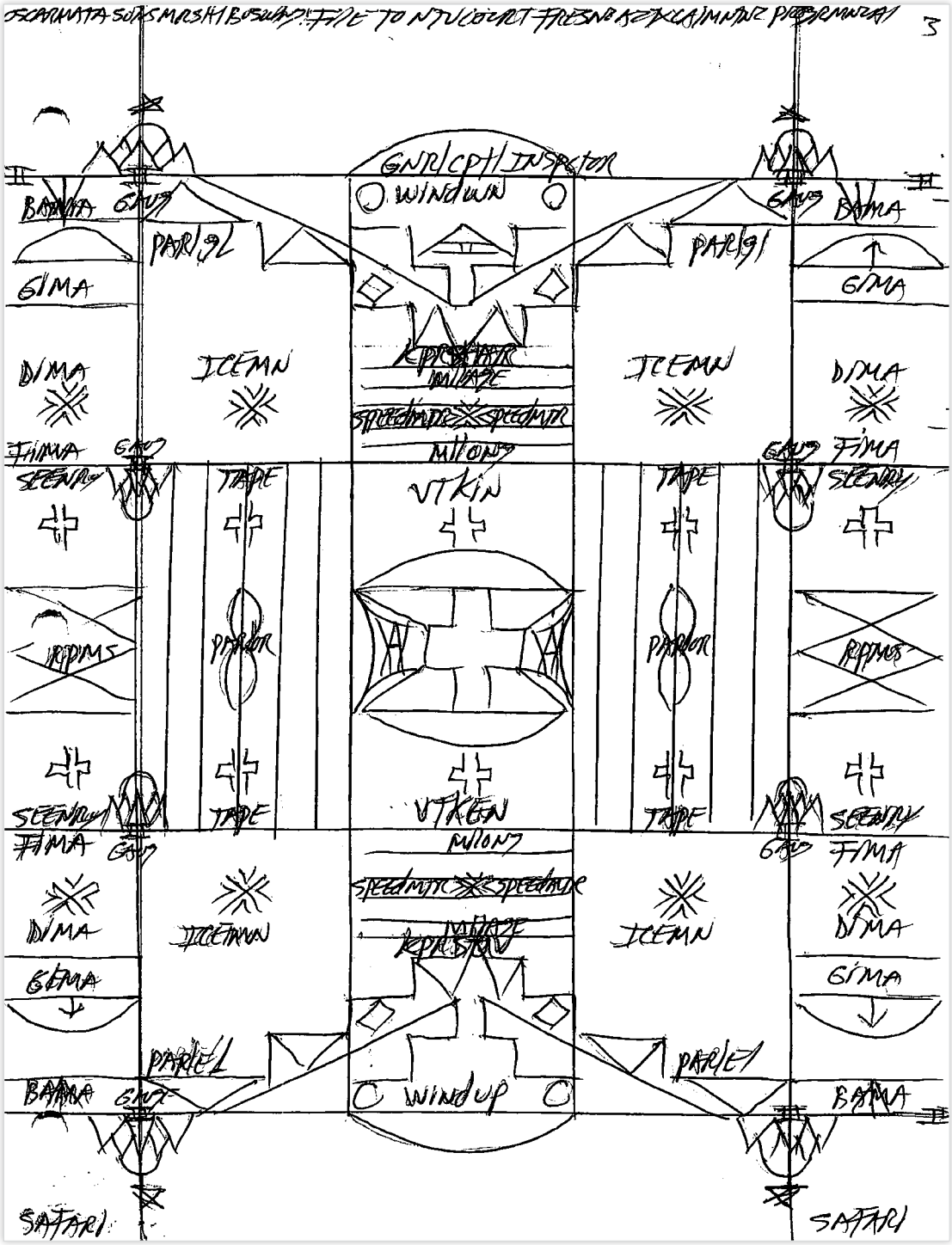
In many instances, the OIG received complaints that were too vague or unintelligible to determine the complainant's allegation or that did not provide sufficient information. These complaints often omitted names, dates, or descriptions pertaining to the alleged activity. In such cases, we informed the complainants they had not provided sufficient information and encouraged them to resubmit their complaint with additional description and documentation.

One example of a vague complaint we received in 2020 was received from an incarcerated person who provided unusual geometric drawings, but who made no further report or request (see Figure 9, next page).

The Novel Coronavirus Disease of 2019 (COVID-19)

The OIG received many complaints regarding the novel coronavirus disease (COVID-19). Overall, we received 350 individual allegations regarding COVID-19 and the department's response to the virus. We also received several telephone and email complaints as part of organized campaigns

Figure 9. Portion of an Unintelligible Complaint Submitted in the Form of a Drawing by an Incarcerated Person to the Office of the Inspector General



Source: One page from several pages included in a complaint submitted by an incarcerated person to our office.

from various advocacy organizations. In many cases, the OIG did not have the authority to implement the requests made by these advocates.

In several instances, we referred these allegations to the department for its staff to conduct health and safety reviews. One incarcerated person reported that a departmental staff member failed to wear proper protective equipment during cell searches despite having tested positive for the virus. We sent a health and safety notification to the prison regarding staff allegedly not wearing mandated face coverings and gloves. Prison staff responded immediately, and the facility captain walked the units to ensure staff wore face coverings, wore gloves when cell feeding and during cell searches, and saw that each unit was equipped with hand sanitizer.

We received multiple complaints from incarcerated persons stating their living areas could not accommodate staying six feet apart from one another and that their living conditions were poor. Our Audits Team was sent to the corresponding prison to interview staff and incarcerated persons; we reported our findings in the OIG's COVID-19 review series.

Another incarcerated person claimed multiple incarcerated persons infected with COVID-19 were placed in his dormitory, even though he had tested negative for COVID-19. Our staff reviewed documents from the department and found that multiple incarcerated persons who had once tested positive for COVID-19, but who had been in isolation for at least 14 days and had limited symptoms, were medically cleared to rejoin the healthy population in accordance with California Correctional Health Care Services policies.

Prison Conditions, Policies, or Operations

These complaints included allegations about living conditions, records information, mail and property, classification and transfers, and access to rehabilitative programs.

In one complaint, an incarcerated person reported poor living conditions due to rain coming in through the window of the cell, causing cold temperatures. Our team contacted the prison and learned that plant operations staff had recently replaced all cell windows. We also received confirmation that cell heaters were functioning properly.

In another example, an incarcerated person alleged safety concerns regarding his transfer to a specific prison and yard,

fearing his life would be in danger. He provided sufficient details for us to verify his concerns. According to prison records, the department had recommended he be transferred to a specific prison and facility where, at the time, he had no documented enemies. However, after his classification review, one of his confidential enemies was transferred to that prison and facility, triggering a safety concern should the transfer take place. Accordingly, the OIG promptly notified the warden, who placed a hold on the transfer and scheduled an institutional classification committee meeting the following week.

Medical, Dental, or Mental Health Care

Complaints in this category often involve allegations of poor care or lack of access to care. Complainants also express disagreement with the decisions of the department's medical care professionals. Several patients indicated they had various chronic illnesses and did not have access to medical care. We verified these patients were receiving medical care by reviewing prison records and informed them we had reviewed their medical files and confirmed they were receiving care. In addition, we advised them to file a request for service (Form 7362 or Health Care Appeal) if they continued to have issues with access to care.

We received a complaint from an incarcerated person who alleged that high-technology military weapons were being used to punish him. He claimed that software was designed to take control of his body and that he suffered pain 24 hours a day. We attempted unsuccessfully to locate any information within departmental databases to confirm that mental health staff were aware of these bizarre statements. However, one recent mental health note indicated the patient had stopped taking his psychotropic medication. We contacted the prison and requested a mental health evaluation that was subsequently conducted by mental health staff.

Alleged Staff Misconduct

Staff misconduct allegations include use of excessive force, discourteous treatment, harassment, threats, intimidation, or other violations of departmental policy by correctional officers and staff.

One incarcerated person alleged multiple officers used excessive force while he was in handcuffs and that he had been hit with a closed fist in the stomach, face, and head. According to departmental records, the department deferred the resolution of this use-of-force incident and sent the case to the department's Institutional Executive Review Committee, pending further review. Within the OIG, our Intake team forwarded the incident to our Force Accountability and Compliance team for review. Upon review of the incident reports, we found no inconsistencies or issues. The incarcerated person then filed a staff misconduct grievance. The departmental reviewer conducted a thorough review of the matter, including interviews of all witnesses and subjects. After considering all evidence, the departmental reviewer concluded the incarcerated person's allegations were unsubstantiated. The OIG concurred.

Grievance Process

Concerns with this process generally involve disagreement with the manner in which the department handled a grievance or appeal. The OIG also often received concerns about in-progress complaints filed with the department.

Disciplinary Process for Incarcerated Persons

When filing complaints about the disciplinary process, complainants often disagree with the outcome of a disciplinary action or the lack of due process afforded during the disciplinary process.

For example, one incarcerated person alleged that an officer wrote a counseling chrono (a written account of an incarcerated person violating policy; a type of warning) because he was absent from work, although he claimed he was sick and had a medical appointment.

According to the department's medical records, the incarcerated person *was* sick and had submitted a Request for Medical Service (Form 7362). The incarcerated person saw a nurse, who verified his illness. The incarcerated person should not have been working, and custody staff should not have issued a counseling chrono. However, according to the incarcerated person's grievance history, he did not file a grievance regarding this disciplinary issue. Although we encouraged him to file a grievance and include supporting medical documentation, prison records showed he did not.

Sexual Abuse in Detention Elimination Act Ombudsperson Claims

In 2020, the department notified the OIG of serious incidents involving alleged sexual misconduct, commonly referred to as Prison Rape Elimination Act (PREA) allegations. The reports included allegations of nonconsensual sexual acts, abusive sexual acts, sexual harassment, and sexual misconduct. Our office received 999 sexual incident reports, as shown below in Table 3, representing a slight increase over the 967 we received in 2019. The department also notified us of 249 critical incidents related to sexual misconduct or sexual harassment allegations made against departmental staff members, a slight decrease over the 284 we received in 2019.

Table 3. Sexual Misconduct Allegations

Type	Incident	Sexual Incident Report	Critical Incident Notification
Incarcerated Person-on-Incarcerated Person	Nonconsensual Sexual Acts	209	7 *
	Abusive Sexual Acts	111	0
	Sexual Harassment	109	0
	Subtotal	**429**	**7**
Staff-on-Incarcerated Person	Sexual Misconduct	276	150
	Sexual Harassment	285	99
	Subtotal	**561**	**249**
Unknown	**Unknown**	**9**	**0**
Total Sexual Misconduct Allegations		**999**	**256**

* The department is not required to notify the OIG concerning allegations made by incarcerated persons against other incarcerated persons as they are reported separately via sexual incident reports. Furthermore, three incarcerated persons could not identify whether the alleged suspect was an incarcerated person or a staff member.

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

According to departmental policy, an incarcerated person may report an allegation of sexual violence, sexual misconduct, or sexual harassment to any staff member, verbally or in writing, via the department's grievance process, the sexual assault hotline, or a third party. In addition, any departmental employee who observes an incident, or receives a report by a victim, must complete and

submit the required reports, including a sexual incident report. A trained departmental investigator must investigate the claims, and the prison's hiring authority must review the results. An incarcerated person may also report allegations directly to the OIG's ombudsperson for sexual abuse in detention elimination. Upon receipt of an allegation of sexual abuse in an incarcerated setting, the OIG reviews the allegation and departmental records to determine whether the department is aware of the allegation. When it appears the incarcerated person has not reported the alleged sexual abuse to the department, the OIG notifies the PREA compliance manager (PCM) at the applicable prison without revealing the source of the complaint.

In 2020, we reviewed 141 complaints received directly from incarcerated persons, family members, and third parties alleging sexual misconduct or sexual harassment policy violations. In 12 instances, we referred these allegations to the department for its staff to take further appropriate action.

One allegation involved an incarcerated person who reported being involved in sexual escort services with an officer while he was on postrelease community supervision. We reported the allegation to the prison's PREA compliance manager, who confirmed this allegation had not been reported to departmental staff. Departmental staff initiated a review and assessment into this allegation. The department notified the Office of Internal Affairs, which ultimately rejected the referral. The department informed our office that it would take no further action on this matter.

In another allegation, an incarcerated person reported being a victim of staff-on-incarcerated-person sexual misconduct, claiming a registered nurse used sexually provocative words before forcing him to perform sexual acts with his hands. We shared his complaint with the department to determine whether an investigation was warranted.

We reviewed the response and learned that a locally designated investigator had interviewed the alleged victim. During the interview, the incarcerated person stated he had been medically assessed by the nurse, who had made an inappropriate remark to the effect that her work schedule would allow her to perform sexual acts on him. The investigator determined there was insufficient corroborating evidence or witnesses to support any of the allegations. As a result, departmental staff concluded the allegation was unsubstantiated.

Complaint Intake and Field Inquiries: Addressing Complaints of Improper Governmental Activities Within the California Department of Corrections and Rehabilitation: Initial Report

In 2020, we published our first report dedicated to the work we perform in response to complaints we receive from incarcerated persons, family members, interest groups, and other concerned individuals. The report, *Complaint Intake and Field Inquiries: Addressing Complaints of Improper Governmental Activities Within the California Department of Corrections and Rehabilitation*, summarizes the work we performed in response to 6,009 complaints we received in the two-year period between July 1, 2017, and June 30, 2019.

The report provides an overview of our processes for reviewing and analyzing the complaints we receive and offers examples of ways we have helped individuals resolve their disputes with the department. The report also summarizes the inquiries our field inspectors performed into 49 complaints that warranted additional scrutiny. Our field inspectors identified instances in which the department responded appropriately and commendably to the concerns we raised. However, in other instances, our field inspectors found policies and practices that were both costly to the State and harmful to the persons the policies and practices affected.

Chief among the concerns we identified is the unintended impact of a regulation the department enacted in 2017, which restricted the department's ability to advance an incarcerated person's release date after discovering staff erred in rescinding the person's sentence reduction credits. The regulation prohibits the department from releasing the person from prison any sooner than 60 days after the error is corrected. After reviewing allegations that the department erroneously rescinded four persons' sentence credits within 60 days of their estimated release dates, we determined that the department's policy of performing audits of incarcerated persons' release date calculations when the person is only 60 days from release imposes an undue hardship on those persons. Because the department cannot fully correct any mistakes staff make in the final 60 days of a person's incarceration, affected persons are forced to forfeit these earned credits, with the only remedy being to initiate litigation against the department, seeking damages for holding them beyond their release dates. In these four cases, the department's mistakes and administrative delays caused these persons to spend a total of 122 additional days in prison, which directly cost the State approximately $28,360 and exposed the department to additional liability for denying incarcerated

persons of the liberty interests they earned that entitled them to an earlier release from prison.

We also reviewed the department's response to 36 complaints we forwarded to hiring authorities statewide that involved allegations of staff misconduct. We determined the department's hiring authorities performed inadequate inquiries into 21 of these complaints and found concerns similar to those we raised in our January 2019 report titled *Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct*. We discovered that hiring authorities did not perform inquiries into four complaints and did not document the inquiries performed into another three complaints. We also found inquiries that were untimely, incomplete, and lacking independence. On the other hand, we discovered that some hiring authorities performed excellent inquiries into several cases, conducting immediate inquiries that were thorough, complete, and well-documented.

The report also raises concerns over the department's handling of various incidents that occurred at three adult prisons. Although we only examined the individual incidents brought to our attention through our complaint intake process, the issues we found may be indicative of harmful practices statewide. In the first case, the department punished an incarcerated person with a disciplinary action that resulted in a 30-day restriction on the incarcerated person's visiting privileges for violating the department's visiting policies and staff directives. Video footage of the incident, however, clearly showed that the incarcerated person and his visitor complied with all staff directives and that the visiting officer's report describing the violations was inaccurate. Although the department implemented our recommendation to reduce the formal disciplinary action to written counseling and to rescind the 30-day visiting restriction 12 days early, it refused to investigate the visiting officer's dishonest report of the incident.

In another case, institutional staff held an incarcerated person in administrative segregation for 81 days while the institution performed an investigation into allegations that the person threatened to harm a lieutenant. The institution completed its investigation in only four days, but staff failed to alert the institution's classification committee of the investigation's closure, which caused the person to languish in administrative segregation well beyond the time period necessary to investigate the threat against staff. Also of concern was the lieutenant's involvement in the investigation of the threat against him and in decisions to rehouse the incarcerated person in administrative segregation,

despite the clear conflict of interest stemming from the threat against his life. Although the department recently implemented a statewide policy for handling threats made against staff, the policy does not instruct the subjects of threats that they have a conflict of interest when it comes to investigating the threats and making decisions affecting the persons who allegedly issued the threats.

In the final case we discuss, the department placed an incarcerated person's safety at risk when it entered inaccurate information in his central file that indicated he was convicted of an offense involving the sexual abuse of a minor. Even though the department corrected the inaccurate entry in the person's file, it placed an inconspicuous notation in the file indicating the information had been revised rather than remove the inaccurate information in its entirety. When we checked the person's file again months later, we found the department had again placed new information in his file, identifying him as a child sex offender. After we raised this concern with the department, it only partially corrected the mistake; staff deleted some of the inaccurate information, but did not remove other information suggesting he had a prior conviction involving a minor. As long as this inaccurate information remains in the person's file, his safety is at risk from individuals who wish harm upon child sex offenders.

Lastly, the report identifies instances in which departmental managers made positive changes after reviewing three of the complaints we forwarded for their review, including closing a gap in one institution's use-of-force reporting policy, remedying another institution's family visiting procedures, and reissuing a corrected decision of the Board of Parole Hearings that had previously contained inaccurate and incomplete information which reflected poorly on the incarcerated person's suitability for parole.

To address the issues that cause incarcerated persons to forfeit sentence reduction credits and to ensure they are released appropriately, we recommended the department take the following actions:

- Amend its policies to require that case records staff perform prerelease audits of incarcerated persons' files at least 180 days prior to their estimated release dates.
- Amend its policies to ensure incarcerated persons receive immediate notice of any changes to their release dates and to provide a system for documenting the date on which they receive notice.

- Treat all decisions to rescind credits as proposed decisions rather than as final decisions. Specifically, we recommend the department provide incarcerated persons with notice of all proposed decisions to rescind credits and adequate time to challenge the rescission of credits before the rescission becomes final.
- Amend its regulations to create a separate process that allows incarcerated persons to challenge release date calculations and credit rescissions according to expedited time frames.
- Consider setting classification committee hearings to occur on the first date a person becomes eligible to have credits restored by an institutional classification committee, at least with respect to people who are within 180 days of their earliest possible release date.

To ensure the department takes consistent and adequate action in response to allegations of staff misconduct, we recommended the department take the following action:

- Amend its regulations to require that all allegations of staff misconduct, regardless of their source, be subjected to the same process the department provides for allegations of staff misconduct that incarcerated persons file. The process should set forth deadlines for inquiries to be performed, require the inquiries involve a thorough review of all relevant records and interviews of all staff likely to have information related to the allegations, and ensure that the steps the reviewer took during the inquiry are documented in a report.

To address the conflicts of interest we identified, we recommended the department take the following actions:

- Amend its policy to prohibit staff who are the subject of threats from participating in any processes or decisions taken in response to discovering an incarcerated person made a threat against staff.
- Review its policies to determine whether there are adequate policies in place that instruct staff on how to recognize and handle conflicts of interest.
- Review its training curriculum to determine whether it provides sufficient ongoing training regarding conflicts of interest.

To ensure that incarcerated persons' disciplinary records contain only accurate information, we recommended the department take the following actions:

- Consider amending its regulations and policies regarding records of disciplinary matters to include a requirement that any inaccurate entries which are later corrected be removed from the affected person's record.
- Perform an audit of its rules violation records to locate rules violations that have been revised and determine whether there is an operational need to maintain those records in the incarcerated person's disciplinary history.

To streamline our access to information related to appeals incarcerated persons file and reduce the amount of time that the department's public information officers spend responding to our requests for records, we recommended the department take the following action:

- Provide our office with direct, electronic access to its inmate appeals tracking system.

Monitoring *The Blueprint*

California Penal Code section 6126 mandates that the OIG periodically review the delivery of the reforms identified by the department in its 2012 report, *The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight, and Improve the Prison System* (the *Blueprint*). In January 2016, the department issued *An Update to the Future of California Corrections* (the *Update*), which provides a summary of the goals identified in the initial *Blueprint* and the progress made, along with the department's vision for future rehabilitative programming, as well as safety and security matters.

In 2020, we released our eleventh *Blueprint* monitoring report. Of the five key *Blueprint* components the OIG monitored, the department previously achieved a 100 percent adherence rate for maintaining custody staffing patterns that matched budgeted levels and for implementing its incarcerated person's classification score system. Our 2020 report evaluated the remaining *Blueprint* components: adhering to the standardized staffing model for education programs and increasing the total number of offenders served in rehabilitative programs. This report also addressed the changes made following the *Update* in rehabilitative

program expansion, specialized housing, gang management, and population management.

To collect data for our report, we visited each of the department's 35 adult institutions from February 6, 2020, through March 10, 2020, and reviewed and reconciled departmental documents, interviewed staff, and observed departmental programs in operation. Of note, these on-site visits occurred just before the department initiated its response to the COVID-19 pandemic. Effective March 18, 2020, the department suspended all Division of Rehabilitative Programs (DRP) treatment programming.

Findings

- Of the 35 institutions, 19 had an academic instructor vacancy rate of 10 percent or less; 10 had rates between 11 percent and 20 percent; and six had rates between 21 percent and 40 percent.
- Of the 35 institutions, 25 had a career technical education instructor vacancy rate of more than 10 percent, including four with rates higher than 40 percent.
- As of February 2020, a total of 219 incarcerated persons had completed the Cognitive Behavioral Interventions for Sex Offenders curriculum.
- The department stated it sent 9,884 California Identification Card program applications to the Department of Motor Vehicles (DMV) for processing between July 1, 2019, and February 29, 2020. The DMV approved and issued 8,175 identification cards (83 percent of applications). The department released 6,385 individuals with an identification card (78 percent of approved applications), while the remaining 1,790 were released without an identification card.
- The department projected a reduction of approximately 10,600 incarcerated persons by 2021–22 resulting from the implementation of Proposition 57. The department reported that in June 2020, it released a total of 1,432 people due to their advanced release date authorized by Proposition 57. According to the department, these individuals earned an estimated average of 153.8 days of additional credit, excluding incarcerated persons released from fire camps.

- As of June 17, 2020, the department housed 1,547 incarcerated persons in public modified community correctional facilities (MCCF). This reflects a total decrease of 2,292 individuals since our 2019 *Blueprint* Monitoring report, in which we reported the department housed 3,839 individuals in MCCFs.

Special Reviews

The Office of the Inspector General completed two special reviews in 2020 that examined the department's response to the novel coronavirus (COVID-19).

COVID-19 Special Reviews

In April 2020, the Speaker of the California Assembly requested that the OIG assess the policies, guidance, and directives the department had implemented since February 1, 2020, in response to COVID-19. The Speaker asked us to focus on three concerns:

1. the department's screening process for individuals entering a prison or facility in which incarcerated persons are housed or are present,
2. its distribution of personal protective equipment (PPE) to departmental staff and incarcerated persons, and
3. how it treats incarcerated persons who are suspected to have either contracted or been exposed to COVID-19.

Our first report, issued in August 2020, focused on the department's efforts to screen prison staff and visitors prior to entry into a facility for signs and symptoms of COVID-19, covering the period from February 1, 2020, through July 5, 2020. Our second report, issued in October 2020, focused on the department's distribution of PPE to departmental staff and incarcerated persons, and staff's and incarcerated persons' adherence to policies and directives regarding face coverings and physical distancing; it encompassed the period from February 1, 2020, through August 31, 2020. Our third report, issued in February 2021, examined what we found took place when California Correctional Health Care Services and the department transferred 189 incarcerated persons from one prison to two others in an attempt to mitigate the spread of the disease within the prison system.

For our assessment, we performed detailed record reviews, surveyed departmental staff at seven prisons,[1] and conducted site visits at five prisons selected based on factors including the prevalence of COVID-19 at the prison and surrounding areas, the prisons' geographic locations and physical layouts, and the prevalence of incarcerated persons with underlying health concerns.[2] In addition, while monitoring 34 of the State's 35 prisons, the OIG documented staff compliance with applicable COVID-19 directives.

Part One: The Department Did Not Apply Its COVID-19 Screening Process in a Consistent Manner, Increasing the Risk of COVID-19 Entering the Prison System

Beginning in March 2020, the department took steps to mitigate the spread of COVID-19 among its staff and incarcerated population. First, it suspended the visiting process on March 11, 2020, allowing only essential visitors such as contracted workers, attorneys, and OIG staff. Effective March 14, 2020, the department required its prisons to verbally screen staff and visitors for signs and symptoms of COVID-19 before allowing them to enter the secure perimeter of the prison. Later in March, the department expanded the screening to include a temperature check, and extended the screening and temperature check to *all* staff and visitors, not just those wishing to enter the secure perimeter. Prisons denied entry to anyone who did not pass the screening or temperature check.

However, these directives were vague and resulted in inconsistent implementation among the prisons. While some prisons funneled all vehicles into a central screening location, where prison staff completed the verbal and temperature screenings of all vehicle occupants, others screened staff and visitors at specified pedestrian prison entrances, which increased the risk that staff or visitors could walk into or through work spaces without being screened.

1. We surveyed all staff at Avenal State Prison; the California Health Care Facility; the California Institution for Men; the California Institution for Women; California State Prison, Los Angeles County; Chuckawalla Valley State Prison; and San Quentin State Prison. In addition, we surveyed staff responsible for performing screenings at the California Health Care Facility; the California Institution for Men; the California Institution for Women; California State Prison, Los Angeles County; and San Quentin State Prison.

2. The five prisons we visited were the California Health Care Facility; the California Institution for Men; the California Institution for Women; California State Prison, Los Angeles County; and San Quentin State Prison.

OIG staff witnessed some of these inconsistencies firsthand. During multiple visits between May 19, 2020, and June 26, 2020, prisons did not screen some of our staff. For example, California State Prison, Sacramento, conducted screening at a building located apart from the prison's administration and secure pedestrian entrances. Also, two OIG staff entered the prison grounds without being screened as they parked their cars, then entered the prison's administration building, again without being screened. Overall, OIG inspectors were not screened in 38 of their 212 visits (18 percent) between May 19, 2020, and June 26, 2020.

Departmental staff supported our observations. We surveyed more than 12,000 staff at seven prisons; 5 percent of the nearly 4,000 respondents indicated they were not always screened upon entry; and, through a separate survey we administered to those who performed screenings at five prisons, we found some temperatures were not accurate, as thermometers malfunctioned, were faulty, or had inoperative batteries. Respondents did not indicate how they conducted screenings when they could not accurately obtain a temperature, and the department's directives did not provide instruction on how to respond in those instances. In addition, our review of a sample of screeners' training records and of screeners themselves revealed that many did not receive formal training regarding the screening process, thereby increasing the risk of infected persons entering the prisons and exposing others to COVID-19.

Part Two: The Department Distributed and Mandated the Use of Personal Protective Equipment and Cloth Face Coverings, but Its Lax Enforcement Led to Inadequate Adherence to Basic Safety Protocols

In addition to issuing statewide memoranda regarding COVID-19 screening, the department issued statewide memoranda regarding the use of personal protective equipment (PPE) and cloth face coverings, as well as physical distancing. In April 2020, the department purchased and distributed cloth face coverings manufactured by the California Prison Industry Authority, and required staff and incarcerated persons to wear them at almost all times. Between April 2, 2020, and the time our COVID-19 Review Series Part 2 report was issued, in October 2020, the department purchased more than 752,000 cloth face coverings from the California Prison Industry Authority and, by April 9, 2020, delivered more than half to prisons for staff and incarcerated persons to use. Despite nationwide PPE shortages early in the pandemic, we found the department generally maintained a

sufficient supply for its staff; during our visits to the five prisons referenced above, we reviewed PPE inventories and spoke to staff, including those in the prisons' health care clinics, and observed most staff in health care areas wearing appropriate PPE. In addition, staff stated they had access to appropriate PPE, with only a few exceptions.

Although the department distributed face coverings to staff and the incarcerated population, and issued memoranda outlining requirements for face coverings and physical distancing, staff and incarcerated persons frequently failed to follow those requirements. During our customary monitoring activities between May 19, 2020, and July 29, 2020, we frequently witnessed departmental staff failing to comply with face covering guidelines during multiple visits to 23 of the department's 35 prisons. Moreover, during a meeting at one prison, OIG staff, including the Inspector General and the Chief Deputy Inspector General, entered a room to find three attendees speaking in close proximity without wearing face coverings. The Inspector General and the Chief Deputy Inspector General also observed multiple prison executives improperly wearing face coverings during a meeting; the prison's warden did not attempt to correct the noncompliance.

Although noncompliance occurred more often among the prison's custody staff, we observed a troubling number of health care staff also failing to wear face coverings properly. We witnessed openly noncompliant health care staff with face coverings on their chins or only covering their mouths. Some raised their face coverings over their noses when they saw us approach, but others did not seem affected by our presence and left the face coverings below their noses or mouths.

Incarcerated persons were also noncompliant with face covering requirements, sometimes with little to no response from prison staff. During our visits to five prisons, we found almost all incarcerated persons in possession of face coverings and that most wore them at least partially. However, many wore them improperly, such as below their noses or mouths, rendering the face coverings useless. Moreover, we observed incarcerated persons not properly wearing face coverings while in close proximity to staff or other incarcerated persons. To obtain departmental staff's perspectives, we administered a survey regarding the use of PPE to more than 12,000 staff at seven prisons. Of the respondents, 31 percent reported they witnessed staff or incarcerated persons failing to properly wear face coverings, and 38 percent stated they witnessed

staff or incarcerated persons failing to comply with physical distancing requirements.

Supervisors' and managers' lax enforcement of PPE and physical distancing requirements likely contributed to the frequent noncompliance by staff and incarcerated persons. Although the department's then-Secretary stated during a legislative hearing on July 1, 2020, that the department was enforcing its face covering requirements, and despite the memorandum the department issued the same day reinforcing the importance of adhering to face covering directives, the department's enforcement efforts were sparse. In fact, based on records provided by the five sampled prisons, supervisors and managers took only 29 actions against staff for noncompliance with face covering or physical distancing requirements over a seven-month period. For instance, the California Institution for Men provided no documentation of disciplinary actions, and San Quentin State Prison provided documentation of only one action. Nearly all actions taken consisted of verbal or written counseling, the lowest level of the progressive discipline process. Through our department-wide review of every formal request for investigation and punitive action from February 1, 2020, through September 2, 2020, we found that hiring authorities statewide requested formal investigations or punitive actions for misconduct related to face covering or physical distancing requirements for only seven of the department's more than 63,000 staff members.

The department did not respond adequately to the improper use of face coverings or noncompliance with physical distancing requirements among the incarcerated population. During a visit to Mule Creek State Prison, we heard staff announce multiple times over the loudspeaker in the exercise yard that incarcerated persons not properly wearing face coverings must return to their cells. Not only did incarcerated persons fail to adjust or put on their face coverings following these announcements, but prison staff did not require noncompliant individuals to return to their cells. When we interviewed the wardens at the five prisons, none reported imposing discipline on incarcerated persons for failing to wear face coverings or adhere to physical distancing guidelines.

Both staff's and incarcerated persons' noncompliance with face covering requirements was also likely due to receiving mixed messages from the department's leaders. Despite increasing cases of COVID-19 in its prisons, the department sent memoranda on June 11, 2020, and June 24, 2020, that relaxed face covering requirements for staff and incarcerated persons, respectively. The updated requirements allowed staff and incarcerated persons to

remove their face coverings while outside and at least six feet away from other individuals.

Other Publications

The Office of the Inspector General completed three special reports in 2020: one concerned the department's handling of allegations of staff misconduct brought to our attention by incarcerated persons' attorneys; one examined the department's efforts to address evolving issues that transgender, nonbinary, and intersex incarcerated persons face while in custody; and one examined the department's mishandling of allegations of misconduct against a high-ranking official.

Letter to Secretary Diaz Concerning the Department's Handling of Allegations of Staff Misconduct Raised by Inmates' Attorneys

In January 2019, pursuant to California Penal Code section 6128, the OIG began receiving copies of letters sent to the department's Office of Legal Affairs from attorneys at the law firm of Rosen, Bien, Galvan & Grunfeld LLP, which represents incarcerated persons in the *Coleman* and *Armstrong* federal class action lawsuits. These letters, known as *advocacy letters*, call attention to allegations of staff misconduct and to mistreatment of the firm's clients. In all, we received 16 advocacy letters pertaining to 14 incarcerated persons. Each letter described serious misconduct that, if true, would result in disciplinary action for the subject employees. On January 21, 2020, the OIG submitted a letter to then-Secretary Diaz to report how the department handled these allegations. In our letter, we reviewed whether the department complied with its own policy and addressed all allegations of misconduct identified in the advocacy letters.[3]

We used several sources to determine the department's action concerning each allegation, such as printed outputs generated by the inmate appeals and tracking system and, if the prisons conducted a staff complaint inquiry or use-of-force allegation inquiry, any documentation the prison completed. We also reviewed correspondence, including documentation showing the process by which the Office of Legal Affairs referred the matters to the department's Division of Adult Institutions.

3. Department Operations Manual, Article 14, Section 31140.1 states: "Every allegation of employee misconduct within the Department of Corrections and Rehabilitation (CDCR or Department) shall be promptly reported, objectively reviewed, and investigated when appropriate."

We found the department, for the most part, did not thoroughly review the issues raised in the advocacy letters. The advocacy letters raised 67 allegations, 31 of which were previously unknown to the department. Of those 31 additional allegations, the department conducted an inquiry into only three.

In addition, the department did not comply with plaintiffs' counsel's request that the allegations be reviewed by personnel outside the prison. The department referred only one allegation of misconduct to the Office of Internal Affairs requesting an investigation. The Office of Internal Affairs rejected the case and returned it to the prison for further inquiry; however, the prison did not conduct further inquiry and the Office of Internal Affairs never followed up with the prison.

The lapse in communication between the prisons and the Office of Internal Affairs extended even further.

While four of the advocacy letters, which were related to only one prison, included additional allegations of misconduct arising from incidents the Office of Internal Affairs had already been investigating, the department did not submit those letters to the Office of Internal Affairs. As a result, not all allegations were investigated.

For most of the advocacy letters, the department failed to provide status updates to plaintiffs' counsel. The Office of Legal Affairs acknowledged nine of the 16 advocacy letters and provided a detailed final response for only seven. In addition, the responses were not timely; one response was provided to plaintiffs' counsel almost 10 months after receipt of the advocacy letter.

The OIG found the department did not take timely action to address allegations of staff misconduct voiced in the advocacy letters, and while it acted upon on some of the allegations, it disregarded many others.

The California Department of Corrections and Rehabilitation Has Taken Thoughtful and Important Steps to Address the Difficult Conditions of Confinement for Incarcerated Transgender, Nonbinary, and Intersex Individuals

In September 2020, we released a special report regarding the department's treatment of incarcerated transgender, nonbinary, and intersex persons. The report, *The California Department of Corrections and Rehabilitation Has Taken Thoughtful and Important Steps to Address the Difficult Conditions of Confinement for Incarcerated Transgender, Nonbinary, and Intersex Individuals*,

summarized our observations of the department's transgender housing and search working group, the department's survey of the population, and staff training sessions conducted by the department. We outlined concerns raised by incarcerated persons during the surveys and at the forums, the concerns raised by external stakeholders, and the department's steps taken toward addressing the issues identified. We found that the transgender, nonbinary, and intersex population was particularly vulnerable to violence and abuse while incarcerated. We commended the department for soliciting input from the transgender, nonbinary, and intersex population when making decisions about departmental policies impacting that population. We found that the department was in the process of adapting departmental policies and practices to improve conditions of confinement for the population.

Since we published our report, Governor Gavin Newsom signed California Senate Bill Nº 132, the Transgender Respect, Agency, and Dignity Act, which requires improving conditions for incarcerated transgender, nonbinary, and intersex individuals. If properly implemented, the law will address some of the concerns of external stakeholders and incarcerated transgender, nonbinary, and intersex persons regarding respectful treatment, professional searches, and safe housing for that population. In addition, we made several recommendations to the department regarding improved policies, practices, and oversight to ensure conditions of confinement are improved for the transgender, nonbinary, and intersex population. We are hopeful the department will continue its work creating a safe environment for the incarcerated transgender, nonbinary, and intersex population.

The California Department of Corrections and Rehabilitation Mishandled Allegations That a High-Ranking Official Engaged in Misconduct

In January 2019, we became aware that allegations of misconduct had been made against a high-ranking official within the department, and the official's subordinate. The allegations included claims the subordinate improperly used a State vehicle for commuting purposes and performed work well below her classification, with the high-ranking official's approval. We immediately reached out to the department to ascertain the steps it had taken in response to the complaint and asserted our authority to monitor the department's process for examining this complaint. This special report, which is a redacted version of a confidential report we provided only to the department's

Secretary, details our observations and assessment of the department's handling of this high-profile case.

Because we did not receive timely notice from the department that these allegations had been raised, we began our monitoring of the process after the department had already performed the bulk of the investigative work it intended to perform and was preparing to dispose of the complaint. Once we intervened and had an opportunity to review the investigative and analytical work that had been performed to date, we quickly determined the process the department used to assess the complaint had been neither thorough nor impartial. The department had only collected a portion of the pertinent information that was readily available to it and had assigned one of the subject's long-time colleagues and legal representatives to assess the allegations against them. The report we reviewed showed clear signs of bias, both against the complainant and in favor of the subjects. The analysis was also logically flawed, dismissing certain allegations based on faulty presumptions and concluding that the subjects' actions were permitted by various departmental policies that did not actually permit their actions.

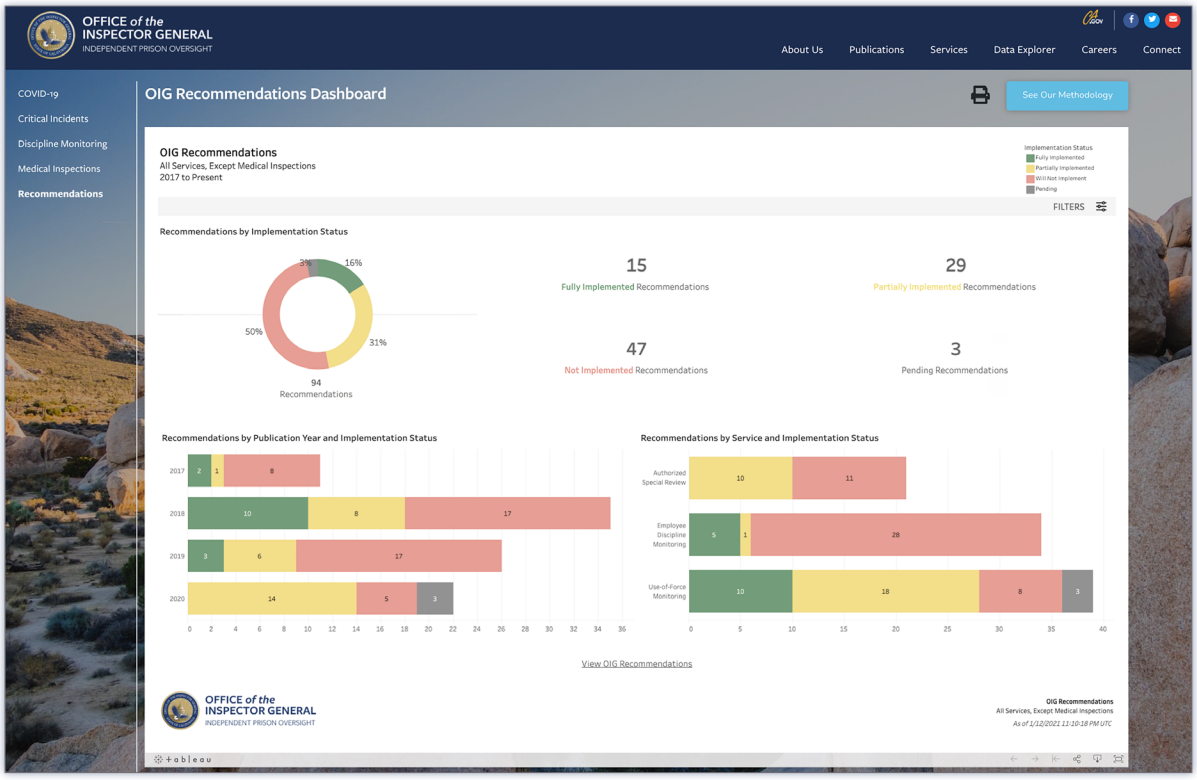
We immediately raised these concerns with the departmental executive who had managerial authority over the office in question and recommended the department refer the complaint to an outside contractor who could provide an independent inquiry into the complaint. The department accepted our recommendation and selected a former inspector general from another branch of government whose experience appeared to qualify him to perform the task. However, the department rejected our other recommendation that the outside contractor not receive the written report that we perceived to be biased and logically flawed. Soon after the department selected this individual to perform the independent assessment, it provided him with a copy of the report.

This single act diminished any independence the contractor was intended to have, as he had been irreversibly exposed to the original reviewer's bias and incorrect conclusions. When we compared the original report with the outside contractor's written assessment of the allegations, we found many similarities between the two products, including the improper policy interpretations and logical flaws that originated in the initial assessment. After departmental executives reviewed the department's initial assessment and the outside contractor's work, they determined the allegations were not credible and chose to not take any further action on the complaint.

Recommendations Made to the Department

The OIG published 22 formal reports, some of which contained recommendations in 2020. These recommendations promote greater transparency, process improvements, increased accountability, and higher adherence to policies and constitutional standards. Details concerning the vast number of recommendations made to the department are available on our dashboards, which can be accessed at our website, www.oig.ca.gov. If viewing this report on our website, clicking on the image below will take the reader to the main interactive dashboard web page. Choose from among several filter options to select a specific group of recommendations: publication year, service (authorized/special review; employee discipline monitoring, and use-of-force monitoring), general topic, associated entity, report title, and report number. A separate dashboard is also available on our site that lists the medical inspection report recommendations we have made to both California Correctional Health Care Services and the department.

Exhibit 1. The Office of the Inspector General's Dashboard Recommendations' Module



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Appendix: Publications Released in 2020

Annual and Semiannual Reports

- *2019 Annual Report: Summary of Reports and Status of Recommendations* (May 20, 2020)
- *Complaint Intake and Field Inquiries: Addressing Complaints of Improper Governmental Activities Within the California Department of Corrections and Rehabilitation: Initial Report* (June 2, 2020)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, July–December 2019* (June 5, 2020)
- *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation* (July 13, 2020)
- *Monitoring the Internal Investigations and Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, January–June 2020* (December 10, 2020)

Periodical Reports

Sentinel Cases

- № 20–01: *Inaugural Case Report* (January 10, 2020)
- № 20–02: *The Department Settled a Case Against an Officer Who Was Dishonest at a State Personnel Board Hearing Regarding Another Officer's Misconduct* (June 11, 2020)
- № 20–03: *The Department Refused to Take Disciplinary Action Against an Officer Despite Evidence That Suggested He Punched His Girlfriend and Slammed a Truck Door on Her Hand, Which Cut Off Part of Her Thumb* (June 15, 2020)
- № 20–04: *The Department Made an Egregious Error in Judgment and Relied on Poor Legal Advice When It Did Not Sustain Dishonesty Allegations and Dismiss Two Officers in a Use-of-Force Case* (August 19, 2020)

Medical Inspection Reports: Cycle 6 Results

- California State Prison, Los Angeles County (July 9, 2020)
- Wasco State Prison (August 21, 2020)
- Valley State Prison (August 28, 2020)
- California State Prison, Solano (September 25, 2020)
- California Correctional Center (September 30, 2020)
- California Rehabilitation Center (December 30, 2020)

Special Reviews

COVID-19 Review Series

- *Part One: Inconsistent Screening Practices May Have Increased the Risk of COVID-19 Within California's Prison System* (August 17, 2020)
- *Part Two: The California Department of Corrections and Rehabilitation Distributed and Mandated the Use of Personal Protective Equipment and Cloth Face Coverings; However, Its Lax Enforcement Led to Inadequate Adherence to Basic Safety Protocols* (October 26, 2020)

Other Publications

- *Letter to Secretary Diaz Concerning the Department's Handling of Allegations of Staff Misconduct Raised by Inmates' Attorneys* (January 21, 2020)
- *The California Department of Corrections and Rehabilitation Has Taken Thoughtful and Important Steps to Address the Difficult Conditions of Confinement for Incarcerated Transgender, Nonbinary, and Intersex Individuals* (September 1, 2020)
- *The California Department of Corrections and Rehabilitation Mishandled Allegations That a High-Ranking Official Engaged in Misconduct* (December 9, 2020)

The Blueprint Monitoring Report

- *The Eleventh Report Concerning 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* (August 6, 2020)

California Rehabilitation Oversight Board (C-ROB) Report

- *C-ROB September 15, 2019, Annual Report* (September 14, 2020)

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

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2020
Annual Report

A Summary of Reports

OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley
Inspector General

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Chief Deputy Inspector General

STATE *of* CALIFORNIA
April 2021

OIG