OFFICE OF THE INSPECTOR GENERAL

• PROMOTING INTEGRITY •

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

WARDEN THOMAS L. CAREY

CALIFORNIA STATE PRISON, SOLANO
VACAVILLE, CALIFORNIA

MARCH 2003

GRAY DAVIS, GOVERNOR

State of California

Office of the Inspector General
P.O. Box 1498
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Memorandum

Date: March 19, 2003

To: EDWARD S. ALAMEIDA, JR.
Director, California Department of Corrections

From: STEVE WHITE
Inspector General

Subject: MANAGEMENT REVIEW AUDIT OF CALIFORNIA STATE PRISON, SOLANO

Enclosed is a report of the recent management review audit conducted by the Office of the Inspector General of California State Prison, Solano and Warden Thomas L. Carey. The audit was performed in accordance with the oversight responsibility provided to the Office of the Inspector General under *California Penal Code* Section 6126.

The audit revealed a number of matters requiring attention. The problems include deficiencies in tracking inmate tuberculosis status, improper assignment of sentence reduction credits, ineffective monitoring of the length of time inmates spend in administrative segregation, unsafe modification to administrative segregation unit buildings, and inappropriate housing for inmates taking psychotropic and anticonvulsant medications. The audit also revealed several issues outside the warden's control that require the attention of the Department of Corrections. Those issues include budgetary restrictions that conflict with department mandates relating to inmate dental care and deficiencies in procedures for conducting inmate death reviews. The recommendations of the Office of the Inspector General with respect to the problems are included in the report.

The department's response to the draft report is included as an attachment to the final report. The Office of the Inspector General also provided a draft version of the report to Warden Carey in January 2003.

Please call me if you have questions concerning this report.

SW/dj

Enclosure

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency
Thomas L. Carey, Warden, California State Prison, Solano

OFFICE OF THE INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

WARDEN THOMAS L. CAREY

CALIFORNIA STATE PRISON, SOLANO
VACAVILLE, CALIFORNIA

REPORT

MARCH 2003

•PROMOTING INTEGRITY •

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EXECUTIVE SUMMARY

This report presents the results of a management review audit conducted by the Office of the Inspector General of Warden Thomas L. Carey of California State Prison, Solano. The audit was conducted under the provisions of *California Penal Code* Section 6051, which assigns the Office of the Inspector General authority to conduct a management review audit of any California Department of Corrections warden who has held that position for more than four years or who has been recently appointed. The management review audit of California State Prison, Solano resulted from the July 2001 appointment of Warden Carey. A management review audit is intended to assess the warden's performance in carrying out the essential functions of the facility. In the case of recent appointments, the management review audit provides a baseline assessment of institution operations. Where deficiencies are noted, the Office of the Inspector General makes recommendations to correct problems.

The Office of the Inspector General found Warden Carey to be well-respected by the staff and management team at California State Prison, Solano, with the staff expressing approval of the warden's management ability and communication skills. But the audit also revealed a number of matters that require the warden's attention. The problems identified by the audit include deficiencies in tracking inmate tuberculosis status, improper assignment of sentence reduction credits, ineffective monitoring of the length of time inmates spend in administrative segregation, unsafe modification to administrative segregation unit buildings, and inappropriate housing for inmates taking psychotropic and anticonvulsant medications. The audit also revealed several issues outside the direct control of the warden that require the attention of the Department of Corrections. Those issues include budgetary restrictions that conflict with department mandates relating to inmate dental care and deficiencies in procedures for conducting inmate death reviews.

Following is a summary of findings from the management review audit. Recommendations of the Office of the Inspector General are included in the body of the report.

FINDING 1

The Office of the Inspector General found evidence that California State Prison, Solano is not adequately tracking inmates with tuberculosis, creating the potential of exposing inmates throughout the state to the disease and presenting a risk to the correctional staff and the general public.

To control outbreaks of tuberculosis in the inmate population, state law and Department of Corrections regulations require state correctional institutions to test inmates for tuberculosis and to document each inmate's tuberculosis status in a statewide database. The purpose is to allow inmates who have been exposed to the disease to be closely monitored and to receive prophylactic medication; to prevent inmates who are receiving medication from having the treatment interrupted; and to provide for medical precautions to be taken when inmates are moved from one institution to another.

The Department of Corrections has developed a coding system for identifying each inmate's tuberculosis status and requires the information to be stored in the department's statewide distributed data processing system for the use of staff assigned to healthcare, classification, case

records, and transportation functions. But the Office of the Inspector General found numerous errors associated with tuberculosis coding and tracking at California State Prison, Solano, with the possibility that inmates infected with tuberculosis may not be receiving medication and as a result may be exposing others to the disease.

FINDING 2

The Office of the Inspector General found that California State Prison, Solano inmates are allowed to earn sentence reduction credit through education and training classes even when classes are not actually held.

California state prison inmates may reduce their time in custody by earning credits through participation in work, education, or training programs at the rate of one day of credit for each day of participation. Like other Department of Corrections institutions, however, California State Prison, Solano is experiencing difficulty filling teacher vacancies for education and training classes, with the result that many classes are not being held. Yet, under a mistaken belief that classes cannot be closed without approval from department headquarters, the institution has continued to assign inmates to classes even when no teachers are available and classes are not held—and even though the classes are not being held, inmates are allowed to earn sentence reduction credit as though they attended the class.

FINDING 3

The Office of the Inspector General found that makeshift partitions in the institution's administrative segregation unit buildings have created blind spots that limit the view of the control booth officers, compromising the safety and security of correctional staff and inmates.

The Office of the Inspector General found that the institution has installed partitions in the administrative segregation buildings beneath the control booth in order to create space for classification committee meetings and other activities isolated from the view of inmates housed in segregation cells. But the partitions block the view of officers on the floor and allow the control booth officer only a limited view of the floor immediately outside the doors of the lower-tier cells.

FINDING 4

The Office of the Inspector General found that a significant number of inmates taking psychotropic medications are inappropriately housed in buildings lacking air conditioning and that some inmates who are taking anticonvulsant medications are not assigned to lower bunks to lessen the possibility of injury in the event of a seizure.

Psychotropic medications can increase the risk of heat-related illnesses by altering the body's temperature-regulating mechanisms or impairing the ability to perspire. Accordingly, patients taking psychotropic medications are advised to avoid exposure to high ambient temperatures. Yet, the Office of the Inspector General found that more than half of the inmates at California State Prison, Solano taking psychotropic medication are assigned to buildings without air conditioning. The Office of the Inspector General also found that 10 inmates taking

anticonvulsant medication for seizure disorders were assigned to upper bunks, putting them at risk of injury in the event of a seizure.

FINDING 5

The Office of the Inspector General found that when inmate deaths occur, the cause and circumstances surrounding the deaths are not examined in a timely manner and that those assigned to conduct the reviews may have a direct interest in the results.

The Department of Corrections has established procedures for reviewing the cause and circumstances surrounding inmate deaths, but the Office of the Inspector General found that the reviews take too long to complete and that those assigned to review the cases sometimes have a direct interest in the results. The process also does not provide for adequate coordination between the institution's investigative staff and the department's Health Care Services Division.

FINDING 6

The Office of the Inspector General found that California State Prison, Solano retains inmates in administrative segregation units longer than justified.

The Office of the Inspector General found that California State Prison, Solano does not effectively monitor the process for determining the length of time inmates spend in administrative segregation, with the result that inmates may be kept in administrative segregation longer than necessary. The problem has been compounded by a recent action of the Department of Corrections to override state regulations requiring that an inmate's stay in administrative segregation be re-evaluated at least every 30 days. A department directive has provided instead that an inmate's continued retention in administrative segregation be evaluated every 90 to 180 days, depending on the reason for the retention.

FINDING 7

The Office of the Inspector General found that California State Prison, Solano is not complying with state regulations governing inmate dental care and as a result may be exposed to the risk of litigation.

California Code of Regulations, Title 15 requires all newly committed inmates to receive a complete dental examination within 14 days of arrival from the reception center. Title 15 also requires all inmates under the age of 50 to receive a dental examination at least once every two years and all inmates over the age of 50 to receive a dental examination every year. The chief dentist at California State Prison, Solano acknowledges, however, that the institution is not meeting these requirements, thereby exposing the institution to possible legal action.

FINDING 8

The Office of the Inspector General found that California State Prison, Solano does not adequately document employee disciplinary proceedings and that the warden inappropriately serves as the hearing officer in appeals of adverse action decisions.

State law and regulations require specific procedures to be followed in disciplinary actions involving California state government employees. The purpose of the provisions is to protect the due process rights of employees to fair and impartial hearings and to afford them an opportunity to appeal adverse action decisions. The Office of the Inspector General found that despite an inherent conflict of interest, the warden of California State Prison, Solano often serves as the hearing officer in appeals of adverse action decisions, and in that capacity often reduces the penalty for sustained misconduct. Although the original adverse action penalty undergoes a thorough independent review, the penalty reduction authorized by the warden does not. Moreover, the reasons for penalty reductions made by the warden are rarely documented, bringing into question the benefit of the process leading up to the adverse action.

FINDING 9

The Office of the Inspector General found that pharmacy record keeping and physical controls over prescription medications stored in the infirmary and clinics are inadequate to prevent unauthorized access and theft.

Although the Office of the Inspector General found no evidence of actual theft of pharmaceuticals at California State Prison, Solano, the audit revealed that pharmaceutical products at the institution are kept in an environment conducive to theft and abuse. In fiscal year 2001-02 the institution spent more than $4 million for pharmaceutical supplies, and the potential exists for theft of even small quantities of drugs to have a significant fiscal impact.

FINDING 10

The Office of the Inspector General found that California State Prison, Solano does not promptly implement medical modification orders and that many were significantly overdue at the time of the audit.

The Office of the Inspector General found that a high percentage of modification orders directing California State Prison, Solano to remedy conditions affecting inmate medical conditions were more than seven months overdue. Delays in implementing medical modification orders can result in serious medical consequences for inmates and expose the institution and the department to possible lawsuits.

FINDING 11

The Office of the Inspector General found that the institution is not properly documenting inmate activity in the administrative segregation units and that in some instances events are logged before they occur.

State regulations and California Department of Corrections policy require that movement and housing of inmates assigned to an administrative segregation unit be recorded in a hardbound logbook — a CDC Form 114 — which provides a single-source record of daily activity within the administrative segregation unit. The log is formatted to include the inmate's cell number and bed assignment, the time of the inmate's entry to or exit from administrative segregation, the

identity of visitors to the unit, and any unusual incidents within the unit. The CDC Form 114 is a legal document subject to be used as evidence in a civil, criminal, or administrative proceeding.

The Office of the Inspector General found that although the administrative segregation staff at California State Prison, Solano maintains the CDC Form 114, the information is not always entered into the log immediately. Instead, information is entered into the logbook only once every 24 hours by the administrative segregation unit's first watch floor officer, using reports from central control to record inmate housing assignments. That practice undermines the purpose of the CDC Form 114 as a source of accurate, up-to-date information about inmate location, diminishes the evidentiary value of the CDC Form 114, and presents a safety risk to staff and inmates.

FINDING 12

The Office of the Inspector General found that California State Prison, Solano prepares an excessive number of daily meals for inmates, resulting in unnecessary added costs for food and related services.

The Office of the Inspector General found that the food service staff at California State Prison, Solano does not effectively monitor the number of meals served and consumed each day and that in at least some cases the number of meals prepared exceeds the inmate population. Although preparing a certain number of extra meals may be necessary to avoid shortages, the institution wastes resources by preparing a large number of meals that are not consumed, particularly given that the entire inmate population is rarely present at any single meal.

INTRODUCTION

Under *California Penal Code* Section 6051, the Office of the Inspector General is assigned authority to conduct a management review audit of California Department of Corrections wardens who have been recently appointed. The audit is intended to provide a baseline assessment of institution operations and includes an assessment of issues relating to personnel, training, communication, investigations, security, and financial matters. The management review audit of California State Prison, Solano resulted from the recent appointment of Warden Thomas L. Carey and was conducted from August 1, 2002 to October 1, 2002. Throughout the review process, the audit team received excellent cooperation and assistance from Warden Carey and the staff at California State Prison, Solano.

BACKGROUND

Thomas L. Carey was appointed warden of California State Prison, Solano by Governor Gray Davis on July 25, 2001 and was confirmed by the Legislature on July 1, 2002. He began his career with the State of California in 1981 as a senior accountant at Patton State Hospital in San Bernardino. Warden Carey had previously spent twelve years in a variety of positions in personnel management in both the private and public sectors. In 1984, Warden Carey was appointed as an administrator of the Prison Industries Authority at San Quentin State Prison. In 1986, he transferred from the Prison Industries Authority to the California Department of Corrections as an associate warden at Mule Creek State Prison. For four months in 1996, Warden Carey was assigned to the Richard A. McGee Training Center before being promoted as chief deputy warden at the Correctional Training Facility in Soledad, California. He was named warden of the California Correctional Institution, Tehachapi in 1998. Warden Carey holds a bachelor's degree in communications from California State University, Fullerton, and a master's degree in education/communications from Whittier College.

California State Prison, Solano opened in August 1984 and is located on 146 acres in Vacaville, California. When it opened in 1984, it was administered by the warden of the adjacent institution, the California Medical Facility, but in January 1992, the two prisons were administratively separated, with a warden assigned to each prison. With about 1,280 employees and an operating budget of approximately $104 million, California State Prison, Solano was designed to house 2,110 inmates, but regularly houses approximately 5,800 inmates in Level II and III facilities. California State Prison, Solano provides a comprehensive work/training program for medium-security inmates with academic and vocational training and industry assignments. The vocational programs include auto body and mechanics, carpentry, eyewear manufacture, landscaping and horticulture, machine shop, mill and cabinet work, and office services. The Prison Industry Authority operates an optical program, including a lens laboratory, as well as a laundry and a bookbindery at the institution.

Warden Carey inherited a significant budget deficit upon his appointment to California State Prison, Solano and the institution currently lacks the resources to meet its mission and has not been provided with an adequate budget with which to operate. Both the warden and health care manager can be held personally liable for expenditures in excess of the budget, yet neither have the discretion to make major policy changes to reduce operating costs. For example, the institution is required to achieve 15 percent salary savings for all positions. Yet the majority of

the institution's positions (63 percent) are posted custody personnel positions that cannot be held vacant to achieve salary savings. In fact, the collective bargaining contract (Bargaining Unit 6) prohibits the warden from imposing that level of salary savings requirement. The current negotiated institution vacancy plan for correctional officers achieves only about 2 percent in savings, leaving the elimination of entire programs, such as education and ancillary staff as the warden's only option to achieve the required savings. Yet the warden is not authorized to make such a reduction without the approval of department headquarters.

Other factors contributing to the deficit at California State Prison, Solano are the continued overflow of inmates requiring administrative segregation placement and increased sick leave usage by the custody staff. The institution was designed to house up to 175 inmates in administrative segregation, but the current administrative segregation inmate population exceeds 350. This is a statewide issue that the Department of Corrections has attempted to address through the budget process with minimal success. The institution has also incurred excessive overtime costs for sick leave usage by the custody staff. Sick leave usage for correctional officers increased by 31 percent during fiscal year 2001-02 over the previous fiscal year, resulting in additional expenditures of $750,000.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the management review audit were to establish a baseline for future reviews by evaluating the institution's performance in the following areas:

- Planning, organizing, directing, and coordinating all correctional, business management, work-training incentive, education, and related programs at California State Prison, Solano; and
- Formulating and executing a progressive program for the care, treatment, training, discipline, custody, and employment of inmates.

In order to accomplish these objectives, the audit team performed various procedures in the general areas of mission focus, communications, institution safety and security, inmate programming, personnel, training, financial management, and external relationships. Those procedures included the following:

- Analytical reviews of various financial information;
- Conducting interviews with the warden, administrative staff, custody and non-custody employees, and inmates, including representatives of the California Correctional Peace Officers Association, California State Employees Association, California Correctional Supervisors' Association and the Inmate Advisory Committees for Facilities I-IV;
- Distributing survey questionnaires to randomly selected California State Prison, Solano employees, requesting responses regarding the warden's effectiveness in communication;
- Touring the facilities and observing its operations;
- Reviewing key internal and external reports and analysis prepared by the Office of the Inspector General, the Department of Corrections Health Care Services Division, Office

of Compliance, and Institutions Division and considering the impact of those reports on audit procedures; and

- Gathering, reviewing, and analyzing pertinent documents related to key systems, functions, and processes to substantiate the observations made through on-site visits and interviews.

In addition to performing field work at the institution between August 1, 2002 and October 1, 2002, the Office of the Inspector General met with the staff of the Department of Corrections Institutions Division, Health Care Services Division, and Education and Inmate Programs Unit in Sacramento to facilitate the review of departmental policies, procedures, and documentation.

The management review audit was performed in accordance with *Government Auditing Standards* issued by the U. S. General Accounting Office.

FINDINGS AND RECOMMENDATIONS

FINDING 1

The Office of the Inspector General found evidence that California State Prison, Solano is not adequately tracking inmates with tuberculosis, creating the potential of exposing inmates throughout the state to the disease and presenting a risk to the correctional staff and the general public.

To control outbreaks of tuberculosis in the inmate population, state law and Department of Corrections regulations require state correctional institutions to test inmates for tuberculosis and to document each inmate's tuberculosis status in a statewide database. The purpose is to allow inmates who have been exposed to the disease to be closely monitored, appropriately housed, and to receive prophylactic medication; to prevent inmates who are receiving medication from having the treatment interrupted; and to provide for medical precautions to be taken when inmates are moved from one institution to another.

The Department of Corrections has developed a coding system for identifying each inmate's tuberculosis status and requires the information to be stored in the department's statewide distributed data processing system for the use of staff assigned to healthcare, classification, case records, and transportation functions. But the Office of the Inspector General found numerous errors associated with tuberculosis coding and tracking at California State Prison, Solano, with the possibility that inmates infected with tuberculosis may not be receiving medication or be medically isolated, and as a result may be exposing others to the disease.

State law and regulations governing tuberculosis monitoring of inmates. Statutes concerning testing and monitoring state prison inmates for tuberculosis are set out in *California Penal Code* Sections 7570 *et seq.* The law requires state correctional institutions to test or evaluate inmates for tuberculosis upon incarceration and at least annually thereafter. The *California Department of Corrections Operations Manual*, in turn, requires institutions to assign codes denoting every inmate's tuberculosis status. The codes reflect the following tuberculosis disease stages and associated need for medical treatment and precautions:

- ***Tuberculosis infection.*** In this initial stage, a person has been infected with the disease, but has no symptoms and is not contagious. A full course of prophylactic treatment with oral medication is required for up to 12 months. Without treatment, 10 percent of cases will go on to develop tuberculosis. Interruptions in treatment can result in development of tuberculosis strains resistant to drugs. Under Department of Corrections regulations, inmates in this stage of the disease can be moved from one institution to another, but the medical staff at the receiving facility must be notified of the need for continued treatment.

- ***Tuberculosis disease.*** In this stage, the person has the disease, is infectious, and requires aggressive treatment for up to 24 months. Under department regulations, inmates in this stage cannot be moved from one institution to another using regular Department of Corrections transportation methods and cannot be transported without special respiratory precautions to protect others. Treatment must be continued without interruption at the new institution. After treatment, the person becomes non-infectious.

Following are the most critical of the codes developed by the Department of Corrections to denote inmate tuberculosis status and to specify treatment to be accorded:

11– Skin test administered but results not yet known. Inmate may not be transported.

21 – Tuberculosis test needed. Inmate may not be transported.

31 – Infectious tuberculosis disease suspected. Inmate may not be transported.

32 – Non-infectious, not on medication. Denotes inmates who have successfully completed tuberculosis treatment. No additional prophylactic medication needed and inmate may be moved by regular transportation. Evaluate annually.

33 – Tuberculosis infection, on medication, non-infectious. Identifies inmates exposed to tuberculosis and receiving medication. Inmate may be moved by regular transportation and medication must be transported with the inmate.

34 – Tuberculosis infection, not on medication, infectious. Identifies inmates who have been exposed to tuberculosis but who either refuse or are unable to complete the treatment regimen. Evaluate annually. Move by regular transportation.

43 – Tuberculosis disease, but non-infectious. Denotes inmates currently under treatment but no longer infectious. Treatment must be continued without interruption.

Inmate medical records show tuberculosis codes inconsistent with medical treatment. To evaluate the accuracy of tuberculosis coding, tracking, and treatment at California State Prison, Solano, the Office of the Inspector General compared the institution's pharmaceutical records to inmate tuberculosis coding. The comparison revealed errors in the records of 131 inmates. Of the 131 inmates, the medical records of 122 inmates with tuberculosis codes of 33 showed no corresponding pharmacy order for the medication *(isoniazid)* used to treat tuberculosis infection. The records of the remaining nine inmates, conversely, showed active medication orders for *isoniazid,* but no tuberculosis code of 33.

The 122 inmates with tuberculosis codes of 33 but without active medication orders may fall into one of the following categories:

- The inmates are not being monitored to ensure uninterrupted completion of the medication regimen, and the medication order has expired.
- The inmates tested positive for tuberculosis, but medication was never ordered, placing these inmates at higher risk for developing active disease. Because the inmates are incorrectly coded as 33, no transportation restrictions or respiratory precautions have been imposed.
- The tuberculosis code was entered incorrectly as 33.

The nine inmates with active medication orders for *isoniazid,* but not coded as 33 fell into two categories:

- Four inmates showed negative tuberculosis tests and no record of a positive tuberculosis test, yet still had active orders for *isoniazid.*

- Five inmates had positive tuberculosis tests in their records and active orders for *isoniazid,* but their tuberculosis codes were never changed to 33.

In addition, among the nine records for inmates with active orders for *isoniazid*, the Office of the Inspector General found one inmate with a code of 34, indicating that the inmate had been exposed to tuberculosis, but had not completed the medication. The inmate's record inexplicably reflected a subsequent code change to 22, indicating that he had never been exposed to tuberculosis, yet there was no evidence of a positive tuberculosis test in the inmate's record, and no explanation for the code change from 34 to 22.

Coding errors may cause disease outbreaks and may result in resistant forms of the disease. Inmates with tuberculosis codes of 33 and no associated order for medication are of particular concern because they may expose others to the disease. Once they are coded as 33, inmates are no longer tested for tuberculosis and have no transportation restrictions. Furthermore, because California State Prison, Solano has inadequate quality control procedures to identify inmates coded incorrectly, the number of inmates in this category is likely to increase. Incorrect tuberculosis coding can also result in improper transportation of infected inmates and an increased risk of an outbreak of tuberculosis among both inmates and staff. Coding errors may also cause interruptions in treatment, resulting, in development of drug resistant forms of the disease, necessitating more aggressive and expensive therapy.

Institution staffing appears to be inadequate for monitoring inmate tuberculosis status. California State Prison, Solano employs only one full-time public health nurse and one part-time infection control nurse who works one day a week to track the tuberculosis status of the institution's 5,800 inmates. The two employees work without clerical support. The public health nurse is responsible for updating all tuberculosis codes in the system-wide database and in each inmate's medical record based on information taken from physicians' progress notes and pharmacy records.

RECOMMENDATIONS

The Office of the Inspector General recommends that California State Prison, Solano take the following actions to improve the identification and tracking of inmate tuberculosis status:

- **Allocate additional personnel resources to the task of monitoring and recording inmate tuberculosis status.**

- **Require the public health nurse to collect all records for inmates who have completed a tuberculosis treatment regimen to ensure that those inmates receive a post-treatment evaluation by a physician.**

- **Require the public health nurse to ensure that tuberculosis codes are properly updated in inmate medical records and in the department's system-wide data base and that a Form CDC 128-C (tuberculosis chrono) is**

forwarded to the central records staff for inclusion in the inmate's central file.

FINDING 2

The Office of the Inspector General found that California State Prison, Solano inmates are allowed to earn sentence reduction credit through education and training classes even when classes are not actually held.

California state prison inmates may reduce their time in custody by earning credits through participation in work, education, or training programs at the rate of one day of credit for each day of participation. Like other Department of Corrections institutions, however, California State Prison, Solano is experiencing difficulty filling teacher vacancies for education and training classes, with the result that many classes are not being held. Yet, under a mistaken belief that classes cannot be closed without approval from department headquarters, the institution has continued to assign inmates to classes even when no teachers are available and classes are not held—and even though the classes are not being held, inmates are allowed to earn sentence reduction credit as though they attended the class.

Regulations governing time credits for program participation. *California Penal Code* Section 2933 provides that inmates in the custody of the Department of Corrections may reduce their time in custody by earning credits through performance in work, education, or training programs. In general, for each day they participate in an approved work, education, or training assignment, inmates may reduce their sentences by one day for up to 50 percent of their terms. Under *California Code of Regulations*, Title 15, Section 3045.3, inmates unable to attend assigned work or education programs may still earn sentence-reducing credit under certain circumstances. Those circumstances include when the institution is on lockdown status, when instructors are absent and no relief instructor is available, when emergency conditions exist, or when other factors that are not the fault of the inmate prevent participation in the work or education program. Time credited to inmates under such circumstances is referred to as "S" time.

Teacher shortages have limited class availability. Teacher shortages at California State Prison, Solano have resulted in part from a statewide hiring freeze on non-custody positions imposed by the Department of Corrections in November 2001. The education department at the institution requested an exemption from the provisions of the hiring freeze in order to fill vacant teacher positions, but because of the potential conversion of California State Prison, Solano to a reception center, the institution obtained permission only to fill limited-term positions. According to the supervisor of correctional education programs at the institution, this severely limited the candidate pool and created further delays in filling vacant positions. The institution presently lacks teachers to substitute for those on vacation or sick leave or who are participating in mandatory continuing education or training, with the result that classes are often closed due to teacher absences.

Misuse of "S" time credits. Although the "S" time credits are meant to cover situations temporary in nature, the Office of the Inspector General found that California State Prison, Solano has been assigning inmates to classes and allowing "S" time credits even when classes have had no teachers available for periods ranging from several months to more than a year.

Operating under the mistaken belief that classes cannot be closed without approval from the Institutions Division of the Department of Corrections, for several years the institution has continued to assign inmates to classes even when teachers are not available to teach the classes and regular classes are not held. An adult basic education program at the institution continued to receive new students in fiscal year 2001-02, for example, even though no instructor was available to teach the class.

A review by the Office of the Inspector General of the institution's monthly education reports showed that 39 percent of the "S" time hours reported in fiscal year 2001-02 resulted from teacher vacancies, training, and meetings. Lockdowns, late releases, and other custody matters accounted for the remaining 61 percent. A chart depicting the breakdown in "S" time hours is shown below:

Description	Academic	Vocational	Combined	%
Custody-Related Hours	533,888	470,025	1,003,913	61
Education-Related Hours	301,280	337,939	639,219	39
Total Hours	835,168	807,964	1,643132	100

The Office of the Inspector General also found that the absence of a teacher and resultant class closing in fact may account for an even greater proportion of the "S" time granted to inmates than that indicated by the monthly education reports. A review of inmate timesheets for an adult basic education class revealed that often when a class was not held, a member of the teaching staff had noted the reason for the inmate's absence as "custody-related" even when the actual reason was that no teacher had been assigned to the class. The supervisor of correctional education programs told the Office of the Inspector General that when a lockdown is in effect, the standard practice of the staff is to attribute inmate absences to custody reasons, even when no teacher is available to teach the class and the class would not have been held if the lockdown had not been in effect.

Whether inmate absences are attributed to custody-related reasons or to education reasons, the Office of the Inspector General found that in 2001-02, inmates actually participated in academic and vocational programs for only about 37 percent of the time scheduled for those programs. Many of the inmates nonetheless received time reduction credits as if they had attended classes full-time. In effect, the practices followed at the institution reduce the sentences of the inmates without requiring commensurate performance by the inmates as intended by *California Penal Code* Section 2933.

The following chart shows the percentage of time inmates participated in academic and vocational programs for fiscal year 2001-02:

Description	Academic	Vocational	Combined
Average Inmate Enrollment	943	910	1,853
Actual Hours Spent in Classes	520,909	456,031	976,940
"S" Time Hours	835,168	807,964	1,643,132
Other Excused Absence Hours	16,144	18,985	35,129
Total Hours	1,372,221	1,282,980	2,655,201
% of Hours Spent in Classes	38%	36%	37%

According to the Institutions Division, although division approval is in fact required to close classes, inmates can and should be removed from programs and placed on waiting lists when a teacher's absence is expected to last longer than 30 days. Inmates are also supposed to be referred to a classification committee and removed from any program that is closed for more than 30 days, even if the Institutions Division has not approved an official request for closure. The Institutions Division issued a memorandum to all institutions on May 16, 2002 clarifying this policy, but key management personnel at California State Prison, Solano advised the Office of the Inspector General that they were unaware of the policy and of the memorandum. The warden told the Office of the Inspector General at an informal meeting that the institution has recently begun closing classes in accordance with departmental policy.

RECOMMENDATION

The Office of the Inspector General recommends that California State Prison, Solano refer all inmates currently assigned to programs without instructors to the classification committee for reassignment in accordance with the May 16, 2002 memorandum from the Department of Corrections Institutions Division and discontinue awarding "S" time to these inmates. California State Prison, Solano should also immediately identify which classes should be closed and take formal steps to do so.

FINDING 3

The Office of the Inspector General found that makeshift partitions in the institution's administrative segregation unit buildings have created blind spots that limit the view of the control booth officers, compromising the safety and security of correctional staff and inmates.

The Office of the Inspector General found that the institution has installed partitions in the administrative segregation buildings beneath the control booth in order to create space for classification committee meetings and other activities isolated from the view of inmates housed in segregation cells. But the partitions block the view of officers on the floor and allow the

control booth officer only a limited view of the floor immediately outside the doors of the lower-tier cells.

The partitioned areas, located on one side of the Building 9 control booth and on both sides of the Building 10 control booth, are used to conduct inmate classification committee meetings and other business in addition to providing an area for custody employees to eat lunch. The partitions are constructed from metal cabinets containing miscellaneous office supplies, along with inmate clothing, towels, and linens. The Office of the Inspector General noted that cardboard file boxes stacked atop the cabinets increase the vertical height of the barrier to about seven and a half feet. Each three-sided partition, combined with the outside wall of the control booth structure, form a rectangular area of roughly 250 square feet (seven cabinets on the longest side, with four cabinets on each of the shorter sides). The photograph below, taken on October 1, 2002, shows the partitioned area from the control booth.

The makeshift partitions, which are not part of the facility's original design plan, present a visual barrier to officers on the floor of the administrative segregation unit. Although the officer in the control booth has an unobstructed view of all cell doors in the unit, he or she is afforded only a limited view of the floor area immediately outside the doors of the lower tier cells and would be unable to provide gun coverage should an incident occur in the blind spots.

When interviewed about these conditions, members of the custody staff remarked that inmates in administrative segregation are moved only under escort and in mechanical restraints and that the possibility of an inmate physically attacking the custody staff without being brought quickly under control is remote. But there have been incidents in other correctional institutions in which inmates have escaped from cells and attacked the staff, and for that reason barriers to the view of correctional officers of inmate activity are discouraged in all parts of correctional institutions.

RECOMMENDATION

The Office of the Inspector General recommends that California State Prison, Solano remove the makeshift barriers in the administrative segregation unit and develop alternatives for creating meeting space.

FINDING 4

The Office of the Inspector General found that a significant number of inmates taking psychotropic medications are inappropriately housed in buildings lacking air conditioning and that some inmates who are taking anticonvulsant medications are not assigned to lower bunks to lessen the possibility of injury in the event of a seizure.

Psychotropic medications can increase the risk of heat-related illnesses by altering the body's temperature-regulating mechanisms or impairing the ability to perspire. Accordingly, patients taking psychotropic medications are advised to avoid exposure to high ambient temperatures. Yet, the Office of the Inspector General found that more than half of the inmates at California State Prison, Solano taking psychotropic medication are assigned to buildings without air conditioning. The Office of the Inspector General also found that 10 inmates taking anticonvulsant medication for seizure disorders were assigned to upper bunks, putting them at risk of injury in the event of a seizure.

A review of the records of 544 inmates taking psychotropic medication as of September 9, 2002 revealed that 289 (53 percent) were housed in facilities lacking air conditioning, putting them at risk for heat-related illness as a result of the high temperatures common during the summer months at California State Prison, Solano. Similarly, a review of housing assignments for inmates receiving anticonvulsant medication for seizure disorders revealed that 10 were assigned to upper bunks, even though inmates at risk of experiencing seizures are normally assigned to lower bunk and lower tier housing.

The failure of the institution to assign inmates to medically appropriate housing not only places inmates at risk of medical complications or injury, but also exposes the institution and the Department of Corrections to the possibility of litigation.

RECOMMENDATION

The Office of the Inspector General recommends that the institution conduct periodic evaluations of the housing assignments of inmates who have been prescribed psychotropic medications or whose medical conditions indicate particular housing needs. When a housing assignment is found to be incompatible with an inmate's medical condition, the institution should take immediate measures to reassign the inmate to appropriate housing.

FINDING 5

The Office of the Inspector General found that when inmate deaths occur, the cause and circumstances surrounding the deaths are not examined in a timely manner and that those assigned to conduct the reviews may have a direct interest in the results.

The Department of Corrections has established procedures for reviewing the cause and circumstances surrounding inmate deaths, but the Office of the Inspector General found that the reviews take too long to complete and that those assigned to review the cases sometimes have a direct interest in the results. The process also does not provide for adequate coordination between the institution's investigative staff and the department's Health Care Services Division.

Inmate death reporting and review requirements. The Health Care Services Division of the California Department of Corrections has set out formal policies and procedures to be followed in inmate deaths to determine the circumstances surrounding the death, including the cause of death and the appropriateness of medical care provided. The policies and procedures are intended to ensure that any necessary corrective measures are implemented to reduce the incidence of preventable deaths and to provide for statistical analysis and research for the purpose of improving the delivery of health care.

The procedures require institutions to send all pertinent information about the death to the Health Care Services Division by the close of the first business day following the date of the death. The information about the death is reviewed by a physician, who refers the case to the division's morbidity and mortality committee if the review identifies circumstances surrounding the death that require investigation or further review. At that point the committee can either close the case or request an additional peer review or an investigation. Peer reviews are typically assigned to the chief medical officer of the institution where the inmate was incarcerated. The warden may also initiate an investigation into the death. Investigations may be performed by either the institution or by the Office of Investigative Services of the Department of Corrections.

The peer review process is not completed promptly. The Office of the Inspector General found from reviewing a database listing cases in which peer reviews had been requested that the reviews are not completed in a timely manner, and in some cases had still not been completed even three years or longer after the death. The database reviewed listed 40 Department of Corrections inmate death cases in which the morbidity and mortality committee had requested peer reviews. The review revealed that 27 (68 percent) of the peer reviews had taken more than a year to complete and that 17 (43 percent) were still incomplete at the time of the Office of the Inspector General's audit. Two of the cases dated back to March and June of 1999, almost four years earlier. The problem is reflected at California State Prison, Solano, where a peer review of nursing issues in a case in which an inmate died of a heart attack took eight months to complete, and nine months after the death a peer review of a physician had still not been performed.

The Office of the Inspector General conducted an in-depth review of the documents pertaining to the inmate death at California State Prison, Solano referred to above and identified a number of issues of concern. The chronology of that case, which occurred in January 2002, is as follows: An inmate who claimed to have had a history of cardiac problems complained to a correctional officer of chest pains. The correctional officer conveyed the information to a nurse at the primary clinic. At the nurse's request, the inmate was walked to the clinic and examined. According to the nurse's notes, the inmate was alert, oriented, and relaxed with no pallor, fatigue, numbness or tingling in the extremities, and "appeared to be in no apparent distress". The nurse's notes said that the inmate was convinced that the pain was gastric in nature and not the result of a heart attack. The nurse performed an electrocardiogram and discussed the symptoms and the patient's history by telephone with the chief medical officer, who prescribed Maalox to relieve gastric discomfort. The inmate was released and walked back to his housing unit. About two hours later a fellow inmate discovered him not breathing and alerted correctional officers. The correctional officers were unable to get a response and summoned the medical staff. The medical staff performed CPR until they were relieved by paramedics from the Vacaville Fire Department medical rescue team, but despite all efforts, the inmate died.

From reviewing the documents in the case, the Office of the Inspector General found the following:

- ***The peer reviewer had a direct interest in the review results.*** The morbidity and mortality committee recommended that a supervising registered nurse employed at California State Prison, Solano perform a peer review of nursing issues involved in the case, even though that person's responsibility for nursing matters at the institution provided a disincentive for a critical and objective analysis. The Office of the Inspector General notes that conflicts of interest are inherent in peer reviews — at least in appearance if not in fact — in that they are referred to the chief medical officer at the institution where the death occurred or to supervisors in charge of the staff undergoing review.

- ***The peer review of nursing issues in the case was inadequate.*** The Office of the Inspector General found a number of flaws in the peer review of the nursing issues surrounding the case. Specifically:

    - ***The peer reviewer did not interview those knowledgeable about the death.*** The peer review report does not indicate that the reviewer interviewed correctional officers, inmates, or anyone else with knowledge about the circumstances surrounding the inmate's death, calling the adequacy of the review into question. The report contains no documentation of an interview with even the attending nurse, and in fact it appears that in conducting the peer review, the reviewer only read the attending nurse's notes, which were written a day after the incident. The Office of the Inspector General found that a supervising nurse conducted an earlier peer review into the death and that that review did not include a review of the inmate's unit health record. That failure prompted the morbidity and mortality committee to return the peer review to the same supervising nurse for a further examination of the records.

    - ***The results of the electrocardiogram are not documented.*** Although an electrocardiogram was apparently performed on the inmate, the report of the peer review does not include the test results. An autopsy confirmed the presence of electrocardiogram patches on the inmate's chest, but the report of the peer review conducted by the supervising nurse notes that the electrocardiogram results were missing. The report contains no information about efforts to locate the results.

    - ***Blood sampling was not examined.*** The peer review report does not discuss whether the attending nurse drew blood from the inmate or whether the doctor ordered a blood sample.

    - ***The reason the inmate was required to walk to the clinic was not examined.*** The peer review did not address the fact that the inmate was required to walk both to and from the clinic even though he was experiencing chest pains and claimed a history of heart problems, nor do the attending nurse's notes address why she determined that it was permissible for the inmate to walk to the clinic.

    - ***Failure of the correctional staff to administer CPR was not addressed.*** Section 51070.3 of the *California Department of Corrections Operations Manual* provides as follows:

An employee discovering a possible death shall immediately summon medical assistance. Pending arrival of medical assistance, the employee shall make every effort to preserve life. This may include first aid, CPR, and other life-saving measures for which the employee is trained.

The department provides CPR training to correctional officers at the academy, along with refresher training. Yet, the correctional staff did not administer CPR in this case, and the peer review did not address that failure or the fact that the staff waited for medical personnel to arrive and to initiate CPR even though the inmate had been found to be not breathing. According to the records available, paramedics arrived at 1:58 p.m., six minutes after they were summoned. The coroner's report documents an interval of at least fifteen minutes before CPR was started.

- ***The warden did not initiate an investigation into the death.*** A warden may initiate an investigation into an inmate death in addition to a peer review requested by the morbidity and mortality committee, but in this case, the warden did not request an investigation, despite indications that an investigation was warranted. Incident reports about the death, prepared by correctional officers, included documentation that an inmate interviewed about the death said the inmate had told him that "medical only gave him Maalox for indigestion and he knows it was not indigestion." The inmate also said that the inmate had told him that "he has had two heart attacks in the past and knows what a heart attack feels like**."** Those comments directly conflict with the notes written by the nurse after the inmate's death, which said the inmate was convinced that the pain was gastric in nature and not the result of a heart attack. The comments raise questions about the evaluation of the inmate's condition when the medical staff saw him just 2 1/2 hours before his death.

- ***Results of the peer review were not provided to the warden.*** The results of the nurse's peer review requested by the morbidity and mortality committee were not provided to or discussed with either the warden or the institution security and investigations unit, and, in fact, the current process is not designed for such communication to occur. The institution would have benefited from an investigation in this case, combining the coordinated skills of medical professionals and investigative staff. Such an investigation might have answered many of the questions that remain unresolved.

RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections develop procedures to require the Health Care Services Division to take the following steps to improve review of inmate deaths:

- **Coordinate review of inmate deaths with the warden and the institution's chief medical officer. The procedures should provide for communication throughout the review process to coordinate the assignment of staff and collection of evidence by the investigative staff when necessary.**

- **Forward pertinent information gathered by the investigations unit of the institution to the morbidity and mortality review committee.**

- **Ensure that those conducting peer reviews are independent of the incident and the individuals involved.**
- **Ensure that peer reviews are completed in a timely manner.**

FINDING 6

The Office of the Inspector General found that California State Prison, Solano retains inmates in administrative segregation units longer than justified.

The Office of the Inspector General found that California State Prison, Solano does not effectively monitor the process for determining the length of time inmates spend in administrative segregation, with the result that inmates may be kept in administrative segregation longer than necessary. The problem has been compounded by a recent action of the Department of Corrections to override state regulations requiring that an inmate's stay in administrative segregation be re-evaluated at least every 30 days. A department directive has provided instead that an inmate's continued retention in administrative segregation be evaluated every 90 to 180 days, depending on the reason for the retention.

Reasons for confining inmates in administrative segregation. Inmates may be kept in administrative segregation when they present an immediate threat to themselves or others or when their presence in an institution's general population endangers institution security. Inmates may also be kept in administrative segregation when they are the subject of a pending criminal prosecution, internal disciplinary proceeding, or investigation; during the resolution of a non-disciplinary issue such as an inmate's concern for his own safety; or while awaiting reclassification to a different custody level.

State regulations governing retention in administrative segregation. *California Code of Regulations,* Title 15, Section 3335 (c), requires the institution classification committee to re-evaluate an inmate's continued retention in administrative segregation at least every 30 days during the inmate's stay and to refer any case involving confinement for more than 30 days to a classification staff representative for additional review and approval. The re-evaluation process is necessary both to protect the due process rights of inmates and because of the high cost of keeping inmates in an administrative segregation unit. Confinement in administrative segregation includes restriction of privileges normally granted to general population inmates. In administrative segregation, inmates are confined to their cells for all but 10 hours a week for exercise and showering and are handcuffed and escorted during any movement outside of cells. Administrative segregation units thus require a higher staffing level than general population facilities, with custody staff also required to serve meals individually to administrative segregation inmates and to maintain the common areas of the housing unit—tasks that inmates housed in general population units normally perform for themselves.

In a memorandum dated November 20, 2001, however, the deputy director of the Department of Corrections Institutions Division, directed wardens, classification staff members, and correctional counselors to extend the frequency of classification committee re-evaluations to 90 days for non-disciplinary matters and to 180 days in disciplinary matters. The Office of the Inspector General found that the memorandum amounts to an "underground regulation" that effectively amends *California Code of Regulations,* Title 15, Section 3335(c) and circumvents

the procedural requirements of *California Government Code* Section 11346 for adopting, amending, or repealing administrative regulations.

An apparent intent of the administrative change was to reduce the time inmates spend in administrative segregation by supplanting the 30 day-review requirement with improved tracking of the reasons for the inmate's placement in administrative segregation housing. The memorandum provided as follows:

> *It is important that these changes not result in increased inmate ASU time. Conversely, we expect reduced ASU retention time by allowing staff resources more time to bring closure to the cases. Upon bringing closure to the case, staff shall schedule that inmate within ten days for ICC to take action to release the inmate to the General Population, establish a Security Housing Unit (SHU) term, and/or refer the inmate for transfer to an alternate facility. None of these changes should be viewed as taking responsibility from staff to actively pursue case closure as quickly as possible. It is paramount that each institution audit and improve tracking systems associated with the reasons for ASU housing.*

Tracking systems for the retention of administrative segregation inmates are ineffective. The Office of the Inspector General found, however, that at California State Prison, Solano the tracking systems for monitoring retention of inmates in administrative segregation units are inadequate. Because the institution has no standard tracking system for monitoring and tracking inmates housed in administrative segregation, each unit involved in the process has developed its own tracking system, with no single staff member having responsibility for ensuring that critical actions are taken. Decisions to place and keep inmates in administrative segregation require timely and accurate communication among more than half a dozen institution and department employees. Breakdowns or delays in communication among these employees can significantly delay the decision process, with inmates left in administrative segregation for unnecessarily long periods as a result.

The Office of the Inspector General found several instances in which various units at the institution failed either to communicate effectively or to complete actions relative to an inmate's continued retention in administrative segregation. Examples include the following:

- ***Delays in gang validation review extend administrative segregation retention.*** The Office of the Inspector General found two cases in which inexplicable delays in completing gang validation reviews caused inmates to be retained in administrative segregation for long periods. In one case, five months elapsed from the time the institution classification committee reportedly requested a gang validation review until the results were made available. In a second case, the gang validation review took seven and a half months. In neither case did the institutional gang investigative unit find sufficient evidence to validate the inmate as a member or associate of a prison gang, yet the inmates remained in administrative segregation pending conclusion of the investigations. According to the institutional gang investigative staff, gang validation reviews can usually be completed in four days. A lack of documentation in the institution records makes it difficult to determine the reason for the delays in these two cases. Because requests for gang validation reviews are made by telephone, it is unclear when the institution classification committee actually requested the reviews and whether the delays resulted from a failure of the committee to

request the investigations in a timely manner or from delays in the investigative process itself.

- ***Institution classification committee not notified promptly of gang review results.*** In two other cases reviewed by the Office of the Inspector General, the institution classification committee was not informed that institutional gang investigative unit investigations had been completed and therefore deferred action until the next scheduled institution classification committee meeting. In one of the cases, the gang validation investigation had been completed for four months before the institution classification committee was notified of the results.

- ***Referral to district attorney extends inmate retention in administrative segregation.*** *California Code of Regulations,* Title 15, allows an inmate to suspend the internal disciplinary process pending possible referral to the district attorney for criminal prosecution, sometimes resulting in the prolonged retention of inmates in administrative segregation. The Office of the Inspector General found one case in which the disciplinary process was suspended by more than a month and a half because of delays in providing the necessary documents to the security and investigations unit for review before referral of the case to the district attorney. Ultimately, the case was not recommended for criminal prosecution, but in the meantime, the inmate remained in administrative segregation.

RECOMMENDATIONS

The Office of the Inspector General recommends that the warden take the following actions:

- **Develop a standard tracking system for use by all of the housing facilities to monitor inmates retained in administrative segregation. The tracking system should record all critical actions, including communication with employees and other units within the institution to ensure that casework is completed in a timely manner.**

- **Emphasize the importance of completing casework before presenting cases at the institution classification committee hearing or submitting cases to the classification services representative for review and approval.**

- **Provide training to correctional counselors and other members of the institution staff to ensure that all actions required in administrative segregation cases are completed and the results documented and communicated to the appropriate staff.**

- **Identify all cases that have been deferred pending action or returned by the classification services representative for completion of additional case work and monitor these cases closely to ensure that tasks are completed by the institution staff in a timely manner.**

The Office of the Inspector General further recommends that the Department of Corrections follow the procedural requirements for amending regulations as required by the *California Government Code.*

FINDING 7

The Office of the Inspector General found that California State Prison, Solano is not complying with state regulations governing inmate dental care and as a result may be exposed to the risk of litigation.

California Code of Regulations, Title 15 requires all newly committed inmates to receive a complete dental examination within 14 days of arrival from the reception center. Title 15 also requires all inmates under the age of 50 to receive a dental examination at least once every two years and all inmates over the age of 50 to receive a dental examination every year. The chief dentist at California State Prison, Solano acknowledges, however, that the institution is not meeting these requirements, thereby exposing the institution to possible legal action.

According to the chief dentist, the institution presently attempts to schedule eight examinations each day for newly arrived inmates and provides dental care to other inmates according to the urgency of need. As time allows, approximately 24 inmates a day also are scheduled for routine care. But inmates receive routine dental services only when they themselves request appointments, and the institution does not attempt to provide the periodic examinations required by Title 15. At the time of the audit, the institution had a patient backlog of approximately five months for routine dental services. The chief dentist maintains that a shortage of facilities and staff prevent the institution from complying with regulatory requirements for periodic dental examinations.

The institution includes a dental clinic, which is operated by the chief dentist and five staff dentists, but has only four dental chairs and four dental assistants. A medical clinic annex under construction at the time of the audit will add two more dental chairs, bringing the total to six. But a planned modification of the correctional treatment center will cause the four existing chairs to be unavailable for six to ten months, temporarily leaving the institution with only two dental chairs. During that period, the patient backlog is likely to increase.

The standard staffing requirement for inmate dental care of the Department of Corrections is one dentist and one dental assistant for every 950 inmates. Since the inmate population at California State Prison, Solano fluctuates between 5,800 and 5,900, the current staffing level of one chief dentist and five dentists complies with departmental standards, but the staff of four dental assistants falls short of departmental standards by two positions. A recent report, "*To Refine and Improve the Delivery of Dental Care to the Inmate-Patients of the California Department of Corrections,"* indicates that the shortage of dental staff is not isolated to California State Prison, Solano, but rather is a statewide problem. The failure of the department to comply with state regulations for inmate dental care may also expose the state to possible legal action.

RECOMMENDATION

The Office of the Inspector General recommends that the California Department of Corrections examine policies and regulatory requirements governing inmate dental care and consider revising requirements to a level achievable under present conditions.

FINDING 8

The Office of the Inspector General found that California State Prison, Solano does not adequately document employee disciplinary proceedings and that the warden inappropriately serves as the hearing officer in appeals of adverse action decisions.

State law and regulations require specific procedures to be followed in disciplinary actions involving California state government employees. The purpose of the provisions is to protect the due process rights of employees to fair and impartial hearings and to afford them an opportunity to appeal adverse action decisions. The Office of the Inspector General found that despite an inherent conflict of interest, the warden of California State Prison, Solano often serves as the hearing officer in appeals of adverse action decisions, and in that capacity often reduces the penalty for sustained misconduct. Although the original adverse action penalty undergoes a thorough independent review, the penalty reduction authorized by the warden does not. Moreover, the reasons for penalty reductions made by the warden are rarely documented, bringing into question the benefit of the process leading up to the adverse action.

Review of adverse action decisions. Statutes and regulations governing employee disciplinary actions are set out in *California Government Code* Sections 3300-3311 and 19635, et seq.; in *California Code of Regulations,* Title 15, Article 13; and in the *California Department of Corrections Operations Manual.* The employee disciplinary process provides for systematic review of decisions pertaining to proposed adverse actions against employees — and at any point in the process, a reviewer can modify the recommended penalty. When an investigation into possible misconduct by an employee sustains a finding of employee misconduct, the warden makes a decision whether to proceed with an adverse action. If the decision is to proceed with the adverse action, the institution's employee relations officer reviews the investigation and consults with Department of Corrections headquarters personnel staff to establish a range of possible penalties based on recent disciplinary actions taken against other employees for similar misconduct. The warden or one of the chief deputy wardens then confers with the employee relations officer to develop a recommended penalty for the employee. The employee relations officer submits the adverse action package, including a recommended penalty, to the department headquarters personnel office for review, and the personnel office forwards the package to the Department of Corrections regional administrator for approval. When all of the reviews have been completed, the employee is served with a notice of adverse action. The employee may then request that the matter be heard by an impartial reviewer in what is known as a "Skelly hearing," and may appeal any adverse action sustained at the Skelly hearing to the State Personnel Board.

Employee disciplinary files lack documentation of the reasons for disciplinary actions. The Office of the Inspector General found that the institution is not adequately documenting the reasons for decisions made in employee disciplinary actions during the review process, making it impossible for an outside reviewer to determine what actions were taken or what information was considered during the disciplinary process. An examination of the files in 21 adverse action cases revealed that the majority did not document the reasoning behind the decisions and that notes from the related Skelly hearings were often illegible or failed to provide a summary of the information the Skelly officer considered in recommending a penalty. The files also lacked documentation of information considered by the regional administrator in reviewing the case, raising questions about the benefit of that review to the adverse action process.

Disciplinary penalties are often reduced as a result of the Skelly hearing. The Office of the Inspector General also found that in more than half the cases reviewed, the penalty was reduced as a result of the Skelly hearing. Because the recommended penalty undergoes extensive review and approval involving the warden, the department personnel office, and the regional administrator, the high percentage of cases in which penalties are reduced suggests that either the process leading up to the Skelly hearing was flawed or that the decision of the Skelly hearing officer was faulty. Of the 21 adverse action cases reviewed by the Office of the Inspector General, 14 advanced to a Skelly hearing, and of those 14, eight resulted in a reduction of the penalty recommended during the earlier stages of the process. In one of the files reviewed, for example, an adverse action penalty was reduced to a letter of instruction even though the original notice to the employee of adverse action had imposed a 5 percent reduction in pay for 12 months.

Reasons for penalty reductions are not adequately documented. California State Prison, Solano officials told the Office of the Inspector General that penalties often are reduced because the employee admits to misconduct at the hearing and expresses sincere remorse, but the files reviewed by the Office of the Inspector General did not support that information. In one of the cases reviewed, for example, a correctional officer received a 5 percent reduction in pay for six months after he was arrested for a hit and run accident and failed to notify the institution of his arrest, but after the Skelly hearing the warden reduced the penalty to a 5 percent pay reduction for three months. A memorandum to the employee reporting the results of the Skelly hearing said that the penalty had been reduced because the employee had admitted guilt and repented, but the adverse action file documented that the employee had been dishonest during the adverse action investigation and had received a second adverse action for driving under the influence a few months before the Skelly hearing. Of the eight files reviewed by the Office of the Inspector General in which penalties were reduced at the Skelly hearing, only two contained documentation describing the reasons for the penalty reduction. Although the files do contain notes from the Skelly hearings, many of the notes are illegible and none provided a summary of the information considered by the Skelly officer in modifying the recommended penalty.

The warden often assumes the role of the Skelly hearing officer. Despite inherent conflicts of interest arising from his role in institution operations and his close association with many of the individuals likely to be involved at various levels of the disciplinary process, the warden of California State Prison, Solano often serves as the hearing officer presiding over Skelly proceedings involving the institution. The Office of the Inspector General found adverse action cases in which the warden had signed the request to initiate an investigation of an employee; signed the majority of the notices of adverse action; participated in recommending the disciplinary action brought forward by the institution; and yet also served as the hearing officer at the Skelly hearing. That practice conflicts with State Personnel Board guidelines governing the selection of Skelly officers. The *State Personnel Board Technical Training Program Manual* provides that Skelly officers should disqualify themselves from the proceedings if they:

- Were directly involved in the investigation of the matters leading to the personnel action;
- Participated in the decision to refer the matter for investigation;
- Personally reviewed the results of the investigation;
- Recommended a specific penalty to the decision maker;

- Have a reason to be biased against the employee; or
- Would be called as a material witness if the case goes to hearing.

RECOMMENDATIONS

The Office of the Inspector General recommends that California State Prison, Solano take the following actions:

- **Take steps to ensure that the employee relations officer and all others involved in possible employee disciplinary proceedings document their actions thoroughly and completely in the adverse action files to provide a complete and accurate history of critical steps in the disciplinary process and assist the employee relations officer in developing consistent disciplinary recommendations in future cases.**
- **Discontinue the practice of the warden acting as the Skelly hearing officer in personnel matters involving California State Prison, Solano.**

FINDING 9

The Office of the Inspector General found that pharmacy record keeping and physical controls over prescription medications stored in the infirmary and clinics are inadequate to prevent unauthorized access and theft.

Although the Office of the Inspector General found no evidence of actual theft of pharmaceuticals at California State Prison, Solano, the audit revealed that pharmaceutical products at the institution are kept in an environment conducive to theft and abuse. In fiscal year 2001-02 the institution spent more than $4 million for pharmaceutical supplies, and the potential exists for theft of even small volumes of drugs to have a significant fiscal impact.

Pharmaceuticals at the institution are classified as either "cold meds," which inmates may take without medical staff supervision, or "hot meds," which require direct administration by the staff. The pharmacy pre-packages "cold meds" for direct delivery to inmates. "Hot meds," however, are sent in the manufacturer's original packaging to the infirmary and clinics where they are stored on open shelves in the nurse's station and used to refill the medical carts from which the staff dispenses medication to inmates. The Office of the Inspector General noted that medical personnel working in the nurse's station have access to drugs stored on the open shelves and on unlocked medical carts, making the items susceptible to theft. During one site visit, the Office of the Inspector General noted that the door to the nurse's station was open, allowing access by other staff members. Drugs classified as narcotics were stored in a locked cabinet. Furthermore, neither the pharmacy nor the medical clinics keep records of the quantities of pharmaceuticals shipped or consumed, providing the staff with no objective means of determining whether pharmaceutical products are missing.

RECOMMENDATIONS

The Office of the Inspector General recommends that the health care manager at California State Prison, Solano take the following actions to improve control over pharmaceuticals:

- **Institute measures to ensure that medications are securely stored at all times consistent with their value and potential for misuse. Medications in the infirmary and clinics should be stored in secured areas under a supervisor's control.**
- **Record the quantity of pharmaceuticals shipped to the infirmary and clinics and periodically compare these records to the quantities prescribed by doctors. Investigate any material variations between the two amounts. Physical inventories of drugs should be conducted periodically and compared to perpetual inventory records maintained by the health care manager.**

FINDING 10

The Office of the Inspector General found that California State Prison, Solano does not promptly implement medical modification orders and that many were significantly overdue at the time of the audit.

The Office of the Inspector General found that a high percentage of modification orders directing California State Prison, Solano to remedy conditions affecting inmate medical conditions were more than seven months overdue. Delays in implementing medical modification orders can result in serious medical consequences for inmates and expose the institution and the department to possible lawsuits.

Under *California Code of Regulations,* Title 15, an inmate may appeal a departmental decision, action, condition, or policy that the inmate can demonstrate may have an adverse effect upon his or her welfare. Decisions favoring an inmate's position may be granted in the form of a "modification order," a directive to remedy the issue or condition precipitating the inmate's appeal.

California State Prison, Solano policy, effective August 1, 2002, requires modification orders to be completed within 30 calendar days of issuance and requires the institution's medical appeals analyst to track medical modification orders and to advise the inmate appeals office when they are completed. The inmate appeals office is responsible for preparing a list of overdue modification orders and distributing it to executive management each week.

But the Office of the Inspector General found that 38 modification orders at the institution were overdue in August 2002 and that 32 of the 38 were medical modification orders. Twenty-five of those 32 —78 percent — were more than seven months overdue. In fact, 23 of the inmates for whom the modification orders were written had since left the institution. The audit also revealed that the institution's report of overdue modification orders was inaccurate in that it omitted four orders from 2001 that had not been implemented and included five orders that had been completed.

According to the warden, as of November 13, 2002, the number of overdue modification orders had been reduced to four.

RECOMMENDATIONS

The Office of the Inspector General recommends that the chief medical officer at California State Prison, Solano assign a staff member to monitor the timely completion of medical modification orders, with priority on resolving the oldest orders first. That staff member should also periodically reconcile the information on the overdue modification orders list to information in the inmate appeals office records to ensure the accuracy of the list.

FINDING 11

The Office of the Inspector General found that the institution is not properly documenting inmate activity in the administrative segregation units and that in some instances events are logged before they occur.

State regulations and California Department of Corrections policy require that movement and housing of inmates assigned to an administrative segregation unit be recorded in a hardbound logbook — a CDC Form 114 — which provides a single-source record of daily activity within the administrative segregation unit. The log is formatted to include the inmate's cell number and bed assignment, the time of the inmate's entry to or exit from administrative segregation, the identity of visitors to the unit, and any unusual incidents within the unit. The CDC Form 114 is a legal document subject to be used as evidence in a civil, criminal, or administrative proceeding.

The Office of the Inspector General found that although the administrative segregation staff at California State Prison, Solano maintains the CDC Form 114, the information is not consistently entered into the log immediately. Instead, information is entered into the logbook only once every 24 hours by the administrative segregation unit's first watch floor officer, using reports from central control to record inmate housing assignments. That practice undermines the purpose of the CDC Form 114 as a source of accurate, up-to-date information about inmate location, diminishes the evidentiary value of the CDC Form 114, and presents a safety risk to staff and inmates.

California Code of Regulations, Title 15, Section 3332 (g) (1), *California Department of Corrections Operations Manual,* Section 52080.22.5, and institution post orders all require that the CDC Form 114 be kept continually up to date. Title 15 provides as follows:

> *[A] Disciplinary Detention Log, CDC Form 114, will be maintained in each designated disciplinary detention unit. Specific information required in this log will be kept current on a daily and shift or watch basis.*

California Code of Regulations, Title 15, Section 3332(g)(2) provides:

> *[A] separate record will be maintained on each inmate undergoing disciplinary detention. This record will be compiled on CDC Form 114-A, Detention/Segregation Record. In addition to the identifying information required on the form, all significant*

information relating to the inmate during the course of detention, from reception to release, will be entered on the form in chronological order.

Similarly, special instructions in the post orders for post numbers 12050 and 12200, Units 9 and 10, for the administrative segregation unit housing officer (first watch), as revised January 2002, provide:

> *You will complete the isolation log and keep it up to date…You will complete the CDC Form 114-A for all inmates on both tiers, seven days per week. Information included will be date, watch, security check, the Housing Officer's last name, any unusual behavior or activity, emergency cell moves, and any supplies distributed. New arrivals will be noted as such and all items distributed upon their arrival will be noted. If an inmate departs the unit, his destination will be noted on the CDC Form 114-A.*

The Office of the Inspector General found that the administrative segregation unit staff at California State Prison, Solano does not follow these procedures. The Office of the Inspector General further noted that in some instances, entries on the detention/segregation records (CDC Form 114-A) for individual inmates were filled out *before* the events the entries purported to record occurred. For example, on August 21, 2002, second watch floor officers in Building 9 (administrative segregation overflow) were making entries recording that inmates had been served dinner, even though that event would not occur until third watch later that day.

One reason for the problem is that officers assigned to administrative segregation units have alternative records and census systems available to provide information on the status of inmate housing assignments. Although those systems provide officers with reasonably accurate information, they do not supplant the need to keep the CDC Form 114 up to date. The CDC Form 114 is intended as the primary legal document for recording inmate movement and housing assignments and, accordingly, is likely to be relied upon as evidence in criminal, civil, or administrative hearings. CDC Form 114s with missing or incomplete information have diminished evidentiary value.

RECOMMENDATION

The Office of the Inspector General recommends that administrative segregation custody personnel institute a practice of recording inmate movements in CDC Form 114 and CDC Form 114-A as they occur, rather than waiting for the first watch administrative segregation floor officer to update the movements after the fact or recording events before they take place.

FINDING 12

The Office of the Inspector General found that California State Prison, Solano prepares an excessive number of daily meals for inmates, resulting in unnecessary added costs for food and related services.

The Office of the Inspector General found that the food service staff at California State Prison, Solano does not effectively monitor the number of meals served and consumed each day and that in at least some cases the number of meals prepared exceeds the inmate population. Although preparing a certain number of extra meals may be necessary to avoid shortages, the institution

wastes resources by preparing a large number of meals that are not consumed, particularly given that the entire inmate population is rarely present at any single meal.

The Office of the Inspector General found that lunches prepared for inmates at California State Prison, Solano in August 2002 exceeded the inmate population by an average of 7.5 percent a day, amounting to 13,526 extra lunches for the month. Applying the daily excess percentage of 7.5 percent to all meals using actual food costs for the fiscal year ended June 30, 2002 results in excess food costs of approximately $400,000 per year, not including labor costs associated with meal preparation. That number is likely to rise because of an expected increase in food costs resulting from a new requirement presently being implemented that institutions provide a "heart healthy" menu for inmates.

California Code of Regulations, Title 15, Section 1243 provides that in "facilities with an average daily population of 100 or more, there shall be employed or available, a food manager who has the training and experience to . . . provide a food cost accounting system." Although California State Prison, Solano does have a food manager and the staff maintains count sheets of meals prepared, the institution does not have an adequate system to account for the number of meals consumed. As a result, the institution has no formal cost information to assist the food service management in determining whether the number of daily meals prepared is excessive or if the costs associated with waste, recycling, and excessive meal preparation are material to the overall cost of the institution's feeding program. According to the food service staff, poor controls over meals also enable inmates to take more than one sack lunch when leaving the dining hall after breakfast and to return to feeding lines numerous times during meals in the dining hall.

RECOMMENDATION

The Office of the Inspector General recommends that the warden and the food manager review the food service process at the institution to identify areas in which controls should be established or strengthened. Controls should include an accurate cost accounting system to record actual meals served, re-cycled, and wasted to assist in estimating future daily meal requirements and in controlling associated costs. The institution should also strengthen custody controls over food service operations to lessen opportunities for inmates to obtain more than one meal.

RESPONSE OF THE

CALIFORNIA DEPARTMENT OF CORRECTIONS

State of California

Department of Corrections

Memorandum

Date : March 11, 2003

To : Steve White
Inspector General
Office of the Inspector General
801 K Street, Suite 1900
Sacramento, CA 95814

Subject : **CALIFORNIA STATE PRISON, SOLANO MANAGEMENT REVIEW AUDIT CONDUCTED BY THE OFFICE OF THE INSPECTOR GENERAL**

This memorandum is prepared in response to the California State Prison, Solano (SOL) Management Review Audit conducted by your office beginning in August 2002.

The SOL administration, under the direction of Ana Ramirez-Palmer, Regional Administrator-North, Institutions Division, and Martha Linney, Regional Administrator, Health Care Services Division, has conducted an in-depth review of the Office of the Inspector General's (OIG) report findings and recommendations. The attached report will provide you with a detailed response and corrective action plan for the following areas:

- **HEALTH CARE SERVICES:**
  - Tuberculosis tracking.
  - Inmate death reviews.
  - Inmate dental care.
  - Pharmacy controls.
  - Medical modification orders.
- **FACILITY OPERATIONS:**
  - Administrative segregation unit blind spots.
  - Administrative segregation retention.
  - Administrative segregation logs.
  - Employee disciplinary process.
  - Food service.
  - Housing for inmates on medication.
  - Sentence reduction credit.

The SOL administration has initiated corrective action measures, and shall ensure self-assessments and ongoing operational reviews are conducted. I am confident that through these efforts SOL will ensure departmental compliance with all policies and procedures.

The OIG Review Audit and the California Department of Corrections recent operational reviews clearly emphasize the importance and commitment to improving our management and operational practices while fulfilling our public safety mission.

If you have any additional questions or require any clarification, please feel free to contact me at 445-7688.

E. S. Alameida

EDWARD S. ALAMEIDA, JR.
Director
Department of Corrections

Attachment

cc: David Tristan, Chief Deputy Director, Field Operations
W. A. Duncan, Deputy Director, Institutions Division
Roderick Q. Hickman, Assistant Deputy Director, Operations and Programs
Ana Ramirez-Palmer, Regional Administrator-North
Thomas L. Carey, Warden, SOL

3/11 Mailed pending Norma a copy.

bcc: Robert Presley, Agency Secretary, Youth and Adult Correctional Agency

CALIFORNIA DEPARTMENT OF CORRECTIONS

RESPONSE TO

OFFICE OF THE INSPECTOR GENERAL

"MANAGEMENT REVIEW AUDIT"

CALIFORNIA STATE PRISON, SOLANO

JANUARY 2003

A. HEALTH CARE SERVICES

➢ Tuberculosis Tracking

Inspector General Finding

The Office of the Inspector General found evidence that California State Prison, Solano is not adequately tracking inmates with tuberculosis, creating the potential of exposing inmates throughout the state to the disease and presenting a risk to the correctional staff and the general public.

Inspector General Recommendation

The Office of the Inspector General recommends that California State Prison, Solano take the following actions to improve the identification and tracking of inmate tuberculosis status:

- Allocate additional personnel resources to the task of monitoring and recording inmate tuberculosis status.
- Require the public health nurse to collect all records for inmates who have completed a tuberculosis treatment regimen to ensure that those inmates receive a post-treatment evaluation by a physician.
- Require the public health nurse to ensure that tuberculosis codes are properly updated in inmate medical records and in the department's system-wide data base and that a Form CDC 128-C (tuberculosis chrono) is forwarded to the central records staff for inclusion in the inmate's central file.

CDC Response

The Health Care Services Department at the California State Prison, Solano will ensure the identification and tracking of all tuberculosis inmates. The testing, diagnosis, need for treatment and follow-up will be monitored and recorded as required by the State of California's Public Health and the United States' Public Health Service federal guidelines for tuberculosis control in jails and prisons. The cited errors of 131 inmates

and the medical records of the 122 with TB codes of 33 have been corrected and the institution has instituted a plan to prevent this from reoccurring. The institution has structured the responsibilities of the Infection Control/Staff Development Registered Nurse to include assisting the Public Health Nurse in coordinating infection control and to cross over as contact person in the event the Public Health Nurse is unavailable.

The Public Health Nurse will be required to monitor and ensure that all inmates including new arrivals through Receiving and Release (R & R), are processed, evaluated, and receive post-treatment evaluation and follow-up by a health care professional, as well as a physician. The Public Health Nurse is also responsible for monitoring the Medical Alert System. The Health Care Services Division has developed a standardized statewide Medical Alert System to identify, track, and report inmate communicable disease information. Through downloads, it assembles information from the Distributed Data Processing System (DDPS), Medical Alert System, and on-site pharmacy data to provide an inmate disease status profile. Currently, TB codes are properly indicated in the inmates' medical records on the California Department of Corrections Form 128-C, chrono-Medical, Psych, Dental, and in the system-wide database. This chron is also forwarded to Records for inclusion in the inmate's central files. The Public Health Nurse will be required to monitor this system and entry into the DDPS and monitor on a monthly basis for compliance, inmate tracking, and to provide a computer edit/audit trail.

The R & R Registered Nurse will be responsible for the initial screening of all inmates upon arrival to ensure correct TB coding and tracking. This Registered Nurse will be responsible to review the Public Health section of the medical record for the date and results of the last TB test. The R & R Nurse will be responsible for administering the purified protein derivative (PPD) test for inmates who are Code 22 and who have not been tested in the past 72 hours. The test will be documented on the CDC Form 7331, Tuberculosis Testing Order/Report, and the inmate will be issued a ducat for the TB PPD to be read in two days by the clinic medical staff. For Code 32, 33, 34, 43, 51, 52, and 53 patients, the Registered Nurse will review the chest x-ray results, any prior drug therapy, evaluate for signs and symptoms and document findings on the CDC Form 7331. A physician will be immediately notified of any patients with positive signs and symptoms.

The Infection Control/Staff Development Registered Nurse duties will be revised to include responsibility to implement and monitor infection control policies and procedures, as well as, provide training for other staff and inmates. The Infection Control/Staff Development Registered Nurse will interact with the Public Health Nurse and investigate infection control incidents as reported by staff or inmates and provide appropriate evaluations and reports.

The Infection Control Committee shall be activated to establish, review, monitor and approve policies and procedures for investigating, controlling, and preventing infections including TB.

➢ Inmate Death Reviews

Inspector General Finding

The Office of the Inspector General found that when inmate deaths occur, the cause and circumstances surrounding the deaths are not examined in a timely manner and that those assigned to conduct the reviews may have a direct interest in the results.

Inspector General Recommendation

The Office of the Inspector General recommends that the Department of Corrections develop procedures to require the Health Care Services Division to take the following steps to improve review of inmate deaths:

- Coordinate review of inmate deaths with the warden and the institution's chief medical officer. The procedures should provide for communication throughout the review process to coordinate the assignment of staff and collection of evidence by the investigative staff when necessary.

- Forward pertinent information gathered by the investigations unit of the institution to the morbidity and mortality review committee.

- Ensure those conducting peer reviews are independent of the incident and the individuals involved.

- Ensure that peer reviews are completed in a timely manner.

CDC Response

The California State Prison, Solano, Health Care Services Department, will ensure that all required forms and reports for death reviews, as specified in the Health Care Services Division Report of Death Policy and Procedures, are submitted to Health Care Services Division Death Review Coordinator within the specified time frames. The actions of the institution's investigation staff and the Health Care Services Division are coordinated. The investigation findings are routinely referred, via the chain of command, to the Health Care Services Division. Because of the unique reporting structure of the Health Care Services Division and Institutions Division, there are occasional routing errors made wherein a report will be routed to the Warden and Institutions Division instead of the Health Care Manager and Health Care Services Division. Investigators are generally assigned from the institution because Health Care Services Division does not have a large cadre of trained investigators. This slows the process and often necessitates the assignment of a subject matter expert to assist with the investigation.

Peer review is protected under Section 1157 of the California Evidence Code, which defines the scope of State peer review protections. Confidential peer review is an essential function of hospitals and medical groups to ensure health care quality, to monitor risk management, and to discipline physicians when necessary. Because of

the confidential nature of the peer review process, certain information could not be shared beyond the committee. Under current law, Section 1157 prohibits the discovery of proceedings or records of organized committees of various health care staff in hospitals, or any related peer review body in any civil action. Section 1157 in its current form also does not compel the testimony of any person in attendance at an organized committee or peer review meeting as to what transpired within. This does not mean that information that could be shared was not. In the cited case, the information provided in the Office of the Inspector General Report is not complete. An investigation into the matter was requested by the acting Health Care Manager and approved by the Warden. A thorough investigation was subsequently conducted by Investigative Services Unit and Adverse Personnel Action was taken against the employee.

In addition, the Emergency Response Review Committee at the institution meets at least once per month to review cases that are referred by the Health Care Manager.

The Health Care Manager is responsible to ensure required reports are submitted in a timely manner and to request investigations as deemed appropriate. The Peer Review Committee will conduct confidential reviews of all cases referred by the Morbidity and Mortality Review Committee and provide findings as required. Peer review is protected under Section 1157 of the California Evidence Code. The Health Care Services Division will provide investigations training to all supervisory and management personnel to expedite investigations. The Health Care Services Division Death Coordinator will be responsible for supplying overdue Death Document reports to the Health Care Services Division Regional Administrator.

➢ Inmate Dental Care

Inspector General Finding

The Office of the Inspector General found that California State Prison, Solano is not complying with state regulations governing inmate dental care and as a result may be exposed to the risk of litigation.

Inspector General Recommendation

The Office of the Inspector General recommends that the California Department of Corrections examine policies and regulatory requirements governing inmate dental care and consider revising requirements to a level achievable under present conditions.

CDC Response

At the time of the audit conducted by the Office of the Inspector General, the institution employed five staff dentists, one Chief Dental Officer but had only four dental chairs in service. The institution now has six dental chairs in service. The two additional chairs were placed in the Level II Annex Clinic and that building has been converted, primarily, to a dental building. The increase in chairs and the location of a second dental facility in the Level II yard will increase the number of dental patients that can be seen and treated.

The institution is also undergoing a phased renovation in preparation for the Correctional Treatment Center licensing process, which is scheduled for completion in June of 2004. This will result in the closing of the Level III facility. In preparation of this closure, attempts are being made to procure temporary modular or mobile dental facilities. While the Correctional Treatment Center construction is taking place, consideration will be given to alternative work scheduling of dental staff, securing temporary mobile trailer facilities and expanded service hours of dentists on weekends and evening hours when inmates are available.

➢ Pharmacy Controls

Inspector General Finding

The Office of the Inspector General found that pharmacy record keeping and physical controls over prescription medications stored in the infirmary and clinics are inadequate to prevent unauthorized access and theft.

Inspector General Recommendation

The Office of the Inspector General recommends that the health care manager at California State Prison, Solano take the following actions to improve control over pharmaceuticals:

- Institute measures to ensure that medications are securely stored at all times consistent with their value and potential for misuse. Medications in the infirmary and clinics should be stored in secured areas under a supervisor's control.

- Record the quantity of pharmaceuticals shipped to the infirmary and clinics and periodically compare these records to the quantities prescribed by doctors. Investigate any material variations between the two amounts. Physical inventories of drugs should be conducted periodically and compared to perpetual inventory records maintained by the health care manager.

CDC Response

The institution will store medications in secure and locked clinics and the Correctional Treatment Center when not in direct use by a licensed health care professional. Floor stock medication will be placed in lockable cabinets. In areas where these cabinets are not currently available, cabinets will be purchased and installed. Lockable roller carts will also be used in special areas for daily medication administration.

The institution currently provides records from the pharmacy to each clinic, as well as the Correctional Treatment Center, for all medications provided. Medication Administration Record sheets are provided for all prescribed inmate medications. All pharmacy distribution records will be kept one year and monitored for clinic audits of stock medications against prescription records and distributions. Controlled drugs are currently monitored and accountability sheets maintained in the pharmacy for three years.

➢ Medical Modification Orders

Inspector General Finding

The Office of the Inspector General found that California State Prison, Solano does not promptly implement medical modification orders and that many were significantly overdue at the time of the audit.

Inspector General Recommendation

The Office of the Inspector General recommends that the chief medical officer at California State Prison, Solano assign a staff member to monitor the timely completion of medical modification orders, with priority on resolving the oldest orders first. That staff member will also periodically reconcile the information on the overdue modification orders list to information in the inmate appeals office records to ensure the accuracy of the list.

CDC Response

The Inmate Appeals Coordinator now prepares an overdue list, which is forwarded to the Warden, Chief Deputy Warden, and all division heads on a weekly basis. The Appeals Coordinator also continues to fax memorandums to other institutions to ensure compliance with overdue modification orders.

Additionally, the Medical Appeals Coordinator has been assigned to monitor the timely completion of Medical Modification orders. This will include the prioritization of all modification orders to resolve the oldest orders first. This staff member will reconcile this information monthly with the Inmate Appeals Office, the Chief Medical Officer/Health Care Manager and/or his or her designee to ensure compliance with the orders.

B. FACILITY OPERATIONS

➢ *Administrative Segregation Unit Blind Spots*

Inspector General Finding

The Office of the Inspector General found that makeshift partitions in the institution's administrative segregation unit buildings have created blind spots that limit the view of the control booth officers, compromising the safety and security of correctional staff and inmates.

Inspector General Recommendation

The Office of the Inspector General recommends that California State Prison, Solano remove the makeshift barriers in the administrative segregation unit and develop alternatives for creating meeting space.

CDC Response

The makeshift partitions are constructed from metal file cabinets that are currently secured to the floor with bolts. A work order has been issued to have the cabinets unbolted and secured to the wall. Removable partitions will be utilized in place of the metal file cabinets and shall be strategically placed closer to the office to ensure the view of the control booth officer is not obscured.

The makeshift partitions that are in Building 10 were constructed out of particleboard and are permanently affixed to the structure. A redline shall be painted on the floor indicating an out-of-bounds area for inmates. A convex mirror will be attached to the support beam to the right of the stairwell to assist the control booth officer with a visual of the area.

➢ ***Administrative Segregation Retention***

Inspector General Finding

The Office of the Inspector General found that California State Prison, Solano retains inmates in administrative segregation units longer than justified.

Inspector General Recommendation

The Office of the Inspector General recommends that the warden take the following actions:

- Develop a standard tracking system for use by all of the housing facilities to monitor inmates retained in administrative segregation. The tracking system should record all critical actions, including communication with employees and other units within the institution to ensure that casework is completed in a timely manner.
- Emphasize the importance of completing casework before presenting cases at the institution classification committee hearing or submitting cases to the classification services representative for review and approval.
- Provide training to correctional counselors and other members of the institution staff to ensure that all actions required in administrative segregation cases are completed and the results documented and communicated to the appropriate staff.
- Identify all cases that have been deferred pending action or returned by the classification services representative for completion of additional case work and monitor these cases closely to ensure that tasks are completed by the institution staff in a timely manner.

The Office of the Inspector General further recommends that the Department of Corrections follow the procedural requirements for amending regulations as required by the *California Government Code*.

CDC Response

The Level III Operations Associate Warden assigned Correctional Counselor II (CCII) is responsible for the overall tracking of administrative segregation cases. A comprehensive system has been implemented to track administrative segregation cases. All inmates have been entered into the system and it is completely functional, however, data needs to be entered into the system as it is a continuous function. It is also compatible with the DDPS and all information regarding inmates housing, as well as, classification tracking from that system downloads into the new administrative segregation tracking system.

The implementation of the administrative segregation unit tracking system in tandem with a word processing technician, which has been assigned in Records to type chronos from ICC, will ensure that cases are presented to the Classification Services Representative (CSR) for review and approval in a timely manner.

The CSR Audit worksheet shall be reviewed and the return to CSR date will be entered into the DDPS notes section of the identified inmate. The inmates next Institution Classification Committee (ICC) schedule date will also be entered into the DDPS three weeks prior to the return to CSR due date to ensure timely return. This will also ensure that the recommendations by the CSR are followed and that all deferrals are tracked and corrected.

The assigned CCII was given instructions on the preparation and time limitation on ICC cases, thus ensuring that inmates are not held in administrative segregation longer than necessary. This also includes, but is not limited to, ensuring that all necessary documentation is in the central file and recommendations by the CSR are addressed.

All hearing timelines issues have been addressed with the circulation of a memorandum from the Chief Deputy Warden regarding processing rules violation reports.

Processes have also been put in place to track and expedite the investigations forwarded to the Investigative Services Unit for safety concerns and gang validations.

The Office of the Inspector General also recommended that the Department of Corrections follow the procedural requirements for amending regulations as required by the California Government Code. This issue shall be referred to the Classification Services Unit via the Director to ensure that the memorandum dated November 20, 2001, regarding frequency of classification is either amended into the California Code of Regulations, Title 15, or rescinded.

➢ ***Administrative Segregation Logs***

Inspector General Finding

The Office of the Inspector General found that the institution is not properly documenting inmate activity in the administrative segregation units and that in some instances events are logged before they occur.

Inspector General Recommendation

The Office of the Inspector General recommends that administrative segregation custody personnel institute a practice of recording inmate movements in CDC Form 114 and CDC Form 114-A as they occur, rather than waiting for the first watch administrative segregation floor officer to update the movements after the fact or recording events before they take place.

CDC Response

Training was given to all administrative segregation custody personnel to institute the practice of recording inmate movements on the CDC Form 114, Disciplinary Detention Log, and CDC Form 114-A, Detention/Segregation Record, as they occur. The Facility Sergeant, Lieutenant, Captain, and Associate Warden will monitor this practice.

➢ ***Employee Disciplinary Process***

Inspector General Finding

The Office of the Inspector General found that California State Prison, Solano does not adequately document employee disciplinary proceedings and that the warden inappropriately serves as the hearing officer in appeals of adverse action decisions.

Inspector General Recommendation

The Office of the Inspector General recommends that California State Prison, Solano take the following actions:

- Take steps to ensure that the employee relations officer and all others involved in possible employee disciplinary proceedings document their actions thoroughly and completely in the adverse action files to provide a complete and accurate history of critical steps in the disciplinary process and assist the employee relations officer in developing consistent disciplinary recommendations in future cases.

- Discontinue the practice of the warden acting as the Skelly hearing officer in personnel matters involving California State Prison, Solano.

CDC Response

The institution will ensure that any person involved in the disciplinary process document their actions thoroughly and completely in the adverse action files. This documentation will provide a complete and accurate history of the critical steps taken during the disciplinary process by institution personnel.

The Warden will continue to act as the Skelly Hearing Officer in personnel matters unless the Warden initiated the investigation leading to the adverse action; participated in the investigation as a witness; recommended a specific level of penalty; or is personally biased against the employee.

➢ Food Services

Inspector General Finding

The Office of the Inspector General found that California State Prison, Solano prepares an excessive number of daily meals for inmates, resulting in unnecessary added costs for food and related services.

Inspector General Recommendation

The Office of the Inspector General recommends that the warden and the food manager review the food service process at the institution to identify areas in which controls should be established or strengthened. Controls should include an accurate cost accounting system to record actual meals served, re-cycled, and wasted to assist in estimating future daily meal requirements and in controlling associated costs. The institution should also strengthen custody controls over food service operations to lessen opportunities for inmates to obtain more than one meal.

CDC Response

The Food Services Department at the institution has revised its method of accounting for the number of meals served, the amount of food leftover, and training provided to designated food service personnel to control associated costs. Staff have also been assigned to ensure inmates do not attempt to eat twice during the same meal.

➢ *Housing for Inmates on Medication*

Inspector General Finding

The Office of the Inspector General found that a significant number of inmates taking psychotropic medications are inappropriately housed in buildings lacking air conditioning and that some inmates who are taking anticonvulsant medications are not assigned to lower bunks to lessen the possibility of injury in the event of a seizure.

Inspector General Recommendation

The Office of the Inspector General recommends that the institution conduct periodic evaluations of the housing assignments of inmates who have been prescribed psychotropic medications or whose medical conditions indicate particular housing needs. When a housing assignment is found to be incompatible with an inmate's medical condition, the institution should take immediate measures to reassign the inmate to appropriate housing.

CDC Response

The list of inmates on psychotropic medications will be reviewed every Friday by the Program Sergeant on each facility. This list is attached to the daily movement sheet every Friday. The Program Sergeant will initiate housing changes to accommodate the

inmates' medical needs. The dedicated housing for inmates on psychotropic inmates are Buildings 2, 3, 7, 8, 16, 19, 24, and Building 10 Administrative Segregation. When the physician issues an inmate a lower bunk chrono a copy is forwarded to the Facility Captain, who will ensure that the inmate is housed appropriately.

Additionally, the nursing staff at the institution administering medication (psychotropic), daily will monitor the housing of all inmates receiving heat medications under the *Coleman* Remedial Plan. These inmates are housed in air-conditioned buildings. When there is no available housing in the designated buildings, the Facility Sergeant/Lieutenant is notified in order to move the inmate to appropriate housing, as soon as possible. On arrival at R&R, the screening Registered Nurse alerts custody of special housing needs of inmates on psychotropic and seizure medications by use of written Custody Housing Needs Form. The institution will monitor the housing of all inmates on the heat alert report issued daily Monday through Saturday to the Watch Commander. Program Sergeants/Lieutenants will check and change housing, based upon the air-conditioned buildings and need to be housed in Buildings 2, 8, 10, 16, 19, and 24, respectively.

➢ *Sentence Reduction Credit*

Inspector General Finding

The Office of the Inspector General found that California State Prison, Solano inmates are allowed to earn sentence reduction credit through education and training classes even when classes are not actually held.

Inspector General Recommendation

The Office of the Inspector General recommends that California State Prison, Solano refer all inmates currently assigned to programs without instructors to the classification committee for reassignment in accordance with the May 16, 2002 memorandum from the Department of Corrections Institutions Division and discontinue awarding "S" time to these inmates. California State Prison, Solano should also immediately identify which classes should be closed and take formal steps to do so.

CDC Response

Education Department is aware that inmates are to be unassigned from educational programs when they are closed for more than 30 days. Most of staff absences are the result of long-term medical problems that cause the removal of inmates from those programs. Many times, these absences are extended beyond the expected time of return, which results in no request to the Unit Classification Committee for removal of inmates from the program. When this occurs, the Supervisor of Academic Instruction or Supervisor of Vocational Instruction will immediately initiate the appropriate documentation for unit classification.