OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

ACCOUNTABILITY AUDIT

REVIEW OF AUDITS OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION ADULT OPERATIONS AND ADULT PROGRAMS

2000 – 2004

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STATE OF CALIFORNIA

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VOLUME II

HIGH DESERT STATE PRISON

IMPLEMENTATION REPORT CARD

Previous recommendations: 31

Fully implemented: 18 (58%)

Substantially implemented: 4 (13%)

Partially implemented: 3 (10%)

Not implemented: 5 (16%)

Not applicable: 1 (3%)

The Office of the Inspector General found that High Desert State Prison has addressed most of the recommendations from a November 2001 audit that were under its control, but the Department of Corrections and Rehabilitation has not implemented several recommendations to provide the institution with needed resources or to take other actions affecting both High Desert State Prison and other institutions.

In November 2001, the Office of the Inspector General conducted a management review audit of High Desert State Prison. The audit determined that the institution was generally well run, but identified a number of deficiencies affecting safety and security, the inmate appeals process, the inmate disciplinary system, employee performance reports, and inmate medical and dental care. The audit also identified issues affecting safety and security and inmate dental care that required action from the Department of Corrections.

BACKGROUND

High Desert State Prison is one of 12 California adult correctional institutions designated for Level IV male inmates. It also houses Level I and Level III inmates. Presently, the institution houses approximately 4,500 minimum to high maximum-custody male inmates, with nearly 60 percent of the inmate population designated Level IV. The prison includes two 180-design facilities, which are considered the most secure in the state correctional system. The institution also operates a 570-bed reception center for inmates remanded to the California Department of Corrections and Rehabilitation from Northern California counties. The institution is located on 325 acres in Susanville, California, adjacent to the California Correctional Center.

Although the institution's mission is to confine inmates, it also provides vocational programs, education programs, and work assignments for inmates who are willing to participate. High Desert State Prison is one of the largest employers in Lassen County. It has an annual operating budget of more than $140 million and has approximately 1,300 employees.

The remote location of High Desert State Prison, coupled with its large population of Level IV inmates, presents particular management challenges. The institution continues to have difficulty recruiting and retaining personnel, especially for medical positions. In addition, ongoing violence among the inmate population, typical of a Level IV institution, often results in institution lockdowns and program closures.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The November 2001 management review audit revealed deficiencies both in institution programs under the direction of the warden and in health care program areas under the direction of the health care manager. The findings consisted of the following:

- Deficiencies in the inmate appeals system undermined the integrity of the appeals process and subjected the inmates to possible safety risks.
- The institution could not document that inmates received hot meals and showers during lockdowns.
- Inmate appeals, especially appeals related to medical issues and to the Americans with Disabilities Act, were not processed within prescribed time limits. Also, modification orders resulting from medical appeals were not being implemented.
- Inmates who paroled from High Desert State Prison and the California Correctional Center paid an additional transportation charge of $55 compared to inmates who paroled from state prisons in Folsom.
- There were numerous safety problems and documentation deficiencies in the administrative segregation housing units and control rooms.
- The design of the cells in the administrative segregation unit did not allow the custody staff to control lights inside the cells.
- Security cameras were not available to monitor activity on the main yards.
- Improvements were needed in documenting the preparation and maintenance of Category I investigations.
- There were several procedural errors in the inmate disciplinary process.
- The detention/segregation records for several inmates in the administrative segregation unit in Building D-7 did not record the inmate's exercise period or the reason the period was not provided.
- Performance and probation reports for employees were not being completed in a timely manner.
- The staff was not completing mandatory training courses in a timely manner and training files did not document the completion of training.
- The institution was budgeted for programs that had never been activated.
- There were deficiencies in the documentation of chronically ill inmates.

- Inmate medications could have been tampered with before they were administered and were not adequately documented in the medical files.

- Thirteen inmates on psychotropic medication were not included in the mental health delivery system.

- The institution was not providing inmates with required dental services.

- Inmates were not being provided with medical, psychiatric, and dental chrono forms in a timely manner.

- Controls over the tracking of prescription drugs were grossly inadequate.

As a result of the November 2001 audit, the Office of the Inspector General made 31 recommendations to the management of High Desert State Prison and to the Department of Corrections.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Department of Corrections and Rehabilitation has implemented the 31 recommendations from the Office of the Inspector General's November 2001 management review audit of High Desert State Prison. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the November 2001 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations. The Office of the Inspector General completed its fieldwork in August 2005. The results are presented in the tables following this section.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 31 recommendations issued by the Office of the Inspector General in November 2001 concerning High Desert State Prison, eighteen recommendations have been fully implemented; four have been substantially implemented; three have been partially implemented; five have not been implemented; and one is not applicable.

The Office of the Inspector General found that High Desert State Prison has made significant progress in implementing recommendations affecting areas under the warden's control, but a number of issues requiring additional funding and policy direction from the Department of Corrections and Rehabilitation central office have not been addressed. The institution has addressed the timeliness of the inmate appeals process, monitoring of inmate modification orders, and ensuring that inmates comply with administrative segregation policies. The institution has also made improvements in the inmate disciplinary process, in documenting services provided during lockdowns, in completing staff performance reports, and in completing mandated training requirements.

In contrast, the Department of Corrections and Rehabilitation has made minimal progress in performing security modifications, including installing security cameras on the main yards, and in pursuing additional release allowance funding for inmates paroling from rural areas.

A number of the recommendations affecting the health care program, which is under the direction of the health care manager, have also been addressed. In particular, the institution has made progress in documenting inmate medical histories before issuing medications; in providing additional escorts for dental services; and in implementing policies and procedures to improve distribution and tracking of inmate medications. But the institution's medical department still has not developed a system to ensure that inmates on psychotropic medications are included in the mental health care delivery system. Also, the department has not eliminated inconsistencies in regulations concerning minimum dental service requirements and has not developed an automated system to schedule and track dental services.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that High Desert State Prison continue to pursue resources to install video cameras on the main yards in order to enhance security.

The Office of the Inspector General recommends that the High Desert State Prison medical department develop a system to ensure that inmates requiring psychotropic medications are included in the mental health delivery system before they receive the medications.

The Office of the Inspector General recommends that the warden of High Desert State Prison hold managers and supervisors in the administrative area accountable for completing annual performance evaluations and probation reports.

The Office of the Inspector General also recommends that the Department of Corrections and Rehabilitation take the following actions:

- **In future construction projects, design buildings to provide the custody staff with the ability to control cell lights from the outside.**
- **Eliminate inconsistencies between California Code of Regulations, Title 15 and the *Department of Corrections and Rehabilitation Operations Manual* concerning inmate dental care.**
- **Implement an automated inventory system to track and monitor prescription drugs.**

The following table summarizes the results of the follow-up review.

INSTITUTION PROGRAMS

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found deficiencies in the inmate appeals system at High Desert State Prison that undermined the integrity of the appeals process and may have subjected the inmates to possible safety risks.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections undertake a thorough revamping of the inmate appeals system statewide to address the deficiencies in the inmate appeals system.	SUBSTANTIALLY IMPLEMENTED	This finding was prompted by complaints from inmates that appeals were often lost or ignored by the staff and that during lockdowns inmates were denied access to appeal lock-boxes and that as a result, appeal forms were gathered by staff members responsible for providing inmates with day-to-day oversight who might themselves be the subject of the complaint. The Department of Corrections and Rehabilitation reported that in order to provide better oversight of the appeals process, the Inmate Appeals Branch designated eight regions, each with a separate facility captain assigned to facilitate communication with the institutions and provide oversight. The department reported that the new system is working reasonably well in light of population pressures, staff turnover, and limited staffing. The facility captains report problems from their respective regions to the chief of the Inmate Appeals Branch, who in turn reports problems and trends to the department administration. The department noted that previous reports by the Office of the Inspector General have cited deficiencies in the informal appeals process, specifically, lost or destroyed appeals and untimely responses. The Inmate Appeals Branch reported that it has worked with institutions to resolve problems with the informal appeals process on an institution-by-institution basis, with the goal of ensuring that measures have been put in place at the local level to ensure the integrity of the institution's appeals process. The department reported that these measures appear to have been successful in mitigating some of the deficiencies noted in the Office of the Inspector General's November 2001 audit. The Inmate Appeals Branch reported, for example, that it has received no complaints of lost

		or destroyed appeals from inmates at High Desert State Prison in the last twelve months. The Office of the Inspector General reviewed its database of letters from High Desert State Prison inmates for complaints concerning lost or destroyed appeals and found that 5 out of the 340 letters received in the last twelve months cited lost or destroyed appeals, along with other complaints about institution operations. The small number of complaints concerning this issue indicates the system is working appropriately. The 340 letters received by the Office of the Inspector General during the last twelve months also demonstrates that inmates are able to correspond during lockdowns, even with outside agencies.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the institution could not document that inmates received hot meals and showers during lockdowns.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden ensure that staff members document services provided to each inmate during lockdowns to ensure that inmates are provided with mandated services and to avoid potential litigation.	SUBSTANTIALLY IMPLEMENTED	High Desert State Prison prepared an addendum to the *Department of Corrections and Rehabilitation Operations Manual*, section 55010, Emergency Operations, pertaining to documenting essential services during periods of lockdown. According to the institution, multiple services were going to be listed in the addendum initially, but several issues were raised during the review process. For example, the institution noted that the California Correctional Peace Officers Association raised the issue of additional workload for bargaining unit 6 personnel. In addition, the institution stated that documentation was already available in inmates' central files, medical records, and other logs and documents maintained by the institution. As a result, the final addendum to the *Department of Corrections and Rehabilitation Operations Manual* required the staff only to document inmate showers during lockdowns.

FOLLOW-UP RECOMMENDATIONS
None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that inmate appeals, especially appeals related to medical issues and the Americans with Disabilities Act, were not processed within prescribed time limits. Furthermore, modification orders resulting from medical appeals were not implemented.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden continue overseeing the inmate appeals process and that the health care manager hold his staff accountable for processing appeals and implementing modification orders in a timely manner.	FULLY IMPLEMENTED	High Desert State Prison reported that it has dedicated a staff member to ensure that medical appeals are processed within prescribed time limits and to track modification orders to ensure that they are implemented within prescribed due dates. The institution also assigns the chief deputy warden to gather reports on all appeals and to inform departmental managers at weekly management meetings of any overdue appeals in their areas. According to the institution, this process ensures that all areas of the institution are completing appeals in a timely manner and requires department managers to take appropriate action on any overdue appeals. High Desert State Prison provided the Office of the Inspector General with a report on overdue appeals that showed only 14 appeals overdue. Twelve of the 14 overdue appeals concerned issues from outside the institution, such as appeals filed by inmates concerning property and disciplinary actions from institutions at which they were previously incarcerated. The institution also provided a tracking report that showed High Desert State Prison had significantly improved its monitoring and completion of modification orders.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that inmates who paroled from the Susanville prisons paid an extra $55 transportation charge compared to inmates paroled from the Folsom institutions.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the wardens of the two Susanville institutions work with the California Department of Corrections headquarters staff to have additional funds allocated to remotely located institutions to make parolee transportation costs more equitable among institutions. The Office of the Inspector General suggested the California Department of Corrections consider transporting parolees to a Greyhound bus station closer to Susanville, such as Red Bluff or Redding. A bus ticket to Los Angeles from either of those locations cost $59 at the time of the audit.	PARTIALLY IMPLEMENTED	The Department of Corrections reported that due to budgetary constraints, inmates cannot be provided with extra transportation funds upon parole. In response to the Office of the Inspector General's report, High Desert State Prison submitted a memorandum on April 19, 2002 to the northern regional administrator recommending that the department consider a change to California Code of Regulations, Title 15, section 3075.2 to provide increased funding for rural areas to cover the extra transportation costs. The northern regional administrator responded that such a change would create inequities for inmates who did not receive the increased amount. The regional administrator also noted that such a change would require legislation to modify the California Penal Code. The department, therefore, did not implement the recommendation. High Desert State Prison stated that budgetary constraints prohibit the institution from transporting all parolees from Susanville to either Redding or Red Bluff. According to the institution, the unbudgeted costs of transporting parolees no longer in the custody of High Desert State Prison on a regular basis to a bus station in a metropolitan area would be exorbitant and fiscally irresponsible. The institution reported that it does address parolee transportation issues on a case-by-case basis, however. For example, because the only shuttle service in the Lassen County area cannot accommodate Americans with Disabilities Act inmates confined to a wheelchair, if such an inmate is paroling and lacks personal transportation, the institution arranges for special transport to the parole location. According to the institution, situations also have arisen in which the parole agent of a high control inmate requested that the inmate be transported to the parole office by High Desert State Prison staff. The institution reported that it has also arranged for special transport in these cases.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found numerous safety problems and documentation deficiencies in the administrative segregation housing units and control rooms.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden ensure that the staff and the inmates comply with the institution's existing policies and procedures.	SUBSTANTIALLY IMPLEMENTED	High Desert State Prison informed the Office of the Inspector General that administrative segregation unit staff are continuously trained regarding the need to ensure that inmates comply with institution policies and procedures. According to High Desert State Prison, the training includes the following areas: • Ensuring that inmates do not cover cell windows • Confiscating inmate fish lines • Documenting cell searches • Documenting inmate misconduct on CDC Form 115 High Desert State Prison reported that it has archived all outdated operations procedures and maintains only current procedures for staff review. According to the institution, post orders are also up to date, and the institution has instructed staff to sign post order acknowledgments monthly. According to High Desert State Prison, administrative segregation sergeants and lieutenants conduct weekly audits of post orders and provide training reiterating the need to sign in and out on isolation logs. Administrative segregation sergeants also monitor the logs and conduct weekly audits of the CDC Form 114 segregation logs. High Desert State Prison provided the Office of the Inspector General with a copy of a weekly audit worksheet to validate those efforts. In May 2004, the Program and Fiscal Audits Branch of the Department of Corrections conducted an audit of High Desert State Prison's administrative segregation unit and reported that the institution was in compliance with 84 percent of the areas reviewed.

		One of the areas identified as deficient in that audit was also identified in the Office of the Inspector General's November 2001 report. The Program and Fiscal Audits Branch found that only 66 percent of the posts in administrative segregation had current post orders available at the job site; 29 percent of the posts had outdated post orders; and five percent had no post orders. The institution reported that it is taking corrective action in these areas.
The Office of the Inspector General recommended that the institution apply a non-slip surface to the metal steps leading from the ground floor to the control room in Facility C, Building 5.	FULLY IMPLEMENTED	High Desert State Prison stated it applied a non-slip material to the stairwell in Building C-5 shortly after the Office of the Inspector General issued its report.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that the design of the cells in the administrative segregation unit did not allow the custody staff to control the lights inside the cells.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that in future construction projects, the Department of Corrections design buildings to provide the custody staff with the capability of overriding and controlling the cell lights from the outside.	NOT IMPLEMENTED	According to High Desert State Prison, due to budgetary constraints, it was not feasible to install exterior light controls for existing cells. High Desert State Prison stated that originally the new administrative segregation unit building was supposed to have exterior cell light controls, but the department eliminated the exterior feature during construction to reduce the cost of the project.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that in future construction projects, the Department of Corrections and Rehabilitation design buildings to provide the custody staff with the ability to control cell lights from the outside.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that security cameras were not available to monitor activity on the main yards.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the prison install video cameras on the main yards.	NOT IMPLEMENTED	The Office of the Inspector General noted in the 2001 audit that placing video cameras on the main yards would enhance institution security, help staff identify inmates involved in incidents and gang activities, and act as a deterrent. The institution could also use the videotapes as evidence for disciplinary actions and as a training tool for staff response to incidents. High Desert State Prison originally submitted a capital outlay budget change proposal to headquarters for fiscal year 2001-02 concerning the need for cameras on the Level IV general population yards. According to High Desert State Prison, headquarters denied the proposal, stating that it would review the matter as a statewide issue. High Desert State Prison submitted another request to the Department of Corrections and Rehabilitation headquarters in October 2004, requesting $2.3 million to install a video surveillance system throughout the institution, but headquarters denied the request. According to High Desert State Prison, headquarters was considering installing the video surveillance system at the new Kern Valley State Prison because the new prison had the infrastructure to allow for easy installation. Based on its response, it does not appear that the department has plans to install cameras at High Desert State Prison in the near future.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that High Desert State Prison continue to pursue resources to install video cameras on the main yards in order to enhance security.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that improvements were needed in documenting the preparation and maintenance of Category I investigations.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden ensure that the investigative services unit captain (1) review documentation used to support Category I investigations, and (2) implement a policy of storing witness interviews on separate tapes.	NOT APPLICABLE	The Department of Corrections and Rehabilitation made significant changes to its investigative process including the elimination of Category I investigations. The new process requires the Office of Internal Affairs to perform all formal investigations. Therefore, this recommendation is no longer applicable.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found several procedural errors in the inmate disciplinary process.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden implement the following policies and procedures to remedy the procedural deficiencies in the inmate disciplinary system.		
The reporting employee must sign the rules violation report to authenticate it. In the rare instance in which the employee is not available, the signed draft report should be attached to the completed rules violation report for verification of authenticity.	FULLY IMPLEMENTED	According to High Desert State Prison, training was provided to all disciplinary officers, captains, and lieutenants directing them to abide by the following guidelines: • The reporting employee must sign the rules violation report to authenticate it. In those rare instances in which the employee is unavailable to sign the rules violation report in time to meet disciplinary time constraints, the facility

		disciplinary officer will sign the rules violation report for the reporting employee and the signed draft report will be attached to the completed rules violation report for verification of authenticity. • Once the rules violation report has been approved and classified, the disciplinary hearing should be conducted. Only the staff member who classifies the rules violation report, or a staff member at the level of captain, or above, is permitted to void the rules violation report. • The person who voids the rules violation report will document the action in a memorandum to the appropriate chief disciplinary officer for inclusion in the registry of rules violation reports.
When the rules violation report has been approved and classified, the disciplinary hearing should be conducted. Only the staff member who classifies the rules violation report or a staff member at a higher level, preferably the hearing officer, should be allowed to void the rules violation report.	**FULLY IMPLEMENTED**	High Desert State Prison addressed this recommendation in the response described above.
A copy of the completed rules violation report should be delivered to the inmate within five working days of the chief disciplinary officer's audit.	**FULLY IMPLEMENTED**	According to High Desert State Prison, institution policy requires a completed copy of the rules violation report to be delivered to the inmate within five working days of the chief disciplinary officer's audit.
The rules violation reports should be filed in the register of institution violations in a timely manner.	**FULLY IMPLEMENTED**	High Desert State Prison reported that its policy requires the file copy of the rules violation report for the registry to be delivered to the appropriate chief disciplinary officer's office within five working days of delivery to the inmate. The institution reported that this practice is still in place and operating without difficulty.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that the detention/segregation records for several inmates housed in the administrative segregation unit in Building D-7 did not record the inmate's exercise period or the reason the period was not provided.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden ensure that the CDC Form 114-A, detention/segregation record, be completed as required.	FULLY IMPLEMENTED	High Desert State Prison reported that this practice is in place and operating without difficulty. According to the institution, it provides continuous training to administrative segregation unit staff on documentation of inmate exercise periods. In addition, the institution reported that administrative segregation unit sergeants conduct weekly documented audits of the CDC Form 114-A files, ensuring that staff members document all pertinent information. According to the institution, captains have conducted training on the completion of CDC Form 114-A's for all members of the administrative segregation unit on all shifts.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that performance and probation reports for employees at High Desert State Prison were not being completed in a timely manner.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden hold managers and supervisors accountable for completing annual performance evaluations and probationary reports in a timely manner.	SUBSTANTIALLY IMPLEMENTED	According to High Desert State Prison, the chief deputy warden reviews the monthly overdue performance/probationary report list provided by the personnel office and provides verbal direction to supervisors who fail to complete reports in a timely manner. The institution reported that the chief deputy warden reviews updates of the overdue performance report list bi-weekly to ensure progress is made in the completion of performance/probationary reports. The chief deputy warden disseminates the information to all division heads in the warden's executive staff meetings. High Desert State Prison informed the Office of the Inspector General that the number of overdue performance reports has been

		significantly reduced since this practice was implemented. The Office of the Inspector General prepared an analysis of overdue performance reports based on data provided by High Desert State Prison and found the following: • Performance reports for 121 employees were overdue. • Overdue reports averaged 81 days (ranging from 30 to 334 days) overdue. • Administration had the most overdue reports, with 48. The November 2001 audit revealed that supervisors completed only 35 percent of annual performance evaluations and 19 percent of probationary reports within prescribed time limits. With only 121 employees on the latest overdue list and more than 1,300 employees at the institution, it appears that supervisors now complete more than 90 percent within the prescribed timeframes — a significant improvement over the 2001 data.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the warden of High Desert State Prison hold managers and supervisors in the administrative area accountable for completing annual performance evaluations and probation reports.

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found that the staff was not completing mandatory training courses in a timely manner, and that training files did not document the completion of training.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution hold employees accountable for completing mandatory training requirements. Furthermore, it was recommended that steps be taken to ensure that the documentation in	FULLY IMPLEMENTED	According to High Desert State Prison, the in-service training unit currently audits the attendance of mandatory training and notifies employees if they are delinquent. The institution reported that it distributes annual training audits for each employee to supervisors and distributes delinquency lists to each division head for corrective action. If an employee does not attend mandatory training, the employee is subject to corrective disciplinary action. Employees who miss a

the training file is adequate to support the automated report.		second mandatory training are subject to adverse action up to and including dismissal for repeat offenses. High Desert State Prison reported that from October 2001 through July 2005, it served 19 adverse personnel actions to employees for failure to attend mandatory training.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 13

The Office of the Inspector General found that High Desert State Prison was budgeted for programs that have never been activated.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden develop a plan to permanently redirect the excess positions for both education and the enhanced outpatient programs to areas of institutional priority.	FULLY IMPLEMENTED	High Desert State Prison reported it reviewed vacancies in the education department following the original audit and determined that 18.8 vacancies existed in academic and vocational programs. Of these vacancies, 6.8 were included in the mandated 826 position reduction required for the Department of Corrections. The institution used the remaining 12 vacancies (five in the academic program and seven in the vocational program) to offset overtime expenditures. High Desert State Prison recently implemented the new bridging program, encompassing fewer instructors and in-cell learning. As a result of the budget cuts associated with this change, High Desert State Prison reported that there are no longer excess positions in the academic or vocational programs. The institution reported that it transferred the 3.6 positions associated with the enhanced outpatient programs to the institution vacancy plan to offset overtime expenditures.

FOLLOW-UP RECOMMENDATIONS

None.

HEALTH CARE PROGRAM

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found deficiencies in the prison's documentation of chronically ill inmates.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that physicians review an inmate's history and documentation before reordering medication. In addition, it was recommended that physicians should document their findings when conducting a chart review and should note the reason they renewed the medication without seeing the patient.	FULLY IMPLEMENTED	According to High Desert State Prison, it is standard procedure for physicians to review an inmate's unit health record before reordering medication. The medical staff is required to state in the progress notes the reason a given medication is ordered or discontinued. High Desert State Prison provided the Office of the Inspector General with medical operating procedure #749 pertaining to unit health record documentation, and the Office of the Inspector General verified that the operating procedure includes instructions for documentation and record-keeping practices to ensure that patients' unit health records remain current. High Desert State Prison noted that it was one of the seven rollout institutions for the Inmate Medical Services Program required by the *Plata* court order. The Inmate Medical Services Program consists of comprehensive and standardized medical policies and procedures to ensure timely access to chronic care, specialty services, reception center processing, medication management, intrasystem transfer process, and access to health care, including nursing triage and physician follow-up.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that inmate medications could have been tampered with before they were administered and that inmate medications were not adequately documented in the medical file.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the prison develop and implement a policy requiring the medical technical assistants to package "hot"[1] medications within two hours of the time they are administered. As an alternative, a pharmacy technician could prepackage the medication in unit doses for the medical technical assistant to administer.	FULLY IMPLEMENTED	According to High Desert State Prison, the new Inmate Medical Services Program policies and procedures, Volume IV, Chapter 11 specifies the following procedures for outpatient clinics: • Medications ordered on an "AM and PM" or twice daily basis must be administered with at least eight hours between the two dosing times unless otherwise indicated on the CDC Form 7221. Prescribers are encouraged to limit medication dosing timeframes to as few times per day as possible while observing the particular medication serum life and clinical efficacy. • When clinically indicated, medications may be ordered as "HS." Medications ordered as "HS" shall be administered after 2000 (8:00 p.m.) • "Stat" medications must be administered within one hour. • Medications must be stored in a safe and secured manner at all times. • Medications must be prepared and administered by the same licensed staff member on the same day. High Desert State Prison also has a Correctional Treatment Center, which is regulated by California Code of Regulations, Title 22. Title 22, section 79635(a)(C)(7), states that in a Correctional Treatment Center, all medications must be administered as soon as possible, but no more than two hours after doses are prepared and must be administered by the same person who prepares the doses for administration. Doses must be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.
The Office of the Inspector General also recommended that the medical staff immediately begin placing labels in the	FULLY IMPLEMENTED	According to High Desert State Prison, the new Inmate Medical Services Program policies and procedures, Volume IV, Chapter 11 also addresses this recommendation. The policies and procedures provide as follows:

[1] "Hot" medications require direct observation when taken.

medication administration record for all cold medications administered to inmates. The medical staff should also document in the record if the inmate receives or refuses the medication. After the medical administration record is documented, it should be sent to the unit health record for filing, so that there is a permanent record in the chart of the inmate receiving the medication.		• All medications must be self-administered unless otherwise ordered, with the exception of medications on the restricted list. • When prescribing self-administered medications, the prescriber shall explain to the inmate-patient how to take the medication. The prescriber must communicate effectively and appropriately based upon the inmate-patient's ability to understand and shall document the notification as necessary on a CDC Form 7230. • Pharmacy and nursing services staff must record on the inmate-patient's medication administration record when the inmate-patient receives his/her self-administered medications. The medication administration record shall include the inmate-patient name, inmate's CDC number, prescription, date, time, and signature of medical personnel distributing the medication. • A medication refusal is when an inmate-patient comes to the pill line and refuses his/her prescribed medication or fails to comply with medication procedures either at the cell front or during pill line. • The facility clinic medical personnel must document each medication refusal on the medication administration record by circling and initialing in red the date and time slot where the medication would have been recorded had it been given. • The facility clinic medical personnel must attempt to determine why the inmate-patient is refusing the medication and document the reason for each medication refused on the back of the medical administration record. • When a referral is made to a prescriber, the medical personnel must document any known reason(s) for the refusal on a CDC Form 7230, interdisciplinary progress note. According to the medical department, staff members currently place cold

		medication stickers in the medication administration record. They also document the medication administration record and send the documentation to be placed in the unit health record. The medical department reported that it developed this operating procedure and put it into practice in July 2003. High Desert State Prison provided the Office of the Inspector General with a copy of Medical Operational Procedure #711 pertaining to medication administration, and the Office of the Inspector General verified that the operating procedures is consistent with the new Inmate Medical Services Program requirements.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that 13 inmates on psychotropic medication were not included in the mental health delivery system.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the medical staff ensure that inmates were included in the mental health delivery system before providing them with psychotropic medication.	NOT IMPLEMENTED	According to High Desert State Prison, it continues psychotropic drugs for newly arrived inmates who have been mental health patients until they can be evaluated during reception center processing. While that explanation addresses reception center inmates, the institution did not explain how it ensures that general population inmates on psychotropic medications units are included in the mental health delivery system. High Desert State Prison acknowledged it has not developed auditing procedures to ensure that all inmates on psychotropic drugs are included in the mental health delivery system. In its response to the Office of the Inspector General, the medical department reported that it has established a quality improvement committee and that it anticipates developing auditing procedures to address this issue, but the

		department provided no timeframe for completion other than to report it would be a lengthy process.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the High Desert State Prison medical department develop a system to ensure that inmates requiring psychotropic medications are included in the mental health delivery system before they receive the medications.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that High Desert State Prison was not providing inmates with dental services required under state regulations.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to improve inmate access to dental services, the Office of the Inspector General recommended that the actions listed below.		
The California Department of Corrections should closely examine the existing policies and regulatory requirements governing dental care and take action to eliminate any inconsistencies between Title 15 requirements and those of the *Department of Corrections Operations Manual*.	NOT IMPLEMENTED	According to High Desert State Prison, the *Department of Corrections and Rehabilitation Operations Manual* and the California Code of Regulations, Title 15, are in close agreement with respect to the staffing ratio of 950 inmates to each dentist/one dental assistant team. The institution acknowledged, however, that the requirement in California Code of Regulations, Title 15, section 3355.1 for a 14-day examination of new commitments is inconsistent with the *Department of Corrections and Rehabilitation Operations Manual.* The Office of the Inspector General noted this inconsistency during the November 2001 audit and reiterates that the inconsistency results in confusion over minimum dental care standards. California Code of Regulations, Title 15, section 3355.1 requires each newly committed inmate to receive a complete examination by a dentist, who must develop an individual treatment plan for the inmate. Yet, section 54050 of the *Department of Corrections and Rehabilitation Operations Manual* allows institutions to give priority to emergency care and to

		limit other dental care depending on available funding. Based on this response, the Office of the Inspector General concludes that the California Department of Corrections and Rehabilitation still has not clarified this inconsistency.
The warden should provide additional custody personnel to escort inmates to dental appointments during lockdowns and additional security coverage while inmates are in the dental clinic to allow more than one inmate to be served at a time.	**FULLY IMPLEMENTED**	According to High Desert State Prison, this recommendation was accomplished under the *Plata* court settlement. While dental care was not part of the lawsuit, the medical escorts hired under the *Plata* agreement serve the dental clinics in addition to the medical clinics.
The health care manager should consider pursuing resources to automate the scheduling and tracking of dental services or explore other measures to increase the productivity of the dental staff.	**PARTIALLY IMPLEMENTED**	According to High Desert State Prison, the Division of Correctional Health Care Services has drafted a dental policy and procedure manual, which will standardize dental services statewide. In addition, the dental department at High Desert State Prison reported that in 2003 it initiated dental peer reviews and monthly quality management committee meetings to improve both the quality and productivity of its dental services. The department reported that it recognizes the shortage in dental staff statewide and the difficulty the majority of the dental departments experience in meeting the examination mandates of Title 15. As a result, the department requested and received in fiscal year 2005-06 an additional 63.5 positions and $13.3 million to implement improvements in the dental program. It is too early to assess the impact for purposes of this review, however.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation eliminate inconsistencies between California Code of Regulations, Title 15 and the *Department of Corrections and Rehabilitation Operations Manual* concerning inmate dental care.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that inmates were not provided with medical, psychiatric, and dental chrono forms in a timely manner, potentially affecting the inmates' health.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the medical department allow staff physicians to issue temporary chrono forms for a one- to two-week duration until the permanent chrono has been approved by the chrono committee.	FULLY IMPLEMENTED	High Desert State Prison reported that the primary care providers complete a comprehensive accommodation chrono when the primary care provider determines that an inmate-patient requires a temporary or permanent accommodation due to a medical condition. If the inmate-patient's condition warrants an immediate accommodation for conditions in which a delay would jeopardize the inmate-patient's health or safety, the primary care provider must complete a physician's order to initiate the temporary or permanent accommodation and document that the chrono is pending. According to the institution, the accommodation chrono will remain current and will be honored by a receiving institution unless a new form is generated indicating a new primary care provider order or until the documented timeframe has expired. The department addresses the accommodation chrono process within the Inmate Medical Services Program Policies and Procedures, Chapter 23. The medical department reported that it holds weekly chrono committee meetings and that the committee signs and delivers approved chronos to inmates in a timely manner.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that the controls over the tracking of prescription drugs were grossly inadequate.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the chief medical		

officer/health care manager take the actions listed below.		
The plastic garbage bags used to transport medications should be replaced with a container that allows for a lock or a seal, to ensure that the contents are not compromised during shipment. The pharmacist should prepare a shipping order listing all medications included in the container. The clinic employees can sign the shipping order to acknowledge receipt of the medications. This would also provide documentation for both the pharmacy and the clinic to update their inventories. A similar procedure should be implemented for the return of medications from the clinics to the pharmacy.	**PARTIALLY IMPLEMENTED**	According to the institution, consideration was given to this recommendation but the institution decided to implement the following procedure: The pharmacy technician delivers the medications personally to the clinics and also picks the medication up from the clinic and returns it to the pharmacy. The Office of the Inspector General notes that the new procedure is an improvement, but the institution still lacks a tracking system to update its pharmacy inventory.
The pharmacy and the clinics should maintain a perpetual inventory of medications, because the medications are costly and are dangerous contraband in the institution.	**NOT IMPLEMENTED**	According to the institution, it maintains various inventories, but the lack of appropriate computer hardware and software limits the process. Based on this response, the Office of the Inspector General concluded that the pharmacy does not maintain a perpetual inventory of medications.
The medications from the pharmacy should be sent directly to the medical clinic, or the medical staff should pick them up at the pharmacy. The medications should not be left at the control room.	**FULLY IMPLEMENTED**	The institution reported that the pharmacy technicians deliver medications twice a day to each of the clinics and no longer leave medications in the control rooms.
Medications should be securely stored at all times due to their value and the danger of misuse in the institution.	**FULLY IMPLEMENTED**	The institution reported that it securely stores medications as a standard practice.
The supervising nurse should have sole	**FULLY IMPLEMENTED**	According to High Desert State Prison, the supervising nurse has sole responsibility for access to the DocuMed machine and for maintaining the

responsibility for access to the DocuMed machine and for maintaining the accountability log.		accountability log, as recommended.
Written operating procedures should be prepared for the health care clinics to assist them in standardizing their operations and implementing proper controls.	**FULLY IMPLEMENTED**	According to High Desert State Prison, a number of operating procedures dictated by the *Plata* agreement are in place and are being followed. The policies and procedures related to the pharmacy are located in Inmate Medication Services Program manual, Volume IX.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation implement an automated inventory system to track and monitor prescription drugs.

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VALLEY STATE PRISON FOR WOMEN

The Office of the Inspector General found that Valley State Prison for Women has improved employee morale and the timeliness and completion of important administrative processes, such as Category I investigations, inmate appeals, and rules violation reports. The institution remains deficient in areas involving employee performance and probation reports, weapons qualification for armed staff, drug disposal, and drug interdiction training.

IMPLEMENTATION REPORT CARD

Previous recommendations: 35

Fully implemented: 24 (68%)

Substantially implemented: 2 (6%)

Partially implemented: 5 (14%)

Not implemented: 1 (3%)

Not applicable: 3 (9%)

The Office of the Inspector General conducted a January 2001 management review audit of Valley State Prison for Women to provide a baseline review in accordance with California Penal Code section 6051. The audit focused on institutional processes relating to communications, personnel, investigations, training, security, and financial matters. As a result of the review, the Office of the Inspector General found that poor morale among the institution staff was pervasive. The Office of the Inspector General also found a number of administrative deficiencies, such as incomplete and untimely Category I investigations and rules violation reports, untimely completion of inmate appeals and employee performance and probation reports, and inadequate control over drug disposal.

BACKGROUND

Valley State Prison for Women, opened in May 1995, is located on 640 acres in Chowchilla, California. The institution has approximately 960 employees and an operating budget for fiscal year 2005-06 of $112 million. Although, Valley State Prison for Women was designed to house 1,980 inmates, it presently houses more than 3,800 inmates in facilities at Levels I through IV, a reception center, and a security housing unit.

Valley State Prison for Women is a work-based, fully programmed prison that provides legally mandated programs and services, including vocational programs in auto mechanics, cosmetology, dry cleaning, eyewear manufacturing, graphic arts, janitorial services, landscape gardening, mill and cabinetry, office services, refrigeration and air-conditioning, small engine repair, and welding. The Prison Industry Authority operates an optical laboratory and a laundry at the institution.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the January 2001 review:

- The morale at Valley State Prison for Women was poor under the warden's leadership. Employee distrust of the warden was deep-seated and respect for him was low.

- The institution's Category I investigations were delayed unnecessarily and were often inadequate.

- The inmate disciplinary process at Valley State Prison for Women was not regularly meeting statutory mandates with respect to timeliness and documentation.

- Inmate appeal forms were not being processed within the time limits required by California Code of Regulations, Title 15, section 3084.6.

- Valley State Prison for Women's training records were inadequate to document that staff members had attended mandatory training classes and completed the minimum hours of required annual training.

- Employee probation and performance reports were not completed in a timely manner.

- Control over the storage and disposal of drugs at Valley State Prison for Women was inadequate.

- The institution projected a budget deficit of $1.2 million for fiscal year 2000-01.

- Valley State Prison for Women failed to respond expeditiously to an inmate's request under the Americans with Disabilities Act, which violated a court-ordered remedial plan and subjected the institution to potential civil liability.

- The institution's quarterly tool audits did not accurately reflect actual conditions at various inventory sites throughout the institution.

- Adverse personnel action case files at Valley State Prison for Women were not adequately monitored, tracked, or documented.

- Equal employment opportunity complaint and investigation case files contained inadequate documentation.

- Valley State Prison for Women had a number of institutional security deficiencies. Staff assigned to armed posts had not met quarterly range qualifications. The institution had inadequate controls to ensure that authority to take home institutional keys resided only with those employees whose current job assignment required take-home keys. There were no written guidelines covering the information the watch commander was to record on the electrified fence log.

- The Valley State Prison for Women warden failed to purchase drug interdiction equipment mandated by the Department of Corrections.

- The institution's emergency operations plan was not submitted in a timely manner.

The Office of the Inspector General made 35 recommendations to the Valley State Prison for Women management as a result of the January 2001 review. The specific recommendations are listed in the attached table.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which Valley State Prison for Women has implemented the 35 recommendations from the Office of the Inspector General's January 2001 review. To conduct the follow-up review, the Office of the Inspector General provided Valley State Prison for Women with a table listing the January 2001 findings and recommendations and asked the institution to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the institution and evaluated the degree of compliance or noncompliance with the recommendations. The Office of the Inspector General's fieldwork was completed during October 2005. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 35 recommendations issued by the Office of the Inspector General in January 2001, 24 recommendations have been fully implemented; two have been substantially implemented; five have been partially implemented; one has not been implemented: and three are no longer applicable.

The Office of the Inspector General found that Valley State Prison for Women has taken measures to improve employee morale and various important administrative procedures, including Category I investigations, rules violation reports, inmate appeals, adverse personnel actions, and equal employment opportunity complaints. The institution has improved the tracking systems for these administrative processes and has established bi-monthly employee advisory council meetings. Valley State Prison for Women has also improved its budget situation by seeking additional funding and operating in a fiscally conservative manner. However, the institution remains deficient in preparing timely employee performance and probation reports; ensuring that staff members assigned to armed posts meet quarterly weapons qualification requirements; providing drug interdiction training; and complying with Department of Corrections and Rehabilitation drug disposal guidelines.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that Valley State Prison for Women take the following additional actions:

- **Hold staff members with responsibility for preparing performance and probation reports accountable for completing and submitting the reports on the required date and use progressive discipline to ensure compliance.**

- **Follow the updated evidence control procedure (operational procedure 83090.04) for the destruction of drugs.**

- **Conduct a quarterly audit of staff members assigned to armed posts to ensure compliance with the quarterly range qualifications.**

- **Instruct armed post supervisors to ensure that their subordinates fulfill their quarterly range requirements.**

- **Pursue progressive discipline against staff members and supervisors who are non-compliant with quarterly range requirements and their supervisors.**

- **Ensure that employees receive drug interdiction training.**

- **Instruct staff members responsible for updating the emergency operations plan to begin the process earlier than in previous years to allow enough time for the warden's review and sign-off by the first week of January, as required.**

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that morale at Valley State Prison for Women was poor under the warden's leadership. The audit revealed that employee distrust of the warden was deep-seated and respect for him was low.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that Valley State Prison for Women management take immediate steps to regain employees' trust and respect by taking the actions listed below.		
Acknowledge the extent to which cynicism and distrust affects the employee population.	FULLY IMPLEMENTED	Valley State Prison for Women reported that its employee advisory committee, which consists of an employee from each department, including plant operations, education, administration, and records, has improved employee trust and respect. The committee meets bi-monthly to discuss issues and concerns raised by the employees. The committee provides copies of its meeting minutes to the warden and area managers for evaluation and resolution. The Office of the Inspector General reviewed the meeting minutes of the July 12 and September 15, 2005 committee meetings. Eight of the committee's 19 members attended the July meeting and five members attended the September meeting. The Office of the Inspector General concluded from reviewing the documents that the committee discussed issues related to employee concerns, such as covered tram stops, employee tram services, soda machines, bomb threats, and employee smoking prohibitions. The Office of the Inspector General also noted that the next meeting was scheduled for November 8, 2005.

Meet with employees to identify and define the issues most important to them.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that the employee advisory committee allows managers to acknowledge important issues affecting employees outside the scope of collective bargaining, which improves daily operations and employee morale. For example, the committee facilitated the establishment of a tram to transport employees from the entrance building to specific locations throughout the institution and worked to improve employee break areas. Valley State Prison for Women also reported that facility captains monitor their respective facilities monthly. In addition, all managers, including the warden, chief deputy warden, and associate wardens, conduct periodic tours of the institution to ensure safety and security and to make themselves accessible to the staff.
Respond immediately to as many of the initially identified employee concerns as practically possible by introducing policy changes, permitting activities, or making other innovations that can be implemented without compromising institutional security or agency policy.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that the employee advisory committee meetings, the monthly facility captain tours of the facility, and the periodic management tours of the institution improved employee morale and did not compromise institutional security or agency policy.
Form a committee of representatives from various employee areas (administration, custody, facilities, programming), to provide a forum for identifying factors relating to employee morale, recommending solutions, and monitoring the effectiveness of the solutions implemented.	**FULLY IMPLEMENTED**	As discussed above, Valley State Prison for Women reported that the employee advisory committee has improved employee morale, trust, and respect and has allowed managers to acknowledge important issues affecting employees outside the scope of collective bargaining.

Conduct regular walking tours of the institution, visiting all work sites to talk with employees about the institution's mission and receiving information directly from employees responsible for carrying out that mission.	FULLY IMPLEMENTED	Valley State Prison for Women reported that its facility captains tour their respective facilities each month to monitor operations and to make themselves accessible to the staff. In addition, all managers, including the warden, chief deputy warden and associate wardens, conduct periodic tours of the entire facility to ensure the safety and security of the institution and to interact with staff. Finally, all managers are encouraged to have an "open door policy."

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the institution's Category I investigations were delayed unnecessarily and were often inadequate.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Investigative Services Unit at Valley State Prison for Women carefully monitor the timeliness of its investigations. Adding a separate column to the incident tracking log for recording the incident date would help to flag the approach of the one-year deadline imposed by Government Code section 3304(d).	NOT APPLICABLE	The Department of Corrections and Rehabilitation's Office of Internal Affairs has eliminated the differentiation between Category I and Category II investigations. All requests for investigations are reviewed by a committee in the central intake unit at Office of Internal Affairs headquarters. Accepted cases are assigned to a senior special agent at a regional internal affairs office. It is the option of the senior special agent to assign the case to an institution's Investigative Services Unit. If a case is assigned to the institution staff, it is supervised by the senior special agent at the Office of Internal Affairs and monitored on a new case management system. The case management system produces a periodic case aging report that provides the senior special agent with information on the age of a case. This feature helps prevent cases from exceeding the statutory completion timeframes.

The Office of the Inspector General recommended that the Investigative Services Unit's newly appointed lieutenant play a strong role in monitoring the quality of every investigation, ensuring that issues are fully explored, relevant witnesses interviewed, conflicting testimony evaluated, and findings supported by sufficient facts and evidence.	NOT APPLICABLE	Refer to previous comment.
The Office of the Inspector General recommended that the Valley State Prison for Women warden exercise good judgment in making the necessary distinctions between Category I and Category II investigations. In cases where the determination is open to interpretation, the warden should consult with the manager of the Office of Investigative Services, Central Region, in making a decision.	NOT APPLICABLE	Refer to previous comment.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that the inmate disciplinary process at Valley State Prison for Women was not regularly meeting statutory mandates with respect to timeliness and documentation.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden's office regularly review the disciplinary action logs (CDC Form 1154) at each of the institution's four housing facilities to identify any incomplete CDC Form 115s.	FULLY IMPLEMENTED	Valley State Prison for Women reported that facility captains review the disciplinary action logs on at least a monthly basis. In addition, the associate wardens and the chief disciplinary officer review the logs on a quarterly basis.
In addition, the warden's office should implement procedures requiring written justification by any official voiding or dismissing a CDC Form 115.	FULLY IMPLEMENTED	Valley State Prison for Women reported that all senior hearing officers (lieutenants) are required to submit a memorandum to the chief disciplinary officer documenting the reason a rules violation report (CDC 115) was voided. The Office of the Inspector General obtained and reviewed the institution's March 2005 institutional disciplinary register. As a result of the review, the Office of the Inspector General identified a number of CDC 115s that appeared to have been voided and requested copies of the memoranda explaining the reason each of the CDC 115s was voided. The institution provided the memoranda, which enabled the Office of the Inspector General to verify that the senior hearing officers submit memoranda for voided CDC 115s to the chief disciplinary officer.
To facilitate proper monitoring and auditing, copies of voided CDC 115s should be provided to the chief disciplinary officer for inclusion in the institutional register.	FULLY IMPLEMENTED	Valley State Prison for Women reported that all voided CDC 115s are submitted to the chief disciplinary officer via memorandum and are recorded in the institutional disciplinary register. As mentioned previously, the Office of the Inspector General verified that the voided CDC 115s are recorded on the institutional disciplinary register via memorandum.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that inmate appeal forms (CDC Form 602) were not being processed within the time limits required by Title 15 of the California Code of Regulations, section 3084.6.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden's office implement effective monitoring processes to ensure that inmate/parole appeals are processed promptly.	FULLY IMPLEMENTED	Valley State Prison for Women reported that the appeals coordinator prepares and submits an appeals report to the warden's office for review every Monday. The report details all of the first and second level appeals on file in the appeals office, including the inmate's name and location, the log number, and the assignment and due dates. The warden and the warden's executive staff members review the report and discuss it during the weekly executive staff meetings. The warden's office informs the appeals coordinator of discrepancies or questionable due dates. The Office of the Inspector General reviewed 26 warden's executive staff meeting minutes covering meetings held during January and June 2004 and January, May, July, and August 2005. The Office of the Inspector General verified that appeals were discussed during 24 of the 26 meetings. According to the minutes, the appeals unit reported only one overdue appeal on May 16, 2005; three overdue appeals on July 25, 2005; one overdue appeal on August 15, 2005, and one overdue appeal on August 29, 2005. The Office of the Inspector General also reviewed a copy of the institution's overdue appeals report dated August 29, 2005 and noted that the institution had one overdue appeal pending that dealt with an Americans With Disabilities Act issue. As of August 29, 2005, the appeal was five days overdue.

The Office of the Inspector General recommended that the monitoring process be combined with appropriate action to enforce adherence to required deadlines in order to be effective.	**FULLY IMPLEMENTED**	As discussed above, Valley State Prison for Women reported that the warden's office has an active role in monitoring the status of appeals. The warden's office reviews the weekly appeals report, discusses the report at the weekly executive staff meetings, and informs the appeals coordinator of any discrepancies or questionable due dates. According to the institution, the appeals coordinator addresses the warden's concerns appropriately and expediently.
The Office of the Inspector General recommended that the warden's office consider the necessity of providing additional training on Valley State Prison for Women's policies and procedures for processing inmate appeals.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that the appeals office staff members receive annual appeals training. In addition, the appeals coordinator develops operational procedures and submits them to the warden's office for review and approval. According to the institution, the review process ensures strict adherence to department policies and procedures. The institution reported that the appeals coordinator has a good understanding of the policies and procedures and implements them in an effective and efficient manner.
The Office of the Inspector General recommended that the institution's appeals coordinator begin filing completed CDC Form 602s in sequential order within the individual appeals folders.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that it implemented a new filing system in 2001. To ensure efficiency, appeals are filed in sequential order. The system enables the appeals office staff to easily locate appeal documents through individual log numbers.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that Valley State Prison for Women's training records were inadequate to document that staff members had attended mandatory training classes and completed the minimum hours of required annual training.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that Valley State Prison for Women and Department of Corrections management place greater emphasis on maintaining complete and accurate training records for Valley State Prison for Women staff.	FULLY IMPLEMENTED	Valley State Prison for Women reported that it tracks each employee's in-service and on-the-job training through an automated system. According to the institution, the training officer updates the record of any employee who attends a training class upon receiving a CDC 844 sign-in form. The training officer files and archives the form after completing the data entry.
The Office of the Inspector General recommended that the warden require the in-service training staff to provide training printouts periodically to supervisors and managers so that they can monitor staff training status.	FULLY IMPLEMENTED	Valley State Prison for Women reported that the institution monitors staff training through supervisors and managers. Each employee's training record is audited annually and/or quarterly to ensure that employees are in compliance. The Office of the Inspector General reviewed the minutes of 26 of the warden's executive staff meetings held in January and June 2004 and in January, May, July, and August 2005. The Office of the Inspector General verified that staff training was a topic at 21 of the 26 meetings.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that employee probation and performance reports were not completed in a timely manner.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden and his management team emphasize the importance of preparing employee performance and probationary reports in a timely manner.	PARTIALLY IMPLEMENTED	Valley State Prison for Women reported that it ensures that performance and probationary reports are completed in a timely manner through the following procedures: The personnel specialist prepares a performance evaluation tracking card when a new employee begins assignment at the institution. The card lists the due dates of all required performance and probationary reports. The personnel specialist sorts the cards numerically by the month due. Each month the personnel specialist pulls the tracking cards for the next month's performance reports, prepares the performance reports, and distributes them to the appropriate division head for disposition. On the 6th day of each month, a personnel specialist prepares a past-due performance report and forwards it to the warden. The warden uses the report to address delinquent performance reports in the executive staff meetings. Valley State Prison for Women also reported that it completes an average of 1,025 performance reports each year and that in 2004 it processed 94 percent of the reports on time. According to the institution, from January through August 2005, 93 percent of the performance reports were on time. The institution reported that overdue performance reports were caused by staff vacations, official business, extended sick leave, and absences. The Office of the Inspector General compared the institution's procedures for preparing performance reports as described above to the procedures recounted to the Office of the Inspector General during the 2001 review and found that the procedures have not changed. The Office of the Inspector General also noted that delinquent performance and probation reports were not included as

		a topic in the minutes of any of the 26 executive staff meetings held in January and June 2004 or in January, May, July, and August 2005. Despite the institution's statement that 93 percent of performance reports were completed on time during the first eight months of 2005, the number of overdue performance reports actually has been increasing since the 2001 review. In August 2000, the last month covered in the 2001 review, the institution had 57 overdue performance reports. In August 2004, the number was the same —57 overdue performance reports. In August 2005, the number jumped to 64 overdue performance reports, and in the 13-month period from August 2004 through August 2005, the institution averaged 72 overdue performance reports and 24 overdue probation reports each month.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that Valley State Prison for Women hold staff members with responsibility for preparing performance and probation reports accountable for completing and submitting the reports on the required date and use progressive discipline to ensure compliance.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that control over the storage and disposal of drugs at Valley State Prison for Women was inadequate.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden of Valley State Prison for Women implement the following procedures: Coordinate the destruction of drugs with local law enforcement as required by the *Department of Corrections Operations Manual.* If this is not practical, Valley State Prison for Women's investigative services unit should transport the drugs to the destruction site in conjunction with Central California Women's Facility staff. Staff from the two institutions should trade and inventory each others' drugs, and sign an acknowledgement verifying counts or identifying discrepancies immediately prior to destruction.	**PARTIALLY IMPLEMENTED**	Valley State Prison for Women reported that the institution's investigative services unit follows the guidelines for destruction of drugs required by the *Department of Corrections and Rehabilitation Operations Manual.* The institution reported that it shares the cost of destruction with the Central California Women's Facility and that the evidence officer of the investigative services unit always signs an acknowledgment verifying counts. The Office of the Inspector General reviewed the institution's evidence control procedure, operational procedure 83090.04, dated June 2005, and found that the institution has updated its procedures to comply with *Department of Corrections and Rehabilitation Operations Manual* requirements. To verify that the institution is following the procedures, the Office of the Inspector General analyzed the supporting documentation from the institution's August 2005 drug destruction. The Office of the Inspector General found that the institution failed to follow the updated procedures after it obtained permission from the Madera County Superior Court to destroy drugs no longer needed for evidence in court proceedings. Instead of coordinating the drug destruction with local law enforcement in order to provide independent verification as required by the *Department of Corrections and Rehabilitation Operations Manual* and the institution's operating procedures, the evidence officer along with another officer from the investigative services unit, transported the drugs to Covanta Energy, which operates a destruction site. Covanta Energy issued a certificate of disposal but made no notation on the certificate describing what was destroyed. Without this documentation or other independent verification there is no assurance that the drugs were properly destroyed.

Appoint one correctional officer as Valley State Prison for Women's evidence officer and restrict drug access to only that individual.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that the investigative services unit has one correctional officer designated as the evidence officer. According to the institution, the evidence officer and his supervising sergeant are the only staff members with access to the evidence locker where confiscated drugs are stored. The Office of the Inspector General verified that the investigative services unit has one evidence officer and that the evidence officer and his supervising sergeant are the only investigative services unit staff members with access to the keys that unlock the evidence locker. The evidence officer is responsible for entering information onto the evidence log and database.
Require that investigative services unit supervisors conduct unannounced inventories of the evidence room at least monthly. The inventories should be documented and maintained for review.	**SUBSTANTIALLY IMPLEMENTED**	Valley State Prison for Women reported that the investigative services unit lieutenant and sergeant both conduct unannounced inventories of the evidence room monthly. According to the institution, the lieutenant and sergeant sign in on the log, pull inventory cards, and review the evidence with the officer. The Office of the Inspector General reviewed the institution's evidence control procedure, operational procedure 83090.4, dated June 2005. Under the procedure, the evidence officer is required to conduct regular inventories of the evidence and document the inventory on the evidence room log-in sheet. The investigative services unit sergeant is required to conduct an unannounced inventory of the evidence room at least once a month. The investigative services unit sergeant is also required to assist the evidence officer with a complete inventory of all items in the evidence room quarterly. The investigative services unit lieutenant is required to conduct periodic inventories of all items in the evidence room to determine if they must be maintained for an administrative hearing or criminal proceeding. The Office of the Inspector General reviewed a copy of the evidence room log-in sheets for the period November 29, 2004 to October 3, 2005 and found that the evidence officer conducted eight inventories during the 10-month period, with three of the eight inventories conducted in tandem with the investigative services unit sergeant. The investigative services unit sergeant conducted nine inventories during the 10-month period, including the three

		inventories conducted in tandem with the evidence officer. The investigative services unit lieutenant conducted two inventories during the 10-month period. For two of the 10 months, however, neither the sergeant nor the lieutenant conducted the required inventories.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that Valley State Prison for Women follow its updated evidence control procedure (operational procedure 83090.04) for the destruction of drugs.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that Valley State Prison for Women projected a budget deficit of $1.2 million for the 2000-01 fiscal year.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden take immediate action to control expenditures and eliminate future budget deficits. The effort required reducing expenditures by eliminating posts and preparing budget change proposals to augment the institution's budget.	FULLY IMPLEMENTED	Valley State Prison for Women reported that it received adequate funding through the budget change process after the January 2001 review and ended fiscal year 2000-01 with a $26,407 surplus. According to the institution, it is operating in a fiscally conservative manner. For example, the managers review custody overtime usage on a daily basis and closely monitor budget allotments and expenditures each month. As a result, Valley State Prison for Women ended fiscal years 2001-02, 2002-03, 2003-04, and 2004-05 with a budget surplus. The Office of the Inspector General reviewed the institution's final budget plan summary for fiscal year 2004-05 and verified that Valley State Prison for Women ended fiscal year 2004-05 with a budget surplus.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that Valley State Prison for Women failed to respond expeditiously to an inmate's request under the Americans with Disabilities Act, thereby violating a court-ordered remedial plan and subjecting the institution to potential civil liability.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden immediately modify the institution's operational procedure for assistive devices to correspond with the departmentally issued remedial plan and its own disability placement procedure.	FULLY IMPLEMENTED	Valley State Prison for Women reported that it has modified its operational procedures for assistive devices and has fully implemented all aspects of the *Armstrong* Remedial Plan, which concerns Americans with Disabilities Act issues. According to the institution, the appeals coordinator gives high priority to all issues and appeals related to inmates with disabilities and processes them in a timely and efficient manner. The institution reported that the appeals coordinator also has attended Americans with Disabilities Act training and fully understands the importance of efficiently processing these documents. Valley State Prison for Women also reported that the warden and the appeals coordinator review appeals each week to ensure that time constraints are met. According to the institution, Valley State Prison for Women staff members meet with attorneys from both the Prison Law Office the department's Legal Affairs Division to resolve Americans with Disabilities Act issues and issues related to the *Armstrong* litigation. In addition, the Prison Law Office tours the institution as part of the *Clark* litigation, and the warden works with the staff and the department's Legal Affairs Division to resolve issues in that case. The Office of the Inspector General reviewed the institution's operational procedure for the issuance of wheelchairs and other assistive devices

		(operational procedure 83080.08) and verified that the procedure corresponds to the department's remedial plan and its own disability placement procedures.
In addition, the Office of the Inspector General recommended that the warden thoroughly investigate the incident and take steps to lessen or eliminate the potential for any similar incident to occur.	**NOT IMPLEMENTED**	Valley State Prison for Women reported that the appeals for the inmate referred to in the finding have been resolved and the appeals coordinator continues to follow established procedure to avoid similar incidents from occurring. Although Valley State Prison for Women modified its operational procedure for assistive devices consistent with the department's remedial plan and its own disability placement procedures, the warden did not investigate the incident beyond resolving the inmate's appeals. The extreme delay in resolving the inmate's appeals was the issue that led to the finding. It is an improvement that the status of appeals is now discussed at the weekly executive staff meeting, however.

FOLLOW-UP RECOMMENDATIONS

No follow-up recommendations due to the length of time since the incident occurred in January 2000.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that Valley State Prison for Women's quarterly tool audits did not accurately reflect actual conditions at various inventory sites throughout the institution.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the tool control officer document all corrective action taken during tool audits and bring all serious policy violations to the warden's attention. Further, any corrective action taken by the tool officer should be summarized in the completed quarterly tool audit report presented to the warden.	FULLY IMPLEMENTED	Valley State Prison for Women reported that the tool control officer documents and reports all tool control policy violations to the warden through a quarterly tool audit report. The Office of the Inspector General reviewed a copy of the tool control officer's second quarter 2005 audit tracking form and found that the officer documented each discrepancy found along with its corresponding corrective action on the report.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that adverse personnel action case files at Valley State Prison for Women were not adequately monitored, tracked, or documented.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
To mitigate the potential for exposing the institution and the department to civil liability, as well as to lessen the possibility of having cases unresolved for unacceptable periods of time, the Office of the Inspector General recommended that the institution's employee relations officer develop a system to track and monitor adverse action cases.	FULLY IMPLEMENTED	Valley State Prison for Women reported that it developed and uses a system to track and monitor all sustained internal affairs investigations that result in either corrective actions (handled administratively) or adverse personnel actions. The institution also reported that its employee relations committee meets once a month to discuss and review all potential adverse action cases. According to the institution, the meetings, coupled with the tracking system, ensure that each case is effectively monitored and addressed in a timely manner. The employee relations committee is composed of the following staff

		members: the warden, the equal employment opportunity coordinator, the investigative services unit lieutenant, the employee relations officer, the return-to-work coordinator, and the personnel officer. The committee met nine out of the twelve months ending July 30, 2005. The Office of the Inspector General reviewed a copy of the institution's employee relations office action log for the period January 1, 2005 to August 5, 2005. The log listed the cases in sequential order and provided essential information, such as the discovery date, which is instrumental in ensuring that a case is resolved within the required timeframes.

FOLLOW-UP RECOMMENDATIONS
None.

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found that equal employment opportunity complaint and investigation case files contained inadequate documentation.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution's equal employment opportunity coordinator develop a system to track and monitor equal employment opportunity cases to ensure that cases are resolved in a timely fashion and that all critical documentation is complete.	FULLY IMPLEMENTED	Valley State Prison for Women reported that it has developed a system to track, monitor, and update case information. According to the institution, equal employment opportunity office staff members update the tracking log at least once a month. Valley State Prison for Women's equal employment opportunity coordinator contacts outside agencies for updates and meets with the warden to inform her about new or existing cases at least once a month. The institution reported that the coordinator monitors and evaluates all cases within the appropriate guidelines and ensures that all cases are being addressed and resolved in a timely manner. The Office of the Inspector General reviewed copies of the institution's

		discrimination complaint activity logs for calendar years 2004 and 2005 (through mid-August 2005), and determined that the logs contained the necessary information, including the complaint's receipt date, which would facilitate the monitoring process and enable the coordinator to ensure the timely resolution of each case.

FOLLOW-UP RECOMMENDATIONS
None.

ORIGINAL FINDING NUMBER 13

The Office of the Inspector General found a number of deficiencies in institutional security at Valley State Prison for Women.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution take the steps listed below to improve institution security.		

Have managers and supervisors conduct periodic audits of training records for employees assigned to armed posts to ensure that those employees meet quarterly proficiency requirements with the weapons maintained in armed post positions.	**PARTIALLY IMPLEMENTED**	Valley State Prison for Women reported that the armory sergeant conducts quarterly weapons qualifications for all staff members assigned to armed posts. According to the institution, the in-service training manager conducts an annual audit of each employee to ensure that weapons qualifications requirements are met. To do so, the manager identifies individuals requiring quarterly qualification and cross-references the names against the automated in-service training records of staff members who have participated in the quarterly and annual range qualifications. The in-service training manager documents any deficiencies and forwards the names of the officers and supervisors who have fallen out of compliance to the division head for appropriate action. Valley State Prison for Women also reported that the monthly in-service training bulletin identifies each post that requires quarterly weapons qualification. The institution instructs its supervisors to periodically inspect officer training cards (gold cards) to ensure that each officer has met his or her quarterly qualification requirements. The Office of the Inspector General found, however, that Valley State Prison for Women personnel assigned to armed posts have not consistently met quarterly range qualification requirements. The Office of the Inspector General reviewed a list of Valley State Prison for Women personnel assigned to armed posts and determined that 86 correctional officers were assigned to armed posts as of August 11, 2005. The Office of the Inspector General also obtained and analyzed automated training records for staff members who had participated in annual and quarterly range qualifications during the seven-quarter period from January 1, 2004 to September 26, 2005. The Office of the Inspector General verified the dates each of the 86 correctional officers was assigned to an armed post and cross-referenced the names of the staff members assigned to armed posts against the automated training records for the seven-quarter period in question. As a result of that review, the Office of the Inspector General determined that only 58 (67 percent) of the 86 staff members assigned to armed posts had completed all of the required quarterly range qualifications and training. As of the end of the third quarter of 2005, the deficiencies consisted of the following:

		• Sixteen (33 percent) of the 49 staff members assigned to an armed post in January 2005 had not completed the three required quarterly range qualifications. • One (33 percent) of the three staff members assigned to an armed post in June 2005 failed to complete the two required quarterly range qualifications. • Ten (30 percent) of the 33 staff members assigned to an armed post in July and August 2005 failed to complete the required range qualification. • One staff member had been assigned to an armed post in 2002, but had completed only three of the last seven quarterly range qualifications.
Modify and expand the *Valley State Prison for Women Operations Manual,* Supplement 55020 to require staff with take-home keys to return those keys to the locksmith after changes in their assignments eliminate the necessity for such keys.	**SUBSTANTIALLY IMPLEMENTED**	Valley State Prison for Women reported that the institution locksmith does not issue keys to an individual changing assignments until the person previously holding the assignment returns the keys to the locksmith. According to the institution, the locksmith also thoroughly reviews all key request forms to verify the validity of the request and conducts biannual audits of all take-home key sets. The Office of the Inspector General reviewed a copy of the *Valley State Prison for Women Operations Manual,* Supplement 55020, dated July 18, 2005. Although the institution had not modified the manual as recommended by the Office of the Inspector General, the manual did include a blank copy of the institution's key request form, which specified that it is the employee's responsibility to return the keys to the key control officer or locksmith upon job change, transfer, or termination.

In conjunction with this, the institution's personnel office should provide a monthly list of all assignment changes to the locksmith, who would provide written notice to employees assigned to posts not requiring take-home keys to turn them in, and who would distribute copies of such notification to the employees' supervisors.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that the personnel office will not finalize an employee's separation, transfer, or retirement until a department report of separation is completed. The form includes a section that must be completed by the institution locksmith, who retrieves institution keys at that time. Valley State Prison for Women also provided the Office of the Inspector General with copies of the July 1, July 8, July 15, July 22, and July 29, 2005, personnel changes report. The Office of the Inspector General reviewed the reports and verified that the personnel office provides the lists to the institution locksmith each week.
Modify and expand the *Valley State Prison for Women Operations Manual,* Supplement 55080 to direct watch commanders to complete the electrified fence log at the end of each watch.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that the electrified fence log is maintained in the watch commander's office and is completed daily on all watches by each watch commander on duty. The Office of the Inspector General reviewed a copy of the *Valley State Prison for Women Operations Manual,* Supplement 55080, dated November 3, 2004 and found that the institution modified the manual to require that watch commanders make all appropriate entries on the electrified fence log during their shift, noting any alarm or other activity related to the electric fence.
Valley State Prison for Women should also provide training on proper completion of the electrified fence log for supervisors and managers and should institute a policy of having the security captain periodically review the log for completeness and report any problems to the warden.	**FULLY IMPLEMENTED**	Valley State Prison for Women reported that the correctional captain reviews the electrified fence log monthly and provides on going training regarding the log. The Office of the Inspector General found that the *Valley State Prison for Women Operations Manual*, Supplement 55080 dated November 3, 2004 directs the correctional captain to review the electrified fence log during the first week of each month for completeness. The Office of the Inspector General also reviewed excerpts from the institution's automated training records and found that staff members received electrified fence training.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that Valley State Prison for Women take the following additional actions with respect to weapons qualifications:

- **Conduct a quarterly audit of staff members assigned to armed posts to ensure compliance with the quarterly range qualifications.**
- **Instruct armed post supervisors to ensure that their subordinates fulfill their quarterly range requirements.**
- **Pursue progressive discipline against staff members and supervisors who are non-compliant with range qualification requirements.**

ORIGINAL FINDING NUMBER 14

The Office of the Inspector General found that the Valley State Prison for Women warden failed to purchase drug interdiction equipment mandated by the Department of Corrections.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden comply with the department directive to purchase the approved security systems outlined in the March 23, 2000 memorandum from the deputy director of the Department of Corrections Institutions Division.	PARTIALLY IMPLEMENTED	As of September 8, 2005, Valley State Prison for Women had not purchased any of the mandated security systems and had not received a dispensation from the department to disregard the mandate. According to the institution's associate warden for business services, the institution did prepare a purchase order for some of the recommended equipment, but withdrew the purchase order due to the lack of funds. The Office of the Inspector General contacted the department to determine whether any institutions purchased the equipment and found that the department staff member who drafted the directive no longer worked at the department. Neither the Institutions Division nor the Facilities Management Division had knowledge of the outcome of the directive. Valley State Prison for Women did report that it had purchased and was

		operating an upgraded version of the Inmate Monitoring Activity Recording System in use during the Office of the Inspector General's January 2001 review.
The Office of the Inspector General also recommended that Valley State Prison for Women provide the necessary training to its staff to enhance its current drug interdiction efforts.	**PARTIALLY IMPLEMENTED**	Valley State Prison for Women reported that its employees receive on-going training to enhance drug interdiction efforts. The Office of the Inspector General reviewed copies of the institution's automated training tracking system and verified that 295 employees received drug interdiction training during the period August 29, 2003 to August 29. 2005, but that total amounted to less than one-third of the approximately 960 employees at the institution.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the institution ensure that all employees receive drug interdiction training.

ORIGINAL FINDING NUMBER 15

The Office of the Inspector General found that Valley State Prison for Women's emergency operations plan was not submitted in a timely manner.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden implement procedures to ensure that the emergency operations plan was updated and ready for submittal to the Department of Corrections for review each January.	FULLY IMPLEMENTED	Valley State Prison for Women reported that it updated its emergency operations plan for 2005 and submitted it to headquarters in a timely manner. The Office of the Inspector General reviewed the institution's 2005 emergency operations plan and found that although the plan was dated January 2005, the warden did not sign off until February 15, 2005. The *California Department of Corrections and Rehabilitation Operations Manual,* section 55010.4 provides as follows: *[D]uring the first week of January, two copies of the Emergency Operations Plan and any revised Resource Supplement pages shall be submitted to the Deputy Director, Institutions, accompanied by a letter from the warden indicating any previous revisions incorporated into the plan. The plan and any revisions thereto shall be approved by the Director.* A representative from the Emergency Operations Unit told the Office of the Inspector General that the institution's emergency operations plan for 2004 was also received well after the first week of January 2004.

FOLLOW-UP RECOMMENDATIONS

None.

SIERRA CONSERVATION CENTER

IMPLEMENTATION REPORT CARD

Previous recommendations: 53

Fully implemented: 38 (71%)

Substantially implemented: 11 (21%)

Partially implemented: 1 (2%)

Not implemented: 1 (2%)

Not applicable: 2 (4%)

The Office of the Inspector General found that the Sierra Conservation Center has successfully addressed nearly all of the deficiencies identified in a May 2001 management review audit. The institution has enhanced the safety and security of its physical plant and has improved procedures relating to inmate appeals, the inmate disciplinary process, staff training, adverse personnel actions, employee grievances, equal employment opportunity complaints, and the reporting of inmate deaths.

As a result of the May 2001 management review audit, the Office of the Inspector General identified safety and security deficiencies related to gun coverage of a recreational yard; physical deterioration of prison dormitories; the use of privacy curtains in inmate living areas; control of flammable substances in a vocational education area; the need for an additional strip search facility; and the securing of utility closets in the administrative segregation unit. The audit also found deficiencies related to the institution's inmate appeals process; inmate disciplinary system; employee grievance process; equal employment opportunity complaints, inmate death reporting, staff training, and the tracking of adverse personnel actions.

BACKGROUND

Situated on 420 acres near Jamestown, California, the Sierra Conservation Center is one of only two institutions in the state responsible for the training and placement of inmates into the conservation camp program. The principal mission of the institution is to provide housing, programs, and services for minimum and medium custody inmates. The institution administers 22 conservation camps — 19 camps for male inmates and three camps for female inmates — located in rural and wilderness areas extending from Central California to the Mexican border. Camp inmates perform community service work, including wild-land fire suppression, firebreak construction, flood abatement, and general conservation projects to assist local government agencies. The institution also operates academic and vocational education programs, as well as substance abuse treatment and other inmate programs.

At present, the institution and the 22 conservation camps house approximately 6,180 minimum and high-medium custody inmates. The main institution includes more than 4,000 inmates in three facilities: the Calaveras and Mariposa dormitory units and Tuolumne, a Level III (high-medium security) unit, which includes administrative segregation housing. The remaining inmates are assigned to the conservation camps.

For fiscal year 2005-06, the institution has an operating budget of approximately $114 million and 1,100 staff positions, with 200 of the positions located at the conservation

camps. The camps are operated jointly with the California Department of Forestry and Fire Protection.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the May 2001 audit:

- The administration failed to follow up on a mandated policy directive to place inmate photographs outside each cell door in the administrative segregation unit. As a result, an inmate was victimized and staff was placed at risk. No manager or supervisor was held accountable for failing to implement the required changes.

- Inmate and staff safety was jeopardized and illegal inmate activities may have gone unnoticed because inmates were allowed to erect unauthorized privacy curtains within the housing units.

- Gun coverage for portions of the Level III yard continued to be inadequate.

- Prison dormitories showed signs of significant deterioration, creating health and safety risks.

- Deficiencies were found in many of the internal affairs investigations reviewed.

- Many of the inmate appeals at the Sierra Conservation Center were not processed within prescribed time limits and numerous other deficiencies were noted in the inmate appeals process.

- In some instances, the inmate disciplinary system at the Sierra Conservation Center was not meeting statutory, constitutional, or procedural mandates.

- The Sierra Conservation Center seldom took disciplinary action against inmates who violated state law and departmental policy by knowingly filing false allegations against peace officers.

- A strip search area was needed at the sally port gate for the Calaveras and Mariposa facilities because of the large number of inmates processed through that entry each day and the importance of institution security and drug interdiction.

- Some vocational education inmates had access to unsecured flammable liquids and chemicals, posing a security risk.

- Utility closet doors in the administrative segregation building were unlocked, jeopardizing institution safety.

- The Tuolumne facility captain was circumventing key control by failing to retain possession of his assigned metal key tag when he was not in the unit.

- Non-custody staff at the Sierra Conservation Center was not fulfilling training requirements and completion of training courses could not be readily verified in the training files.

- Adverse personnel action case files at the Sierra Conservation Center were not adequately monitored, tracked, or documented.

- The institution did not have a process to adequately monitor or track employee grievances and as a result, the institution may not have been in compliance with the memorandum of understanding for each bargaining unit.

- Equal employment opportunity complaint and investigation case files lacked a standardized organizational format.

- The process of and responsibilities for documenting and reporting an inmate's death were not clearly defined, making it difficult to determine if the Sierra Conservation Center had adequately fulfilled its medical and legal responsibilities.

- The controls governing the Sierra Conservation Center mailroom were inadequate.

The Office of the Inspector General made 53 recommendations to the management of the Sierra Conservation Center as a result of the May 2001 management review audit. The recommendations are shown in the table following the narrative portion of this report.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Sierra Conservation Center has implemented the 53 recommendations from the Office of the Inspector General's May 2001 audit. To conduct the follow-up review, the Office of the Inspector General provided the Sierra Conservation Center with a table listing the May 2001 findings and recommendations and asked the institution to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the institution, and evaluated the degree of compliance or noncompliance with the recommendations. Additional field work was also conducted in September 2005. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 53 recommendations issued by the Office of the Inspector General in the May 2001 management review audit, 38 recommendations have been fully implemented; 11 have been substantially implemented; one has been partially implemented; one has not been implemented; and two are no longer applicable.

The Office of the Inspector General found that the Sierra Conservation Center has made important improvements in its physical plant and operational procedures. The institution

has enhanced gun coverage of the recreational yard; constructed a needed strip search area; enhanced controls in the mailroom; secured utility closets in the administrative segregation unit; improved controls over hazardous substances in the vocational education area; limited the use of privacy curtains in inmate living areas; and made needed repairs to inmate dormitories. The institution has also developed monitoring tools to ensure that inmate appeals and inmate disciplinary actions are processed in a timely fashion; taken steps to ensure that staff training requirements are fulfilled; improved monitoring and tracking of adverse personnel actions and employee grievances; improved organization of equal employment opportunity complaints; and improved reporting of inmate deaths.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the warden of the Sierra Conservation Center take the following additional actions:

- Hold managers and supervisors accountable for failure to follow through with their responsibilities.
- Ensure that letters of instruction are issued when merited.
- Maintain a tracking log with complete and up-to-date information on the disposition of letters of instruction.
- Continue to enforce the order that the staff remove all sheets and makeshift privacy curtains in housing units that would obstruct the view of officers.

The Office of the Inspector General also recommends that the form used for the administrative officer of the day inspection sheets be revised to include a review of the disciplinary logbooks.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the administration failed to follow up on a mandated policy directive and that an inmate was victimized and staff was placed at risk as a result. No manager or supervisor was held accountable for failing to implement the required changes.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden take appropriate steps to ensure that policy directives are appropriately implemented. The recommendation specified that the actions listed below should be taken.		
Develop a system that (a) ensures that policy directives are reviewed and read by all affected employees and (b) provides follow-up from managers and supervisors that the affected employees have read or been made aware of the policy directive. This could be accomplished by (a) requiring employees to sign off after reading or being advised of the new policy and (b) setting a deadline for the managers to certify that all affected employees have signed off.	SUBSTANTIALLY IMPLEMENTED	The Sierra Conservation Center administration reported that policy directives are reviewed by the warden and submitted to the appropriate division head with specific instructions and a completion date for implementation. The Sierra Conservation Center also conducts audits for compliance and training. The administration also reported that managers are responsible for ensuring that post orders are revised annually. Addenda to post orders are established between annual revisions when necessary and are incorporated into post orders upon revision. According to the administration, all employees are aware of their responsibility to read the post orders upon assuming a post and are required to sign CDC Form 1860, (post order acknowledgement) as verification. These forms are submitted to the appropriate captain at the end of each month for review and filing. The administration also reported that the administrative officer of the day is responsible for conducting audits to ensure that post orders are reviewed, updated, and signed by employees. The officer reports deficiencies to the chief deputy warden for review or corrective action. The Office of the Inspector General reviewed four administrative officer of the day reports for the period July 7, 005 through August 4, 2005. The reports require the administrative officer of the day to review five out of nine specified

		operational areas. Two of the nine areas specified for review are post orders and operational procedures. Three of the four reports reviewed by the Office of the Inspector General covered the status of the institution's operational procedure supplements to the *California Department of Corrections and Rehabilitation Operations Manual*, and three of the four reports covered the status of post orders. In one of the four reports, the administrative officer of the day reported finding that operational procedure supplements needed revision and in another report, the officer found that post orders had not been signed by the supervisor.
Hold managers and supervisors accountable for failure to follow through with their responsibilities.	**PARTIALLY IMPLEMENTED**	The Sierra Conservation Center administration reported that managers and supervisors are held accountable for failure to follow through with responsibilities through counseling, letters of expectation, letters of instruction, and adverse action. The institution provided and the Office of the Inspector General reviewed a tracking log for letters of instruction, but the review found the information to be incomplete. The log lists the names of ten employees, the alleged misconduct, and the dates the alleged misconduct occurred; but in eight of the ten instances, the log does not include the date the letter of instruction was issued. The information in the log, therefore, does not document that the letters were issued.
Review the current status of inmate identification photographs for the administrative segregation unit to ensure that there are no continuing security concerns.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution's Operational Procedure #119 requires staff to affix inmate photographs to the outside of administrative segregation unit cell doors to ensure that inmates are placed in the proper cells. The administration reported that photographs are taken of every inmate upon arrival at the institution and that four photographs must accompany all inmates placed in the administrative segregation unit. The Office of the Inspector General reviewed a copy of Operational Procedure #119 and noted that page 6, paragraph F, states: "Inmates housed in the ASU will have their identification photograph affixed to the outside of their cell door within 72 hours." The Office of the Inspector General toured the administrative segregation unit and confirmed that inmate photographs were placed outside the cells.

Ensure that administrative segregation procedures are revised to include the directive in question.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that Operational Procedure #119 has been revised to incorporate the Office of the Inspector General's recommendations and findings. The Office of the Inspector General confirmed that Operational Procedure #119 includes the directive.
Enhance training and modify post orders of staff assigned to the administrative segregation unit to incorporate unit procedures.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that all staff members assigned to the administrative segregation unit completed training on administrative segregation procedures as detailed in Operational Procedure #119. It also reported that the post orders reference Operational Procedure #119. The unit sergeant forwards on-the-job training sign-in sheets to the facility captain for review following the implementation of a new policy or directive. The Office of the Inspector General reviewed three copies of the in-service training sign-in sheets for classes addressing Operational Procedure #119 and determined that 38 administrative segregation unit staff members attended the classes from July 3, 2003 to September 14, 2004.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the warden of the Sierra Conservation Center take the following additional actions:

- **Hold managers and supervisors accountable for failure to follow through with their responsibilities.**
- **Ensure that letters of instruction are issued when merited.**
- **Maintain a tracking log with complete and up-to-date information on the disposition of letters of instruction**.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that inmate and staff safety was jeopardized and illegal inmate activities may have gone unnoticed because inmates were allowed to erect unauthorized privacy curtains within the housing units.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden issue and enforce an order that staff remove all sheets and other makeshift privacy curtains from showers, bunks, and other areas that would obstruct the view of officers within the housing units.	SUBSTANTIALLY IMPLEMENTED	The Sierra Conservation Center administration reported that Warden Kramer issued an order dated March 28, 2001, directing staff to remove sheets and other makeshift privacy curtains that obstructed the view of staff from showers, bunks, and other areas. The administration noted, however, that inmates continue to erect privacy curtains and that the staff continues to enforce the order through the disciplinary process. The Office of the Inspector General confirmed the contents of the warden's March 28, 2001 order and also reviewed a memorandum dated February 3, 2003 from a Tuolumne Building correctional sergeant reminding the staff of the requirement to conduct at least five cell searches during each shift and to remove any contraband, including window coverings. The Office of the Inspector General toured several dormitories in September 2005 and found several instances where inmates had hung privacy curtains from upper bunk beds and other instances where privacy curtains had been erected between the shower areas and general sleeping areas.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the warden continue to enforce the order that the staff remove all sheets and makeshift privacy curtains in housing units that would obstruct the view of officers.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that gun coverage for portions of the Level III yard continued to be inadequate.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections seek additional funding to move the substance abuse program building, the improper siting of which prevented the control staff from fully observing the yard and the entrance to dining hall 5.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that it did not pursue a formal request for funds to move the substance abuse program building because a review by the regional administrator determined that modification of the fence line and construction of a catwalk would resolve the issue. The modification and catwalk were subsequently completed. The administration reported that the changes appear to have resolved the gun coverage inadequacy, since there have been no incidents to indicate otherwise and the area adjacent to the dining rooms is visible from tower #9. The Office of the Inspector General reviewed documents requesting approval for construction of a catwalk on top of the gym, which the institution had proposed so as to allow the Tower 15 officer to view the dining hall entrance and exit. At the time of the proposal, the cost of moving the substance abuse program building was estimated to be $94,000, while construction of the catwalk could be completed with existing institution funds and labor. The Office of the Inspector General toured the site and found that gun coverage appears to be adequate with the erection of the catwalk. The post orders for the gun officer require routine tours of the roof to provide adequate security. Although the Office of the Inspector General's recommendation was not implemented, it appears that the problem was solved through alternative means.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that prison dormitories showed signs of significant deterioration, creating health and safety risks.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution temporarily cover the holes in the ceiling to prevent inmates from hiding themselves or concealing contraband. The recommendation noted that the warden should direct staff to monitor the repairs to ensure they remain in place.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that as of April 2001, all holes in the ceilings in the dormitories in the Calaveras and the Mariposa units were temporarily sealed with painted marine plywood. The administration also reported that in April 2000, a capital outlay budget change proposal for a major renovation of all dormitories was approved but was not funded. The administration reported that the institution is continuing to perform repairs as time and money permit. The Office of the Inspector General toured several dormitories, including the Mariposa unit, and found no holes in the ceilings or other significant deficiencies. Copies of budget requests were also verified.
The Office of the Inspector General recommended that the Department of Corrections consider using a portion of its allotted $10 million special repair budget to correct this immediate threat to institutional health and safety.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that the department has a $10 million budget to cover special repair projects at the institutions. The $10 million funding level has been the same since fiscal year 1990-91, and there is currently a backlog of $137 million in special repair projects. Because of the limited funding, the department has had to defer some special repair projects and this project has not yet received priority for funding. The Office of the Inspector General reviewed department documents approving the project, which demonstrated that the project has received consideration, although it has not been funded.
As an alternative, the Office of the Inspector General recommended that the institution proceed with a separate budget change proposal to fix the problem. The recommendation noted that although the request is in the department's five-year major	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that it submitted a major capital outlay budget change proposal and a special repair request for this purpose, but that neither has been funded. In the interim, the institution has identified dormitories with leaks emanating from the shower area and is gradually making necessary repairs. The repairs necessitate moving inmates from one dormitory at a time and housing them elsewhere for two or three

capital outlay plan, the department should address the security and housing risks sooner.		weeks to allow time for the epoxy used in the repairs to cure. To date, repairs to 26 of the dormitories with the worst problems have been completed. The process will continue until the capital outlay budget change proposal or special repair budget is funded. The Office of the Inspector General reviewed a fiscal year 2002-03 budget request that was approved by the Department of General Services to correct infrastructure problems in the housing units. The project was approved as a major capital outlay project scheduled to be completed in 2007, but there is no evidence that it has been approved for funding through the budgetary process.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found deficiencies in many of the internal affairs investigations reviewed.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended` that the Sierra Conservation Center investigative services unit take appropriate steps to prevent deficiencies in future investigations. To correct the deficiencies, the recommendation noted that investigative services unit should take the actions listed below.		
Play a strong role in monitoring the quality of every investigation, ensuring that the issues are fully explored, relevant witnesses are interviewed, conflicting testimony is evaluated, evidence is complete, and findings are supported by the facts.	NOT APPLICABLE	The Department of Corrections and Rehabilitation has made significant changes to its investigative process including the elimination of category I investigations, which were previously performed by the institutions. The new process requires the Office of Internal Affairs to perform or oversee all formal investigations. Therefore, this recommendation is no longer applicable.

Carefully monitor the timeliness of investigations. One method would be to add a separate column to its investigation tracking log to identify the incident date.	NOT APPLICABLE	See previous comment.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that many of the inmate appeals at the Sierra Conservation Center were not being processed within prescribed time limits and noted numerous other deficiencies in the Sierra Conservation Center's inmate appeals process.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Sierra Conservation Center take immediate steps to remedy the deficiencies identified in the inmate appeals process. The recommendation specified that the actions listed below should be taken.		
The warden's office should implement monitoring tools to ensure that inmate appeals are processed promptly at the formal levels. At least weekly, either the warden or the chief deputy warden should review the status of the reports with the facilities and, if necessary, take appropriate action to ensure proper resolution.	SUBSTANTIALLY IMPLEMENTED	The Sierra Conservation Center administration reported that the warden has monitoring tools in place to ensure that appeals are processed promptly. According to the administration, the warden and chief deputy warden receive a report each week listing the status of overdue appeals and the warden reviews the report at a weekly associate wardens' meeting chaired by the chief deputy warden. The administration also reported that some appeals that had appeared to be overdue in the past actually were not overdue. According to the administration, the problem occurred because due dates for appeals that had been granted extensions under California Code of Regulations, Title 15, section 3084.6 (5) (A) (B) (C) (6), had not been changed on the forms. The administration noted

		that it has corrected the problem by requiring the staff to change due dates when extensions are granted. The administration reported that the medical department has now hired a medical appeals coordinator, which has improved the content and timeliness of medical appeals. The Office of the Inspector General reviewed a memorandum dated August 20, 2004 from the institution's chief deputy warden, instructing division heads to complete and return overdue appeals to the appeals coordinator within the next three working days. A document attached to the memorandum listed two overdue appeals and included assigned dates and due dates. The Office of the Inspector General noted that the memorandum was written within a week of the due dates. Data obtained from the Sierra Conservation Center identified only 12 appeals originating from the institution as overdue, representing an improvement over the 25 appeals found to be overdue at the time of the original audit.
The appeals coordinator should receive comprehensive training in the appeals process and the rules and regulations governing inmate appeals.	**SUBSTANTIALLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the department provides one week of training for appeals coordinators each year and that those employees are required to complete an additional 52 hours a year of training at the institution. According to the administration, the appeals coordinator receives two hours of training per month through a headquarters conference call. The institution provided the in-service training records for the appeals coordinator for the period August 18, 2004 through August 5, 2005, showing that she received a total of 87 hours of training, including 25.5 hours covering the inmate appeals process. The institution also provided fax cover sheets from the department's Institution Standards and Operations Section advising staff of scheduled conference calls during which specialized training would be provided.
Staff should properly complete and date the appeal forms.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the appeals coordinator has been reviewing the appeals and that staff members are completing and dating appeals properly.

The Office of the Inspector General also recommended the actions listed below to improve tracking and monitoring of staff complaints. The institution should create a form to enable the chief deputy warden to document the review, assignment, and disposition of staff complaint appeals.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that an Allegation of Staff Misconduct Form for inmate appeals has been developed to enable the chief deputy warden to document the review, assignment, and disposition of staff complaint appeals. The Office of the Inspector General reviewed the form and found it to be adequate.
The institution should create a log of staff complaints as a management tool, possibly using computer spreadsheet software that identifies the staff person and the appellant.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that since the Office of the Inspector General's review, the appeals office has instituted an appeals tracking system program that enables staff to produce various reports, including staff complaints.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that in some instances the inmate disciplinary system at Sierra Conservation Center was not regularly meeting statutory, constitutional, or procedural mandates.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden implement policies and procedures to remedy the deficiencies in the inmate disciplinary system. The recommendation specified that the warden should ensure that the actions listed below take place.		

CDC Form 115s are processed promptly. On a regular basis, either the warden or the chief deputy warden should review the status of the reports with the facilities and, if necessary, take appropriate action to ensure proper resolution.	**SUBSTANTIALLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution is in compliance with this recommendation. According to the administration, the chief deputy warden reviews all CDC Form 115 second-level appeals. Administrative officers of the day periodically review disciplinary logbooks during their tours and report findings to the warden through weekly reports. Corrective action is taken if disciplinary logbooks are not complete. CDC Form 115s are continually tracked to ensure that they are processed promptly. The unit sergeant, unit lieutenant, unit captain, and chief disciplinary officer review the CDC Form 115s to ensure that due process time constraints are met. In addition, the unit lieutenant checks the disciplinary logbook daily, and at least on a monthly basis, the facility captain reviews and signs the logbook to ensure compliance. The Office of the Inspector General reviewed administrative officer of the day inspection sheets provided by the institution and noted that although an older version of the form provides for a review of disciplinary logbooks, a new version of the form does not.
A written explanation is required of the official authorizing the voiding or dismissal of a CDC Form 115. Furthermore, for proper monitoring and auditing purposes, a copy of the voided and dismissed CDC Form 115 should be included in the chief disciplinary officer's institutional registers and files.	**SUBSTANTIALLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution is in compliance with this recommendation. According to the administration, voided CDC Form 115s are signed off at the associate warden's level and copies of voided CDC Form 115s are maintained in the unit. The person voiding a CDC Form 115 is required to document the reason for voiding in the disciplinary logbook. The Office of the Inspector General reviewed a sample of a voided CDC Form 115 and found it to be adequate, but noted that the institution has elected to maintain a copy of the form in the unit rather than in the chief disciplinary officer's files.
The institutional registers are completed promptly and properly.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution is in compliance with this recommendation. According to the administration, the staff has been directed to complete institutional registers promptly and properly and the chief disciplinary officer is responsible for reviewing registers to make sure they are properly completed and for reporting the findings to the warden.

Reporting employees and hearing officers sign the CDC Form 115 to authenticate the reports. In the rare instances in which the employee is not available, the signed draft reports should be attached to the completed CDC Form 115 for verification of authenticity. [The recommendation noted that before the audit report was released, the associate wardens issued a joint memorandum establishing the appropriate policy, but that the Camp Operations Division should have been included in the directive.]	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that reporting employees sign 98 percent of CDC Form 115s and that in order to conform to CDC Form 115 time limits, supervisors sign the remaining 2 percent in the absence of the reporting employee. According to the administration, in such instances, the supervisor must review the CDC Form 115 Employee's Rough Draft Report to ensure it is true and correct before signing. The administration reported that the Legal Affairs Division advised the Sierra Conservation Center that signing for another employee does not violate inmates' due process rights, the *California Department of Corrections and Rehabilitation Operations Manual,* or California Code of Regulations, Title 15. The Office of the Inspector General reviewed the Reporting Employee's Rough Draft and noted that it includes a signature space for both the reporting and the reviewing employee.
A copy of the completed CDC Form 115 and 115-A is delivered to the inmate within five working days of audit by the chief disciplinary officer.	**SUBSTANTIALLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution is in compliance with this recommendation, with the exception that an inmate who transfers or paroles following the disciplinary hearing may not receive the final copy of the CDC Form 115 within five days of review by the chief disciplinary officer. The date the inmate receives the final copy is recorded on the disciplinary action log, CDC Form 1154 for review and audit purposes. The Office of the Inspector General reviewed five months of disciplinary action logs provided by the administration and found that in 92 percent of the cases (380 of 412) the final copy of the CDC Form 115 was provided to the inmate within the five-day requirement.
The disciplinary actions logs (CDC Form 1154) at all facilities are completed properly and contain all necessary dates and signatures.	**SUBSTANTIALLY IMPLEMENTED**	The Sierra Conservation Center administration reported that it is in compliance with *California Department of Correction and Rehabilitation Operations Manual* requirements governing completion of the disciplinary action logs. The administration reported that each unit technician or office assistant ensures compliance by monitoring the CDC Form 1154 disciplinary action log and that facility captains conduct follow-up audits. The Office of the Inspector General reviewed five months of disciplinary action logs provided by the administration and found that 91 percent (373 of 412) of the inmate disciplinary action records were properly completed with

		the necessary dates and signatures.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the form used for the administrative officer of the day inspection sheets be revised to include a review of the disciplinary logbooks.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that the Sierra Conservation Center seldom took disciplinary action against inmates who violated both state law and departmental policy by knowingly filing false allegations against a peace officer.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution take steps to ensure that allegations of staff misconduct are handled appropriately. The recommendation specified that the institution take the actions listed below.		The Sierra Conservation Center administration reported that rule violation reports are rarely written for the specific charge of filing a false complaint against a peace officer because it is difficult to determine whether an inmate "knowingly" filed a false complaint or whether the inmate's perception was simply inaccurate.
Ensure that inmates filing staff complaints sign the standard CDC Form 1858.	FULLY IMPLEMENTED	The administration reported that the appeals coordinator and the investigative services unit lieutenant ensure that inmates properly complete complaint forms.
Develop a tracking system to follow up on inmate staff complaints.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that the institution's appeals office uses an appeals tracking program to track inmate staff complaints. The Office of the Inspector General reviewed supporting documentation submitted by the administration and determined that the institution uses a computer program entitled "Inmate/Parolee Appeals Tracking System – Level I & II." to track inmate staff complaints.

Assign responsibility to the investigative services unit to review the findings of all staff misconduct investigations and issue rule violations against inmates who knowingly file false complaints against a peace officer.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that the institution's investigative services unit reviews all staff misconduct investigations. The administration also reported that although rule violation reports are issued to inmates who blatantly file false allegations against peace officers, the district attorney rarely accepts these misdemeanor cases for criminal filings and routinely refers them back to the institution to be handled administratively.
The Office of the Inspector General further recommended that the Department of Corrections consider issuing statewide policies and procedures to ensure that every institution adheres to the recommendations noted above.	FULLY IMPLEMENTED	In response to this finding, the Sierra Conservation Center administration reported that Administrative Bulletin 98-10, issued by the department, defines specific procedures for processing inmate/parolee appeals alleging staff misconduct. The administration also noted that the hiring authority is responsible for ensuring compliance with the procedures at each institution and that the inmate appeals coordinator at each institution tracks the appeals generated by inmate allegations of staff misconduct. The Office of the Inspector General reviewed a copy of Administrative Bulletin 98-10 and found that it does prescribe procedures for processing inmate/parolee appeals alleging staff misconduct.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that a strip search area was needed at the sally port gate for the Calaveras and Mariposa facilities because of the large number of inmates processed through that entry each day and the importance of institution security and drug interdiction.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution continue its effort to acquire a building for conducting unclothed body searches at the sally port gate.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that in 2003 two family visiting units located adjacent to the main vehicle sally port pedestrian gate were retrofitted. The retrofit facilitates the searches of Calaveras and Mariposa unit inmates returning from work sites outside the security perimeter.

		The Office of the Inspector General toured the building that was retrofitted to for processing inmates as they enter the facility and found that it is sufficient to conduct the unclothed body searches of the work crews.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that some vocational education inmates had access to unsecured flammable liquids and chemicals, posing a security risk.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden implement monitoring procedures to ensure that managers and supervisors follow departmental policy controlling inmate access to dangerous and toxic substances.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that supervisors and managers have been instructed to make regular tours of the areas to ensure compliance. According to the administration, the supervisor of vocational instruction inspects the vocational areas to ensure that flammable liquids and chemicals are properly controlled and secured. The fire chief, the investigative services unit, and the Environmental Health Services Section of the California Department of Health Services conduct independent audits. The fire chief conducts audits twice a year, the investigative services unit conducts quarterly audits, and the Environmental Health Services Section conducts an annual audit. The Office of the Inspector General reviewed the fire chief's audit report for the period January 2003 through July 2005 and found no recent violations in the vocational shops. A June 2004 report of the Department of Health Services identified only one minor infraction in the vocational shops — the absence of a date on waste thinner. The Office of the Inspector General also reviewed the duty statement for the supervisor of vocational instruction and found that it includes responsibility for ensuring that safety hazards and unsafe operations are reported and corrected.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that utility closet doors in the administrative segregation building were unlocked, jeopardizing institution safety.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that staff continue to keep the utility closet doors in the administrative segregation unit locked.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that all utility doors in the administrative segregation unit have been and continue to be secured. The administration reported that the administrative segregation unit staff is required to check all cells, locks, doors, and windows each day and has received on-the-job training on keeping utility doors locked. The Office of the Inspector General reviewed documents provided by the institution and found that the recommendation was implemented on August 13, 2004 — approximately three years and three months after the recommendation was issued and fifteen days after the institution was notified of the present follow-up review. The Office of the Inspector General toured the administrative segregation building and found that the utility closet doors were locked.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found that the Tuolumne facility captain was circumventing key control by failing to retain possession of his assigned metal key tag when he was not in the unit.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the warden enforce adherence to the key control policies, requiring employees to exchange assigned metal key tags for the keys issued.	FULLY IMPLEMENTED	The Sierra Conservation Center administration noted that this finding concerned only one employee who was not checking out keys properly and reported that corrective action was taken to ensure that the staff follows proper key control policies. The administration also reported that control room officers inventory and properly account for all keys, and that the investigative services unit staff reviews the inventories as part of their quarterly audits and reports discrepancies to the warden and division heads. The Office of the Inspector General reviewed an "inventory listing and adjustment log" provided by the administration covering security equipment and keys. The administration did not provide written evidence that corrective action was taken against the Tuolumne facility captain, but reported that the action consisted of verbal counseling.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 13

The Office of the Inspector General found that the non-custody staff at Sierra Conservation Center was not fulfilling training requirements and that completion of training courses could not be readily verified in the training files:

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution take appropriate steps to ensure that non-custody staff fulfill training requirements. The recommendation specified that the actions listed below should take place.		
The warden should take steps to emphasize the	FULLY	The Sierra Conservation Center administration reported that the in-service

importance of non-custody staff fulfilling mandatory training requirements.	**IMPLEMENTED**	training department offers mandatory classes for non-custody staff in block training every year. The administration reported that the 40-hour mandated block-training schedule is published monthly along with the non-custody block-training schedule. Employees are noticed that they must attend in the in-service training department bulletin approximately three months before their birth month. They are also noticed at the same time to complete the six mandatory training modules. The Sierra Conservation Center reported that the training has improved considerably since the original audit. The Office of the Inspector General reviewed a recent in-service training department bulletin and verified that employees are noticed ahead of time to complete the required training.
Supervisors should use the rating guide published in the monthly training bulletin when completing an employee's annual performance evaluation. If employees fail to comply with training requirements, supervisors should issue a poor evaluation in the area of training.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution will continue to publish the rating guidelines in the in-service training department bulletin and will instruct supervisors to use the guide when completing annual performance evaluations. The administration reported it will also continue to instruct supervisors to address non-compliance with training requirements in annual evaluations and to note that employees who do not complete mandatory training classes must be given a less than standard evaluation. According to the administration, the in-service training staff and the employee relations officer will continue to audit performance reports to ensure that ratings are correct. The Office of the Inspector General reviewed a recent in-service training bulletin and rating guide and found that in addition to listing the names of staff members required to attend training, the bulletin advises the staff that training classes accumulated will be included in performance evaluations.
The in-service training staff should ensure that quizzes for all mandatory courses are dated and documented in the training files.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that quizzes for all mandatory classes are dated and placed in employees' training files. The administration also reported that employee attendance is documented on attendance sheets and that information is entered onto the in-service training computer.
The Department of Corrections should consider issuing a certificate, as proposed by	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that completion of sexual harassment prevention training is documented in the employee's

Sierra Conservation Center, or some other means of documenting completion of sexual harassment prevention training.		training file and entered into the in-service training computer. The administration provided the Office of the Inspector General with a sample copy of an automated "IST Staff Report," containing a comprehensive listing of the training completed by the staff. The list included "EEO & Sexual Harassment" training.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 14

The Office of the Inspector General found that adverse personnel action case files at Sierra Conservation Center were not adequately monitored, tracked, or documented:

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution take steps to improve the monitoring, tracking, and documentation of adverse personnel action cases. Specifically, the Office of the Inspector General recommended the actions listed below.		
The employee relations officer should receive immediate training to allow the officer to better manage the caseload.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that the employee relations officer did not receive training immediately after the audit, but that the present employee relations officer, who assumed the position on May 15, 2004, received employee relations officer training and training related to the *Madrid* requirements between June 1 and June 11, 2004. The administration noted that the employee relations officer's caseload is large because that person also has responsibilities related to litigation.

		The Office of the Inspector General reviewed the training records of the employee relations officer and confirmed that the training described was provided less than a month after the incumbent assumed the position.
The warden should ensure that the employee relations officer receives adequate clerical support.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that an office technician is assigned full time to assist the employee relations officer.
The employee relations officer should assign sequential case numbers by year for all incoming adverse actions.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that as of September 1, 2004, it intended to have the employee relations officer log adverse actions in sequential order.
The employee relations officer should reorganize the files to ensure that all necessary documents are included in the same general order. Every effort should be made to complete the adverse action checklist and a case chronology log to note any significant changes, directives, or actions taken on a case.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that as of September 1, 2004 it intended to have the employee relations officer ensure that all necessary documents are included in the same general order. The administration reported that the employee relations officer would accomplish that task by using an adverse action checklist and a chronological case log. The Office of the Inspector General reviewed samples of an adverse action checklist and activity chronology sheet and found that the forms allow the employee relations officer to document the key information necessary to track cases.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 15

The Office of the Inspector General found that the institution did not have a process to adequately monitor or track employee grievances and that, as a result, the institution might not be in compliance with the memorandum of understanding for each bargaining unit.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the employee relations officer improve the system for logging and tracking employee grievances by taking the measures listed below.		
Computerize the log and add columns indicating response due dates for each level of grievance and the name of the staff person assigned to respond.	SUBSTANTIALLY IMPLEMENTED	The Sierra Conservation Center administration reported that the employee relations officer has transferred the grievance log for 2004 and 2005 to a computer database. The Office of the Inspector General reviewed an automated report of grievances and confirmed that the 2004 and 2005 data was transferred to an automated report. The report includes columns for the due dates but does not include columns for the name of the person assigned to respond.
Prepare a matrix identifying the submission and response time frames and key provisions related to employee grievances for each bargaining unit.	FULLY IMPLEMENTED	The Office of the Inspector General reviewed a matrix provided by the Sierra Conservation Center administration and found that it provides for the necessary information. The matrix includes spaces for the bargaining unit number, the grievance issue, the date received, the dates responses were rendered, and the date the response was received by the grievant.
Reorganize the employee grievance files, purging outdated files, organizing the remaining files by log number, and ensuring that documentation is complete and accurate.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that as of November 1, 2004, employee grievances would be organized by log number order, outdated files would be purged, and remaining files would be reorganized.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 16

The Office of the Inspector General found that equal employment opportunity complaint and investigation case files lacked a standardized organizational format.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution's equal employment opportunity coordinator develop a standardized filing system for equal employment opportunity complaints that includes a case diary to document all contacts, documents received, and documents prepared.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that all informal equal employment opportunity case files include a case diary documenting contacts received and documents prepared.
The Office of the Inspector General further recommended that the equal employment opportunity files be organized and that documents in the file include the case number, be marked confidential, and be bound into the file to prevent accidental loss.	SUBSTANTIALLY IMPLEMENTED	The Sierra Conservation Center administration reported that all equal employment opportunity files are organized and contain a case number and that all documents are marked confidential. According to the administration, the documents are filed under lock and key and are accessible only to the equal employment opportunity coordinator, the equal employment opportunity assistant, and the equal employment opportunity office technician. The administration's response was silent on the binding of the case files.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 17

The Office of the Inspector General found that the process of and responsibilities for documenting and reporting an inmate's death were not clearly defined, making it difficult to determine if the Sierra Conservation Center had adequately fulfilled its medical and legal responsibilities.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution improve its process for documenting and reporting inmate deaths. The recommendation specified that the institution take the actions listed below.		

Clearly outline the steps and requirements related to an inmate's death, noting who is responsible and indicating when and by whom each step is to be completed. Affix the outline to each file as a checklist to ensure that all necessary steps have been taken.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution's *California Department of Corrections and Rehabilitation Operations Manual* supplement, Chapter 5, Article 7 (Deaths), clearly outlines the steps and requirements relating to an inmate's death, including those responsible for accomplishing the requirements. A death worksheet and checklist are used to ensure that all necessary steps are taken. The Office of the Inspector General reviewed the inmate death worksheet, the medical emergency response timeline checklist, and the *California Department of Corrections and Rehabilitation Operations Manual* supplement, Chapter 5, Article 7 regarding inmate deaths and determined that the supplement clearly outlines the steps, requirements, and responsibilities related to an inmate's death. All three documents were last revised in March 2003.
Organize each file so that reports and documents are readily accessible.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the institution's coordinator for use of force matters and the *California Department of Corrections and Rehabilitation Operations Manual* reviews inmate death cases and ensures that the case files are complete and readily available.
Modify the medical emergency response timeline and inmate death worksheet to include the inmate's name, number, and date and time of death as well as the name, title, and signature, with date, of the employee completing the form.	**SUBSTANTIALLY IMPLEMENTED**	The Sierra Conservation Center administration reported that the staff has revised the medical emergency response timeline and the inmate death worksheet to include the Office of the Inspector General's recommendations. The Office of the Inspector General reviewed the documents submitted by the administration and determined that the worksheet entitled "Medical Emergency Response Timeline" includes a space for the name of the "Incident/Camp Commander." The worksheet entitled "Inmate Death Worksheet" includes spaces for the name, classification, and signature of the person completing the form, a space for the inmate's name and number, and a space entitled "Pronouncement of death [Who/Date/Time]." The worksheets were last revised in March 2003. The Office of the Inspector General reviewed inmate death worksheets for two recent deaths and found that one of the worksheets did not include the date and time of death or the name of the person who pronounced the death.

Work with the chief medical officer and relevant staff at headquarters to incorporate the recommended changes into an up-to-date *Department of Corrections Operations Manual* supplement.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that it is in compliance with this recommendation and referenced the institution's *California Department of Corrections and Rehabilitation Operations Manual* Supplement, Chapter 5, Custody/Security Operations, as verification. The Office of the Inspector General reviewed the supplement and confirmed the institution's compliance.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 18

The Office of the Inspector General found that the controls governing the Sierra Conservation Center mailroom were inadequate.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Sierra Conservation Center make alterations as necessary to enhance accountability and control access to the mailroom. Suggested improvements included those listed below.		
Reconfigure the mailroom so that non-mailroom staff members have access only to a designated area. The designated area could allow officers access to a specific box to pick up or drop off mail for only their specific living units. An officer who delivers mail on Saturdays could have access only to a box that contains the outgoing mail for that day.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that the institution has installed a chain link fence sally port at the mailroom entrance accessible only to mailroom staff. The administration also reported that the mailroom was secured after hours, weekends, and holidays. The Office of the Inspector General toured the mail room and found that the alterations were adequate to improve controls and operations. The institution no longer has a post office box; therefore, all mail is delivered and picked up by the U. S. Postal Service. Only mailroom employees are allowed in the mailroom.
Require every staff person opening mail to log all checks and money orders.	FULLY IMPLEMENTED	The Sierra Conservation Center administration reported that the mailroom staff is maintaining a log for checks and cash. It also reported that partitions in the

		mailroom have been removed. According to the administration, the current mailroom configuration allows for acceptable supervision and is open, allowing constant visual observation by all mailroom employees. The Office of the Inspector General confirmed that the partitions have been removed, which allows for improved supervision of employees.
Require all cash, checks, and money orders to be delivered to the accounting office on a daily basis.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that cash is taken to accounting on a daily basis, while checks and money orders are stored in the mailroom safe and taken to accounting the following day.
Install a video camera in the mailroom over the area where the mail is opened to discourage theft and monitor activity and access.	**FULLY IMPLEMENTED**	The Sierra Conservation Center administration reported that this recommendation was not implemented, but removing the partitions from the mailroom has allowed for improved supervision of the mailroom staff, eliminating the need for video surveillance. Although a video camera was not installed in the mailroom, removal of the partitions appears to have resolved the potential problem.
Have mailroom staff work as partners in close proximity to one another as a check on cash receipts.	**NOT IMPLEMENTED**	The Sierra Conservation Center administration reported that mailroom staff members do not work as partners, but do work in close proximity to one another, and are easily supervised now that the partitions have been removed. Removal of the partitions appears to have resolved the problem. The administration noted that the institution is in compliance with state procedures.

FOLLOW-UP RECOMMENDATIONS

None.

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LEO CHESNEY COMMUNITY CORRECTIONAL FACILITY

The Office of the Inspector General found that most of the recommendations from a 2001 audit of the Leo Chesney Community Correctional Facility have been fully implemented, but that the Department of Corrections and Rehabilitation has not addressed deficiencies identified in the audit relating to the need for written policies governing investigations into alleged misconduct at community correctional facilities by non-department employees.

IMPLEMENTATION REPORT CARD

Previous recommendations: 22

Fully implemented: 15 (68%)

Substantially implemented: 1 (5%)

Partially implemented: 2 (9%)

Not implemented: 1 (5%)

Not applicable: 3 (13%)

In 2001, the Office of the Inspector General conducted an audit of the Leo Chesney Community Correctional Facility, which is operated by Cornell Corrections of California, Inc. under a contract with the Department of Corrections and Rehabilitation. The audit report was issued in October 2001. The audit identified numerous problems with the facility's operation and with the department's management of the facility. Some of the most significant problems included an absence of formal policies and procedures for investigating allegations of inmate and staff misconduct; failure by the department's Office of Investigative Services to adequately respond to allegations of sexual misconduct; the contractor's use of inmate welfare funds to purchase non-allowable items and subsidize its budget; and a lack of clear guidelines governing the use of revenues generated from inmate telephone calls.

BACKGROUND

California Penal Code sections 2910 and 6250 authorize the California Department of Corrections and Rehabilitation to establish, operate, and contract for "community correctional centers" for the housing, supervision, and counseling of inmates.

Twelve community correctional facilities presently exist statewide. Six are public facilities operated by cities and counties and six are private facilities operated by private entities. One additional private facility is expected to be opened in 2006. Contract management is the responsibility of the Community Correctional Facility Administration, which is within Adult Operations of the Department of Corrections and Rehabilitation.

Appended to the contract between the Department of Corrections and Rehabilitation and the private community correctional facilities are the *California Department of Corrections Statement of Work for Private Community Correctional Facilities* and the *Financial Management Handbook for Private Community Correctional Facilities*, both of which provide specific guidelines and state requirements for operating private community correctional facilities under the department contracts.

The Leo Chesney Community Correctional Facility is one of six privately operated community correctional facilities. It was constructed in the late 1980s and received its

first inmates in May 1989. The facility is operated by Cornell Corrections of California, Inc., a subsidiary of Cornell Companies Inc., and is the only facility for female inmates in the community correctional facility program. The Leo Chesney Community Correctional Facility is located in the community of Live Oak, California, approximately 50 miles north of Sacramento.

The contract between the department and Cornell Corrections of California, Inc. expired on September 30, 2005. The department notified Cornell on June 14, 2005 of its intent to award the company the new contract, but the contract had not been finalized by the end of the Inspector General's audit fieldwork on October 21, 2005. The original contract gave the official name of the facility as the Leo Chesney Center, while the new contract refers to the facility as the Leo Chesney Community Correctional Facility. These names are used interchangeably in this report.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the October 2001 audit:

- Allegations of misconduct by staff and inmates at the Leo Chesney Center were not adequately investigated.

- The Leo Chesney Center used monies from the inmate welfare fund to subsidize its budget and to purchase unallowable items.

- The Leo Chesney Center was using revenues generated from inmate telephone calls to make capital improvements.

- Despite the overwhelming percentage of inmates incarcerated for drug-related offenses at the Leo Chesney Center, the institution did not have a mandatory substance abuse program.

- The California Department of Corrections staff member assigned to the Leo Chesney Center had a practice of cashing inmate trust account checks and release checks for inmates paroling from the institution.

- The Leo Chesney Center did not have an adequate system to ensure that inmate appeals are processed promptly and properly.

- Cornell Corrections was not forwarding unclaimed trust funds to the California Department of Corrections.

- Cornell Corrections was not preparing annual budgets for inmate welfare fund operations and was not preparing and submitting quarterly inmate welfare fund financial statements in a timely manner to the Leo Chesney Center or the Department of Corrections Community Correctional Facility Administration.

- Cornell Corrections was not properly managing the lease payments for the Leo Chesney Center.

- Staff duties for the management of inmate trust accounts at the Leo Chesney Center were not properly segregated.

- The Leo Chesney Center was not processing incident reports properly.

- Leo Chesney Center's inmate disciplinary reports contained inaccuracies.

- A significant number of staff performance appraisals and probationary reports for employees at the Leo Chesney Center were overdue.

- Some Leo Chesney Center employees had not attended mandatory training classes or met the minimum hours of annual training, and the facility training files contained errors and lacked adequate documentation.

- The invoice form used by the California Department of Corrections for community correctional facility reimbursement was outdated, and the department had not provided guidance to the facilities on claiming payment for beds when they exceed the monthly maximum reimbursement amount.

- Inmates assigned to the administrative unit of the Leo Chesney Center had access to performance information pertaining to other inmates, even though that access is specifically prohibited by state regulations.

- Inmates assigned to the adult basic education program were not receiving the required number of education hours.

- Floor tiles in the kitchen were cracked, creating a safety hazard.

The Office of the Inspector General issued 22 recommendations as a result of the 2001 audit.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Department of Corrections and Rehabilitation and Cornell Corrections have implemented the 22 recommendations from the Office of the Inspector General's October 2001 audit of the Leo Chesney Community Correctional Facility. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the October 2001 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations. The fieldwork for the follow-up audit was completed on October 21, 2005. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 22 recommendations issued by the Office of the Inspector General in October 2001, 15 recommendations have been fully implemented; one has been substantially implemented; two have been partially implemented; one has not been implemented, and three are no longer applicable.

The Office of the Inspector General found that Cornell Corrections has improved the investigative process by developing procedures for investigating allegations of inmate or employee misconduct. These procedures provide for investigations involving inmates to be conducted jointly with the Department of Corrections and Rehabilitation's Office of Internal Affairs. But the department does not have clear policies to guide the investigative process when the alleged misconduct involves individuals employed by the contractor.

The Office of the Inspector General also found that the Community Correctional Facility Administration provided for better approval and control of inmate telephone revenues earned by the contractor by negotiating a contract amendment executed in May 2004. The amendment addressed the spending of the revenues, but it did not address the ownership of any remaining balance at the end of the contract. The department reported that this important issue will be addressed in an arrangement that will cover all future contracts. Under that arrangement, inmate telephone services will be provided through a statewide contract that will result in the revenues generated from the contracts being paid to the state general fund. The new arrangement will completely eliminate the problems identified by the Office of the Inspector General in the handling of inmate telephone revenues.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following additional actions:

- **Develop and implement clear policies to guide the investigative process related to investigations into alleged misconduct by individuals at community correctional facilities who are not employed by the department.**

- **Continue to use the new statewide Inmate Telephone System agreement to provide inmate telephone services for all future community correctional facility contracts.**

- **Continue efforts to implement a program that provides inmates with release monies at the time of parole, but eliminates the need for department employees to cash inmate checks.**

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that allegations of misconduct by staff and inmates at the Leo Chesney Center were not adequately investigated.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Leo Chesney Center develop formal policies and procedures for investigating allegations of inmate or employee misconduct not of a sexual nature. The recommendation noted that the procedures should set investigation parameters and guidelines and establish timeframes for completion.	FULLY IMPLEMENTED	The department provided the Office of the Inspector General with a copy of written Operational Procedure #208-1 of Cornell Corrections, which was developed in response to the recommendation. The procedure addresses investigations into allegations of employee misconduct, including claims of sexual or other types of harassment, claims of discrimination in any form, acts of violence in any form, and misappropriation of company or state property. The procedure specifically provides that investigations that involve inmates will be conducted jointly with the department's Office of Investigative Services (now known as the Office of Internal Affairs).
The Office of the Inspector General also recommended that the Department of Corrections Office of Investigative Services conduct a thorough investigation of the allegations described in the report involving possible sexual misconduct between Leo Chesney Center staff and inmates.	NOT IMPLEMENTED	The department reported that in February 2001, the Office of Investigative Services reviewed an investigation conducted by the Leo Chesney Community Correctional Facility into rumors of criminal and non-criminal misconduct between staff and inmates at the facility. Based upon conflicting statements and a lack of substantive information, the Office of Investigative Services found no evidence to either prove or disprove the rumors. No victims of sexual misconduct were identified and there were no witnesses to provide credible evidence of any criminal violation. The allegations were received on February 14, 2001, and the male staff member rumored to be the subject was terminated by the facility director on February 16, 2001 for unrelated reasons. That action removed the alleged threat, which contributed to the finding of lack of cause to warrant a formal investigation. The Office of the Inspector General noted in the October 2001 audit report that the Leo Chesney Community Correctional Facility lacked a formal investigative process to guide investigations and that its investigation into this

		matter, therefore, may have been inadequate. In its response, the Department of Corrections and Rehabilitation further noted that under section 289.6 of the California Penal Code, it is a crime for a staff member, including an employee of a private correctional facility, to engage in sexual activity with inmates and parolees. Accordingly, alleged sexual conduct by employees (including contract employees) with an inmate, parolee, or family or friends of an inmate or a parolee, under department policy, is a Category II offense mandated to be investigated by the Office of Investigative Services. The Office of Investigative Services, therefore, should have conducted a criminal investigation into the allegations of sexual misconduct between Leo Chesney Center staff and inmates in the matter referred to the Office of Investigative Services by the Leo Chesney facility director in 2001. The fact that the employee had been terminated by the facility did not relieve the department from a responsibility to investigate the matter. As a result of the follow-up review, the Office of the Inspector General found that the department does not have a written policy governing investigations of alleged misconduct with inmates at community correctional facilities by non-department employees and non-peace officers.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation develop and implement clear policies to guide investigations into alleged misconduct by individuals at community correctional facilities who are not employed by the Department of Corrections and Rehabilitation.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the Leo Chesney Center used monies from the inmate welfare fund to subsidize its budget and to purchase non-allowable items.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections revise the *Financial Management Handbook for Private Community Correctional Facilities* to provide clear guidelines defining allowable expenditures from the inmate welfare fund. The recommendations specified that the guidelines should be consistent with existing statutory requirements.	NOT APPLICABLE	The department reported that the *Financial Management Handbook for Private Community Correctional Facilities* requires the contractor to comply with California Penal Code section 6006 and *Department of Corrections and Rehabilitation Operations Manual* sections 54070, 53080, 23020.6.2, and 23010.8, which define allowable and unallowable inmate welfare fund expenditures. Accordingly, the Community Correctional Facility Administration maintains that revision of the handbook is unnecessary. As a preliminary matter, the Office of the Inspector General reviewed the code and policy sections cited by the department and found the references to be in error. The relevant California Penal Code section is 5006, and the relevant section of the *Department of Corrections and Rehabilitation Operations Manual* is 23010.6.2. Section 23020.6.2 of the manual does not exist. Based on additional action taken by the department, the Office of the Inspector General has determined that the original recommendation is not necessary as stated. In response to the issues raised by the Office of the Inspector General in its original report, the department took the following action: The original report issued by the Office of the Inspector General identified a number of different types of expenditures that had been made from the inmate welfare fund. The most significant item identified was $3,524 spent on textbooks, which were specifically prohibited. In response, the department agreed that textbooks are an unauthorized expenditure was the result of a data coding error. The department stated that the error was corrected and the money was returned to the inmate welfare fund. The department also told the Office of the Inspector General that effective September 2001, Cornell Corrections discontinued the practice of purchasing household items, such as curling irons and blow dryers, with inmate welfare

		funds. However, the department told the Office of the Inspector General that personal care products such as shampoo and soap are used for prizes during special events and are still purchased with inmate welfare funds in accordance with *Department of Corrections and Rehabilitation Operations Manual* section 23010.6.1. As discussed in the original Office of the Inspector General audit report, the *Financial Management Handbook for Private Community Correctional Facilities,* section 23010.6.2 prohibits inmate welfare fund expenditures for items already funded in the community correctional facility contract. The determination of what is specifically funded in the contract is subject to interpretation. The *Financial Management Handbook* provides in section IV.C.8 that operating expenses, including personal supplies, are funded in the contract. Confusion arises when the contractor buys products that fall into these categories but are in excess of the minimum required to be provided to the inmates, such as hair dryers, curling irons, or name brand toiletries. The Office of the Inspector General has concluded, however, that this purchase is so small that it does not create concern over subsidizing the budget of the contractor for non-allowable items. Lastly, the Office of the Inspector General questioned amounts charged to the inmate welfare fund for an allocated amount of the facility's monthly charges for computer telephone lines and computer services. While the nature of the expenditure was allowable, the facility was unable to explain how it had arrived at the allocated amount at the time of the original audit. However, subsequent to the audit the facility provided a reasonable explanation of the allocated amount.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that the Leo Chesney Center was using revenues generated from inmate telephone calls to make capital improvements.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections clearly define the ownership and use of telephone commission revenues in contracts with community correctional facility operators, in the *California Department of Corrections Statement of Work for Private Community Correctional Facilities,* and in the *Financial Management Handbook for Private Community Correctional Facilities.* The recommendation noted that the documents should address the following issues: • The ownership of the revenues, including whether the funds revert to the California Department of Corrections or the state general fund or remain with the community correctional facility operator upon termination of the contract; • Whether the funds can be used for the operating expenses of community correctional facilities; and • What expenditures are allowable from inmate telephone revenues.	**PARTIALLY IMPLEMENTED**	The misuse of inmate telephone revenues was first reported by the Office of the Inspector General in the October 2001 audit of the Leo Chesney Community Correctional Facility. The Office of the Inspector General brought the issue to the attention of the director of the Department of Corrections again in correspondence dated March 25, 2002 and September 30, 2003. In those communications, the Office of the Inspector General noted that improper use of inmate telephone revenues obtained by the community correctional facilities through subcontracts with telecommunications service providers enables the contractor to increase profits by offsetting costs or obtaining unbudgeted augmentations to the program. The Office of the Inspector General advised the director that this practice circumvents state budget control and oversight since neither the Governor nor the Legislature has considered and approved these funds through the budget process. The practice also distorts the true cost of operating the community correctional facilities. In September 2003 the annual revenues collected by all community correctional facilities was estimated at more than $2.7 million. Inmate telephone revenues are earned by the state-operated prisons and youth correctional facilities as well as community correctional facilities. Such revenues collected by state-operated facilities are paid to the state general fund. In 2004, inmate telephone revenues paid to the state general fund totaled approximately $26 million. The issue of inmate telephone revenues received by the community correctional facilities was most recently reported to the department director in a report issued by the Office of the Inspector General in November 2004 entitled *Review of Inmate Telephone Revenues at the Victor Valley Modified Community Correctional Facility.* The Office of the Inspector General recommended that all future contracts or contract renewals include language

		specifically addressing the disposition of inmate telephone revenues received by the community correctional facilities. The Office of the Inspector General recommended that such disposition include one of the following options: • Remitting inmate telephone revenues to the state general fund, consistent with the disposition of revenues received through contracts for inmate telephone services provided at state-operated prisons and youth correctional facilities, or • Including inmate telephone revenues as a source of funding for the operation of community correctional facilities through the state budget process. In a September 2004 response to this finding, the department told the Office of the Inspector General its legal counsel had determined that inmate telephone revenue funds are program income that belongs to the state and that the funds may be retained and used within the program for specified purposes at the facility. According to the department, when the contract is terminated, the inmate telephone revenue fund balance is forwarded to the state or offset against contract payments. The department also told the Office of the Inspector General that the Community Correctional Facility Administration initiated negotiations with its contractors to include new inmate telephone revenue fund language in each of the community correctional facility contracts. The new language requires contractors to submit annual budgets for the inmate telephone revenue fund. Fund beginning balance, revenues, expenditures, and ending balance also must be included in quarterly cost reports. The Office of the Inspector General reviewed Amendment 11 to the Leo Chesney Center contract dated May 24, 2004, which addresses inmate telephone revenues, and found that while the new contract language controls approval and spending of the funds, it is silent on the ownership of the balance that may exist at the termination of the contract. The Office of the Inspector General made additional inquiries to the

		Community Correctional Facility Administration to determine whether the revenues are currently being reported through the state budget process. The administration told the Office of the Inspector General that under all new contracts, inmate telephone services will no longer be provided through a contract initiated by the facility contractor. Instead, the services will be provided through a statewide contract known as the Inmate Ward Telephone System agreement between the Department of General Services and the telephone service provider. The revenues generated from these contracts will be paid to the state general fund, consistent with the arrangement in effect for state-operated facilities. As of October 2005, that new arrangement was in effect for only one of the 12 contracted facilities — the McFarland Community Correctional Facility. Contracts for two other existing facilities and for one new facility are expected to include that provision as new contracts are completed. The department reported it expected the contracts, all with Cornell Corrections of California, Inc. to be finalized by January 2006. The department told the Office of the Inspector General that eight of the nine remaining contracts include signed contract amendments covering approval and spending of telephone revenue funds similar to that of the Leo Chesney amendment discussed above. The department will amend the provision covering telephone services as each facility contract expires. The department told the Office of the Inspector General that three of the nine contracts will expire in 2007; three will expire in 2009; one will expire in 2011; and the last two will expire in 2017. The department is pursuing legal remedies against one contractor who disputes the state's ownership of the inmate telephone revenues. That dispute was the subject of the review issued by the Office of the Inspector General in November 2004: *Review of Inmate Telephone Revenues at the Victor Valley Modified Community Correctional Facility*.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation continue to use the

new statewide Inmate Telephone System agreement to provide inmate telephone services for all future community correctional facility contracts.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that despite the overwhelming percentage of inmates incarcerated for drug-related offenses at the Leo Chesney Center, the institution did not have a mandatory substance abuse program.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections consider implementing a mandatory substance abuse program at the Leo Chesney Center giving consideration to the implications of Proposition 36. The recommendation noted that the program should emphasize the treatment of alcohol and controlled substance addiction to help inmates reintegrate into society.	FULLY IMPLEMENTED	The department reported that the facility has a voluntary substance abuse program and that the Community Correctional Facility Administration has explored the possibility of implementing a mandatory substance abuse program, but that program costs, facility design, department needs, and contractual issues have precluded implementation. Mandatory substance abuse programs are available at each of the four women's prisons when an inmate's case factors require such placement. The department can assign the inmate to the programs through the normal classification process, but the department noted that it attempts to secure voluntary placement in substance abuse programs.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that a California Department of Corrections staff member assigned to the Leo Chesney Center had a practice of cashing inmate trust account checks and release checks for inmates paroling from the institution.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections take the steps listed below to end the practice of department employees cashing inmate trust fund and release checks.		
Issue a policy memorandum directing employees to stop cashing trust fund and release checks for inmates.	SUBSTANTIALLY IMPLEMENTED	The department told the Office of the Inspector General that the practice of employees cashing inmate trust account checks was discontinued immediately upon discovery and will not be resumed. The Community Correctional Facility Administration issued a policy memorandum to all community correctional facilities to this effect, but until the department implements another method for providing cash to paroling inmates, it cannot direct the staff to stop cashing release fund checks.
Explore other methods of addressing the need of paroling inmates for cash, such as establishing a revolving fund or petty cash fund. Internal control procedures should be designed for the custody and issuance of cash from the fund.	PARTIALLY IMPLEMENTED	According to the department, it has explored two options since the original audit to address the need of paroling inmates for cash. The department first developed a proposed policy (draft dated December 2, 2004) for the use of a petty cash fund. Implementation of that policy was placed on hold to explore the possibility of providing debit cards to inmates who will be released. Neither proposal has been implemented. The Community Correctional Facility Administration told the Office of the Inspector General that it recently learned that the Parole and Community Services Division (now known as the Division of Adult Parole Operations) will be the first to implement the debit card program, but that it is not expected to be implemented for another year. It has been more that four years since the Office of the Inspector General made this recommendation, and although the department has considered options to address the need of paroling inmates for cash, it has not taken corrective action.

FOLLOW-UP RECOMMENDATION

The department should continue its efforts to implement a program that provides inmates with release monies at the time of parole, but eliminates the need for department employees to cash inmate checks.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that the Leo Chesney Center did not have an adequate system to ensure that inmate appeals were processed promptly and properly.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections require the Leo Chesney Center to establish procedures for the inmate appeals process to ensure the accuracy of the inmate appeals log and timely processing of appeals.	FULLY IMPLEMENTED	The department reported that the local inmate appeals coordinator, a department employee at the correctional counselor II level, is charged with ensuring that logging requirements and time constraints for processing inmate appeals are in accordance with California Code of Regulations, Title 15, section 3084 and *California Department of Corrections and Rehabilitation Operations Manual,* sections 54100.12 and 54100.9. The Office of the Inspector General found that Cornell Corrections Operational Procedure 246-1 concerning inmate grievance procedures, which was updated in August 2004, addresses this finding. The department also reported that to ensure compliance, the inmate appeals process is audited at least annually during Community Correctional Facility Administration's Internal Quarterly Audits. The Office of the Inspector General confirmed that the Community Correctional Administration reviewed the inmate appeals process in its third quarter 2005 internal audit and found full compliance. In addition, the department reported that its Program and Fiscal Audits Branch conducted a program compliance audit of the facility's operations in August 2004 and found the facility to be in full compliance in this area. The

		Office of the Inspector General reviewed the August 2004 report issued by the Program and Fiscal Audits Branch and confirmed that the audit reviewed all levels of the inmate appeals process, as well as the tracking and monitoring system, and found full compliance with department regulations.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that Cornell Corrections was not forwarding unclaimed trust funds to the California Department of Corrections.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections institute procedures to ensure that community correctional facility operators credit each inmate's trust account for the amount of any unclaimed checks at the end of each quarter. The recommendation also noted that at the end of each quarter, community correctional facilities should send to the Department of Corrections a check for all unclaimed trust funds held for more than seven months and a list of inmates whose accounts have been credited.	FULLY IMPLEMENTED	The Community Correctional Facility Administration reported that it has advised each contractor of requirements provided in the *Financial Management Handbook for Private Community Correctional Facilities* regarding unclaimed trust funds. The administration further told the Office of the Inspector General that the Leo Chesney Community Correctional Facility contractor paid all unclaimed trust fund amounts identified by the Office of the Inspector General in the 2001 audit and is in compliance with the requirements for identifying and forwarding all unclaimed trust funds. The Office of the Inspector General reviewed the facility's report for the quarter ended June 30, 2005 and determined that the facility is current with the required reporting for unclaimed trust fund checks.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that Cornell Corrections was not preparing annual budgets for inmate welfare fund operations and was not preparing and submitting quarterly inmate welfare fund financial statements in a timely manner to the Leo Chesney Center or the Department of Corrections Community Correctional Facility Administration.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections take steps to ensure that community correctional facility operators prepare and submit quarterly financial statements and annual budgets for inmate welfare fund operations in a timely manner. The recommendation noted that the financial statements should be sent to both the California Department of Corrections and the community correctional facility and should be posted in the inmate canteen and the law library.	FULLY IMPLEMENTED	The department reported that it monitors the receipt of quarterly inmate welfare fund cost reports and follows up if the reports are not received. The department told the Office of the Inspector General that Leo Chesney has corrected this problem and that quarterly reports are submitted as required. The Office of the Inspector General reviewed a report issued by the Department of Finance in May 2002 that found the facility did not meet inmate welfare fund annual and quarterly reporting requirements. In July 2003, the Department of Finance issued a report of a follow-up review in which it reported that the facility had taken corrective action and had prepared the required report for 2003-04, which was submitted to the Department of Corrections. The Department of Finance also observed that the facility posts the current Inmate Welfare Fund Statement of Operations in the canteen and the library.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that Cornell Corrections had not properly managed the lease payments for the Leo Chesney Center.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections direct Cornell Corrections to calculate the amount of the potential liability for uncollected lease payments and determine whether these amounts are within the reimbursement contract amount. The recommendation specified that the department should review all future scheduled lease adjustments to ensure that lease payments are accurately reported in the monthly invoices submitted to department for reimbursement.	NOT APPLICABLE	The department reported that Cornell Corrections has purchased the property, which was previously leased from a third party. As a result, the recommendation is no longer applicable.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that staff duties for the management of inmate trust accounts at the Leo Chesney Center were not properly segregated.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Leo Chesney Center administration reevaluate the inmate management system access assigned to administrative assistants. The recommendation noted that system access should be limited to screens necessary to complete assigned duties. Reconciliation and supervisory review procedures should be established to eliminate internal control weaknesses.	FULLY IMPLEMENTED	The department reported that the facility management re-evaluated the access of administrative assistants to the inmate management system and made the following changes: • The administrative assistants have access to all screens but do not have the capability to initiate inmate files. • The intake counselor has been assigned the responsibility of initiating inmate files within the system. The department also reported that the trust accounts are reconciled by the administrative assistant II and that the fiscal officer reviews the reconciliation and the work of administrative assistants I and II.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that the Leo Chesney Center did not process incident reports properly.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Leo Chesney Center log all incidents in the incident log book and ensure that they are reported to the California Department of Corrections Community Correctional Facility Administration	FULLY IMPLEMENTED	The department reported that the department's inmate disciplinary coordinator, a correctional lieutenant who works at the facility, is charged with ensuring that incidents, events, and activities that occur within the jurisdiction of the facility that are of immediate interest to the department, other governmental agencies, or the news media are properly reported to the department in accordance with current policies and procedures. Applicable

headquarters in a timely manner.		policies and procedures are described in California Code of Regulations, Title 15, section 3382 and *California Department of Corrections and Rehabilitation Operations Manual*, section 51030.1. The department also reported that to ensure compliance, the incident reporting process is audited at least annually during quarterly internal audits performed by the Community Correctional Facility Administration. The department reported that the Program and Fiscal Audits Branch of the Department of Corrections conducted a program compliance audit of the facility's operations in August 2004 and found the facility to be in full compliance in this area. The Office of the Inspector General reviewed the August 2004 report issued by the Program and Fiscal Audits Branch and confirmed that the audit examined the facility's incident report procedures and found that the facility experienced no reportable incidents in the year preceding the audit The Office of the Inspector General also confirmed that the Community Correctional Facility Administration reviewed the logging of incident reports in its third quarter 2005 internal audit and found full compliance.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found inaccuracies in the Leo Chesney Center's inmate disciplinary reports.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Leo Chesney Center disciplinary officer ensure that all disciplinary	FULLY IMPLEMENTED	The department told the Office of the Inspector General that the department's inmate disciplinary coordinator is charged with ensuring that all disciplinary actions occurring within the jurisdiction of the facility are properly recorded

actions are properly recorded in the incident log.[1] The recommendation specified that the facility director should request periodic status reports on inmate disciplinary activity so that she can be fully informed about inmate disciplinary activity.		in accordance with the policy and procedures outlined in the California Code of Regulations, Title 15 section 3310, *et seq.,* and the *California Department of Corrections and Rehabilitation Operations Manual*, section 52080.1, *et seq*. The department also reported that the inmate disciplinary processes are audited at least annually during the Community Correctional Facility Administration's quarterly audits. In addition, the program compliance audit conducted by the Program and Fiscal Audits Branch in August 2004 found the facility to be in full compliance in this area. The department further reported that periodic status reports regarding inmate disciplinary activity are addressed in monthly management meetings attended by facility management and local department staff. The Office of the Inspector General confirmed that the Community Correctional Administration reviewed the logging of disciplinary actions in its third quarter 2005 internal audit and found full compliance. The Office of the Inspector General also reviewed the August 2004 report issued by the Program and Fiscal Audits Branch and confirmed that the audit examined the facility's inmate discipline process and procedures and found full compliance in all areas reviewed relating to discipline.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 13

The Office of the Inspector General found that a significant number of staff performance appraisals and probationary reports for employees at the Leo Chesney Center were overdue.

[1] "Incident log" should have read "disciplinary log."

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Leo Chesney Center director take the actions listed below to ensure the timely evaluation of employee performance.		
Notify all staff members of the importance of performance appraisals and probation reports to the mission of the Leo Chesney Center.	FULLY IMPLEMENTED	The department told the Office of the Inspector General that Cornell Corrections employees are aware of the importance of submitting performance appraisals in a timely manner, and that this is reiterated during the facility's weekly meetings for department heads. The Office of the Inspector General reviewed minutes of meetings that documented discussion of performance reports.
Instruct the personnel officer to log all delinquent appraisals and reports. The log should be submitted to the facility director each month and made a topic of management meeting discussions.	FULLY IMPLEMENTED	The department reported that the administrative assistant III maintains a tickler file on all appraisals and probation reports and, as noted above, reported that appraisal and probation reports are distributed and discussed during the weekly department head meetings.
Hold supervisors accountable for completing timely performance appraisals and probationary reports.	FULLY IMPLEMENTED	The department stated that the facility director or assistant director ensures that supervisors clearly understand they are held accountable if performance appraisals and probationary reports are not submitted in a timely manner. The department reported that all performance evaluations have been completed for 2005. The Office of the Inspector General reviewed the signature pages of the performance reports completed for facility staff during 2005 and found that they were prepared on time.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 14

The Office of the Inspector General found that some Leo Chesney Center employees had not attended mandatory training classes or met the minimum hours of annual training and that the facility training files contained errors and lacked adequate documentation.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections and Cornell Corrections ensure that employees at the Leo Chesney Center adhere to required training hours and attend mandatory training courses. In addition, the recommendation specified that the Department of Corrections and Cornell Corrections should take the steps necessary to ensure that employee training records are complete and accurate.	FULLY IMPLEMENTED	The department reported that facility management conducts audits of training files on a quarterly basis. According to the department, the training records are also audited at least annually during internal quarterly audits performed by the Community Correctional Facility Administration. The department also said the training records are audited on an annual basis by the Board of Corrections and were audited by the department's Program and Fiscal Audit Branch in August 2004. The department stated that all mandatory training and requirements have been met. The Office of the Inspector General reviewed documentation to support each of the audits referred to by the department and found that all audits reported full compliance with the training requirements reviewed.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 15

The Office of the Inspector General found that the invoice form used by the California Department of Corrections for community correctional facility reimbursement was outdated and that the department had not provided guidance to the facilities on claiming payment for beds when they exceed the monthly maximum reimbursement amount.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections revise the monthly participant usage invoice and the related instructions in the *Financial Management Handbook for Private Community Correctional Facilities* to ensure accurate reporting by facilities.	FULLY IMPLEMENTED	The department reported that it revised the monthly participant usage invoice and that the revised form would be incorporated into all new contract awards after September 13, 2005. The Office of the Inspector General reviewed a copy of the revised invoice form and found that the department simplified the form and addressed the issues identified in the finding.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 16

The Office of the Inspector General found that inmates assigned to the administrative unit of the Leo Chesney Center had access to performance information pertaining to other inmates, even though that access is specifically prohibited by state regulations.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Leo Chesney Center change its procedures to retain CDC 1697 forms in a locked compartment; prohibit inmate access to CDC 1697 forms; and provide for the forms to be filed by the facility staff.	FULLY IMPLEMENTED	The department told the Office of the Inspector General that all CDC 1697 forms are now kept in a locked cabinet and that inmates no longer file the forms.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 17

The Office of the Inspector General found that inmates assigned to the adult basic education program were not receiving the required number of education hours.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections require the Leo Chesney Center to adhere to its contract requirement of offering a minimum of six hours a day of adult basic education unless or until the contract is modified by the department.	NOT APPLICABLE	The Office of the Inspector General reevaluated the provision in the *California Department of Corrections Statement of Work* pertaining to required hours of education and concluded that the provision may not refer to the number of hours required to be provided to each student. The provision in question, section III.E.6, reads: "Educational programs shall be conducted…a minimum of six hours daily." The Office of the Inspector General found that the provision may refer to the total number of hours of education the facility is required to provide each day rather than to the number of hours the facility must provide to each student. The department furnished documentation showing that the facility conducts seven hours per day of adult education. The Office of the Inspector General therefore has determined that the recommendation is not relevant.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 18

The Office of the Inspector General found that floor tiles in the kitchen were cracked, creating a safety hazard.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Leo Chesney Center replace the kitchen floor in the dining hall.	FULLY IMPLEMENTED	The department reported that the kitchen floor in the dining hall has been replaced.

FOLLOW-UP RECOMMENDATIONS

None.

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LOCAL ASSISTANCE PROGRAM

IMPLEMENTATION REPORT CARD

Previous recommendations: 6

Fully implemented: 4 (66 %)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 1 (17%)

Not applicable: 1 (17%)

The Office of the Inspector General found that the Parole and Community Services Division has made significant improvements in its oversight of the Local Assistance Program.

In January 2002, the Office of the Inspector General conducted a special review of the Parole and Community Services Division's Local Assistance Program, which reimburses local jurisdictions for the costs of detaining state parolees in local facilities. The review determined that the program had overpaid local jurisdictions $8.2 million in the previous two fiscal years by reimbursing for services at rates that exceeded the maximum daily rate allowed under the State Budget Act. The review also found that the program did not adequately monitor non-routine medical services provided to state parolees in Los Angeles County and that the department's procedures for processing invoices from local jurisdictions were deficient.

BACKGROUND

California Penal Code section 4016.5 was enacted on July 1, 1975 to relieve cities and counties of the cost of detaining state parolees held for parole violations. Under its provisions, the Department of Corrections and Rehabilitation reimburses local jurisdictions for costs incurred as a result of detaining state parolees when the detention relates only to parole violations and does not involve new criminal charges. Beginning in the 1990s, the Department of Corrections supplemented the local assistance payments by negotiating contracts with certain counties to set aside beds for state inmates and parolees under the authority of California Penal Code section 2910. The state has such contracts with three local entities: Santa Rita Jail in Alameda County, Peter Pitchess Detention Center in Los Angeles County, and Rio Cosumnes Correctional Center in Sacramento County.

The State Budget Act of 2005 includes $32.1 million for local assistance payments and $49.4 million for contract payments. The Parole and Community Services Division of the Department of Corrections and Rehabilitation is responsible for managing the Local Assistance Program, and cities and counties submit invoices to regional parole offices for local assistance and contract reimbursements. The Department of Corrections and Rehabilitation supplies sheriff and police departments with a manual that sets forth guidelines and procedures for calculating costs related to state prisoner and parolee detention and revocation proceedings — termed the "daily jail rate." Beginning in 1993, State Budget Acts have restricted local jurisdictions from recovering detention costs of more than $59 per day per parolee.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the January 2002 review of the Local Assistance Program:

- The Department of Corrections overpaid local jurisdictions by more than $8.2 million over a two-year period by reimbursing for services provided to state parolees at rates that exceeded the maximum daily amount allowed under the State Budget Act. A large share of the overpayments was made to Parole Region III, which covers Los Angeles County. The overpayments occurred because the department paid local jurisdictions separately for non-routine medical care provided to state parolees and those costs were not included in the maximum daily rate for reimbursement.

- The Department of Corrections did not adequately monitor non-routine medical care provided to state parolees in Los Angeles County. As a result, parolees received costly medical services that may have been inappropriate under the circumstances.

- The Department of Corrections had not established standard written procedures to ensure that invoices from local jurisdictions were accurate and were processed consistently.

- The Department of Corrections lacked an information system capable of efficiently validating information reported on invoices submitted by local jurisdictions.

As a result of the January 2002 review, the Office of the Inspector General provided the following six recommendations to the Department of Corrections:

- Limit reimbursement to the maximum daily rate allowed in the State Budget Act.

- Amend the Daily Jail Rate Manual to include non-routine medical costs in the daily jail rate calculation.

- Include in the 2002 State Budget Act and future budget acts the actual cost of prisoner care in state correctional facilities.

- Establish a process to more closely monitor cases involving non-routine medical care for state parolees in Los Angeles County. The process should include consulting with the department's medical personnel to evaluate treatment options for state parolees. Consideration should also be given to transporting state parolees requiring long-term medical care to state correctional medical facilities.

- Develop written statewide procedures for administering and monitoring the Local Assistance Program.

- Develop enhancements to the Revocation Scheduling and Tracking System to allow reports to be generated to help parole staff fully verify invoices submitted by cities and counties for reimbursement of parole retention services.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the California Department of Corrections and Rehabilitation has implemented the six recommendations from the Office of the Inspector General's January 2002 review of the Local Assistance Program. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the January 2002 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations. Review fieldwork was completed in August 2005. The results are presented in the tables following this section.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the six recommendations issued by the Office of the Inspector General in January 2002 concerning the Local Assistance Program, four recommendations have been fully implemented, one has not been implemented, and one is no longer applicable.

The Office of the Inspector General found that the Parole and Community Services Division has improved its monitoring of the Local Assistance Program. The Department of Corrections worked with the Department of Finance and the California Sheriffs' Association to revise the methodology for calculating the daily jail rate and to amend the state budget act language for reimbursement to local jurisdictions. The resulting agreement excludes non-routine medical costs from the daily jail rate calculation. The amended state budget act language resolves previous confusion over the interpretation of California Penal Code requirements for calculating reimbursement to local jurisdictions. The Parole and Community Services Division has also improved its procedures and monitoring efforts to reduce the non-routine medical costs associated with the Local Assistance Program. The Parole and Community Services Division's information system, however, needs further improvement to more efficiently verify and process invoices submitted by local jurisdictions.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation continue to pursue developing an information system to improve the Local Assistance Program invoice verification process.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the Department of Corrections had overpaid local jurisdictions more than $8.2 million in the previous two fiscal years by reimbursing for detention services provided to state parolees at rates that exceed the maximum amount allowed under the State Budget Acts.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections take the actions listed below: Limit reimbursements to the maximum daily rate allowed in the State Budget Act.	FULLY IMPLEMENTED	The Office of the Inspector General's original recommendation addressed the fact that reimbursements to local jurisdictions exceeded the $59 maximum daily rate allowed in the State Budget Act because the local entities were paid separately for non-routine medical costs and were not required to include those costs in calculating the daily jail rate — the maximum daily rate for reimbursement. The Office of the Inspector General recommended that the Department of Corrections include all costs, including the costs of non-routine medical care, in its daily jail rate calculation and limit local jurisdictions to the maximum daily rate allowed in the State Budget Act. In response to the Office of the Inspector General's review, the Department of Corrections Legal Affairs Division reviewed applicable laws, regulations, and policies and concluded that the department is both permitted and obligated to reimburse local jurisdictions for non-routine medical costs independent of Penal Code section 4016.5. Although the Office of the Inspector General does not concur with the Legal Affairs Division's opinion, the budget act language has since been amended to resolve the issue. The 2005 State Budget Act language increases the maximum daily jail rate, and the methodology adopted by the Department of Finance specifically excludes non-routine medical costs from the calculation.

Amend the Daily Jail Rate Manual to include non routine medical costs in the daily jail rate calculation.	NO LONGER APPLICABLE	As stated above, the methodology adopted by the Department of Finance and included in the State Budget Act of 2005 now excludes non-routine medical costs from the daily jail rate calculation. Therefore, this recommendation is no longer applicable.
Include in the 2002 State Budget Act and future Budget Acts the actual cost of prisoner care in state correctional facilities.	FULLY IMPLEMENTED	The 2005 Budget Act methodology for calculating the maximum is predicated on 95 percent of the state's average cost for housing inmates in similar state facilities, excluding the cost of non-routine medical care. However, the state will continue to reimburse local entities for the cost of non-routine medical care on a case-by-case basis, consistent with current practice. Based on this revised methodology, the Department of Finance approved a maximum Daily Jail Rate for fiscal year 2005-06 of $68.22 per inmate. The Department of Corrections will submit future adjustments to the Daily Jail Rate to the Department of Finance in the spring, before each new fiscal year, to reflect any changes related to the state's cost for housing inmates in similar facilities.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the Department of Corrections did not adequately monitor non-routine medical care provided to state parolees in Los Angeles County, resulting in parolees receiving costly medical services that may have been inappropriate under the circumstances.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections establish a process to more closely monitor cases involving non-routine medical care in Los Angeles County. The process should include consulting with the	FULLY IMPLEMENTED	The Parole and Community Services Division, in conjunction with the Fiscal and Business Management Audits Unit of the Department of Corrections and Rehabilitation, revised the Daily Jail Rate Manual by delineating allowable and unallowable costs, expanding the definition of non-routine medical care, and effective July 1, 2002, instituted notification requirements when parolees in local detention require non-emergency medical care. Under the revised policies and

department's medical personnel to evaluate treatment options for state parolees in Los Angeles County. Consideration should also be given to transporting state parolees requiring long-term medical care to state correctional medical facilities.		procedures, once a parole unit is notified by a local jurisdiction of a non-emergency medical need, the Parole and Community Services Division will use medical expertise from the department's Health Administration Unit to assist in evaluating individual cases and recommending appropriate disposition, including when it would be acceptable to release a parole hold or transfer parolees to a state facility. The Office of the Inspector General reviewed the medical expenditures for fiscal year 2004-05 and found that expenditures were about the same as those of the previous year, but were significantly less than the total in fiscal year 2002-03. In fiscal year 2002-03, medical expenditures were $10.3 million. Fiscal year 2004-05 medical expenditures were $6.4 million, or 38 percent less than fiscal year 2002-03. The department reports that it anticipates non-routine medical expenditures to flatten out and even decline in fiscal year 2005-06 as a result of the new notification procedures.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that the Department of Corrections lacked established written procedures and managerial oversight to ensure that invoices from local jurisdictions are accurate and were processed consistently.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Parole and Community Services Division develop written statewide procedures for administering and monitoring the Local Assistance Program.	FULLY IMPLEMENTED	The Parole and Community Services Division has developed and distributed the Local Assistance Program, Contract & Daily Jail Rate Reimbursements Program Guide. The program guide provides consistent procedures for reconciliation, approval, and payment of jail detention, revocation hearings, and medical care invoices, including documentation, tracking, and prescribed timelines.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that Department of Corrections had not established an information system adequate to verify information reported on invoices submitted by local jurisdictions.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections develop enhancements to the Revocation Scheduling and Tracking System to allow reports to be generated to help the parole staff fully verify invoices submitted by cities and counties for reimbursement of parole retention services.	NOT IMPLEMENTED	To verify that invoices are accurate, the parole staff must confirm that a parolee was detained at the local jurisdiction on an active parole hold during the period claimed and that no local charges were pending at the time. The department reported that the Revocation Scheduling and Tracking System cannot be programmed to allow continuous tracking of individual parolee movements. Instead, the department said it is continuing to use a tracking system developed only for Parole Region III (Los Angeles County). The department did not provide a timetable for when a tracking system will be available statewide.

FOLLOW-UP RECOMMENDATION

The Department of Corrections and Rehabilitation should continue to pursue developing an information system to assist with the Local Assistance Program invoice verification process.

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INMATE APPEALS BRANCH

IMPLEMENTATION REPORT CARD

Previous recommendations: 1

Fully implemented: 0 (0 %)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 1 (100%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation Inmate Appeals Branch has made efforts to enhance its inmate appeals tracking system to integrate appeals at the third-level review but other departmental priorities have hampered its efforts.

A special review of the Department of Corrections Inmate Appeals Branch, issued by the Office of the Inspector General in February 2001, identified serious deficiencies in the third-level inmate appeals process. The problems had caused unacceptable delays in the processing of inmate appeals and had created a significant and growing backlog of appeals that had not been completed within the 60-day time frame required by California Code of Regulations, Title 15.

In September 2004, the Office of the Inspector General conducted a follow-up review that determined the Inmate Appeals Branch had made significant progress in addressing the deficiencies identified in the February 2001 review. In particular, the follow-up review found that the Inmate Appeals Branch was meeting required deadlines in responding to third-level appeals; had virtually eliminated its former backlog of overdue appeals; and had developed a formal training manual and written guidelines for new appeals examiners. The Inmate Appeals Branch also had developed a system for tracking inmate appeals for use at all institutions, but at the time of the follow-up review, online interconnectivity between the prisons and the Inmate Appeals Branch was still in the planning stages. The Inmate Appeals Branch reported that it would begin improvements by November 2004 that would allow the system to be used as a tool for identifying systemic problems, including policies and procedures needing revision.

BACKGROUND

California Department of Corrections and Rehabilitation Operations Manual, section 54100.2 declares that the purpose of the inmate appeals process is to provide for resolution of inmate grievances in a timely manner and at the lowest possible level. The process directs inmate complaints through one informal and two formal levels of appeal at the institution and a final third-level review at the director's office. In addition, the inmate appeals process is intended to serve as a vehicle for improving department policies and procedures. The *California Department of Corrections and Rehabilitation Operations Manual* specifies that the appeals process is designed to audit the internal practices and operation of the Department of Corrections and Rehabilitation to "identify, modify, or eliminate practices which may not be necessary or may impede the accomplishment of correctional goals." The Inmate Appeals Branch is responsible for oversight of the Department of Corrections and Rehabilitation's inmate appeal process.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the September 2004 follow-up review, the Office of the Inspector General found that integration of the inmate appeals tracking system with third-level appeals still had not been accomplished and remained in the planning stages because other department technology projects had been given higher priority.

The Office of the Inspector General recommended that the Inmate Appeals Branch continue to work with the Information Systems Division to develop and enhance the new inmate appeals tracking system to include third-level appeals and statewide reporting of first- and second-level appeals and also to allow review of appeals granted and partially granted as a vehicle for identifying policies and procedures needing revision.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Department of Corrections and Rehabilitation has implemented the recommendation from the Office of the Inspector General's September 2004 follow-up review of the Inmate Appeals Branch. To conduct the follow-up review, the Office of the Inspector General provided the Department of Corrections and Rehabilitation with a table listing the September 2004 finding and recommendation and asked the department to provide the implementation status of the recommendation. The Office of the Inspector General reviewed the response, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendation. The fieldwork for the follow-up review was completed during December 2005. The results are presented in the table following this section.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

The Office of the Inspector General found that the Inmate Appeals Branch has made continuous efforts to enhance its inmate appeals tracking system. However, notwithstanding the passage of six years, the Information Systems Division continues to assign a low priority to this project.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation require the Information Systems Division to either integrate the inmate appeals tracking system with the third-level appeals or contract with a private firm to do so.

ORIGINAL FOLLOW-UP FINDING NUMBER 1

The Office of the Inspector General found that integration of the inmate appeals tracking system with third-level appeals was still in the planning stage.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Inmate Appeals Branch continue to work with the Information Systems Division to develop and enhance the new inmate appeals tracking system.	NOT IMPLEMENTED	The Inmate Appeals Branch reported that it has continued to work with the Information Systems Division to complete the Inmate Appeals Tracking System improvements. According to the department, the scope of the project now requires the Inmate Appeals Branch to complete a feasibility study to justify the need for the project. The department originally scheduled the enhancements to take place in November 2004 but other department priorities delayed the project. The Inmate Appeals Branch informed the Office of the Inspector General in December 2005 that it was working with the Information Services Division to complete the feasibility study by December 21, 2005. The department had not completed the feasibility study at the close of the Office of the Inspector General's fieldwork.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation require the Information Systems Division to either integrate the inmate appeals tracking system with the third-level appeals or contract with a private firm to do so.

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SALINAS VALLEY STATE PRISON, INMATE APPEALS AND DISCIPLINARY PROCESSES

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 3 (44%)

Substantially implemented: 1 (14%)

Partially implemented: 1 (14%)

Not implemented: 1 (14%)

Not applicable: 1 (14%)

The Office of the Inspector General found that the number of overdue inmate appeals at Salinas Valley State Prison has increased since a September 2003 review, primarily because of a significantly higher volume of appeals from inmates. In addition, although the institution has improved its inmate disciplinary process, it has not developed a corrective action plan to address deficiencies in the process identified in the September 2003 review.

In September 2003, the Office of the Inspector General conducted a follow-up review of the inmate appeals and disciplinary processes at Salinas Valley State Prison. The purpose of the review was to assess the institution's progress in addressing the findings of a March 2000 audit of the inmate appeals and disciplinary processes. The September 2003 review found that the institution had significantly improved the inmate appeals process since the earlier audit, but that problems remained in the inmate disciplinary process. The Office of the Inspector General made seven recommendations to the management of Salinas Valley State Prison for improving the inmate disciplinary process as a result of the September 2003 follow-up review.

BACKGROUND

Salinas Valley State Prison, located in Soledad, California, opened in May 1996 as a Level IV (maximum security) prison designed to house 2,024 inmates in four facilities located in Complex I and Complex II. Complex I contains Facilities A and B, while Complex II contains Facilities C and D. Since its opening, the institution has had problems with staff turnover and inmate unrest. Problems with inmates have led to a significant number of total or partial lockdowns, impairing the institution's ability to provide academic and vocational programs. In response to the problems, the Office of the Inspector General conducted an audit of the inmate appeals and inmate disciplinary processes at the institution in March 2000. The audit found significant deficiencies in both processes and made recommendations to correct the problems.

In response to an inmate's complaint, the Office of the Inspector General returned to Salinas Valley State Prison during January 2003 to initiate an investigation of certain aspects of the inmate disciplinary process. As a result of that investigation, the Office of the Inspector General found that the prison had violated the rights of more than 80 inmates in administering the inmate disciplinary process following an inmate work stoppage in October 2002. The Office of the Inspector General subsequently conducted a follow-up review of the March 2000 audit to assess the institution's progress in addressing the earlier findings. The results of the follow-up review were published in September 2003.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the September 2003 follow-up review, the Office of the Inspector General found that Salinas Valley State Prison had developed a corrective action plan to address the deficiencies identified in the 2000 audit and had significantly improved its inmate appeals process. Inmate appeals processing times had improved and there was no longer a backlog of appeals waiting to be addressed. The inmate disciplinary process, however, continued to be deficient.

The Office of the Inspector General made the following specific findings as a result of the September 2003 follow-up review:

- The inmate appeals process had significantly improved.

- Salinas Valley State Prison had made little progress in improving its inmate disciplinary process.

The Office of the Inspector General made the following seven recommendations to the Salinas Valley State Prison management as a result of the September 2003 follow-up review:

- Continue using the current inmate appeals process, including the logging of all informal appeals.

- Require chief disciplinary officers to develop their own independent registry logs in lieu of relying on the information provided by the facilities.

- Regularly audit the registry logs, the disciplinary action logs, and the register of institution violations to ensure they comply with the requirements of Penal Code section 2081, the California Code of Regulations, and the Department of Corrections Operations Manual.

- Hold staff members with responsibility for the inmate disciplinary system, including chief disciplinary officers, accountable for the quality of their work. Use progressive discipline if necessary to ensure compliance with the requirements of the California Code of Regulations and the *Department of Corrections Operations Manual.*

- Use the automated disciplinary management system to monitor performance indicators associated with the inmate disciplinary process, including compliance with timeliness criteria.

- Continue providing periodic training to staff on the inmate appeals and inmate disciplinary processes.

- Modify the corrective action plan to incorporate these recommendations, and specify completion dates rather than notations such as "ongoing" for implementing each recommendation.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which Salinas Valley State Prison has implemented the seven recommendations from the Office of the Inspector General's September 2003 follow-up review of the inmate appeals and disciplinary processes at Salinas Valley State Prison. To conduct the follow-up review, the Office of the Inspector General provided Salinas Valley State Prison with a table listing the September 2003 findings and recommendations and asked Salinas Valley State Prison to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the institution, and evaluated the degree of compliance or noncompliance with the recommendations. Fieldwork was completed during February 2006. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the seven recommendations issued by the Office of the Inspector General in September 2003 concerning the institution's inmate appeals and disciplinary processes, three have been fully implemented; one has been substantially implemented; one has been partially implemented; one has not been implemented; and one is no longer applicable.

The Office of the Inspector General found that Salinas Valley State Prison has improved its inmate disciplinary process by requiring chief disciplinary officers to maintain independent registry logs and to regularly audit the logs for compliance. However, the institution has not developed a corrective action plan to address the deficiencies in the disciplinary process identified in the September 2003 follow-up review, and the disciplinary system procedures developed by the institution still fail to hold staff members accountable for the quality of their work. Moreover, the Office of the Inspector General found that the number of overdue appeals has increased since the March 2000 follow-up review. The rise in the number of overdue appeals is attributable to a significantly higher volume of appeals from inmates, the process of logging informal appeals, and a lack of staffing to handle the increase in appeals.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that Salinas Valley State Prison take the following additional actions:

- **Develop an alternative method of tracking informal inmate appeals instead of logging each informal appeal in the appeals tracking system.**

- **Provide for staff accountability in the inmate disciplinary system procedures.**

- **Prepare and execute a corrective action plan to address deficiencies in the inmate disciplinary process.**

The following table summarizes the results of the follow-up review.

FOLLOW-UP FINDING NUMBER 1

The Office of the Inspector General found that the inmate appeals process had significantly improved.

FOLLOW-UP FINDING NUMBER 2

The Office of the Inspector General found that Salinas Valley State Prison had made little progress in improving its inmate disciplinary process.

RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that Salinas Valley State Prison management take the actions listed below to improve the inmate appeals and inmate disciplinary processes.		
Continue using the current inmate appeals process including the logging of all informal appeals.	FULLY IMPLEMENTED	Salinas Valley State Prison reported that although appeals were significantly backlogged at the time of the March 2000 review, the inmate appeals process has improved to the point that informal appeals are no longer a significant problem. The institution also reported, however, that the logging of informal appeals has placed an additional unfunded workload on an already depleted staff and violates section 3084 of the California Code of Regulations. Tracking informal appeals requires two additional staff members, but because additional staff is not available, the existing staff has assumed that function, which has contributed to an appeals backlog. As a result, the institution is requesting that the California Department of Corrections and Rehabilitation release it from this recommendation and allow the appeals unit to comply with section 3084 of the California Code of Regulations. If the request is approved, the institution will revise Operational Procedure 48 to include the change. Until then, the appeals staff will continue to log the informal appeals. The Office of the Inspector General reviewed Salinas Valley State Prison Operational Procedure 48 covering inmate/parolee appeals, which was developed in November 1997 and revised in July 2004, and found that the procedure clearly outlines the inmate/parolee appeals process for staff and inmates, including

		entering informal appeals into the appeals tracking system. The Office of the Inspector General reviewed several appeals tracking system reports provided by the institution and verified that informal level appeals are entered into the appeals tracking system. The Office of the Inspector General also found, however, that the appeals backlog has returned since the September 2003 follow-up review. As reported in the September 2003 review, the backlog of appeals had been entirely eliminated as of July 2003. But according to information provided by Salinas Valley State Prison, the backlog of overdue informal appeals totaled 228 as of September 25, 2004 and had increased to 251 as of February 11, 2006. Meanwhile, the backlog of overdue Level I and II appeals totaled 154 as of September 25, 2004, but had decreased to 39 by February 11, 2006. The Office of the Inspector General noted that Salinas Valley State Prison inmates submit a significantly higher number of appeals now than they did at the time of the March 2000 review. At that time, inmates at the prison typically submitted approximately 3,300 appeals requiring formal action each year. (The number of informal appeals filed is unknown because the institution did not track informal appeals at that time.) In comparison, inmates filed 19,068 appeals in 2005, with 6,356 requiring formal action, 5,456 requiring informal action, and 7,256 screened out because they did not meet appeal criteria. According to a Salinas Valley State Prison official, staffing in the Inmate Appeals Office has remained at four employees since March 2000, contributing to the increase in overdue appeals.
Require chief disciplinary officers to develop their own independent registry logs in lieu of relying on the information provided by the facilities.	**FULLY IMPLEMENTED**	Salinas Valley State Prison reported that the chief disciplinary officers for Complex I and II maintain a separate registry log that is independent of the facilities. According to the institution, a register clerk inputs and maintains the data and attests to the accuracy of the information on a weekly basis. The institution reported that Complex I does not have an appeals backlog and that Complex II has a backlog that it is addressing. The Office of the Inspector General verified the existence of the logs.
Regularly audit the registry logs, the disciplinary action logs (CDC-Form 1154s),	**SUBSTANTIALLY IMPLEMENTED**	Salinas Valley State Prison reported that its desk procedures for register clerks require each chief disciplinary officer to audit the registry logs, disciplinary action

and the register of institution violations (and the rules violation reports therein) to ensure that they comply with the requirements of Penal Code section 2081, the California Code of Regulations, and the *Department of Corrections Operations Manual*.		logs, and the register of institution violations. Furthermore, the chief disciplinary officer is required to conduct monthly reviews of the register of institution violations and confirm the review by signing the register audit log. The institution also reported that the chief disciplinary officer is required to compare the register of institution violations against the registry and disciplinary action logs from each facility to ensure accuracy and completeness. Salinas Valley State Prison provided copies of each chief disciplinary officer's most recent audit reports. The Office of the Inspector General noted that as of September 27, 2005, the chief disciplinary officer for Complex I had completed audits from January to August 2005 for Facilities A and B. As of October 19, 2005, however, the chief disciplinary officer for Complex II had completed only the March 2005 audit for Facility C and the January through March 2005 audits for Facility D. Institution officials said they are addressing this backlog.
Hold staff with responsibility for the inmate disciplinary system, including chief disciplinary officers, accountable for the quality of their work. Use progressive discipline if necessary to ensure compliance with the requirements of the California Code of Regulations and the *Department of Corrections Operations Manual.*	**NOT IMPLEMENTED**	Salinas Valley State Prison reported that the primary source of accountability for the disciplinary process is the independent tracking system used by the register clerk, the facility logs, and the register of institution violations. The Office of the Inspector General reviewed the desk procedures for register clerks and concluded that although the procedures delineate the chief disciplinary officer's responsibilities with respect to the disciplinary system, the procedures do not address staff accountability.
Use the automated disciplinary management system to monitor performance indicators, including compliance with timeliness criteria, associated with the inmate disciplinary process.	**NOT APPLICABLE**	Salinas Valley State Prison reported that the automated disciplinary management system is no longer available to all staff members involved in the review and approval steps of the disciplinary process. According to the institution, when the corrective action plan was developed in 2002 in response to the Office of the Inspector General's 2000 audit, the institution's computers used an operating system that was compatible with the automated disciplinary management system. By late September 2004, however, most of the institution's computers had been converted to the Windows XP operating system, which is not compatible with the automated disciplinary management system. Salinas Valley State Prison reported that staff members monitor performance

		indicators through the independent tracking system used by the register clerk, as well as through the facility logs and the register of institution violations.
Continue providing periodic training to staff on the inmate appeals and inmate disciplinary processes.	**FULLY IMPLEMENTED**	Salinas Valley State Prison reported that staff members involved with the inmate appeals and disciplinary processes have received periodic training. For example, the appeals unit conducted on-site training in both facilities during May 2003, and the Inmate Appeals Board (third-level appeals) provided training related to staff complaints during September and October 2004. Salinas Valley State Prison also reported that register clerks received training between September 13, 2004 and October 14, 2004. Senior hearing officers were required to complete a certification process and received rules violation reports training on September 9 and November 5, 2005. According to the institution, appeals unit staff members provided training to medical staff in July 2005 and to newly promoted sergeants in September 2005. The Office of the Inspector General reviewed copies of the institution's training records for the period September 1, 2004 through October 27, 2005 and verified that 818 staff members received inmate appeals process training during that 14-month period. The Office of the Inspector General also verified that 147 staff members received training on the disciplinary process during the same period.
Modify the corrective action plan to incorporate these recommendations, and specify completion dates rather than notations such as "Ongoing" for implementing each recommendation.	**PARTIALLY IMPLEMENTED**	The Office of the Inspector General reviewed the corrective action plan for overdue inmate appeals signed by the acting warden on October 27, 2005 and verified that it addressed the Office of the Inspector General's previous recommendations relating to overdue appeals and specified completion dates. The Office of the Inspector General determined, however, that the institution does not have a corrective action plan to address previous recommendations relating to the inmate disciplinary process.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that Salinas Valley State Prison take the following additional actions:

- **Develop an alternative method of tracking informal inmate appeals instead of logging each informal appeal in**

the appeals tracking system.

- **Provide for staff accountability in the inmate disciplinary system procedures.**
- **Prepare and execute a corrective action plan to address deficiencies in the inmate disciplinary process.**

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CALIFORNIA REHABILITATION CENTER, INMATE APPEALS PROCESS

IMPLEMENTATION REPORT CARD

Previous recommendations: 5

Fully implemented: 4 (80 %)

Substantially implemented: 0 (0%)

Partially implemented: 1 (20%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the California Rehabilitation Center has improved its process for handling inmate appeals by maintaining adequate staffing in the inmate appeals office, providing orientation on the appeals process to new inmates, and having management monitor inmate complaints against staff. The institution continues to experience problems with transferring inmate property.

In August 2000, the Office of the Inspector General completed its review of the inmate appeals process at the California Rehabilitation Center. The review was prompted by a letter from an inmate reporting a backlog in the inmate appeals process. The Office of the Inspector General found that the institution had taken action to significantly reduce the number of overdue appeals and that the backlog was manageable. The review also identified several issues that could be addressed to further improve the institution's inmate appeals process.

BACKGROUND

Located in Norco, California, the California Rehabilitation Center is the Department of Corrections and Rehabilitations Level II, medium-security state prison for both male and female felons and for addicts convicted of civil drug offenses. The primary mission of the facility is to maintain the secure housing of inmates, protect the safety of the public, and provide a substance abuse treatment program. The California Rehabilitation Center is the only California prison that houses both male and female inmates within a shared exterior perimeter.

The inmate appeals process is prescribed under Title 15 of the California Code of Regulations to provide inmates with a system and process for filing complaints. Inmates file complaints by filling out and submitting a CDC-602 inmate/parolee appeals form. The process usually begins with an attempt to resolve at an informal level the issue between the appellant and staff involved in the incident prompting the complaint. California Code of Regulations, Title 15, Section 3084 specifies that staff respond to informal-level appeals within ten working days.

If the complaint is not resolved at the informal level, or if the nature of the complaint requires waiving the informal level, the complaint moves to the formal appeals process, which encompasses three appeal levels.

At the first level of appeal, form CDC-602 appeals are filed, screened, and logged into the appeals database by the institution's appeals office. The appeals coordinator is responsible for assigning appeals to appropriate staff members and for monitoring the

status of appeals to ensure that they are processed in a timely and appropriate manner. The decision to grant, partially grant, or deny an appeal is rendered by the staff person assigned to the case.

If the first level is waived under California Code of Regulations, Title 15, or if the inmate is dissatisfied with the response at the first level, the appeal moves to the second level. Decisions on the appeal at this level are typically made by the warden or the chief medical officer of the institution based on staff recommendations. These appeals are also logged into the appeals database.

If the inmate is dissatisfied with the second-level response, the inmate may appeal to the Inmate Appeals Branch in Sacramento for a third and final review. The Inmate Appeals Branch is responsible for overseeing the Department of Corrections and Rehabilitation's inmate appeals process and its review is the final administrative remedy available for inmate grievances.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the August 2000 review, the Office of the Inspector General made the following specific findings:

- The California Rehabilitation Center had reduced the appeals backlog to a manageable level by devoting additional staff resources to the appeals office.

- Inmates appeared to be unfamiliar with the appeals process, causing a high percentage of claims to be rejected during the screening process.

- A high percentage of the inmate appeals at the California Rehabilitation Center concerned the forwarding of inmate property and trust funds to other institutions.

- A high percentage of inmate appeals at the California Rehabilitation Center concerned complaints against staff.

In addressing these findings, the Office of the Inspector General recommended that the California Rehabilitation Center take the following five actions:

- Maintain the present level of re-directed staffing in the appeals office to ensure that the backlog is eliminated entirely and remains at a manageable level in the future.

- Incorporate into the inmate orientation program an explanation of the inmate appeals process.

- Discontinue the practice of waiting for an inmate appeal from a transferred inmate before sending property to the new institution.

- Investigate the need for increased staffing in the inmate trust fund accounting office so that trust funds belonging to inmates transferring to other institutions are forwarded more than once or twice a month.

- Review and analyze a representative sample of appeals categorized as complaints against staff to determine the cause of their frequency and implement corrective action.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the California Rehabilitation Center has implemented the five recommendations from the Office of the Inspector General's August 2000 review. To conduct the follow-up review, the Office of the Inspector General provided the California Department of Corrections and Rehabilitation with a table listing the August 2000 findings and recommendations and requested the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the California Rehabilitation Center, and evaluated the degree of compliance or noncompliance with the recommendations. The Office of the Inspector General also conducted additional fieldwork to verify various elements of the California Rehabilitation Center's responses. Fieldwork was concluded in February 2006. The results are presented in the table following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the five recommendations issued by the Office of the Inspector General in August 2000, four have been fully implemented and one has been partially implemented.

The Office of the Inspector General found that the California Rehabilitation Center has fully implemented the recommendations to adequately staff the inmate appeals office, incorporate inmate appeals information in its orientation process, investigate increased staffing for the inmate trust fund office, and review and analyze staff complaints to identify systemic problems. The Office of the Inspector General found, however, that the California Rehabilitation Center has not adequately addressed the timely transfer of inmate property when an inmate is transferred to another institution.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Rehabilitation Center consider initiating procedures to transfer inmate property at the time of the inmate's relocation rather than waiting for the inmate to return a form once he or she is permanently housed at another institution.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The California Rehabilitation Center had reduced the appeals backlog to a manageable level by devoting additional staff resources to the appeals office.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Rehabilitation Center maintain the present level of re-directed staffing in the appeals office to ensure that the backlog is eliminated entirely and remains at a manageable level in the future.	FULLY IMPLEMENTED	The California Rehabilitation Center reported that two full-time staff members are devoted to the inmate appeals office: one correctional counselor II and one office assistant. This staffing level is consistent with the Office of the Inspector General's recommendation. The institution also reported that the backlog has been eliminated but, if a backlog should occur, the appeals coordinator immediately notifies management and appropriate action is taken. The California Rehabilitation Center provided the Office of the Inspector General with the February 27, 2006 overdue appeals report listing 12 overdue appeals. Eleven of the 12 overdue appeals pertained to issues beyond the institution's control. Examples included inmate property and trust fund issues that arose while the inmate was at other institutions and legal concerns during a time when the individual was under parole jurisdiction. The remaining appeal was a medical issue that was four days delinquent.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

Inmates appeared to be unfamiliar with the appeals process, causing a high percentage of claims to be rejected during the screening process.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Rehabilitation Center incorporate into the inmate orientation program an explanation of the inmate appeals process.	FULLY IMPLEMENTED	The Office of the Inspector General reviewed the inmate orientation document delineating the acceptable use of the form CDC-602 for inmate appeals. The document clearly informs inmates about appeal preparation, the screening process, time limits, system abuses, and Americans with Disabilities Act-related appeals. Additionally, the California Rehabilitation Center reported that it presents an orientation video for new inmates that includes a segment on the inmate appeals process.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

A high percentage of the inmate appeals at the California Rehabilitation Center concerned the forwarding of inmate property and trust funds to other institutions.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the receiving and release unit of the California Rehabilitation Center discontinue the practice of waiting for an inmate appeal from a transferred inmate before sending property to the new institution.	PARTIALLY IMPLEMENTED	The California Rehabilitation Center reported that, when an inmate is transferred to another institution, the center's receiving and release staff provides the inmate with a form to be returned to the center once the inmate is permanently housed at another institution. The returned form alerts the staff to transfer the property to the inmate's new location. The Office of the Inspector General found that the new inmate property transfer process simply traded the inmate appeals form with another form. The effect is continued delays in transferring inmate property, as evidenced by an increase in the property-related appeals. The percentage of property-related inmate appeals filed in the first two quarters of 2004 increased to 23 percent from the 18 percent of such appeals filed in the first two quarters of 2000.

The Office of the Inspector General also recommended that the California Rehabilitation Center administration investigate the need for increased staffing in the trust fund accounting office so that trust funds belonging to inmates transferring to other institutions are forwarded more than once or twice a month.	**FULLY IMPLEMENTED**	According to the California Rehabilitation Center, the number of trust office staff positions is based on a ratio of one trust staff member per 691 inmates. Since the inmate trust fund office has historically been staffed in accordance with the staff-to-inmate ratio, no additional staffing has been allocated. Because the inmate fund transfer process has been given increased priority, however, the number of appeals in this category has been reduced by 6 percent. The institution affirms that it now processes inmate trust fund transfers weekly. The Office of the Inspector General found that appeals relative to inmate trust funds have decreased since the original review. In the first two quarters of 2000, trust fund appeals represented 15 percent of total inmate appeals. In the same two quarters of 2004, inmate trust fund appeals accounted for only 9 percent. The Office of the Inspector General was also informed that an automated inmate trust system is being developed and is projected to be implemented in July 2007. This system will eliminate the need for fund transfers between institutions and should result in fewer inmate appeals of this type.

FOLLOW-UP RECOMMENDATION

The California Rehabilitation Center should consider initiating procedures to transfer inmate property at the time of the inmate's relocation rather than waiting for the inmate to return a form once he or she is permanently housed at another institution.

ORIGINAL FINDING NUMBER 4

A high percentage of the inmate appeals at the California Rehabilitation Center concerned complaints against staff.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the management of the California Rehabilitation Center review and analyze a representative sample of appeals categorized as complaints against staff to determine the cause of their frequency and implement corrective action.	FULLY IMPLEMENTED	The California Rehabilitation Center stated that it prepares a quarterly report which management uses to assess the need for intervention, staff training, or further investigation.

FOLLOW-UP RECOMMENDATIONS

None.

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DEUEL VOCATIONAL INSTITUTION, INMATE APPEALS PROCESS

IMPLEMENTATION REPORT CARD

Previous recommendations: 2

Fully implemented: 2 (100 %)

Substantially implemented:0 (0%)

Partially implemented:0 (0%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that Deuel Vocational Institution has improved its inmate appeals process by implementing both of the Office of the Inspector General's recommendations from a September 2000 review. Specifically, the institution upgraded the software used for the inmate appeals tracking system and began including informal level inmate appeals in the tracking system.

The September 2000 review of the inmate appeals process at Deuel Vocational Institution by the Office of the Inspector General determined that the process was generally efficient and well-run, but that the computer system in the inmate appeals office needed to be upgraded with the most recent version of the inmate appeals tracking system software. The Office of the Inspector General also noted that the institution was not tracking informal inmate appeals.

BACKGROUND

Deuel Vocational Institution, located in Tracy, California, houses level I and level III inmates. Opened in 1953, the institution serves as both a reception center for inmates from six northern California counties and as a mainline institution providing educational opportunities and vocational programming.

The inmate appeals process provides inmates with the opportunity to resolve grievances. The process begins with the inmate's submission of an inmate/parolee appeal form, CDC-Form 602. Consideration of the appeal commences with an attempt to resolve the appeal at the informal level. In general, appeals resolved at the informal level are not submitted to the inmate appeals coordinator. Instead, they are handled directly between the inmate and the staff involved in the action or decision. At the informal level of appeal, staff members interview the inmate, review all pertinent documentation and information, and, if possible, resolve the issue. At the time of the Office of the Inspector General's September 2000 review, most informal level appeals at Deuel Vocational Institution were not logged or tracked.

Most inmate appeals are initially filed and screened at the first formal level. The first formal level requires the inmate appeals coordinator to log the appeal into the automated inmate appeals tracking system. The inmate appeals tracking system automatically assigns a log number to each appeal and calculates a due date for a response. The inmate appeals coordinator then assigns the appeal to the appropriate staff for a response. If the inmate is not satisfied with the response at the first formal level, the appeal goes to the second formal level (unless the first level of review is waived under California Code of Regulations, Title 15, section 3084.7).

The second level of appeal is also logged into and tracked by the inmate appeals tracking system. If not satisfied with the second formal level response, the inmate may appeal to a third formal

level by forwarding the appeal to the Inmate Appeals Branch in Sacramento. This review is conducted under the supervision of the chief of the Inmate Appeals Branch and constitutes the third and final formal appeal level decision.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the September 2000 review:

- The computer system needed to be upgraded with the most recent version of the inmate appeals tracking system software so that accurate quarterly reports and other program statistics could be generated.

- The institution was not tracking informal inmate appeals.

The Office of the Inspector General made the following two recommendations as a result of the September 2000 findings:

- The California Department of Corrections should consider upgrading the computer system used by the institution's inmate appeals office with the most recent version of the inmate appeals tracking system software. The inmate appeals office staff also should be provided with training and manuals for the new version of the software.

- Although the institution had strong management controls that mitigated the need for a tracking system for informal appeals, the inmate appeals staff and the warden should continue to diligently monitor all informal appeals to ensure that the informal process works as designed and that a tracking system remains unnecessary.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which Deuel Vocational Institution has implemented the two recommendations from the Office of the Inspector General's September 2000 review. To conduct the follow-up review, the Office of the Inspector General provided Deuel Vocational Institution with a table listing the September 2000 findings and recommendations and requested the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by Deuel Vocational Institution and evaluated the degree of compliance or noncompliance with the recommendations. Fieldwork for the follow-up review concluded in November 2005. The results are presented in the tables following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Both of the recommendations issued by the Office of the Inspector General in September 2000 concerning the Deuel Vocational Institution's inmate appeals process have been fully implemented. The institution upgraded the inmate appeals tracking system software to the most recent version and now includes informal inmate appeals in the tracking system.

FOLLOW-UP RECOMMENDATIONS

None.

The following table presents the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the computer system in the inmate appeals office needed to be upgraded with the most recent version of the inmate appeals tracking system software so that accurate quarterly reports and other program statistics could be generated.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections consider upgrading the computer system used by the inmate appeals office at the Deuel Vocational Institution inmate appeals office by installing the most recent version of the inmate appeals tracking system software and providing the inmate appeals staff with training and manuals on the new software version.	FULLY IMPLEMENTED	According to Deuel Vocational Institution, version 2.02 (Build 7) of the inmate appeals tracking system was installed at the institution in February 2004. The institution reported that the system was installed statewide and represented the most recent version as of July 2005. The institution reported that in conjunction with the implementation of the new tracking system, the inmate appeals office staff attended training on the use of the new system at the Correctional Training Center in February 2004. The Office of the Inspector General reviewed the inmate appeals tracking system manual for the new software, which was also used for the training, and found it had been installed and was in use.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the institution was not tracking informal inmate appeals.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General noted that the institution had strong management controls that mitigated the need for a tracking system for informal appeals, but recommended that the inmate appeals staff and the warden continue to diligently monitor informal appeals to ensure that the informal process is working as designed and that a tracking system remains unnecessary.	FULLY IMPLEMENTED	Deuel Vocational Institution reported that the inmate appeals office began posting informal inmate appeals to the inmate appeals tracking system in September 2004. According to the institution, informal appeals are assigned to the appropriate division head for consideration and, when completed, are returned to the appeals coordinator for final quality control review; compliance with rules, regulations, and policies; and disposition. The Office of the Inspector General reviewed sample inmate appeals reports and confirmed that informal inmate appeals are now included in the inmate appeals tracking system.

FOLLOW-UP RECOMMENDATIONS

None.

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CORRECTIONAL FACILITY MAIL PROCESSING

IMPLEMENTATION REPORT CARD

Previous recommendations: 27

Fully implemented: 14 (51%)

Substantially implemented: 10 (37%)

Partially implemented: 1 (4%)

Not implemented: 1 (4%)

Not applicable: 1 (4%)

The Office of the Inspector General found that the California Department of Corrections and Rehabilitation has reported making significant progress in implementing the recommendations from the July 2002 review of correctional facility mail processing. Eighty-eight percent of the recommendations have been reported as either fully or substantially implemented.

In July 2002, the Office of the Inspector General conducted a review to determine whether mail handling procedures and processes could be changed to improve efficiency and reduce costs while maintaining mandated service levels and institution security. In addition to reviewing the California Code of Regulations, Title 15 and the correctional facility plans of operations for mail handling for nine institutions, the Office of the Inspector General conducted in-depth site visits to the California State Prison, Solano; the California Institution for Men; and the California Institution for Women. The Office of the Inspector General estimated that implementing the recommendations at all of the department's institutions could generate $1.3 million in operational savings and provide timelier mail delivery.

BACKGROUND

Department of Corrections and Rehabilitation inmates and staff send and receive millions of pieces of mail through the U.S. Postal Service each year. At each of the department's 33 institutions, mail is processed through the mailroom before it is sent to the postal service or after it comes from the postal service for delivery to inmates and staff. Inmates consider mail a vital link to family, friends, and the outside world, as well as a vehicle for communicating with legal advisers, government officials, and clergy. Recognizing the important role that mail plays in inmate attitude and behavior, California Code of Regulations, Title 15, Division 3, sections 3130 through 3147 and section 3165 mandate how the department handles and processes mail. Wardens, superintendents, and other heads of correctional facilities are also required to establish plans of operation for mail processing at each facility. Through its plan of operations, each correctional facility establishes mail-processing procedures that must be approved by the Director of the Department of Corrections and Rehabilitation. Typically, these operational plans include such elements as establishing a seven-calendar-day mail delivery standard, processing certified and registered mail on the day received, and recording legal and confidential mail in approved mailroom logs.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

The Office of the Inspector General made the following specific findings as a result of the July 2002 review:

- State prisons were not taking effective advantage of the services provided by the U.S. Postal Service.
- Some of the state prisons made inadequate use of correctional officers for mail processing duties.
- Institutions were often inefficient in conducting the initial search of incoming mail.
- The processing of standard mail was often delayed by mail requiring special handling.
- Procedures for handling cash found in inmate mail differed at each facility and the mailroom process for handling checks and money orders was inefficient.
- Some of the selected institutions had inefficient processes for handling unstamped mail.
- The prisons reviewed spent significant amounts of time creating duplicate logs when processing legal mail.
- Some of the selected institutions did not fully comply with California Code of Regulations, Title 15 requirements.
- The Office of the Inspector General was unable to determine whether the prisons reviewed complied with delivery standards for regular inmate mail.
- The Office of the Inspector General found no first-class mail designated for disposal at the prisons reviewed.

The Office of the Inspector General issued 27 recommendations as a result of the July 2002 review.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the California Department of Corrections and Rehabilitation has implemented the 27 recommendations from the Office of the Inspector General's July 2002 review of correctional facility mail processing. To conduct the follow-up review, the Office of the Inspector General provided the department with a table listing the July 2002 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the department, and evaluated the degree of compliance or noncompliance with the recommendations. Fieldwork was completed during January 2006. The results are presented in the table following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the 27 recommendations issued by the Office of the Inspector General in July 2002, 14 recommendations have been fully implemented; 10 have been substantially implemented; one has been partially implemented; one has not been implemented; and one is no longer applicable (based on a review of the corrective action plans provided by each of the Department of Corrections and Rehabilitation's 33 institutions).

The Office of the Inspector General found that implementation of the recommendations had been delayed because the previous departmental administration neglected to provide direction to the institutions on implementing the needed improvements. It was only after the Office of the Inspector General's follow-up audit that instructions and guidelines were issued to the institutions.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following additional actions:

- **Ensure that the California State Prison, Sacramento has implemented the recommendation to use automatic letter openers.**
- **Ensure that the California Institution for Men and Salinas Valley State Prison have implemented the recommendation to develop a list of acceptable publications that employees can immediately place in housing unit mailbags.**
- **Ensure that the California Institution for Men eliminates the practice of verifying all inmate addresses.**
- **Ensure that Salinas Valley State Prison fully implements the recommendation to standardize the process for handling cash to conform to the process for handling other contraband.**
- **Ensure that the California Correctional Institution fully implement the recommendation to rely on accounting personnel to monitor inmate trust accounts for sufficient funds to pay postage on outgoing mail and provide pre-stamped envelopes to indigent inmates.**
- **Develop the standard checklist for reviewing mail operation plans submitted by the prisons.**
- **Provide an updated list of courts to all 33 institutions.**
- **Ensure that the California Medical Facility and the Correctional Training Facility fully implement the recommendation to institute a**

modified tracking system based on mail trays and bins rather than stamping or logging each piece of first-class mail.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the state prisons were not taking effective advantage of the services provided by the U.S. Postal Service.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that state correctional facilities take the actions listed below.		
Rent post office boxes for each housing unit and at least one box for administrative mail.	SUBSTANTIALLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that most of its institutions have incorporated this recommendation. Those facilities that have not instituted post office boxes indicated that post office boxes were either unavailable at their local post office or did not appear to be cost-effective. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 21 of the 33 institutions stated that they had implemented the recommendation.

Evaluate either having the U.S. Postal Service deliver and pick up mail at the sally port or having a correctional officer escort the mail truck from the entrance gate to the mailroom. Mail room employees could reject damaged or torn packages when the U.S. Postal Services truck is unloaded.	PARTIALLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that the recommendation was implemented at institutions where the U.S. Postal Service provides the level of service described in the recommendation. According to the department, however, the recommendation could not be implemented at institutions in certain rural locations, where postal services are not necessarily timely. Moreover, some rural post offices are not even staffed to deliver mail to the institutions. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that six of the 33 institutions stated that they had implemented the recommendation.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that some of the state prisons made inadequate use of correctional officers for mail processing duties.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the prisons use correctional officers, perhaps those who are on "light duty," for the following mail processing purposes: • Helping search mail for contraband. • Segregating legal, certified, and re-routed mail; and searching incoming	NOT APPLICABLE	The California Department of Corrections and Rehabilitation reported that this recommendation is no longer applicable in light of various labor relations issues associated with the issuance of California Code of Regulations, Title 15, Division 3, section 3436. This new regulation, effective January 31, 2005, restricts the placement of employees designated for light duty assignments in vacant positions outside the employee's bargaining unit. Because correctional officer positions are not budgeted within the mailroom, the institution cannot assign a correctional officer to perform a mailroom function.

mail when schedules permit to save time of mailroom employees. • Setting aside items received from inmates requiring special handling. • Re-routing mail for inmates who have moved. • Helping search incoming and outgoing mail.		

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that the institutions were often inefficient in conducting the initial search of incoming mail.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that correctional facilities improve the efficiency of the initial search of incoming mail by taking the actions listed below.		

Require mailroom employees to use automatic letter openers to ensure full use of available equipment and save time.	**SUBSTANTIALLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 32 of the 33 institutions stated that they had implemented the recommendation. California State Prison, Sacramento reported that it did not implement this recommendation.
Develop a list of acceptable publications that employees can immediately place in the housing unit mailbags when publications are reviewed.	**SUBSTANTIALLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 31 of the 33 institutions stated that they had implemented the recommendation. The California Institution for Men and Salinas Valley State Prison reported that they did not implement the recommendation.
Designate a specific staff member to review all publications because of the nature of some of the publications.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all of the 33 institutions stated that they had implemented the recommendation.
Eliminate the practice of verifying all inmate addresses. Mailrooms should verify inmate addresses only when inmate mail is returned for an incorrect address.	**SUBSTANTIALLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that, except for the California Institution for Men, all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by the institutions and found that 32 of the 33 institutions stated they had implemented the recommendation. The California Institution for Men reported that it did not implement the recommendation.

Provide mailrooms with direct access to the Distributed Data Processing System (DDPS) and the Offender Based Information System (OBIS) to verify inmate addresses more quickly.	**SUBSTANTIALLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that some of its institutions were unable to incorporate this recommendation. Institutions with the ability to provide direct Distributed Data Processing System and Offender Based Information System access to mailroom staff have implemented the recommendation. Some, however, cannot directly access the Offender Based Information System because of physical plant differences and telephone line capabilities. In those cases, institutions have been directed to provide mailroom staff access to the Offender Based Information System terminals in alternate locations, unless calling for verification is more expedient. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 32 of the 33 institutions stated they that had implemented the recommendation. Salinas Valley State Prison reported that it has Distributed Data Processing System capabilities but contacts the institution's records department to locate inmates who have left the institution. According to Salinas Valley State Prison, the physical plant prohibits the outlay of fiber optics to facilitate the use of the Offender Based Information System in the mailroom.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following additional actions:

- **Ensure that the California State Prison, Sacramento has implemented the recommendation to use automatic letter openers.**
- **Ensure that the California Institution for Men and Salinas Valley State Prison have implemented the recommendation to develop a list of acceptable publications that employees can immediately place in housing unit mailbags.**
- **Ensure that the California Institution for Men eliminates the practice of verifying all inmate addresses.**

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that the processing of standard mail was often delayed by mail requiring special handling.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the prisons take the actions listed below.		
Set up mailroom procedures to enable employees to process standard mail without interruption.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.
Have employees first sort properly addressed mail from mail with problems, then search and process the "good" mail, and last, locate the correct addresses on misaddressed mail.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.

Handling of mail containing contraband should not delay other mail processing.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.
Provide mailroom employees with tools and materials acceptable for use within the facility. If inmates are allowed to receive staples or stickers, facilities should provide staplers and stickers to the mailroom for re-sealing inmate mail.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that procedures for handling cash found in inmate mail differed at each facility and that the mailroom process for handling checks and money orders was inefficient.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections take the actions listed below.		
Standardize the process for handling cash to conform to the process for handling other contraband. The process should include a special "cash as contraband" form, giving the inmate the option of donating the cash to a predetermined charity or returning it at the inmate's expense.	SUBSTANTIALLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The department also reported that, according to departmental policy, inmates are not permitted to donate cash. Therefore, the cash is returned by check to the sender. Finally, the department reported that it will develop a triplicate form that verifies the receipt of cash as contraband as of March 1, 2006. A copy of the form will be issued to the inmate, accounting, and the sender. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 32 of the 33 institutions stated that they had implemented the recommendation. Salinas Valley State Prison reported that it had not fully implemented the recommendation.
Set up a standard procedure for handling money orders and checks sent to inmates to limit the handling of money orders and checks by mailroom employees while retaining staff accountability.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.

Establish procedures for institution mailrooms in which, upon receiving a check or money order, mailroom employees would ensure that the item includes all required information, including the inmate's name and number. Employees would then add any additional information required, stamp the envelope to verify receipt, and write the date and amount on the envelope for delivery to the inmate. The envelope becomes the inmate's receipt and the check or money order is held for delivery to accounting.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.
Create a standard "funds received" form, in triplicate, for the mailroom staff to use to list all money orders and checks received each day.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation ensure that Salinas Valley State Prison fully implements the recommendation to standardize the process for handling cash to conform to the process for handling other contraband.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that some of the selected institutions had inefficient processes for handling unstamped mail.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the facilities rely on accounting personnel to monitor inmate trust accounts for sufficient funds to pay postage on outgoing mail and provide pre-stamped envelopes to indigent inmates.	SUBSTANTIALLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 32 of the 33 institutions stated that they had implemented the recommendation. The California Correctional Institution reported that it had not fully implemented the recommendation.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation ensure that the California Correctional Institution fully implement the recommendation to rely on accounting personnel to monitor inmate trust accounts for sufficient funds to pay postage on outgoing mail and provide pre-stamped envelopes to indigent inmates.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that the prisons reviewed spent significant amounts of time creating duplicate logs when processing legal mail.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections establish standard procedures for processing legal mail. Facilities should use the "proof of service" form presently used at the California Institution for Men to track outgoing legal mail. Since the inmate fills out the form, the mailroom could simply verify the information and file the mailroom copy for	SUBSTANTIALLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that most of its institutions have incorporated this recommendation. Some institutions, however, have developed a computerized database to track all incoming and outgoing legal mail as opposed to the "proof of service" method cited in the recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 21 of the 33 institutions stated that they had implemented the recommendation

future reference. This would greatly reduce the time spent creating duplicate logs.		through the "proof of service" form. The remaining 12 institutions indicated that they had implemented this recommendation through a computerized database.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that some of the selected institutions did not fully comply with California Code of Regulations, Title 15 requirements.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections and the institutions reviewed take the actions listed below.		
The Department of Corrections should develop a standard checklist for reviewing mail operation plans submitted by the prisons.	NOT IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that this recommendation was fully implemented. The Office of the Inspector General reviewed the individual corrective action plans provided by the institutions and found, however, that the department had not yet provided a standard checklist for reviewing mail operation plans. Further, the Office of the Inspector General contacted the department and verified that, in lieu of developing a standard checklist, the department had compared the contents of each institution's revised operation plan against the

		recommendations listed in the Office of the Inspector General's July 2002 review.
The California Institution for Men should implement procedures to inform new inmates of department regulations and institution-level procedures governing inmate mail.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that this recommendation was fully implemented. The Office of the Inspector General reviewed the California Institution for Men's corrective action plan and found that the California Institution for Men stated that it had implemented the recommendation.
The Department of Corrections should periodically provide all 33 facilities with an updated list of courts and require that each facility keep its lists available for inmate use.	**SUBSTANTIALLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that this recommendation was fully implemented. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 32 of the 33 institutions stated that they had received an updated list of courts. The Substance Abuse Treatment Facility and State Prison, Corcoran indicated that it had not received an updated list of courts.
The California Institution for Women should search all returned inmate mail as required by California Code of Regulations, Title 15.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that this recommendation was fully implemented. The Office of the Inspector General reviewed the California Institution for Women's corrective action plan and found that the California Institution for Women stated that it had implemented the recommendation.

The California Institution for Men's mailroom should process all identified contraband items using the established CDC Form 1819, Notification of Disapproval of Mail-Packages-Publications, and all forms should be provided to the facility captain for review and approval.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that this recommendation was fully implemented. The Office of the Inspector General reviewed the California Institution for Men's corrective action plan and found that the California Institution for Men stated that it had implemented the recommendation.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following additional actions:

- **Develop the standard checklist for reviewing mail operation plans submitted by the prisons.**
- **Provide an updated list of courts to all 33 institutions.**

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General was unable to determine whether the prisons reviewed complied with delivery standards for regular inmate mail.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Department of Corrections either establish the procedures described below for tracking first-class mail or explore other ways to show compliance with established standards.		

Institute a modified tracking system based on mail trays and bins rather than stamping or logging each piece of first-class mail. At the beginning and end of the workday, the mailroom supervisor should enter into a log (preferably an automated spreadsheet) the following information for first class mail: • For regular envelopes and post cards in all mail trays: At the beginning of each workday, record the time and date of entry and supervisor's name; date the mail was received; and number of inches of mail in each dated tray (normal trays contain approximately 850 letters when full). At the end of each workday, record the time and date of entry and supervisor's name; the date the mail in the tray was received; and the number of inches of mail in each dated tray. • For large envelopes in mail bins: Use the same process, except that, because of their irregular size, envelopes should be counted rather than measured.	**SUBSTANTIALLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that 31 of the 33 institutions stated that they had implemented the recommendation. The California Medical Facility and the Correctional Training Facility reported that they did not fully implement the recommendation.

Require the correctional officer responsible for mailroom operations to review the daily logs at least three times a week to ensure that they are promptly and accurately prepared and to determine whether extraordinary circumstances may have affected mail processing and to annotate evidence of the review.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation ensure that the California Medical Facility and the Correctional Training Facility fully implement the recommendation to institute a modified tracking system based on mail trays and bins rather than stamping or logging each piece of first-class mail.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found no first-class mail designated for disposal at the prisons reviewed.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that correctional facilities limit how mailroom employees are allowed to dispose of mail. Mailroom supervisors should periodically review the type of mail being discarded to prevent mail from being inappropriately thrown away.	FULLY IMPLEMENTED	The California Department of Corrections and Rehabilitation reported that all of its institutions have incorporated this recommendation. The Office of the Inspector General reviewed the individual corrective action plans provided by each of the department's institutions and found that all 33 institutions stated that they had implemented the recommendation.

The Office of the Inspector General recommended that the California Institution for Women discard fourth-class and undeliverable mail instead of returning it to the post office, using appropriate controls for disposal.	**FULLY IMPLEMENTED**	The California Department of Corrections and Rehabilitation reported that this recommendation was fully implemented. The Office of the Inspector General reviewed the California Institution for Women's corrective action plan and found that the California Institution for Women stated that it had implemented the recommendation.

FOLLOW-UP RECOMMENDATIONS

None.

PRISON INDUSTRY AUTHORITY OPTICAL PROGRAM AT THE RICHARD J. DONOVAN CORRECTIONAL FACILITY

IMPLEMENTATION REPORT CARD

Previous recommendations: 2

Fully implemented: 2 (100 %)

Substantially implemented: 0 (0%)

Partially implemented: 0 (0%)

Not implemented: 0 (0%)

Not applicable: 0 (0%)

The Office of the Inspector General found that the optical program laboratory at the Richard J. Donovan Correctional Facility resumed operations during August 2000. The Prison Industry Authority also implemented a process to confirm that inmates applying for jobs in the optical laboratory meet the eligibility requirements set forth in Penal Code section 5071.

The Office of the Inspector General's May 2000 audit of the Prison Industry Authority optical program at the Richard J. Donovan Correctional Facility was conducted in response to a request from the Secretary of the Youth and Adult Correctional Agency, now known as the California Department of Corrections and Rehabilitation. In May 1999, the California Department of Corrections closed the optical laboratory operation at the Richard J. Donovan Correctional Facility because inmate workers had gained access to the personal information of Medi-Cal beneficiaries. The department also closed the remaining optical laboratories until corrective action was taken to eliminate future problems. The department authorized the re-opening of each optical laboratory, except the Richard J. Donovan optical laboratory, soon after the Prison Industry Authority developed new policies and procedures to prevent inmate access to sensitive information. The Office of the Inspector General evaluated the corrective action taken by the Prison Industry Authority in its optical program to determine whether the new policies and procedures could prevent inmate access to sensitive information and whether the optical laboratory at the Richard J. Donovan Correctional Facility should be re-opened. Because the Richard J. Donovan optical laboratory operation was closed, the Office of the Inspector General evaluated the implementation of the new policies and procedures of the optical laboratory at the California State Prison, Solano. The Office of the Inspector General found that the new policies and procedures could effectively prevent inmate access to Medi-Cal beneficiary information in all areas of the optical program and recommended that the optical laboratory at the Richard J. Donovan Correctional Facility resume full operation.

BACKGROUND

The Prison Industry Authority is a semi-autonomous, fiscally self-supporting entity within the California Department of Corrections and Rehabilitation, whose mission is to use inmate labor to operate California's prison industries in a manner similar to that of private industry. The Prison Industry Authority was established to develop and operate manufacturing, agricultural, and service enterprises that provide work opportunities for inmates under the jurisdiction of the California Department of Corrections and Rehabilitation. Prison Industry Authority work assignments support prison safety, help reduce violence, reimburse victims, provide career training, and offer productive activity for inmates. The Prison Industry Authority operates over 60 programs at 22 correctional facilities statewide and employs approximately 6,000 inmates in various industries such

as license plate production, eyewear production, office furniture manufacturing, and food and printing services.

Through an interagency agreement, the Department of Health Services has contracted with the Prison Industry Authority since 1988 to furnish and fabricate optical eyewear for the California Medical Assistance Program (Medi-Cal). The term of the current interagency agreement is July 1, 2003 through June 30, 2006, with expenditures not to exceed $61,200,000.

Statewide, the Prison Industry Authority optical program has invested over $10 million in buildings and state-of-the-art optical equipment in its four optical laboratory facilities at the Richard J. Donovan Correctional Facility, Pelican Bay State Prison, Valley State Prison for Women, and the California State Prison, Solano. In total, the Prison Industry Authority optical program employs 391 inmates, including 110 inmates at the Richard J. Donovan Correctional Facility. The laboratories fill approximately 860,000 prescriptions annually and ship them to about 2,400 providers. Finally, the Prison Industry Authority services about 754,602 Medi-Cal beneficiaries in all of California's 58 counties through such providers as optometrists and opticians.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the May 2000 review, the Office of the Inspector General made the following specific findings:

- Prison Industry Authority-prescribed internal controls are in place at the California State Prison, Solano.
- Stronger controls are needed for the Richard J. Donovan optical program.
- Inmates working in the optical laboratory program must be properly screened.

As a result of the May 2000 review, the Office of the Inspector General made the following recommendations to the Prison Industry Authority management team:

- The California Department of Corrections should re-open the optical program laboratory at the Richard J. Donovan Correctional Facility.
- Prison Industry Authority management at all California Department of Corrections institutions should continuously screen all inmates applying for job assignments in the optical laboratories. The screening process should confirm that inmates meet the eligibility requirements set forth in Penal Code section 5071.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Prison Industry Authority has implemented the two recommendations from the Office of the Inspector General's May 2000 audit of the optical program at the Richard J. Donovan Correctional Facility. To conduct the follow-up review, the Office of the Inspector General provided the Prison Industry Authority with a table listing the May 2000 findings and recommendations and asked the Prison Industry Authority to provide the

implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with documentation provided by the Prison Industry Authority, and evaluated the degree of compliance or noncompliance with the recommendations. Fieldwork was completed during January 2006. The results are summarized in the table following this narrative.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Both of the recommendations issued by the Office of the Inspector General in May 2000 have been fully implemented. The Office of the Inspector General found that the optical laboratory program at the Richard J. Donovan Correctional Facility re-opened during August 2000. Furthermore, the Prison Industry Authority verifies that inmates assigned to work in the optical laboratories are in compliance with Penal Code section 5071. The California Department of Heath Services audits each optical laboratory annually for compliance. According to the Prison Industry Authority, the aforementioned measures have been successful because the Department of Health Services has verified that procedures are now in place to ensure that confidential information does not enter the optical laboratory.

FOLLOW-UP RECOMMENDATIONS

None.

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ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that Prison Industry Authority-prescribed internal controls and procedures were in place at California State Prison, Solano.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that stronger controls were needed for the Richard J. Donovan optical program.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that inmates working in the optical laboratory program must be properly screened.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections re-open the optical program laboratory at the Richard J. Donovan Correctional Facility.	FULLY IMPLEMENTED	The Prison Industry Authority reported that the optical program laboratory at the Richard J. Donovan Correctional Facility resumed full operation during August 2000.
The Office of the Inspector General recommended that Prison Industry Authority management at all California Department of Corrections institutions continuously screen all inmates applying for job assignments in the optical laboratories. The process should confirm that inmates meet the eligibility requirements set forth in Penal Code section 5071.	FULLY IMPLEMENTED	The Prison Industry Authority reported that it verifies inmates assigned to the optical laboratory program are in compliance with Penal Code section 5071. Further, the interagency agreement between the Prison Industry Authority and the Department of Health Services for the period July 1, 2003 through June 30, 2006 stipulates that the optical laboratories must have a copy of each inmate's Classification Chrono (CDC Form 128G) available for Department of Health Services and other authorized agency inspection. The Department of Health Services performs annual compliance audits of all optical laboratory programs. A Prison Industry Authority Optical Specialist reviews inmate files on an annual basis to validate assignments to the Prison Industry

		Authority program. Finally, the Prison Industry Authority reported that the aforementioned measures have proven to be successful because the Department of Health Services has verified that procedures are now in place to ensure that confidential information does not enter the optical laboratory. The Office of the Inspector General reviewed the current Interagency Agreement between the Prison Industry Authority and the Department of Health Services and verified that the agreement requires optical laboratories to keep a copy of an inmate's Classification Chrono on file and available for inspection. In addition, the agreement also stipulates that the Prison Industry Authority shall not assign any inmate who has been convicted of an offense involving forgery or fraud, misuse of a computer, or the misuse of another person's personal or financial information. The agreement also prohibits the hiring of any inmate who is required to register as a sex offender pursuant to Penal Code section 290.

FOLLOW-UP RECOMMENDATIONS

None.

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KONOCTI CONSERVATION CAMP NUMBER 27

IMPLEMENTATION REPORT CARD

Previous recommendations: 8

Fully implemented: 5 (63%)

Substantially implemented: 0 (0%)

Partially implemented: 2 (25%)

Not implemented: 0 (0%)

Not applicable: 1 (12%)

The Office of the Inspector General found that the Department of Corrections and Rehabilitation has clarified rules and procedures governing the use of inmate labor for conservation camp work projects; has improved accountability over reimbursements for work projects; and has instituted limits on reimbursement amounts.

In April 2001, the Office of the Inspector General conducted a special review into allegations of misappropriation of state funds and inappropriate use of inmates on work projects and in the vocational auto body program at the Konocti Conservation Camp, which was operated by the former Department of Corrections. As a result of that review, the Office of the Inspector General found that some of the work projects conducted by the Konocti Conservation Camp violated state laws, regulations, and department policy and that the camp had received inappropriate reimbursements for those projects. The review also determined that the management of the Konocti Conservation Camp circumvented fiscal controls, failed to maintain proper accounting for reimbursements obtained through inmate labor, and failed to observe requirements governing the vocational auto body program.

BACKGROUND

The California Department of Corrections and Rehabilitation jointly operates 31 fire-fighting conservation camps with the California Department of Forestry and Fire Protection. Sixteen of the camps, including Konocti, are under the direct supervision of the California Correctional Center in Susanville, which receives, houses, and trains minimum-custody inmates for placement into one of the Northern California conservation camps.

The California Department of Forestry and Fire Protection is responsible for using inmate work crews for fire-fighting and conservation projects, while the Department of Corrections and Rehabilitation is responsible for providing inmates for the projects. To perform their respective functions, the two departments enter into interagency agreements, under which each department agrees to be responsible for ensuring that camp operations are conducted in accordance with applicable state and federal laws, state regulations, and department policies. *Camp Operations Handbook 6400* defines each department's specific duties under the agreements.

California Penal Code section 270l provides that state prison inmates may be employed in the rendering of services for public use. Section 6522 of *Camp Operations Handbook 6400* specifies that conservation work projects "must be sponsored by a government agency and must be of a nature that would not normally be performed by private industry or citizen labor." Section 6522 of *Camp Operations Handbook 6400* provides that camps

may not charge for inmate labor or base pay, but may recover standard reimbursements such as the cost of fuel and equipment incurred as a result of participation in conservation projects.

SUMMARY OF PREVIOUS FINDINGS AND RECOMMENDATIONS

As a result of the April 2001 special review, the Office of the Inspector General found that the Department of Forestry and Fire Protection had inappropriately used inmate work crews on work projects undertaken for private sponsors under a scheme that circumvented the state prohibition against charging for inmate labor on conservation projects. Under the arrangement, Konocti Conservation Camp Number 27 inappropriately received reimbursements unrelated to standard reimbursements for fuel, mileage, and equipment.

The Office of the Inspector General made the following specific findings as a result of the April 2001 review:

- Konocti Conservation Camp engaged in work projects involving inmate labor to perform work that would normally be performed by private industry or citizen labor, thereby violating state law and department policy.

- Konocti Conservation Camp collected reimbursements in excess of actual costs for projects performed with inmate labor, used the excess reimbursements to augment its budget, and failed to properly account for the reimbursements.

- Konocti Conservation Camp failed to observe requirements for the vocational auto body program by allowing inmates to perform work outside the scope of the approved curriculum and exceeding the 60-day limitation on projects.

- Konocti Conservation Camp failed to maintain proper supervision over camp operations. Site visits by supervisors were infrequent, and training and monitoring were inadequate.

As a result of the review, the Office of the Inspector General made the following recommendations to the Department of Corrections and the Department of Forestry and Fire Protection:

- Discontinue the practice of providing inmate labor to non-governmental entities and using inmates for work normally provided by private industry or citizen labor.

- Develop guidelines for allowable standard reimbursements for projects involving inmate labor and ensure proper accountability for those reimbursements.

- Assess the advisability of continuing the vocational auto body program in camp settings.

- Improve supervision over the Konocti Conservation Camp to ensure compliance with applicable laws and regulations.

- Develop a training plan to assess training needs and deliver needed training to camp commanders and employees.

- Develop a plan to provide for regular review or audit of the state's fire-fighting conservation camps on a cyclical basis.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2006 follow-up review was to determine the extent to which the Konocti Conservation Camp has implemented the recommendations from the Office of the Inspector General's April 2001 special review. To conduct the follow-up review, the Office of the Inspector General provided the management of Konocti Conservation Camp with a table listing the April 2001 findings and recommendations and asked management to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the responses, along with supplementary documentation provided, and evaluated the degree of compliance or noncompliance with the recommendations. The fieldwork for the follow-up review was completing during September 2004. The results are presented in the table following this narrative and reflect the department's responses as of September 2004.

SUMMARY OF THE 2006 FOLLOW-UP RESULTS

Of the eight recommendations issued by the Office of the Inspector General in the April 2001 special review of the Konocti Conservation Camp, five recommendations have been fully implemented, two have been partially implemented, and one is no longer applicable.

The follow-up review determined that *Camp Operations Handbook 6400* was revised in November 2002 and that the revisions address the problems identified in the review. Section 6522.5 of the handbook now provides that conservation camp work projects must have a clear and direct public benefit. Similarly, section 6531.1.4 of the handbook now limits reimbursement amounts and specifies that reimbursements must be directly related to project operation or crew availability. Training of supervisors at the Konocti Conservation Camp has improved management's awareness of regulations and statutes governing the use of inmate workers on private land; reimbursement limitations on inmate labor; and accountability for reimbursements. Deficiencies related to the vocational auto body program at the camp are no longer applicable because the program has been eliminated.

FOLLOW-UP RECOMMENDATIONS

None.

The following table summarizes the results of the follow-up review.

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found substantial and credible evidence that some of the Konocti Conservation Camp work projects violated applicable state law, state regulations, and departmental policies.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Forestry and Fire Protection discontinue the practice of providing inmate labor to non-governmental entities and using inmates for work normally performed by private industry or citizen labor.	FULLY IMPLEMENTED	In response to this recommendation, the Department of Corrections and Rehabilitation reported that *Camp Operations Handbook 6400* section 6522.1 requires conservation camp commanders to review all inmate work projects as part of the joint California Department of Forestry and Fire Prevention/Department of Corrections and Rehabilitation approval process. The department said that the requirement provides checks and balances to ensure that inmate work projects are consistent with applicable state law. The department also reported that in addition to approval by the camp commander, the management of the California Correctional Center must now approve projects that include work on private land before the work begins. The Office of the Inspector General notes, however, that section 6522.1 of *Camp Operations Handbook 6400* was in effect in its present form at the time of the April 2001 administrative review and did not prevent the deficiencies identified in the review. The California Department of Forestry and Fire Prevention reported that it has clarified policy with respect to using inmate labor on private property. Section 6522.5 of *Camp Operations Handbook 6400,* which was revised in November 2002, now states that crews will work on private property only when the project will have a clear and direct public benefit. Section 6522 of the handbook, which was in effect at the time of the 2001 review, further provides that conservation camp projects must be "of a nature that would not normally be performed by private industry or citizen labor."

		The Office of the Inspector General reviewed the revisions to *Camp Operations Handbook 6400* and confirmed that the management of the Department of Corrections and Rehabilitation and the Department of Forestry and Fire Prevention are aware of the new provisions. The Office of the Inspector General also confirmed that management of the California Correctional Center now must approve projects that include work on private land.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found substantial and credible evidence that the Konocti Conservation Camp improperly charged for inmate labor by collecting reimbursements beyond out-of-pocket costs and used the reimbursements to augment its budget. This practice appears to have afforded preferential treatment to a non-governmental entity to the possible detriment of legitimate fire protection and conservation efforts.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Forestry and Fire Protection and the California Department of Corrections jointly develop guidelines for allowable standard reimbursements on projects involving the use of inmate labor. Guidelines should also be developed to ensure proper accountability over the standard reimbursements.	FULLY IMPLEMENTED	The Department of Corrections and Rehabilitation reported that the California Correctional Center has established standards and methods for seeking reimbursement for work projects involving inmate labor. The standards are applicable to projects involving the department as either the lead agency or as the agency with reimbursement authority under the terms of a project agreement. Neither the California Correctional Center nor department staff assigned to the California Correctional Center is involved in the reimbursement process when the Department of Forestry and Fire Prevention is the lead agency. According to the associate warden of the California Correctional Center's Camp Division, the California Correctional Center and Northern California conservation camps follow applicable state and department rules when seeking reimbursement from other governmental agencies for inmate work projects. Applicable state rules are provided in sections 6463 and 8752 of the *State*

		Administrative Manual. The associate warden informed the Office of the Inspector General that the management of the Department of Corrections and Rehabilitation is aware of the limitations on reimbursement for inmate labor services.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found substantial and credible evidence that the Konocti Conservation Camp circumvented state controls and failed to maintain proper accounting for the reimbursement of items obtained through inmate labor.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Forestry and Fire Protection and the California Department of Corrections jointly develop guidelines for allowable standard reimbursements on projects involving the use of inmate labor. Guidelines should also be developed to ensure proper accountability over the standard reimbursements.	FULLY IMPLEMENTED	[For the response of the Department of Corrections and Rehabilitation and the California Correctional Center to this recommendation, see Finding 2, above.] The California Department of Forestry and Fire Prevention reported that its policy was revised in November 2002 to identify an acceptable reimbursement for conservation camps. The policy, delineated in section 6531.1.4 of the *Camp Operations Handbook 6400,* limits the amount of any reimbursement, requires that reimbursement items be directly related to the project in question, and requires that all reimbursements be strictly accounted for. The Office of the Inspector General confirmed that the recent revision of the handbook addresses the recommendation and that managers of the Department of Corrections and Rehabilitation and of the Department of Forestry and Fire Prevention are aware of its provisions.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found substantial and credible evidence that the Konocti Conservation Camp staff failed to observe the requirements of the vocational auto body program. Moreover, some of the work performed appears to have violated the intended purpose and scope of the program.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections assess the advisability of continuing the vocational auto body program in camp settings.	FULLY IMPLEMENTED	According to the Department of Corrections and Rehabilitation, all vocational programs in Northern California conservation camps were discontinued in 2001.
In the event the program continues, the Office of the Inspector General recommended that the department impose controls and reporting requirements to ensure that the program complies with legal mandates, policies, and procedures.	NOT APPLICABLE	According to the Department of Corrections and Rehabilitation, all vocational programs in Northern California conservation camps were discontinued in 2001.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found substantial and credible evidence that the California Department of Corrections and the California Correctional Center had failed to maintain proper supervision of Konocti Conservation Camp operations:

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Department of Corrections develop a training plan to assess training needs and provide such training to camp commanders and employees.	FULLY IMPLEMENTED	According to the Department of Corrections and Rehabilitation, a comprehensive training plan, the *Camp Commander Orientation and Training Guidelines Manual,* was developed in 2001 to provide conservation camp-specific orientation and training to camp commanders. At the time of the manual's completion, all camp commanders were given training, with the training manual as a guide. All new camp commanders receive the same training before reporting to their camp. Refresher training is provided periodically. The Office of the Inspector General confirmed the existence of the training manual.
In addition, the Office of the Inspector General recommended that the Department of Corrections and the California Correctional Center improve supervision over the Konocti Conservation Camp to ensure compliance with state laws and regulations.	PARTIALLY IMPLEMENTED	According to the Department of Corrections and Rehabilitation, a joint management audit tool for the Department of Corrections and Rehabilitation and the Department of Forestry and Fire Prevention was developed in the 1980s and was revised in 1999 to ensure that both agencies would comply with applicable laws, policies, procedures, and regulations. Joint department management audits are conducted cyclically and each conservation camp is audited at least once every two years. As a result of the management audits, the *Camp Commander Orientation and Training Guidelines Manual* was developed to assist camp management. The California Conservation Center camp management staff also performs periodic inspections of camps and related projects. The Office of the Inspector General examined a January 2004 audit conducted by the Department of Corrections and Rehabilitation and the Department of Forestry and Fire Prevention management teams and found that the intent of the recommendation has been met. Yet, the guidelines, manuals, and audit process described here existed before the April 2001 administrative review and did not provide the administrative controls needed to prevent abuse of state assets or improper use of work crews identified in that review.
As part of that improved supervision, the Office of the Inspector General recommended that the California Department of Corrections develop a plan to provide for regular review or	PARTIALLY IMPLEMENTED	The Department of Corrections and Rehabilitation reported that each camp receives periodic inspections by the California Correctional Center's Camp Division facility captain, warden, and associate warden in addition to scheduled management audits.

audit of the state's fire-fighting conservation camps on a cyclical basis.		The Office of the Inspector General confirmed that section 6440.6 of *Camp Operations Handbook 6400* requires camps to be inspected at least biannually, but noted that the requirement also was in place at the time of the April 2001 administrative review.

FOLLOW-UP RECOMMENDATIONS

None.

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ATTACHMENT

RESPONSE FROM THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

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State of California

Department of Corrections and Rehabilitation

Memorandum

Date : April 12, 2006

To : Matthew L. Cate
Inspector General

Subject: **RESPONSE TO THE OFFICE OF THE INSPECTOR GENERAL'S ACCOUNTABILITY AUDIT OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION'S ADULT OPERATIONS AND ADULT PROGRAMS**

This memorandum is prepared as the California Department of Corrections and Rehabilitation's (CDCR) response to the complete draft of the Office of the Inspector General's (OIG) 2006 Accountability Audit of CDCR's Adult Operations and Adult Programs. Of the twenty-two audits and reviews represented by this undertaking, all twenty-two relative CDCR program areas provided status updates. This unprecedented response from the largest state department is evidence of CDCR's dedication to improvement.

It is gratifying to acknowledge that staff and management of individual institutions are highly responsive to recommendations previously presented by the OIG and we appreciate the acknowledgement of their efforts. Although department administrators have been slow to implement some of the OIG's recommendations, CDCR, as a whole, has either fully or substantially implemented 75 percent of the 394 recommendations previously provided by the OIG. In the face of CDCR's tremendous reorganization effort currently underway, this is a substantial percentage and an astounding accomplishment by a department in transition.

We agree CDCR still has areas where significant improvement is necessary. The areas most deficient, and most complex and critical, are information technology, medical care, and successful pre-release preparation for paroling inmates. Restructuring CDCR will establish clear lines of reporting, accountability, responsibility and performance assessment that will ultimately improve services.

- CDCR's Information Technology Strategic plan includes compelling initiatives which mirror the new department's operating model, including timely access to relevant, reliable offender information, coordination of business processes, information sharing, and the technology to better meet the day-to-day activities of offender management and control. Efforts are underway to create an ongoing department wide technology infrastructure (cabling, server rooms, telecommunications, HVAC, electrical, etc.) investment program to provide information technology connectivity to any worksite within CDCR settings. The initial Feasibility Study Report and associated budget documents will be submitted to the Department of Finance in the Fall Budget process.

- The CDCR is working to assist The Federal Receiver appointed by the U.S. District Court to stabilize the health care system and create a sustainable system that meets constitutional standards. This fundamental reform will affect a variety of areas, including management structure, information technology and health care services. CDCR staff and management recognize the gravity of the health care problem and are committed to facilitating the Receivership. CDCR is confident that upon return of control to the State, CDCR's health care system will be able to function effectively and in compliance with basic constitutional standards.

- CDCR's Right Prison, Right Mission (RPRM) realignment will assist us in managing the unprecedented inmate population pressures and allow a clearer focus on reducing recidivism. The RPRM strategy of housing the inmate population in the most appropriate manner will have a dramatic impact and allow CDCR to effectively manage this population and focus on successful completion of specific missions with a degree of flexibility which CDCR lacks at this time.

- CDCR's Office of Audits and Compliance has undergone an internal reorganization and is in the process of developing new audit protocols, instruments, and methodologies, expanding the current approach to auditing. Program audits are conducted on a cyclic basis, with special reviews requested by executive management. In addition, the development of a Risk Assessment methodology will allow CDCR to conduct proactive rather than reactive audits and will assist in the identification of systematic problems.

It is important to recognize programmatic pressures caused by the inordinate increase in the inmate population, the lack of facility space for medical, programming, and other purposes, as well as wide-ranging infrastructure deficiencies and the thinning of staff resources. It is equally important to recognize that achieving sustainable solutions will require CDCR, state policymakers, and the public to collectively explore and address available options.

We would like to thank the OIG for its continued professionalism and guidance in CDCR's efforts to improve its operations. CDCR's commitment to Health Care, Information Technology, and Programs for Rehabilitation is evident and while transformation is painstaking, significant improvements are being made. Should you have any questions or concerns, please feel free to call this office at (916) 323-6001.

JOE MCGRATH
Chief Deputy Secretary
Adult Operations