OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

SPECIAL REVIEW OF HIGH-RISK ISSUES AT THE HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

FEBRUARY 2007

STATE OF CALIFORNIA

Matthew L. Cate, Inspector General

Office of the Inspector General

February 26, 2007

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

Dear Secretary Tilton:

Enclosed is the public version of the Office of the Inspector General's *Special Review of High Risk Issues at Heman G. Stark Youth Correctional Facility* in Chino.

The special review determined that the Heman G. Stark Youth Correctional Facility has not made substantive progress in improving unsafe or unsatisfactory living conditions for wards in its special management program despite being alerted to those conditions in previous audits by the Office of the Inspector General.

Such conditions included various forms of contraband and inadequate levels of education and counseling services to wards who are confined to their rooms for all but two hours per day. The special review also found that the facility's transitional program, intended to help wards transition from its special management program, is essentially an extension of the special management program without formal policies that provide the critical protections for such a restricted program.

The Office of the Inspector General also found that ineffective or inadequate punishment hampers the facility's ability to hold wards accountable for sexual misconduct directed toward staff members.

The Department of Corrections and Rehabilitation's written response to this special review appears as an attachment to the report.

Thank you for the courtesy and cooperation extended to my staff during the special review.

Sincerely,

MATTHEW L. CATE
Inspector General

Enclosure

cc: Bernard Warner, Chief Deputy Secretary, CDCR, Division of Juvenile Justice
Kingston Prunty, Undersecretary, CDCR
Sandra Youngen, Director, Division of Juvenile Facilities, CDCR
Ramon Martinez, Superintendent (Acting), H.G. Stark Youth Correctional Facility
Kim Holt, External Audits Coordinator, Office of Audits and Compliance, CDCR

CONTENTS

EXECUTIVE SUMMARY

This report presents the results of a special review conducted by the Office of the Inspector General at the Heman G. Stark Youth Correctional Facility. Because past reviews conducted by the Office of the Inspector General at the facility identified instances of unsafe or unsatisfactory living conditions for wards assigned to restricted programs, the special review examined the living conditions for wards assigned to those programs. The Office of the Inspector General expanded its review based on issues it identified as it conducted fieldwork. The review was conducted pursuant to the Office of the Inspector General's responsibility under California Penal Code section 6126 for oversight of the California Department of Corrections and Rehabilitation and its subordinate entities, including the Division of Juvenile Justice.

The Office of the Inspector General found that the failure of the division and the facility's management to ensure staff perform room inspections and adhere to existing related policies allows wards to maintain contraband in its highly restricted *special management program* in the form of window coverings, makeshift ropes, and other items. In three separate visits made to the facility throughout 2006, the Office of the Inspector General found contraband in over half of the rooms that it inspected in the facility's special management program. The contraband that the Office of the Inspector General found included fabric items used by the wards as curtains to cover their room doors and windows. The danger presented to both wards and staff in permitting wards to cover their windows was tragically illustrated in the Office of the Inspector General's December 2005 report on a ward suicide at N.A. Chaderjian Youth Correctional Facility. In that case, a ward on lockdown status had covered his window and was unresponsive to staff. Staff delayed entering the ward's room, in part because of safety concerns associated with unlocking a room with a blocked window. When staff finally entered the ward's room, they discovered the ward hanging from the upper bunk of his single occupancy room with a bed sheet tightly fastened around his neck. He had covered the windows of his room to keep staff from observing his actions. Based on its findings during its three visits in 2006, however, the Office of the Inspector General does not believe that staff at the Heman G. Stark Youth Correctional Facility have heeded the lessons to be learned from this tragic event.

The Office of the Inspector General additionally found that delivery of mandated services to wards on restricted programs was deficient. For example on six dates selected for examination in 2006, only seven wards (2 percent) of 323 restricted program wards reviewed received at least three hours out of their rooms, and the facility's official mandated services log showed evidence of only two of those wards, fewer than 1 percent, receiving educational instruction of any kind on those dates.

The presence of contraband such as window coverings, combined with wards' isolation to their rooms and the facility's inadequate delivery of mandated services such as education and counseling, presents an environment conducive to suicide attempts and may contribute to wards' propensity to commit assaults against staff members.

The Office of the Inspector General also found that Heman G. Stark Youth Correctional Facility operates a program intended to help violence-prone wards transition from its special management program to less-restrictive programs, but it does not provide to these wards the necessary protections designed to facilitate their rehabilitation. Although the facility has designated the transitional program as part of its general population, it operates part of the program in many respects like a special

management program. For example, approximately half of the wards in the transitional program reviewed are given limited time out of their rooms for recreation—typically two hours daily—and are generally not permitted to leave the building in which they are housed, in contrast to wards in a traditional general population unit who may be allowed to leave their rooms to participate in work assignments, eat meals, and attend school.

Nonetheless, the facility does not provide the wards assigned to this half of the program the critical protections that are built into the special management program. For example, unlike a special management program, which limits the duration of a ward's stay to 90 days absent special approval, the transitional program has no limit. Indeed, the Office of the Inspector General found that as of December 5, 2006, the 47 wards in the transitional program's *X company* had been in the program an average of 153 days. Of those wards, seven had cumulative stays exceeding approximately ten months (300 days) and another eight wards had cumulative stays exceeding over six months (200 days). Furthermore, the transitional program does not ensure that staff work with these wards to develop a plan to transition to a less-restrictive environment. The Office of the Inspector General also found that the facility is not providing adequate education services to these wards. Because this program does not have the same stringent monitoring standards to which special management programs are subjected, staff cannot objectively evaluate wards' readiness for transition and wards may be kept indefinitely in the program without adequate resources to prepare them for a less-restrictive general population environment.

Furthermore, the Office of the Inspector General found that the facility's ability to hold wards accountable for sexual misconduct is hampered by its use of ineffective or inadequate sanctions, and by its failure to consistently submit for prosecution instances of ward sexual misconduct. Consequently, wards have little concern about being held accountable and commensurately little incentive to curtail their negative behavior. Staff members at the facility told the Office of the Inspector General that some wards who direct repeated acts of indecent exposure toward them are not held accountable for their behavior. According to these staff members, morale has suffered as a result among some female staff who feel victimized, yet powerless to prevent the behavior because the sanctions given to these wards by the administration are ineffective.

In addition to the negative effects on staff morale, the Office of the Inspector General found that Heman G. Stark Youth Correctional Facility's failure to curtail repeated misconduct by its wards can also endanger public safety. For example, one ward, who was committed for performing lewd and lascivious acts, and who had directed at least eight acts of indecent exposure at staff while at the facility, received only punishments such as "loss of canteen" and "loss of late nights." Despite these actions while at the facility, the ward was released from custody in September 2006 when his confinement term ended, without being subject to additional criminal sanctions or further parole supervision.

The Office of the Inspector General also found that a critical mental health screening process designed to flag certain indicators of potential mental health problems including thought disorder, suicide risk, depression, and anxiety is not being consistently performed for wards coming into the facility's parole violator program. As a result, wards in this program are potentially being placed at risk for suicide while their assignments to specialized treatment programs or other mental health services are being unnecessarily delayed.

Finally, the Office of the Inspector General made findings concerning security issues that are not being made public, pursuant to Penal Code section 6126.4.

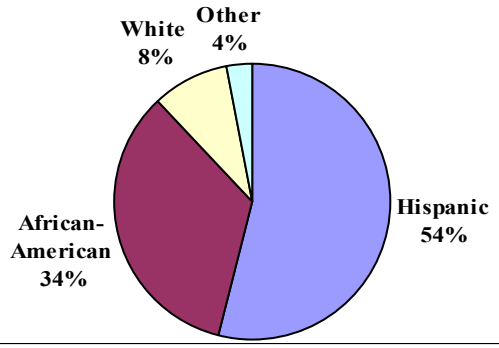
The Office of the Inspector General has made 20 recommendations as a result of this special review.

INTRODUCTION

In February 2006, the Office of the Inspector General initiated a special review of the Heman G. Stark Youth Correctional Facility to evaluate living conditions for wards in its restricted programs, including the special management program and temporary detention. Past audits conducted by the Office of the Inspector General at the facility identified instances of unsafe and unsatisfactory living conditions for wards assigned to restricted programs. The Office of the Inspector General visited the facility on three occasions during 2006 for this review. The facility experienced a management change during the period of the review when in November 2006, a new superintendent assumed management duties. The review was conducted pursuant to the Office of the Inspector General's responsibility under California Penal Code Section 6126 for oversight of the department and its subordinate entities, including the Division of Juvenile Justice (division).

BACKGROUND

CHART 1
COMPOSITION OF WARD POPULATION BY ETHNICITY AT HEMAN G. STARK YOUTH CORRECTIONAL FACILITY
(AS OF 12/21/06)



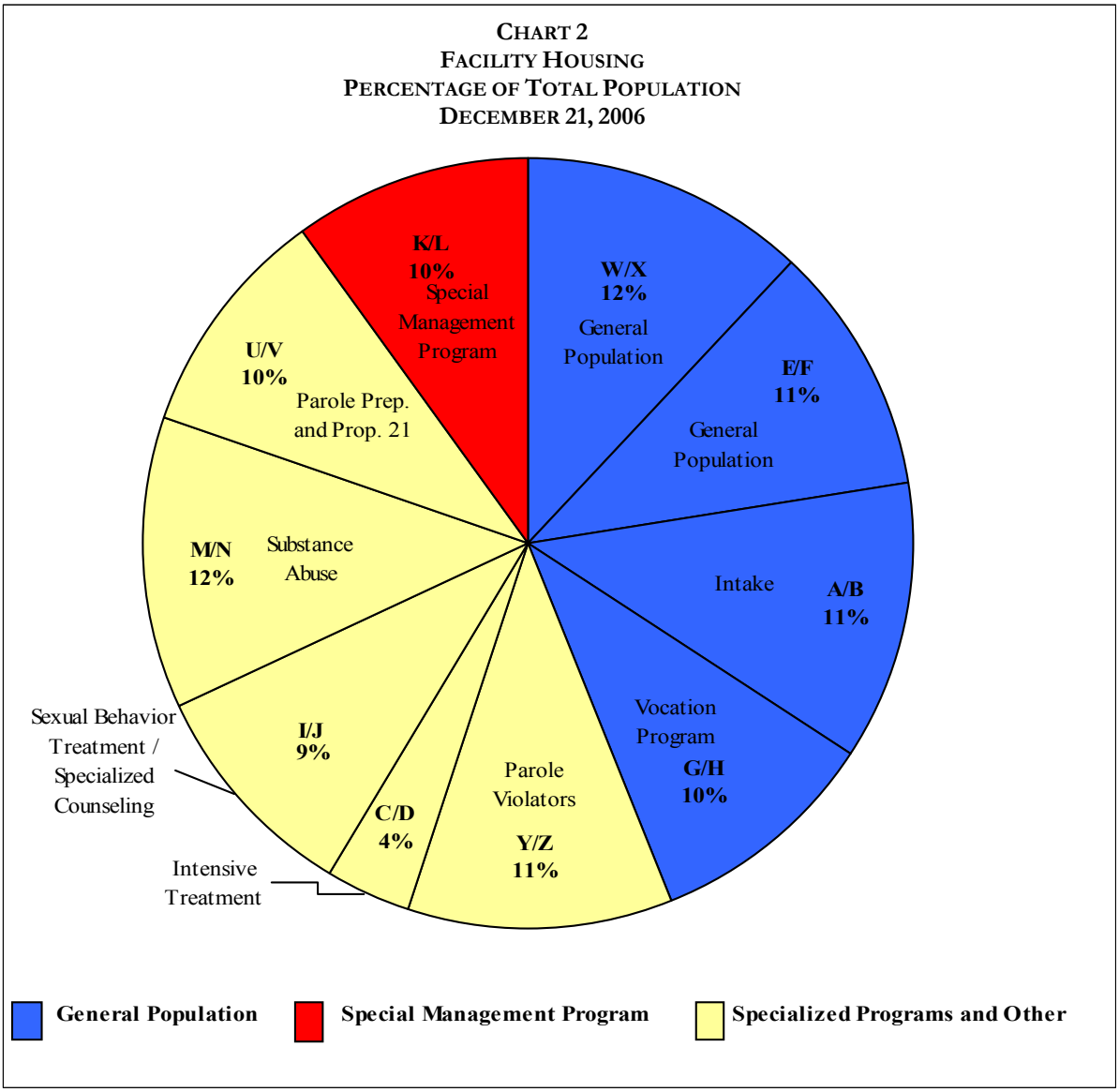
Heman G. Stark Youth Correctional Facility (the facility) is located in Chino and serves a ward population consisting generally of older and more serious offenders than that found at most other division facilities. For example, as of December 21, 2006, the facility housed 88 wards who had already served time in adult prisons and had been sent to the facility to finish division confinement terms. The facility also is responsible for 36 "dual commitment" wards undergoing court processing or serving adult prison sentences. The division typically releases wards by age 25 unless a ward's sentence is extended under the provisions of section 1800 of the Welfare and Institutions Code by the court that originally committed the ward to the division. Welfare and Institutions Code section 1800 allows extension of a ward's confinement time if he is considered a danger to the public because of "the ward's mental or physical deficiency, disorder, or abnormality which causes the person to have serious difficulty controlling his or her dangerous behavior." The facility housed three such wards who were over the age of 25 at the time of the Office of the Inspector General's special review. In addition, the facility provides custody, treatment, and educational services for approximately 15 wards who are Proposition 21 cases — minors whose crimes are so serious that they were tried as adults and sentenced to state prison. These juvenile offenders are transferred to the division until they reach age 18, or age 21 if their terms of imprisonment expire by their 21st birthday.

The facility's budget for fiscal year 2006–2007 is approximately $78.6 million, which includes the estimated annual salary expense for 872 personnel. Heman G. Stark Youth Correctional Facility is the division's largest facility with a population of 779 wards on December 21, 2006. The next largest facility, Preston Youth Correctional Facility in Ione, had a population of 392 on the same date. As of December 21, 2006, the majority of the ward population at Heman G. Stark Youth Correctional Facility was Hispanic. (See Chart 1.) The average ward age was 20.5 years and the average length of a

ward's stay at the facility is approximately 19 months. However, this average includes parole detainees with short confinement terms.

The facility houses its wards in *programs*, with each program composed of two *companies* identified by letters of the alphabet. Each program's composition and mission is shown in Chart 2.

CHART 2
FACILITY HOUSING
PERCENTAGE OF TOTAL POPULATION
DECEMBER 21, 2006



Under normal circumstances, wards in the general population or in specialized programs have relatively few restrictions and are allowed to leave their rooms for several hours daily to receive various services such as academic or vocational classes, individual or group counseling, and exercise or leisure activities. In addition, such wards may also be allowed to leave their rooms to participate in work assignments; to eat meals; to obtain medical and dental care; and for telephone calls, visitations, and religious services.

In contrast, the division limits the movements of certain wards, and thus the time that these wards spend outside their rooms, under what the division calls "restricted programs." The division has three types of restricted programs. The *special management program*—the entire K/L living unit—is for wards who have exhibited ongoing violent and disruptive behavior. Consequently, the program segregates these wards into a structured environment to provide them education, counseling, medical care, and mental health services. Wards in the special management program generally spend the majority of their time in their rooms except for time allowed for showers and exercise. The other types of restricted programs for wards generally occur by temporarily restricting wards to their already-assigned rooms. Specifically, wards assigned to any living unit can be placed on *temporary detention* whereby they are isolated in their rooms for short periods of time, generally a day or two, if they pose a danger to themselves or others or are themselves endangered. Alternatively, an entire living unit or facility may be placed on *administrative lockdown* due to an operational emergency when it becomes necessary to restrict a large number of wards. Each of these conditions results in a "restricted program" for a ward.

As is true with wards in general population and specialized programs, youth correctional facilities are required to provide wards in restricted programs, including the special management program with access to certain "mandated services" unless their delivery would compromise the safety and security of the facility. These services include exercise, education, counseling, and treatment. However, because of the potentially violent or disruptive behavior exhibited by wards in special management programs, the facilities provide education and counseling services in secure program areas—typically, the wards' rooms due to lack of other available space.

The Department of Corrections and Rehabilitation's general policy governing restricted programs is that such programs be temporary. The division's Institutions and Camps Branch Manual states in section 7200 that "a ward should be programmed in a general population setting. When it becomes necessary to restrict a ward(s) program, staff shall take every step necessary to reintegrate the ward(s) back into the general population as soon as it is safe to do so." Department policy also stipulates that the average length of assignment to the special management program be 60 to 90 days and that extended stays in the program require special approval from the Departmental Review Committee.

Historically, the division's practices confined wards in the restricted programs to their rooms for 23 hours per day, allowing wards out of their rooms for one hour of exercise. This was referred to as 23-and-1 confinement. However, in July 2004, the division expanded this out-of-room period to a minimum of three hours.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the Office of the Inspector General's special review were to assess the living conditions for wards on restricted program status at the facility and to identify any situations in which the Division of Juvenile Justice or the Heman G. Stark Youth Correctional Facility did not deliver to these wards the minimum mandated services required by regulation, and to evaluate other conditions discovered during the course of fieldwork that may jeopardize the safety of staff, wards, or the public. The Office of the Inspector General did not examine the level of services or programming provided to wards other than those on restricted program status and certain wards housed in X company, which is part of the facility's transitional program.

In conducting the fieldwork for this special review, the Office of the Inspector General performed the following procedures:

- Interviewed appropriate senior management and other institutional staff, including the facility's superintendent, department staff, and a representative of the San Bernardino County District Attorney's Office.

- Interviewed wards in the special management program and in the X company housing unit.

- Reviewed institutional files, logs, records, and other relevant documents.

- Reviewed various laws, policies and procedures, and other criteria related to key facility systems, functions, and processes.

- Conducted physical inspections of various areas of the facility.

- Observed ward movements and activities.

- Analyzed the information gathered through the above procedures and formulated conclusions.

In reviewing the facility's transitional program, the Office of the Inspector General limited its fieldwork to the X company. Accordingly, activities in the facility's F company were not reviewed.

FINDINGS AND RECOMMENDATIONS

FINDING 1

Contraband in the form of window coverings and makeshift ropes, combined with wards' isolation in their rooms and inadequate delivery of mandated services such as education and counseling, present an environment conducive to suicide attempts and potentially dangerous to staff.

During three separate visits to the Heman G. Stark Youth Correctional Facility, the Office of the Inspector General found unsafe conditions and potentially dangerous materials in the rooms of wards whose violent or disruptive behavior elevate the risk that they will exploit these unsafe conditions or use the dangerous materials to attack staff or injure themselves. The Office of the Inspector General found fabric used to cover windows and make clotheslines that could be used for suicide attempts in over half of the rooms inspected at Heman G. Stark Youth Correctional Facility. Despite the reporting of similar problems to the California Department of Corrections and Rehabilitation in January 2005 and again in December 2005, the division and the facility appear complacent in allowing these contraband items to exist in wards' rooms, not performing adequate room inspections, and not enforcing existing policies banning such dangerous materials and conditions.

Compounding the danger posed by these conditions, the Office of the Inspector General found that many wards are not receiving the required amount of time out of their rooms, education, and counseling services while in the special management program. The absence of these important services may foster feelings of hopelessness and, if left unaddressed, elevate the risk of the wards attempting suicide or participating in assaults against staff.

Presence of contraband creates an unsafe environment for staff and wards. The Office of the Inspector General visited the facility three times in 2006, in February, April, and December. During each of these visits, the Office of the Inspector General found contraband in over half of the rooms occupied by wards housed in the special management program. The contraband found by the Office of the Inspector General included fabric items used as curtains over room doors and windows. Curtains, ostensibly used by wards for temporary privacy, block staff's view into the wards' rooms and thus permit opportunity for illicit activity or suicide attempts. Other contraband observed during the Office of the Inspector General's visits included makeshift ropes and clotheslines, both of which could be used by wards to commit suicide by hanging themselves.

The dangers presented to both wards and staff in permitting wards to cover their windows was tragically illustrated in the Office of the Inspector General's December 2005 report, *Special Review Into the Death of a Ward on August 31, 2005 at the N. A. Chaderjian Youth Correctional Facility*.[1] In that case, a ward on lockdown status had covered his window and was unresponsive to staff. Staff delayed entering the ward's room, in part because of safety concerns associated with unlocking a room with a blocked window. For example, staff must be cognizant that rather than committing suicide, a ward may intend to attack staff when the door is opened. When staff finally entered the ward's room, they discovered the ward hanging from the upper bunk of his single occupancy room with a bed sheet

[1] A copy of this report can be found on the internet at www.oig.ca.gov/reports/pdf/death_of_a_ward.pdf.

tightly fastened around his neck. He had covered the windows of his room to keep staff from observing his actions.

The department focused its attention on the issue of wards obstructing their windows when the director of its Division of Juvenile Justice Facilities issued a March 29, 2006 memorandum to the superintendents of all youth facilities. The memorandum states, in relevant part,

> *For safety and security purposes, it is imperative [that] staff have a clear unobstructed view of all wards while they are in their rooms. When wards cover their windows and obstruct the view of staff, it is a security issue requiring immediate attention.*

However, staff at the Heman G. Stark Youth Correctional Facility have not heeded the lessons to be learned from the tragic event at N.A. Chaderjian Youth Correctional Facility. During a February 2006 visit, the Office of the Inspector General inspected the rooms assigned to wards in the facility's special management program, as well as those assigned to wards on temporary detention. The Office of the Inspector General found contraband items in 52 of the 92 rooms inspected (57 percent). In another visit to the facility in April 2006, the Office of the Inspector General again examined rooms in the special management program and found contraband items in 42 of the 71 rooms inspected (59 percent). Moreover, despite pointing out these unsafe conditions to the facility's management during its two earlier visits, the Office of the Inspector General found even worse conditions during a December 2006 visit to the facility's special management program, finding contraband in 53 of the 77 occupied rooms examined (69 percent).

Recognizing that wards assigned to restricted programs often have histories of violence against other wards or staff, and that some wards are at risk for suicide, section 7200 of the division's Institutions and Camps Branch Manual requires staff to "be vigilant" in monitoring these wards for suicidal behavior, and provides that wards' placement in a restricted program be "a temporary condition."

The department further recognizes that contraband poses a particular threat to wards and prohibits wards from possessing it. Section 5005 of the manual defines contraband as including any item "that could be injurious to persons or property or would adversely affect institutional security," and any "material that is deemed to be a threat to the safety and security of the institution." Section 5015 of the manual requires that staff routinely conduct random searches for contraband. In addition, section 8052 of the facility's administration and operations manual instructs staff to ensure that nothing obstructs their view into wards' rooms.

Among contraband items that the Office of the Inspector General observed during its three separate visits in 2006 were lines made from sheets or T-shirts twisted or braided and hung from a wall, bed, or light fixture. According to facility staff, because the facility has no laundry facility of its own, wards use these as clotheslines to hang self-laundered clothes rather than send clothes to the laundry facility at the nearby California Institution for Men. Staff reported that clothes laundered at the neighboring prison are often lost, returned discolored, or replaced with inferior clothing.

In addition to finding contraband in occupied rooms, the Office of the Inspector General noted three vacant rooms containing either clotheslines or curtains. By allowing such contraband to remain in

vacant rooms, the facility communicates a message to wards that such items are permissible room fixtures.

Other contraband items were more elaborate. For example, one ward had a punching bag fashioned from a rolled-up mattress hanging from the ceiling with a rope made of sheets (Photo 1). The ward demonstrated for the Office of the Inspector General's staff that he could strike the punching bag hard enough to make it sway but not fall from the ceiling. Other wards demonstrated their use of ropes made of braided sheets strong enough to hold their body weight as they performed several pull-ups. During the Office of the Inspector General's February 2006 visit, one ward was storing a variety of disallowed food items and excess hygiene items in lidded containers. Food items are often used to make "pruno," an alcoholic beverage, while lidded containers can be used to hold bodily fluids that wards throw at staff in a practice referred to as "gassing." Indeed, in its December 2006 visit, the Office of the Inspector General's staff discovered that one ward had hidden at least 17 styrofoam cups under his bed and toilet area that contained ingredients for making pruno (Photo 2). During this same visit, the Office of the Inspector General also found a ward-manufactured tattoo device in another room.

Photo 1
Ward with makeshift punching bag
February 2006

The existence of makeshift ropes and curtains is of particular concern to the Office of the Inspector General in light of the fact that it observed the same conditions and brought them to the former California Youth Authority's attention in a January 2005 report, *Accountability Audit: Review of Audits of the California Youth Authority, 2000-2003*.[2]

Room inspections are not being conducted. One reason why the wards in the facility's special management program are able to maintain contraband in their rooms is that staff are not regularly inspecting the rooms to identify contraband. The facility's administration and operations manual instructs staff to ensure that wards' room windows are clear of any obstruction; however, the department has not developed a policy governing the conditions of living quarters for wards in special management programs or any related monitoring requirements. To the facility's credit, the special management program's treatment team supervisor developed a daily room inspection form that staff could use to document efforts to monitor wards' room conditions. However, facility staff do not appear to be regularly inspecting rooms in the special management program. In a visit by the Office of the Inspector General to the facility in March 2006, the facility's staff could produce only nine of the 28 forms that should have been prepared for each day in February 2006 as

Photo 2
Pruno discovered during inspection
December 2006

[2] A copy of this report can be found on the Internet at www.oig.ca.gov/reports/pdf/AccountabilityAudit-CYA.pdf.

evidence of daily inspections. When again asked for these inspection forms by the Office of the Inspector General's staff in December 2006, the special management program's treatment team supervisor was unable to produce them. Based on the amount of contraband found in each of its visits to the facility, the Office of the Inspector General does not believe that facility staff are regularly inspecting the rooms of the wards in the special management program.

Wards in restricted programs are receiving inadequate levels of mandated services. Compounding the security concerns raised by the presence of contraband in the special management program wards' rooms, the facility is not providing the necessary services to these wards. Contrary to the Division of Juvenile Justice's mission of "providing education, training, and treatment services for youthful offenders," the Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility does not provide the minimal services to most special management program wards necessary for them to transition to general population living units where the wards can receive services that prepare them for release to the community.

Section 7210 of the division's Institutions and Camps Branch Manual requires that wards on any restricted program have access to exercise, education, counseling, and treatment services unless delivery of such services compromises the safety and security of the facility. It adds that the withholding of these services must be approved by the appropriate supervisor except when the facility is under administrative lockdown. In that case, only the facility superintendent may determine which mandated services may be withheld.

Fundamental to this discussion is the amount of time wards are allowed to leave their rooms. Prior to July 2004, the former California Youth Authority had a practice of confining wards with psychological and behavioral problems to their rooms for 23 hours per day. In July 2004, formal direction from headquarters in the form of a memorandum advised institution superintendents that so-called "23-and-1" confinement was no longer an acceptable practice for wards in special management programs. In its *Accountability Audit: Review of Audits of the California Youth Authority, 2000-2003*, issued in January 2005, the Office of the Inspector General reported that as of September 2004, a significant number of wards at four institutions, including Heman G. Stark Youth Correctional Facility, were still on 23-and-1 confinement schedules and found numerous unsafe conditions in wards' rooms at the facility, including blocked windows and a makeshift rope. The Office of the Inspector General found in that audit that the department's memorandum did not spell out implementation procedures for ending 23-and-1 status, but directed the institutions' superintendents to develop their own solutions to getting special management program wards out of their rooms for a minimum of three hours per day and for documenting compliance with the directive. The Office of the Inspector General reported that, consequently, implementation had been inconsistent among the institutions. As a result, the Office of the Inspector General recommended that the California Youth Authority develop an implementation plan for eliminating the 23-and-1 schedule in favor of additional education and treatment services, and that it implement previous recommendations to hold staff accountable for failing to follow policies related to wards' living conditions, particularly those that threaten safety and security. The Office of the Inspector General further recommended that the California Youth Authority define confinement schedules for wards in restricted programs, and promulgate and enforce uniform policies and procedures to ensure consistency throughout the department.

In 2006, the Office of the Inspector General's team reviewed the facility's records regarding the amount of time wards are allowed to leave their rooms, and its delivery of mandated services including education and counseling to wards on restricted programs, and found significant deficiencies in the facility's delivery of these services.

Time Out of Rooms

The Office of the Inspector General found that few of the wards on restricted programs receive the minimum three hours of time outside their rooms. This is of concern because extended confinement combined with lack of exercise or recreation can further aggravate existing mental health problems and increase the risk of suicide. Indeed, several of the wards on restricted programs were identified by the facility as being suicide risks. In March 2006, the director of the Division of Juvenile Facilities told the Office of the Inspector General that staff are expected to have wards housed in restricted programs out of their rooms at least three hours per day. Notwithstanding the director's expectations of staff, the Office of the Inspector General notes that the department still has not developed uniform policies and procedures for eliminating the 23-and-1 program as recommended by the Office of the Inspector General in January 2005.

Heman G. Stark Youth Correctional Facility is not meeting the three-hour standard. As shown on Table 1, the Office of the Inspector General found that on six dates examined in 2006, only seven of the 323 restricted wards reviewed (two percent) received at least three hours out of their rooms. Furthermore, because ten of the 54 wards on the February 22, 2006 mandated services log selected by the Office of the Inspector General for examination were identified by the facility to be at high risk for suicide, and 15 of the wards were prescribed psychotropic medications for mental conditions, it is important that such wards be provided with adequate time out of their rooms.

Table 1

Number of Hours Restricted Wards Spent Outside of Their Rooms During Six Days Reviewed

Date	Total Number of Wards	Number (Percent) of Wards Receiving Time Out of Rooms				
		Less than 60 minutes	60 to 119 minutes	120 to 179 minutes	180 minutes or more	Total With less than 3 Hours
2/22/06	**54**	**23 (43%)**	**10 (18%)**	**20 (37%)**	**1 (2%)**	**53 (98%)**
3/22/06	**53**	**2 (4%)**	**23 (43%)**	**22 (42%)**	**6 (11%)**	**47 (89%)**
4/13/06	**51**	**0**	**3 (6%)**	**48 (94%)**	**0**	**51 (100%)**
11/26/06	**47**	**0**	**11 (23%)**	**36 (77%)**	**0**	**47 (100%)**
11/30/06	**51**	**0**	**4 (8%)**	**47 (92%)**	**0**	**51 (100%)**
12/07/06	**67**	**0**	**4 (6%)**	**63 (94%)**	**0**	**67 (100%)**
Totals	**323**	**25 (8%)**	**55 (17%)**	**236 (73%)**	**7 (2%)**	**316 (98%)**

Note: November 26, 2006, totals do not include 10 wards who refused their exercise period.
Source: Mandated services logs maintained on the WIN system

The director of the Division of Juvenile Facilities even conducted a meeting with superintendents on April 4, 2006, to emphasize that the standard for wards is a minimum of three hours time out of their rooms daily. As shown in Table 1, there is some improvement in the amount of time wards were allowed out of their rooms following the April 4, 2006 meeting. Nonetheless, for the dates examined by the Office of the Inspector General in 2006, most wards on restricted programs at the facility did not receive the required minimum time of three hours outside of their rooms.

Education

The Office of the Inspector General further found that despite a requirement that wards in restricted programs receive educational services, very few in fact did so, in part because of severe staff shortages. Specifically, the Office of the Inspector General found that on six days selected for examination in 2006, the facility's mandated services log showed evidence that only two wards had received *any* educational services on at least one of the six days. Stated differently, the facility had provided less than 1 percent of the 323 educational service days that would have been needed to provide the required educational services to the wards during the period reviewed.

The California Education Code establishes four hours as the minimum school day for high school students except in the case of regional occupational centers and continuation high schools. In addition, section 7210 of the Institutions and Camps Branch Manual requires that wards be provided educational services by the second school day after being placed in a restricted program. The facility's superintendent and principal are additionally required to develop a plan to deliver all mandated elements of the facility's education program to wards in the least restrictive environment possible.

In February 2006, the Office of the Inspector General interviewed the principal and members of the teaching staff and was told that the facility had only one teacher assigned to the special management program. Because many wards in this program exhibit behavioral problems, the teacher provides one hour of instruction to wards individually, instead of instructing a group of wards in a classroom. However, assuming one hour of instruction plus preparation time, a teacher utilizing this method of teaching individual wards would be able to meet with each ward only once every 18 days—far short of the four-hour-per-day requirement. The Office of the Inspector General noted evidence of improvement in the teaching methods at the special management program during its December 2006 visit, observing a teacher instructing groups of up to five wards simultaneously.

According to the principal, the facility's inability to provide adequate educational services is attributable to excessive teacher vacancies and inadequate classroom space in the restricted program living areas. The personnel office at the facility listed 35 teacher vacancies out of 94 authorized positions (a 37 percent vacancy rate) and 15 assistant teacher vacancies out of 27 authorized positions (a 56 percent vacancy rate) as of December 1, 2005. By December 11, 2006, the facility's records showed improvement, listing 19 teacher vacancies and seven assistant teacher vacancies.

Compounding the facility's teacher shortage is a disproportionate allocation of its teaching staff to the individual program areas. According to a report prepared by the educational staff at the facility and updated on March 2, 2006, "*2003-2009 Accreditation Single Plan for Pupil Achievement, Midterm Progress Report*," 48 percent of the facility's wards who have not completed high school must be instructed in satellite or alternative settings, including the special management program, yet only 27 percent of the facility's teachers are assigned to those program areas.

The facility's deputy superintendent told the Office of the Inspector General that when the vacant teaching positions are filled, he planned to address the special needs of restricted program wards by expanding class hours and possibly implementing an afternoon education program. This additional educational program time is intended to mitigate the risk of racial and gang strife while enabling teachers to provide restricted wards with the required instruction.

Counseling

Though not as severe as the shortfall in providing wards with time out of their rooms and education, there is also a deficiency in providing daily counseling to wards on restricted programs. Specifically, as shown in Table 2 below, the facility provided only 77 percent of the counseling treatment during the six dates examined that was needed to meet the standard.

Table 2
Counseling Treatment Provided to Restricted Wards During Six Days Reviewed

Date	Total Number of Wards Sampled	Number (Percent) of Wards Who Received Counseling
2/22/06	54	49 (91%)
3/22/06	53	52 (98%)
4/13/06	51	9 (18%)
11/26/06	57	47 (82%)
11/30/06	51	47 (92%)
12/07/06	67	51 (76%)
Total	**333**	**255 (77%)**

Counseling is particularly vital to the facility's restricted wards, many of whom have mental health problems, are taking psychotropic prescription medications, or are at high risk for suicide. To address these wards' behavior effectively, counseling sessions should be thorough and consistent. Nonetheless, the facility's current practice is to provide brief, infrequent counseling sessions.

Section 7210 of the Institutions and Camps Branch Manual requires that:

> *A ward on a restricted program shall be provided counseling. A minimum of ten minutes of daily behavior intervention counseling shall be provided on every school day in which the ward is unable to attend school in the facility's school area as a result of his/her inappropriate behavior. Counseling may be provided individually or*

in small groups. If counseling is delivered in a small group, each ward's behavioral issues are to be addressed. Counseling shall include a discussion of his/her behavior and steps required to return to a regular program. Additional individual and/or small group counseling shall also be provided in accordance with each ward's prescribed treatment program.

The treatment team supervisor in charge of the facility's special management program told the Office of the Inspector General that one reason the program does not meet the standard for providing counseling services to wards is because the special management program population consistently has a high count of 86 or 87 when there are supposed to be only 75 wards in the program. Additional youth correctional officers help with supervision on the recreation yard but are not youth counselors and, therefore, are not expected to perform counseling.

RECOMMENDATIONS

The Office of the Inspector General recommends that the administration of the Division of Juvenile Justice:

- **Develop uniform policies and procedures to support existing directives intended to eliminate 23-and-1 confinement, including establishing a minimum acceptable duration for which restricted program wards are to be out of their rooms and for documenting daily either the means by which this was accomplished for each ward, or the reasons for failing to do so.**

- **Refine its policies and procedures to more clearly define the standards for wards' living quarters and to enhance its youth facilities' ability to provide wards in restricted programs with safe living conditions. These policies and procedures should include examples of the specific types of contraband items to be removed from restricted wards' rooms, the frequency of staff inspections, proper documentation of those inspections, and sanctions for non-compliance.**

The Office of the Inspector General also recommends that the management of the Heman G. Stark Youth Correctional Facility take the following actions:

- **Use progressive discipline to hold staff accountable for conducting daily room inspections for wards on restricted programs, removing all contraband discovered, and documenting room inspections in writing.**

- **Administer appropriate sanctions against wards violating the rules prohibiting contraband.**

- **Consider installing laundry equipment in the special management program unit, using existing plumbing and electrical hookups to reduce the incentive for wards to construct makeshift clotheslines.**

- **Improve supervisory monitoring over staff's delivery of mandated services to ensure that all wards assigned to restricted programs are provided with required services including three hours of time out of their rooms daily, education, and behavior counseling.**

- **Facilitate compliance with educational standards by:**

  - **Hiring sufficient teaching staff to enable wards access to four hours of daily instruction.**

  - **Allocating additional dedicated space in the living units in which to provide educational programs.**

- **Reallocate the facility's existing teachers among its living units in proportion to the number of non-high school graduate wards attending school in those living units.**

FINDING 2

The step-down transitional program at Heman G. Stark Youth Correctional Facility, despite its name, operates as an extension of the facility's highly restrictive special management program, but lacks the critical protections required of such a program.

Heman G. Stark Youth Correctional Facility operates a "step-down" program intended to help violence-prone wards transition from its special management programs to less-restrictive programs. Although well-intentioned, the step-down program resembles a restrictive special management program in that wards typically eat meals in their rooms, are not allowed to attend school in a classroom environment away from the unit, and are released from their rooms for just over two hours daily for recreation. However, the step-down program lacks the policies and procedures intended to provide critical protections accorded wards in special management programs. For example, unlike a special management program, which has policies intended to limit the duration of a ward's stay to 90 days, the transitional program has no established limit. As a result, the Office of the Inspector General found that as of December 5, 2006, the 47 wards in the transitional program's *X company* had been in the program an average of 153 days. Special management programs require treatment staff to develop a transition plan preparing wards for return to the general population, where wards have fewer restrictions. However, the transitional program has no such requirement. Lastly, the transitional program is not required to document the education, exercise, and counseling services provided to wards on a "mandated services" log as is the case with a special management program. As a result of these shortcomings, the transitional program appears to be an indefinite extension of the special management program, but it is without clear operating policies and procedures to limit the time wards spend in the transitional program to that which is necessary to prepare them for a less-restrictive environment.

The W/X general population unit is used by the facility as a transitional program. As discussed in the Introduction of this report, the facility is comprised of several programs with different missions. One of these programs is W/X, so named because it is composed of two distinct *companies*, to which wards are assigned based on their level of behavior. Together, these companies house wards who have been assigned to the facility's transitional program. Wards with serious behavioral issues, but who do not merit assignment to the facility's special management program, are assigned to X company, while those wards who are less violent are assigned to W company. On December 12, 2006, there were 46 wards assigned to X company and 44 to W company.

The facility's goal for X company wards, according to the W/X program's treatment team supervisor, is that the wards will transition to W company where they may attend school in a classroom environment. The facility's goal for wards successful in W company's programming environment is to transition them into general population units that are less-restrictive and offer services that meet the wards' primary treatment needs.

The facility does not ensure wards receive mandated services due to a lack of formal policies and procedures. The facility's management told the Office of the Inspector General that this transitional program was established at least six years ago but was unable to provide documentation concerning the program's origin, history, official mission, or operating procedures. Even though the

facility restricts the services it provides to wards in the W/X program, it does not provide safeguards––as it does with its special management program wards—to ensure that the wards receive minimum levels of services. During its three visits to the facility, the Office of the Inspector General found that the daily routines of wards in the transitional program continue to resemble those of wards in a special management program. Wards housed in the facility's X company typically eat meals in their rooms and are not allowed to attend school in a classroom environment away from the unit, unlike wards in traditional general population units or specialized treatment programs who may be allowed to leave their rooms to participate in work assignments, eat meals, and attend school.

Despite its functional similarity to a special management program, the transitional program does not provide the safeguards that exist in the special management program to ensure that wards receive minimum levels of services, such as education. Departmental policy requires the facility to document its delivery of minimum levels of education, exercise, and counseling services to its special management program wards and limit their stay to no more than 90 days on that program without special permission. However, because the facility has classified the W/X program as a general population unit, it does not provide wards housed in X company with these same safeguards. In the absence of documentation recording the time wards are provided out of their rooms and other mandated services, the Office of the Inspector General was unable to determine if these wards received these services or the required minimum of three hours out of their rooms. The Office of the Inspector General observed small groups of wards in X company meeting with counselors, and noted evidence of counseling sessions recorded in individual wards' unit files. Further, the logs maintained on the housing unit show that wards in X company are allowed outside of their rooms for recreational activity daily for a period averaging just over two hours, but the frequency and duration of additional time out of rooms cannot be independently verified because these events are not required to be officially recorded for wards in the transitional program.

Because the transitional program operates without formal policies and procedures and lacks critical protections present in the special management program, wards are provided inadequate programming opportunities for extended periods of time. Ultimately, this shortcoming detracts from the goal of rehabilitation and training and leaves wards not only unprepared for transition to less-restrictive programs but also for reentry to society.

X Company wards receive limited education. Welfare and Institutions Code section 1120.1 (b) states that "the department shall ensure that each ward who has not attained a high school diploma or equivalent shall be enrolled in an appropriate educational program." In the absence of mandated services logs like those used for the special management program, the Office of the Inspector General reviewed the educational records for ten wards assigned to X company as of December 2006 and found that eight had not yet attained a high school diploma or equivalent. The Office of the Inspector General found that the facility is not providing adequate educational services to these wards. One ward had not been assigned to any classes despite having been in the unit for three months. The remaining seven wards were each enrolled in at least one class, but five of these wards had at least one class to which no teacher was assigned. Therefore, the Office of the Inspector General questions the benefit such wards may be receiving without proper instruction. Indeed, only one of the eight non-graduate wards reviewed had actually earned any credits during his 160 days while housed in X company.

According to the facility's academic scheduler, all wards are enrolled in school, but many wards are not actually attending school, whether in a classroom or on the housing unit. The number of teacher vacancies at the facility creates difficulties in supplying the instruction needed to provide adequate educational services, according to the scheduler. In fact, according to statistics provided by the educational administrative office, there were only three teachers assigned to teach classes in the W/X program, and those teachers also had to teach classes at two other housing units at the facility. The effect of this teacher shortage is especially detrimental to X company wards, most of whom must be instructed individually in their rooms because they are not allowed to leave the building in which they are housed.

Wards remain in the transitional program indefinitely. Unlike a special management program under which a ward's maximum length of stay is limited to 90 days in the absence of special approval, there is no official limitation on the time that wards may be assigned to the X company transitional program. The Office of the Inspector General obtained length-of-stay data from the Division of Juvenile Justice for wards on the X company roster as of December 5, 2006, and found that the average length of stay was approximately five months (153 days) for the 47 wards on the roster, including seven wards with cumulative stays exceeding approximately ten months (300 days) and another eight wards with cumulative stays exceeding over six months (200 days).

One reason wards stay so long in the X company may be because the facility does not assess the wards' progress at proper intervals. The Division of Juvenile Justice has a case conference process to determine, among other things, whether wards are appropriately placed in their program assignments. For wards not in a special management program, section 4035 of the Institutions and Camps Branch Manual establishes that the initial conference should occur within five weeks of a ward's arrival at the institution, with the next conference due 60 days thereafter, and subsequent conferences every 120 days "or sooner as needed to properly supervise the treatment activities of an individual ward." For wards in a special management program, section 7285 of the manual calls for the initial conference to take place within five working days of a ward's arrival in the program, with the next conference due within 60 days. Wards assigned to a special management program beyond 90 days are to receive a progress case conference every 30 days thereafter pursuant to section 7285 of the manual.

According to facility staff, rather than using the criteria for special management programs requiring case conferences every 30 days, the W/X program uses a 90-day interval between case conferences. Case conferences held every 30 days, however, would permit staff to monitor wards in the X company more closely by providing more frequent opportunities to detect problems, to alter treatment plans, and to identify wards who may be ready to progress to a less-restrictive program.

Additionally, the facility does not always provide timely assessments. Based on information obtained from the facility's Ward Information Network as of April 5, 2006, case conferences were overdue by an average of 42 days for 17 of 47 (36 percent) of all wards housed in X company, even when using the less-stringent standard for general population wards. As of December 12, 2006, however, for all 46 wards on the unit, these figures had improved to a days-overdue average of only nine days for the three wards (seven percent) whose case conferences were overdue. Even though the facility has improved its timeliness in holding case conferences using criteria applicable to general population wards, the frequency of case conferences for wards subject to the level of restrictions imposed in X company appears inadequate.

Another reason for the length of wards' stay in the X company may be the facility's lack of policies and procedures governing the transitional process. Special management programs have rules guiding the transition of wards from the program. Section 7285 of the Institutions and Camps Branch Manual provides guidelines for the transition of wards from a special management program. The facility's management told the Office of the Inspector General, however, that the transitional program currently has no such formal plan or structure for transition. Although section 7285 is directed to the transition of wards while still assigned to a special management program, it remains relevant to Heman G. Stark Youth Correctional Facility's intent for wards housed in its W/X general population transitional program. The section states that a special management transitional program shall include "a transition plan to gradually move the ward back into the general population." The section further expands on the concept of a transition plan, stating that:

> *A transition plan will be developed by the treatment team. A SMP Transition Plan form shall be completed outlining the ward's specific transition activities.*
>
> *A transition plan may include the following activities:*
>
> - *Regular visits to the designated receiving living unit*
> - *Attending school in the general population school area*
> - *Attending small group or resource groups on the designated receiving unit*

Without formal transition plans by which to define, measure, and monitor wards' activities, the current transitional program cannot objectively measure wards' progress in achieving behavior goals, and it overlooks wards that may be ready to move to less-restrictive programs.

The Office of the Inspector General spoke with a ward whose situation illustrates the indefinite tenure of wards' assignments to X company. During a visit to the facility in April 2006, the Office of the Inspector General interviewed a ward with the assistance of his Spanish-speaking youth correctional counselor. The ward, assigned to X company since August 2005, had a disciplinary history reflecting no incidents of violent behavior for nearly a year at the time of the interview. His youth correctional counselor said that the ward was considered to be a "positive programmer." Despite the ward's record of non-violence for the prior 12 months, facility staff could not explain why the ward had not been transferred to a less-restrictive housing unit.

RECOMMENDATIONS

The Office of the Inspector General recommends that the administration of the Division of Juvenile Justice consider officially recognizing the step-down transitional program at Heman G. Stark Youth Correctional Facility as an extension of the special management program by developing policies and procedures for the program, providing it with the resources necessary to prepare wards for a successful transition to programming units, and subjecting it to the provisions of Institutions and Camps Branch Manual section 7200, et. seq.

The Office of the Inspector General also recommends that the management of the Heman G. Stark Youth Correctional Facility take the following actions:

- **Until the Division of Juvenile Justice develops statewide policies and procedures for step-down transitional programs, develop local policies and procedures utilizing the guidelines of Institutions and Camps Branch Manual section 7285 for the transitional program. These policies and procedures should provide a means by which to establish individual transition plans for wards in the program and to objectively measure and monitor wards' progress in achieving treatment goals.**

- **Maintain mandated services logs for wards in the transitional program such as those used in the special management program to record the level of mandated services delivered to those wards and to ensure that they receive a minimum of three hours out of their rooms daily.**

- **Conduct a progress case conference for each ward in the transitional program within 60 days of the initial conference and every 30 days thereafter to assess the ward's readiness to be transitioned to general population housing.**

FINDING 3

Existing methods of addressing sexual misconduct by wards at Heman G. Stark Youth Correctional Facility are ineffective, resulting in repeated and continuing misconduct by wards and a failure to identify wards whose conduct ultimately presents a threat to public safety.

The facility's ability to hold wards accountable for sexual misconduct is hampered by its use of ineffective or inadequate sanctions and by its failure to consistently submit instances of ward sexual misconduct for prosecution. Consequently, wards have little concern about being held accountable and commensurately little incentive to curtail their negative behavior. In addition to having a negative effect on staff who become the targets of this activity, this type of behavior may be an indicator of wards' potential as threats to public safety once they are released from custody. For example, one ward, who was committed for performing lewd and lascivious acts and who had directed at least eight acts of indecent exposure at staff while at the facility, received only punishments such as "loss of canteen" and "loss of late nights." Despite his committing these actions while at the facility, the facility did not pursue criminal prosecution of the ward. In failing to do so, the facility bypassed an opportunity to extend his custody, and when his available confinement time expired in September 2006, he was released from custody without being subject to further parole supervision and without having received effective treatment for his potentially dangerous behavior.

Some wards have directed repeated acts of indecent exposure toward staff members but are not effectively held accountable for their behavior. As a result, morale has suffered among some female staff members who feel victimized yet powerless to prevent the behavior because the sanctions given by the administration to these wards are ineffective. In addition, staff said the institution's administration does not provide any type of counseling or support group for staff who feel victimized by this type of behavior. This perception by staff of management's indifference to ward misconduct can potentially expose the department to legal action.

The facility's sanctions are ineffective in deterring wards' sexual misconduct. The volume of indecent exposure incidents at the facility, combined with the number of wards repeatedly participating in such behavior, suggests that the facility's sanctions are not an effective deterrent. Section 7300 of the Institutions and Camps Branch Manual establishes a Disciplinary Decision-Making System that provides a graduated array of sanctions commensurate with the seriousness of a ward's offense. Level 3 misconduct is the most serious and includes "making verbal or written comments or physical gestures of a sexual nature." Existing sanctions include loss of privileges or applying programming restrictions, and can be as severe as extending a ward's projected parole consideration date. These sanctions, however, do not appear to curb wards' sexual misconduct. Some wards have minimal time left to serve on their sentences, making even the most severe sanctions imposed by the department for sexual misconduct ineffective.

The Office of the Inspector General reviewed incidents of wards committing among the most serious types of level 3 sexual misconduct – exposing genitals, and masturbating in view of staff. The facility provided from its Ward Information Network system a listing reflecting 234 incidents occurring from

January 3, 2005, through February 20, 2006. This listing represents an average of 17 incidents per month of this type of sexual misconduct. The Office of the Inspector General found that a relatively small segment of the ward population was responsible for over two-thirds of these more serious incidents. In examining the 234 incidents involving 118 wards, the Office of the Inspector General found that 44 wards—roughly six percent of the facility's population—were the subjects of 160 (68 percent) of these incidents. In fact, 11 wards received at least five behavior reports for this type of misconduct. These statistics support the conclusion that the facility's sanctions are not effectively deterring wards' sexual misconduct.

In examining disciplinary sanctions administered during 2006 for sexual misconduct occurring in December 2005, the Office of the Inspector General found 23 behavior reports alleging this type of offense. In 13 of these cases, the facility recommended extending the ward's projected parole consideration date one to four months. In three cases, the facility imposed a loss of program or canteen privileges, and in one other case the facility settled for the time the ward had served on temporary detention as a result of the incident. The facility had dismissed two of the cases. The final four cases involving one ward's sexual misconduct were not completed because the ward was sentenced to a state prison term for a January 2006 staff assault. The Office of the Inspector General further found that two wards with minimal time left on their sentences received only "loss of program" for their behavior.

The Office of Inspector General noted that the 23 reports pertaining to the above cases alleging serious sexual misconduct were written by 14 different staff members working in various classifications including youth correctional officers, youth correctional counselors, medical technical assistants, and registered nurses. The variety of staff writing reports suggests that the wards' sexual misconduct was neither targeted at particular staff members nor were the reports the product of a few staff members who might be accused of being zealous or overly sensitive to such misconduct.

The facility does not submit for prosecution instances of sexual misconduct. Even though the facility's use of administrative sanctions to address wards' negative behavior are appropriate in certain circumstances, the facility has not submitted instances of repeated indecent exposure to the local county District Attorney's Office for potential prosecution. As a result, the facility is not using criminal prosecution as a means of holding wards accountable for instances of repeated or egregious behavior.

Section 7382 of the Institutions and Camps Branch Manual provides superintendents of youth correctional facilities with the option of consulting with the local county District Attorney's Office, regarding possible investigation and prosecution when a ward commits an offense in the facility. According to the manual, the option is available in these situations:

- *A ward's confinement time is near expiration and the staff believes that more confinement time is necessary for treatment or as discipline for his/her misconduct.*
- *A ward's misconduct is so negative and serious that the staff believes:*
  - *it is necessary to have an additional commitment in order to extend his/her Available Confinement Time (ACT).*
  - *more confinement time is necessary in order to deter others from committing the same misconduct.*

- *A ward, who is 18 years of age or older, demonstrates misconduct which is so negative and serious that the staff believes he/she cannot benefit from Youth Authority [now the Division of Juvenile Justice] programs and therefore, should be committed to state prison.*

In addition, state law provides that repeat incidences of sexual misconduct have the potential for a felony conviction. Section 314 of the Penal Code, concerning indecent exposure, states in relevant part:

> *"Every person who willfully and lewdly, either:*
> *Exposes his person, or the private parts thereof, in any public place, or in any place where there are present other persons to be offended or annoyed thereby . . . is guilty of a misdemeanor . . . Upon the second and each subsequent conviction under subdivision 1 of this section, or upon a first conviction under subdivision 1 of this section after a previous conviction under Section 288, every person so convicted is guilty of a felony, and is punishable by imprisonment in state prison."*
> (emphasis added)

In April 2006, the facility's superintendent and one of its investigators expressed their belief to the Office of the Inspector General that the local county District Attorney's Office had no interest in prosecuting misdemeanor cases, as first-time convictions for indecent exposure are generally categorized. However, a deputy district attorney at the San Bernardino County District Attorney's Office told the Office of the Inspector General that his office evaluates each case on its individual merits and that the facility had not submitted any sexual misconduct cases for prosecution for at least six months.

In December 2006, an investigator at the facility told Office of the Inspector General staff that the number of such incidents by wards was decreasing. The Office of the Inspector General examined behavior reports and found seven cases in October 2006 and six in November 2006, well below the average of 17 cases per month the facility experienced from January 2005 through February 2006. The investigator attributed this decline to a July 2006 memorandum from the superintendent to all staff and a notice provided to all wards, advising them that repeat offenders would be subjected to criminal prosecution. However, at the time of the Office of the Inspector General's visit to the facility in December 2006, no cases for this type of behavior had been submitted to the district attorney.

Inadequate sanctions may be detrimental to public safety. Not only do the facility's inadequate sanctions for ward sexual misconduct allow its staff to be subjected to continued inappropriate behavior, but it may allow these same wards to ultimately pose a risk to public safety. One example of the potential risk to public safety resulting from the facility's use of ineffective sanctions is a ward who was committed to the Division of Juvenile Justice for performing lewd and lascivious acts. The ward engaged in at least eight acts of either exposing his genitals or masturbating in view of staff while at Heman G. Stark Youth Correctional Facility, receiving only punishments such as "loss of canteen" and "loss of late nights" for one or more months at a time. Some of these incidents occurred while the ward was assigned to the sexual behavior treatment program, where he stayed for approximately ten months and was subsequently removed because he was resistive to treatment. He finally left the custody of the Division of Juvenile Justice after reaching the end of his available confinement time. The Youth Authority Board attempted to petition the court under Welfare and Institutions Code section 1800.5, which allows extension of a ward's confinement time if he is considered a danger to the public because of "the ward's mental or physical deficiency, disorder, or abnormality which causes

the person to have serious difficulty controlling his or her dangerous behavior." However, the ward's available confinement time expired before this could be done, and he was released from custody in September 2006 without being subject to further parole supervision.

Another example is a ward who was committed to state juvenile custody for assault with intent to commit rape. While in another youth correctional facility, the ward committed a sexual assault on another ward, resulting in his own conviction as an adult. After serving his sentence in a state adult prison in December 2005, the ward entered Heman G. Stark Youth Correctional Facility as a "dual commitment" ward to complete his original juvenile sentence. While there, he received disciplinary actions in August 2006 for exposing his genitals and in September 2006 for masturbating. In the latter incident, the ward committed the act while in an office with a female parole agent during his program review. Both of these incidents occurred after the facility's superintendent distributed the July 6, 2006, memorandum advising staff that repeated offenses of this nature by wards would be subject to criminal prosecution. The memorandum specifically prescribes filing a misdemeanor complaint for a second offense and a felony if a third offense is committed by a dual commitment ward. However, instead of following its own guidelines and taking substantive action against this ward with a history of criminal sexual behavior, the facility administered sanctions involving only "loss of program" for both offenses. This ward was released on parole from Heman G. Stark Youth Correctional Facility in December 2006.

Both of these are examples in which the facility failed to substantially address sexual misconduct by wards who had sex crimes underlying their commitment offenses. After experiencing relatively little in the way of consequence for their in-custody behaviors, these wards may be emboldened to continue such behavior when no longer in custody.

Pelican Bay Prison Plan may provide a model for Heman G. Stark Youth Correctional Facility. A possible model to support the facility's handling of indecent exposure cases is found in a court-ordered pilot program, scheduled to run until March 2007, addressing such behavior by inmates at Pelican Bay State Prison. The Pelican Bay State Prison Plan for Management of Indecent Exposure Incidents includes several "security measures that are designed to decrease the opportunity for the inmate to repeat the behavior and/or minimize the impact that the behavior has on prison staff."

The pilot program's measures include:

- Training staff to ensure that all indecent exposure incidents are reported;
- Evaluating each report for possible referral to the local District Attorney's Office;
- Ensuring that inmates engaging in indecent exposure receive a mental health screening;
- Establishing a committee to monitor the program's effectiveness and review cases; and
- Providing each employee observing an indecent exposure incident with support, including the Employee Assistance Program and the Employee Post Trauma Program.

RECOMMENDATIONS

The Office of the Inspector General recommends that the management of the Heman G. Stark Youth Correctional Facility take the following actions:

- **Consistently apply the directives of the superintendent's July 6, 2006, memorandum in administering disciplinary sanctions to wards engaging in sexual misconduct.**

- **Prepare and refer all cases of egregious or continuous sexual misconduct falling under the criteria of section 7382 of the Institutions and Camps Branch Manual and Penal Code 314 to the District Attorney's Office for criminal filing, allowing the District Attorney's Office to evaluate each case on its individual merit.**

- **Consider adopting the Pelican Bay State Prison sexual misconduct treatment model, or if necessary a modified version of it, at Heman G. Stark Youth Correctional Facility.**

Finding 4

The process for performing an important mental health screening test at Heman G. Stark is in disarray, potentially placing parole detainees at risk for suicide and unnecessarily delaying their assignments to treatment programs or other mental health services.

Despite a requirement that treatment needs assessments (TNA) be administered to all parole detainees, the Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility is not always administering the assessments and, in some instances, is delaying the scoring or evaluation of the assessments. These problems can delay the identification and treatment of mental health disorders that, if left untreated, can result in an increased risk that a ward may injure himself or others.

Among the methods the Division of Juvenile Justice utilizes to assess wards' mental health is a treatment needs assessment process which identifies at-risk wards needing specific types of treatment services at the time of their admission to a facility. Indicators of thought disorder, suicide risk, distress and restraint, depression and anxiety, and anger have been defined by the division as potential red flags for mental health problems needing treatment. Section 6260 of the Institutions and Camps Branch Manual requires that "all incoming wards, including commitments, diagnostic and contract cases, recommitments, and parole violators" be scheduled for testing through the process "no later than the third week following admission" to the facility. Next, the assessments must be mechanically scored within one day of their completion, and if the scoring indicates elevated levels of certain suicide, anger, or thought disorders, the assessments are to be forwarded to a psychologist for evaluation by the end of that workday.

Although Heman G. Stark Youth Correctional Facility does not directly receive wards newly committed to the Department of Juvenile Justice, it does receive those who return to custody for parole violations. However, staff at the facility do not always administer the treatment needs assessment for these wards, score the assessments, or complete psychological reviews of the assessments within the required time frames. During its December 2006 visit to the facility, the Office of the Inspector General's review team examined the records of five parole detainees admitted between January 2006 and September 2006 and found several problems with the administration, scoring, and evaluation of the treatment needs assessments.

In fact, for three of the five parole detainees, treatment needs assessments had not been completed, even though the three wards had been confined at the facility for 2-1/2 months, 6-1/2 months, and 9 months, respectively. For the other two wards, the treatment needs assessments were not scored within one day of completion as required, and even though one of the assessments indicated a suicide score that necessitated review by a psychologist, that review was delayed 20 days – an inexcusable delay considering that the treatment needs assessment for this ward indicated a red flag for suicidal tendencies.

According to a psychologist at the facility, at times there has been a complete breakdown of the process – so bad, in fact, that at one point during the year, she discussed this issue with the treatment team supervisor because she had not received any assessments for two months. She further added that

there is no one person in charge to provide oversight. She told the Office of the Inspector General that the failure to administer the treatment needs assessment to each ward was caused by staffing problems; specifically, the youth correctional counselor position responsible for administering the tests had been only intermittently filled because of transfers, promotions, or other issues. As a consequence, the tests still were not being reliably administered. The psychologist further indicated that she was unaware of the requirement to review flagged assessments within one day and explained that she tries to review the assessments on the same day she receives them, but there are times when her workload prevents her from doing so. Finally, the psychologist told the Office of the Inspector General that scoring the assessments is delayed because the facility does not have a Scantron scoring machine and instead must send the assessments to Sacramento to be scored.

Regarding the responsibility for oversight of the process, section 6260 of the Institutions and Camps Branch Manual states that "the senior psychologist or an assigned TNA psychologist at the reception centers and clinics is responsible for the oversight and direction of the TNA testing process."

Treatment needs assessments are designed to provide information about a ward's mental health status at the earliest possible time to ensure that wards identified as needing counseling, medication, or other mental health service can receive those services as soon as possible. Wards who suffer from mental health disorders but who are not properly or promptly screened to identify the disorders can be a danger to themselves or others. In addition, delays or failures to identify needed mental health services may prevent wards' placement in specialized treatment programs.

RECOMMENDATIONS

The Office of the Inspector General recommends that the management of the Heman G. Stark Youth Correctional Facility take the following actions:

- **Designate a psychologist on the parole violator unit as the individual responsible for overseeing and directing the treatment needs assessment process at Heman G. Stark Youth Correctional Facility.**

- **Through the designated psychologist, hold staff accountable for administering and conducting treatment needs assessments completely and within the time limits prescribed by policy.**

- **Obtain a Scantron scoring machine to allow immediate scoring and evaluation of wards' treatment needs assessment tests at the facility to reduce delays in assessing the mental health needs of wards coming into the parole violator unit.**

FINDING 5

The Office of the Inspector General made confidential findings related to security issues at Heman G. Stark Youth Correctional Facility.

The special review made recommendations concerning security-related findings. Pursuant to Penal Code section 6126.4, however, these findings and recommendations cannot be presented in a public document. Therefore, they were presented only to the Governor and the Department of Corrections and Rehabilitation.

RESPONSE FROM THE DEPARTMENT OF CORRECTIONS AND REHABILITATION

Memorandum

Date : February 20, 2007

To : Matthew L. Cate
Inspector General
Office of the Inspector General

Subject: **RESPONSE TO THE OFFICE OF THE INSPECTOR GENERAL'S DRAFT REPORT ENTITLED, "SPECIAL REVIEW OF HIGH RISK ISSUES" AT THE HEMAN G. STARK YOUTH CORRECTIONAL FACILITY**

This memorandum is in response to the Office of the Inspector General's (OIG) draft report entitled, *"Special Review of High Risk Issues"* at the Heman G. Stark Youth Correctional Facility (HGSYCF). CDCR appreciates the OIG's extensive efforts and time spent conducting this special review.

After careful review, CDCR acknowledges the OIG's continued commitment to improving the living conditions and safety of wards within our care. The Division of Juvenile Justice (DJJ) has been proactive during the course of this review and has taken many steps to address the deficiencies in areas where significant improvement in oversight is necessary.

Specifically, the following actions are in process or have been completed:

- DJJ is implementing six court approved remedial plans related to Medical Care, Education, Mental Health, Disabilities, Sexual Behavior, and Safety and Welfare. These plans are a comprehensive blueprint for enhancing rehabilitation and treatment efforts. Given the broad scope of the reforms, it will take a minimum of four years to fully implement. At the request of the legislature, DJJ modified its initial implementation plan to concentrate on reform efforts on one institution for Fiscal Year 2006/2007 with some additional statewide program efforts. HGSYCF is the first institution designated for a complete reform effort this Fiscal Year.

- Specifically, as it relates to this audit, the Special Management Program (SMP) beds at HGSYCF will be changed to Behavior Treatment Programs. A substantially different treatment model for housing wards with the most challenging behavioral needs will be implemented with new standards for treatment in these programs.

- The W & X living units will be converted to a Core Treatment Program as part of our remedial plan efforts. This program will incorporate a full range of treatment and educational services as well as establish a cap for the number of wards assigned to these units.

- In 2006, HGSYCF took several critical steps to ameliorate the ward sexual misconduct concerns predicated on the 2005 audit information, by implementing a table of ward misconduct sanctions in June 2006 and making substantial changes in the process and personnel assigned to the Disciplinary Decision Making System. Further, DJJ has developed a proposed statewide policy on ward sexual misconduct which already incorporates most of the recommendations made by the OIG in this report.

- [*Here the Office of the Inspector General has redacted the agency's response to recommendations concerning security-related issues in accordance with Penal Code section 6126.4*.]

We would like to thank the OIG for its continued professionalism and guidance to CDCR in its improvement efforts. The DJJ's commitment is evident and while transformation is painstaking, significant improvements are being made.

Should you have any questions, please contact me at (916) 323-6001 or Bernard Warner, Chief Deputy Secretary, DJJ at (916) 341-7012.

ORIGINAL SIGNED BY
K.W. PRUNTY for

JAMES E. TILTON
Secretary
California Department of Corrections and Rehabilitation

cc: K. W. Prunty, Undersecretary
Bernard Warner, Division of Juvenile Justice
Stephen Stenoski, Office of Audits and Compliance