Office of the Inspector General

Matthew L. Cate, Inspector General

Accountability Audit

Review of Audits of

The California Youth Authority

2000-2003

January 2005

State of California

OFFICE OF THE INSPECTOR GENERAL

Promoting Integrity

January 3, 2005

Walter Allen III, Director
California Youth Authority
4241 Williamsbourgh Drive
Sacramento, CA 95823

Re: Accountability Audit

Dear Director Allen:

In the past four years, the Office of the Inspector General has performed nine audits identifying deficiencies in the institutions and programs of the California Youth Authority and has issued 241 recommendations to address the problems. The Youth Authority agreed with nearly all the recommendations at the time the audits were issued and promised to fix the deficiencies. The Accountability Audit presented here determined that 57 percent of the previous recommendations have been fully or substantially implemented, but additional progress is needed.

Many of the deficiencies that have not been corrected are central to the Youth Authority's core mission of rehabilitating the young men and women entrusted to its care. For example, my office found that some wards are still confined to cells 23 hours per day with little access to the education and counseling services that are so critical to rehabilitation efforts.

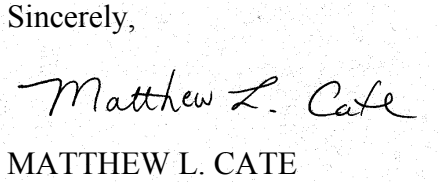
Additionally, the Youth Authority must improve in its efforts to provide wards with the minimum requirement of four hours of education per day and with required mental health assessment and counseling services.

As you know, almost every ward of the Youth Authority will eventually be released back into society, and historically, the recidivism rate for these young people has been more than 70 percent — a number that everyone agrees is unacceptable. While the present administration inherited almost all of the problems identified in this audit, it is imperative that additional steps be taken to see that these fundamental problems are addressed.

P.O. BOX 348780, SACRAMENTO, CALIFORNIA 95834-8780 PHONE: (916) 830-3600 FAX: (916) 928-5974

In closing, I would like to thank you for the professionalism displayed by you and your staff during the audit process. Throughout the state, California Youth Authority employees welcomed my staff and promptly provided them with all requested materials. Your courtesy is greatly appreciated.

Sincerely,



MATTHEW L. CATE
Inspector General

cc: Governor Arnold Schwarzenegger
Roderick Q. Hickman, Secretary, Youth and Adult Correctional Agency

Enclosure

Office of the Inspector General

Matthew L. Cate, Inspector General

Accountability Audit

Review of Audits of
The California Youth Authority
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To Determine Compliance with
Previous Recommendations of the
Office of the Inspector General

January 2005

State of California

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EXECUTIVE SUMMARY

This report presents an assessment of the progress made by the California Youth Authority in implementing recommendations resulting from nine audits and reviews conducted by the Office of the Inspector General between 2000 and 2003. The report represents the first phase of a comprehensive follow-up review—an Accountability Audit—of 32 previous reviews and audits of Youth and Adult Correctional Agency departments and boards by the Office of the Inspector General since April 2000. In addition to the nine audits and reviews represented here, the original audits included two reviews of the Board of Prison Terms and 21 audits and reviews of Department of Corrections programs and institutions. Results of the remaining 23 follow-up reviews in the Accountability Audit will be presented in two subsequent reports.

The Accountability Audit of California Youth Authority programs and institutions determined that in certain areas, the department has made significant progress in implementing solutions to problems previously identified by the Office of the Inspector General. In other areas, however, the results were not as good. Although the department has had as long as four years to take action, numerous important recommendations have not been implemented and problems either remain the same or have worsened. Many of the failings reach to the department's core mission of providing education, training, and treatment services to youthful offenders. Others require prompt action for reasons of safety and security. Recognizing that the present administration has been in place for less than a year, the Office of the Inspector General nonetheless urges the California Youth Authority to take immediate steps to address the following serious problems:

- Despite recent efforts by the new department director to remedy the situation, large numbers of wards in California Youth Authority facilities throughout the state—9 percent of the wards at the five facilities audited—are still confined to cells 23 hours a day with little opportunity for education and training and minimal access to counseling and other treatment services. For example:

  √ At the N.A. Chaderjian Youth Correctional Facility in Stockton, 39 wards in administrative lockdown have been on 23-and-1 confinement for 30 days or more and three have been so confined for more than 200 days.

  √ At the Heman G. Stark Youth Correctional Facility in Chino, an estimated 103 wards are under 23-hour-a-day confinement for the sole reason that the institution lacks enough teachers to provide mandated education classes.

  √ At the N.A. Chaderjian Youth Correctional Facility, wards in the special management program are allowed to spend three hours a day outside cells, but during that period are confined one or two at a time to a 10' x 16' cyclone-fenced asphalt enclosure designed for one ward, with no recreation equipment or toilet facilities and only a small amount of water. If a ward asks for more water or to use the restroom, the "three hours" automatically ends and he is returned to his cell.

- The California Youth Authority continues to fail at providing wards with the four hours a day of education mandated by state law. For example:

  √ At the Southern Youth Correctional Reception Center and Clinic, the effectiveness rating for the high school was 40 percent for fiscal year 2003-04, meaning that wards received an average of only 40 percent of available instruction time during the year.

  √ At the Heman G. Stark Youth Correctional Facility the high school effectiveness rating was even worse: 30 percent for fiscal year 2003-04 — a drop of 7 percentage points from 2002-03.

  √ At the Ventura Youth Correctional Facility an average of 18 classes a day are cancelled, largely because of teacher absences. Between April and August 2004, 30 percent of scheduled classes were not held because the teacher was unavailable and the facility has only one substitute teacher available to fill in.

- Perhaps as a result of the deficiencies, California Youth Authority wards are falling further behind in academic achievement levels. The review found the following:

  √ At the Southern Youth Correctional Reception Center and Clinic, approximately 78 percent of wards at the facility's high school had cumulative subject scores below the 25th national percentile rate in 2004, compared to 67 percent in 2002 and 69 percent in 1998.

  √ At the Heman G. Stark Youth Correctional Facility, standardized test scores have steadily declined in all subject areas since 1998. In 2004, 88 percent of wards at the facility's high school had cumulative subject scores below the 25th national percentile rate, compared to 68 percent of the wards in 1998.

- The California Youth Authority also is not consistently providing wards with mandated treatment services and is failing to provide diagnostic assessments within required time limits. The Office of the Inspector General found the following:

  √ The Heman G. Stark Youth Correctional Facility has regressed in providing wards with mandated counseling since an audit conducted in 2000. The 2004 review found that only 33 percent of wards sampled at the facility had received required individual and small group counseling. Among a sample of general population wards—who comprise most of the facility's population—not a single ward had received the mimimum amount of required individual and small-group counseling. In the same tests conducted by the Office of the Inspector General in 2000 and 2002, 56 percent and 31 percent, respectively, of wards had received the counseling.

  √ At the Southern Youth Correctional Reception Center and Clinic, 82 percent of initial diagnostic assessments held between January and August 2004 were not conducted within the required 45-day time limit. In one instance, the audit team

found that the time limit was exceeded by 93 days. At that institution, 25 percent of randomly selected wards had not received required counseling in the preceding year.

√ Even though department policy requires newly committed wards and parole violators to receive treatment needs assessments within 21 days of arrival at the California Youth Authority, the Office of the Inspector General found that between January and November 2004, 114 wards newly committed to the California Youth Authority did not receive treatment needs assessments within that time limit, and that a few wards did not receive assessments for as long as 10 months. During the same period, 627 parole violators did not receive treatment needs assessments at all.

SUMMARY OF FINDINGS

In the original audits and reviews that are the subject of this follow-up Accountability Audit, the Office of the Inspector General made 241 specific recommendations to improve the department's programs and institutions. Of those 241 recommendations, the California Youth Authority has fully implemented 103 (43 percent), has substantially implemented 34 (14 percent), and has partially implemented 58 (24 percent). Of the 241 original recommendations, 42 (17 percent) have not been implemented and another 4 (2 percent) are no longer applicable. In some instances, the department has successfully addressed the problems by implementing alternative solutions, and wherever that has occurred, those achievements are acknowledged in the body of this report. In other instances, the department appears to have begun efforts to implement recommendations only after the initiation of the Accountability Audit. In that respect, the audit appears to have served the purpose of prompting the department to action.

Following is a summary of the findings from each of the nine follow-up reviews comprising the California Youth Authority Accountability Audit. New recommendations resulting from each of the nine reviews are also included.

23-AND-1 CONFINEMENT

Of the four recommendations issued by the Office of the Inspector General as a result of a December 2000 review of 23-and-1 confinement practices, none have been fully implemented; none have been substantially implemented; two have been partially implemented and two have not been implemented.

In December 2000, the Office of the Inspector General examined the California Youth Authority's practice of confining wards with psychological and behavioral problems to cells 23 hours per day. The 2000 review determined that 16.4 percent of wards at six institutions — one in six — were on so-called "23-and-1" schedules at that time. The Office of the Inspector General also found that the reasons wards were confined for all but one hour a day were not clearly documented; that the wards did not appear to be receiving mandated services; and that the cells had inadequate light and heating and were generally in disrepair.

Restriction to cells 23 hours a day over long periods of time deprives wards of programming opportunities, thereby detracting from the ultimate goal of rehabilitation and lengthening the ward's stay in California Youth Authority institutions. Long periods of isolation and the consequent lack of sensory stimuli may also increase the wards' needs for mental health services. In sum, the long-term confinement of wards on a 23-and-1 schedule is both ineffective and dehumanizing. The practice of 23-and-1 confinement should cease as soon as possible.

In his August 2004 confirmation hearing before the Senate Rules Committee, the new director of the California Youth Authority announced that the 23-and-1 confinement practice had ended. Yet, the 2004 follow-up review determined that a significant number of wards are still under 23-and-1 confinement. Visits to five of six institutions covered in the December 2000 review found 140 wards still on 23-and-1 confinement schedules. In addition, the review found an estimated 103 additional wards on *de facto* 23-and-1 confinement, not for behavioral reasons, but simply because the institution lacks the resources to provide education services. The total amounts to 9 percent of the wards in the five California Youth Authority facilities visited. Only one institution —the Southern Youth Correctional Reception Center and Clinic—appears to have ended 23-and-1 confinement practices.

The follow-up review revealed a number of other findings. Most significantly, the Office of the Inspector General found that 27 wards who were on 23-and-1 administrative lockdown at the Heman G. Stark Youth Correctional Facility, in fact, were not being allowed out of their rooms at all, except for five-minute daily showers. At the N.A. Chaderjian Youth Correctional Facility, 39 wards had been on administrative lockdown for more than 30 days and 3 had been on administrative lockdown for more than 200 days, even though administrative lockdown— in which all wards in a living unit or a facility are confined to cells because of an operational emergency — is supposed to continue only as long as necessary to restore safe operation of the facility.

The Office of the Inspector General also found instances of unsafe and unsatisfactory conditions for wards at some facilities. In one living unit at the Heman G. Stark Youth Correctional Facility, cell windows were blocked with paper and towels, hampering the ability of the staff to monitor the activities of wards inside the cells. In one cell at that facility, auditors found a rope made from a twisted bedsheet draped over a ceiling light fixture. At the N.A. Chaderjian Youth Correctional Facility, the audit team found that, as a means of providing three hours of outdoor exercise time, the staff frequently places two special management program wards together in 10'x16' cyclone-fenced asphalt enclosures designed for one with no recreation equipment or toilet facilities and only a small amount of water.

Documentation that wards have received mandated services also continues to be lacking, and in some instances, appears to be inaccurate. At the Heman G. Stark Youth Correctional Facility, for example, a log documenting mandated services indicated that one ward had received one or more services on 11 of the 14 days reviewed, yet a further check revealed that the ward had been in court during the entire period.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following additional actions:

- **Determine the conditions — if any—under which it is appropriate to confine wards to cells for 23 hours a day. If these conditions are found to exist, develop clear policies and procedures to identify these conditions. If the conditions are not found to exist, develop an implementation plan for eliminating the 23-and-1 schedule in favor of additional education, treatment, and programming services.**
- **Evaluate the reason for the extended administrative lockdown at the N.A. Chaderjian Youth Correctional Faclility and take steps to place the wards in appropriate programs.**
- **Define confinement schedules for wards in restricted programs and promulgate and enforce uniform policies and procedures, including those governing the size of outdoor exercise enclosures and provision of water, toilet facilities, and recreation items, to ensure consistency throughout the department.**
- **Address the inconsistency that allows wards in special management programs to receive more time out of their cells than many wards who are not in special management programs.**
- **Review methods for tracking mandated services and implement procedures to ensure that weekly and monthly, as well as daily, services are accurately documented.**
- **Direct the task force on conditions of confinement to develop and implement policies and procedures that provide clear justification for isolating wards in restricted programs.**
- **Implement the previous recommendation to hold staff accountable for failing to follow policies related to wards' living conditions, particularly those that threaten safety and security.**

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

Fewer than half of the recommendations from a July 2002 review of the Heman G. Stark Youth Correctional Facility have been fully implemented. Of 25 recommendations issued in 2002, 8 have been fully implemented; 1 has been substantially implemented; 9 have been partially implemented; and 7 have not been implemented.

The Office of the Inspector General found from an October 2000 management review audit that the Heman G. Stark Youth Correctional Facility was failing to consistently fulfill two of

the department's core functions: providing wards with education and providing them with treatment services, including individual and small-group counseling. In light of the seriousness of the findings, in July 2002 the Office of the Inspector General conducted a follow-up review of the facility's progress in implementing the recommendations from the October 2000 audit. That review determined that the institution had implemented fewer than half of the earlier recommendations and had regressed in providing individual and small-group counseling to wards, as evidenced by compliance rates significantly lower than the unsatisfactory rates revealed in the October 2000 audit.

As a result of the 2004 follow-up to the 2002 review, the Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility continues to fail at providing mandated education and treatment services to wards.

The Office of the Inspector General made the following particularly significant findings:

- The effectiveness rating of the institution's Lyle Egan High School for fiscal year 2003-04 was only 30 percent, meaning that wards received an average of only 30 percent of available instruction time during the year. This is a drop of seven percentage points from the 37 percent effectiveness rating for fiscal year 2002-03. Because wards are mandated to receive only four hours of academic instruction per day, any lost time is particularly harmful.

- Class closures averaged 540 per month for fiscal year 2003-04, compared to 460 per month the previous fiscal year. More classes are closed now than were closed during the Office of the Inspector General's management review audit in 2000.

- The Office of the Inspector General's review of standardized test scores showed that scores have continually declined in all subject areas since 1998. For example, in 2004 88 percent of Lyle Egan wards had cumulative subject scores below the 25th national percentile rate compared to 68 percent of the school's wards in 1998.

- In the past two years, Lyle Egan High School has reported absenteeism rates of 36 percent and 45 percent, respectively. Those absenteeism rates are significantly higher than the unsatisfactory 24 percent absenteeism rate found in the Office of the Inspector General's October 2000 management review audit.

- As a result of teacher vacancies, combined with ward absences, wards enrolled for at least 90 days during the past academic year earned an average of only 9.45 high school credits.

- Of the 21 randomly selected wards reviewed, only one ward had had a teacher attend his initial case conference, the purpose of which is to help coordinate the ward's treatment and education. No teachers had attended progress case conferences for any of the 21 wards selected. In addition, only three (14 percent) of the 21 wards' files showed that the ward had been assigned to an education or work program within four days of his arrival at his permanent living unit.

- Only 30 percent of the special education wards assigned to special day classes received the services prescribed in their individual education plans. That figure represents a

decrease of eight percentage points from the 38 percent rate found by the Office of the Inspector General in the October 2000 management review audit.

- None of the 14 general population wards sampled by the Office of the Inspector General had received the minimum amount of weekly individual and small-group counseling. Conversely, all 7 of the wards sampled from the specialized programs had received such counseling. General population wards, however, comprise most of the facility's population. In the same tests from the 2000 management review audit and the 2002 follow-up to that audit, the Office of the Inspector General found compliance rates of 56 and 31 percent, respectively. Thus, the facility not only continues to fail, but has regressed in providing required counseling to wards.

- Many treatment team supervisors did not routinely perform the required monthly audits of ten ward files to ensure that mandated treatment is being provided. Of seven treatment team supervisors reviewed, an average of only one supervisor per month audited ten ward files during the ten-month period reviewed by the audit team. One treatment team supervisor acknowledged that he performed no file reviews. Some treatment team supervisors attempted to delegate their responsibilities to subordinates, in violation of institution policy.

- California Youth Authority headquarters relieved the institutions of responsibility for conducting *California Youth Authority Institutions and Camps Branch Manual* section 4000 annual treatment services self-audit reports due to the need to implement parole hearing changes at the facilities in the wake of Senate Bill 459. Thus, a proven tool for monitoring treatment services has not been used for more than a year.

The Office of the Inspector General found improvement in some areas of facility operations. The most noteworthy improvements include the following:

- To their credit, the present superintendent and deputy superintendent have attempted to monitor casework. The Office of the Inspector General obtained memoranda and other documents showing that these officials had found discrepancies in monthly small group reports and had ordered remedial action and, in some cases, progressive discipline. However, the persistent failure of the facility since 2000 to provide individual and small-group counseling indicates the facility needs to intensify its efforts.

- According to the institution, as of August 1, 2004, it had filled all youth correctional counselor vacancies. In addition, the ward information network (WIN 2000) system has been updated to assist staff with tracking disciplinary decision-making system actions and administrators and treatment team supervisors reportedly monitor the living units daily to ensure that disciplinary actions are processed in a timely manner.

- The Office of the Inspector General conducted an on-site review at the facility to verify that each living unit had an up-to-date suicide risk list. In addition, the audit team asked the staff to locate the Hoffman tool, a safety knife for quickly cutting down wards who attempt to hang themselves. The audit team found that all units had an up-to-date suicide risk list and were able to present the Hoffman tool within 8 to 21 seconds.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Heman G. Stark Youth Correctional Facility take 16 additional actions to remedy the deficiencies. Among the most significant recommendations are the following:

- **The California Youth Authority Education Services Branch and the facility should continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include working with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive compensation for teachers.**

- **The principal should continue to monitor the causes of ward absenteeism and make efforts to improve ward attendance and accurately report ward average daily attendance. The monitoring should include audits of the student ward attendance tracking system to ensure that absences are appropriately documented and justified.**

- **The Education Services Branch and the principal should continue their efforts to develop trade advisory committees at the facility to guide vocational instruction.**

- **The facility management should intensify efforts to provide individual and small group counseling to wards. The efforts should include reiterating to staff the importance of counseling to the mission of the department, providing ongoing training as necessary, and using progressive discipline up to and including termination for employees who fail to meet counseling requirements.**

- **The California Youth Authority should immediately take whatever steps necessary to ensure efficient monitoring of weekly small-group and individual counseling.**

- **In order to ensure that counseling is being provided, the superintendent should use progressive discipline to hold treatment team supervisors accountable for performing the required audits of 10 ward files per month.**

- **The California Youth Authority should immediately resume the *California Youth Authority Institutions and Camps Branch Manual* section 4000 annual self-audit reporting requirement for all facilities.**

- **To help coordinate ward education and treatment programming, the superintendent and the principal should require teachers to participate in case conferences as facilitated by the alternative education schedule.**

- **In order to improve the institution's ward programming efforts, the California Youth Authority should thoroughly test the WIN 2000 system to ensure that access is controlled properly, that programming requests are assigned priority according to departmental policy, and that timely feedback on the status of service requests is provided to institutions and other users.**

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

Out of 77 recommendations resulting from a 2003 management review audit of the Southern Youth Correctional Reception Center and Clinic, 32 (42 percent) have been fully implemented; 8 (10 percent) have been substantially implemented; 21 (27 percent) have been partially implemented; and 16 (21 percent) have not been implemented.

The Office of the Inspector General identified serious problems at the Southern Youth Correctional Reception Center and Clinic as the result of a June 2003 management review audit, extending to nearly every aspect of the facility's operation. Deficiencies were found in institution security, the ward diagnostic assessment process, mental health services, suicide prevention, education, medical care, the ward disciplinary decision-making system, the ward grievance system, and employee evaluations. The Office of the Inspector General noted that the then-recently appointed superintendent had made significant improvements during his short tenure, and that some of the deficiencies, such as those relating to ward education, fell outside the superintendent's authority and required attention from California Youth Authority headquarters.

The 2004 Accountability Audit determined that the Southern Youth Correctional Reception Center and Clinic has improved some of its operations since the June 2003 audit, but that numerous deficiencies remain. The institution has enhanced safety and security; improved the intensive treatment program; and improved screening for wards with communicable diseases. But wards are still not receiving mandated education services and have fallen further behind in academic achievement; diagnostic assessments are still not being completed on time; not all wards are receiving mandated counseling services; and required mental health and suicide prevention procedures are not consistently followed.

Key findings revealed by the 2004 Accountability Audit are the following:

- Wards are still not receiving mandated education services. The effectiveness rating of the high school for fiscal year 2003-04 was only 40 percent, meaning that wards received an average of only 40 percent of available instruction time during the year. That figure represents a drop of one percentage point from the 41 percent effectiveness rating for fiscal year 2002-03.

- Wards have fallen further behind in academic achievement, with cumulative test scores steadily declining since 1998. Approximately 78 percent of wards at the facility's Jack B. Clarke High School had cumulative subject scores below the 25th national percentile rate in 2004, compared to 67 percent of the school's wards in 2002 and 69 percent of the school's wards in 1998.

- Ward absenteeism from school has increased from 9 percent to 13 percent over the past two years.

- Wards are still not being processed through the diagnostic assessment within required time limits to ensure that they receive the proper education and treatment services. The review found that 237 (82 percent) of the 288 initial case reviews held between January and August 2004 were not conducted within the 45-day time limit. The auditors noted that in one instance, the 45-day time limit was exceeded by 93 days. Several recommendations relating to improving the timeliness of the diagnostic assessment process have still not been implemented.

- Not all wards are receiving the weekly individual and small-group counseling required by California Youth Authority policy. Nine (25 percent) of 36 randomly selected wards who had been at the facility 12 months or less had not received the required counseling. Although all 13 of the intensive treatment program wards sampled had received the required counseling services, none of the wards in the work experience program had received the counseling.

- Special program needs assessments are not consistently completed on time. Although the institution claimed that 97 percent of special program needs assessments are completed by psychologists within 10 days, the audit team's review of internal tracking records found 43 (54 percent) of 80 special program needs assessments were late during the July through December 2003 reporting period, while 65 of 136 (48 percent) were late in the period April through August 2004. In addition, the audit team found that 4 of the 18 wards taking psychotropic medications had not received special program needs assessments prior to being administered the drugs, in violation of departmental policy.

- The mental health staff does not consistently obtain parental or guardian consent to administer psychotropic medication to wards.

- Although the institution reported that a checklist has been in use since October 2002 to ensure that wards receive timely orientations, the review found that all of the checklists in the files of wards in the work experience program were prepared immediately before the arrival of the audit team.

- Recommendations to correct deficiencies in the suicide prevention assessment and response program have been only partially implemented. Some staff members do not attend mandatory refresher training, and attendance at institution monthly meetings has been poor among security and medical staff.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center and Clinic take 27 additional actions to address the deficiencies. The most important of the recommendations are the following:

- **Continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include working with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive compensation for teachers.**

- **Improve the high school's effectiveness rating by striving to make more classroom time available to wards.**

- **Institute the Education Services Branch's student ward attendance tracking (SWAT) system at the facility's high school.**

- **Notify courts that refer wards to the California Youth Authority of their obligation to provide complete special education data under *Welfare and Institutions Code* section 1742. Develop a plan with court representatives to accomplish that purpose, including a timetable for submitting special education information. If cooperation is not forthcoming, refuse to accept wards who do not have complete special education background packages.**

- **Develop an automated process to track and monitor caseworker productivity and to ensure that the diagnostic assessment process for each ward is completed within required time limits.**

- **Ensure the timely completion of special program assessment of needs evaluations.**

- **Ensure that the work experience program provides weekly individual and small-group counseling to wards.**

- **Monitor the casework of all living units, including the work experience program, to ensure that the casework management system is being used to manage the counseling of wards.**

- **Ensure that all staff receive annual refresher training in suicide prevention assessment and response.**

- **Remind staff of the importance of the suicide prevention and response committee, and enforce attendance at committee meetings.**

- **Do not administer psychotropic medications to wards who have not received treatment needs assessments.**

- **Ensure that employees obtain consent forms to administer psychotropic medication to wards under age 18.**

- **Improve the thoroughness and overall quality of the annual *California Youth Authority Institutions and Camps Branch Manual* section 1800 security audits.**

VENTURA YOUTH CORRECTIONAL FACILITY

Forty-nine (48 percent) of the 101 recommendations from a June 2002 management review audit of the Ventura Youth Correctional Facility have been fully implemented; 22 (22 percent) have been substantially implemented; 16 (16 percent) have been partially implemented; and 10 (10 percent) have not been implemented. Four (4 percent) of the previous recommendations are no longer applicable.

As a result of a June 2002 management review audit, the Office of the Inspector General identified a number of serious problems at the Ventura Youth Correctional Facility, which at that time was the California Youth Authority's only coeducational institution. Many of the problems stemmed from the difficulty of providing education, treatment, and other services to male and female wards while keeping the genders separated. The audit determined that operating the institution as a coeducational facility disrupted programs, caused services to be duplicated, and in some cases prevented Ventura Youth Correctional Facility wards from receiving the services provided to wards at other institutions.

In the 2002 audit, the Office of the Inspector General found that only 47 percent of a sample of wards had received required weekly counseling sessions and that only 54 percent had received timely case conferences. Only 29 percent of a sample of female wards had received treatment needs assessments within the required three weeks of arrival at the institution. Pregnancy care for female wards was inadequate; wards with communicable diseases were not adequately screened from working in food services; and the segregation of male and female wards limited access to medical services for both genders. The academic achievement of wards at the institution also was low compared to that of wards at other California Youth Authority institutions. The Office of the Inspector General found that a number of the deficiencies identified in education and medical care resulted from a shortage of resources and inadequate policy direction from California Youth Authority management.

The 2004 Accountability Audit determined that the Ventura Youth Correctional Facility has improved its operations since the June 2002 audit and has made considerable progress in implementing the previous recommendations. Treatment services, mental health assessments, medical care, security, aspects of education, employee investigations, ward discipline, and the ward grievance process have all improved. A number of the problems were solved by converting the facility to an all-female institution, providing the facility with a higher staff-to-ward ratio than before and making it easier to provide wards with services. As a result of the conversion to an all-female institution with a relatively small ward population, however, the budgeted cost per ward at the Ventura Youth Correctional Facility is now among the highest of all California Youth Authority institutions. In addition, education services continue to be hampered by not having enough teachers, with an average of 18 classes a day cancelled because teachers are absent and there is no one available to fill in.

Key findings revealed by the 2004 Accountability Audit are the following:

- Whereas the 2002 audit found that only 47 percent of a sample of wards had received the weekly individual and small group counseling required by section 4050 of the *California Youth Authority Institutions and Camps Branch Manual*, the 2004 follow-up review found that 44 (94 percent) of a similar sample of 47 wards had received the counseling. Most of the recommendations pertaining to treatment services have been implemented.

- The institution has either fully or substantially implemented most of the recommendations pertaining to mental health assessment services. Yet, a review of ward files found that only 12 wards out of a sample of 18 had received treatment needs assessments within the required three weeks of arrival and that three wards had not received treatment needs assessments at all.

- The institution has improved medical services for pregnant wards; has improved procedures for handling wards with communicable diseases; and has eliminated barriers to medical care caused by operating the facility as a coeducational institution.

- Although three of the seven recommendations pertaining to education have been fully implemented, problems resulting from teacher vacancies and the inadequacy of the substitute teacher pool remain. From April 2004 through August 2004, 30 percent of the classes at the facility's Mary B. Perry High School were cancelled because teachers were not available. Even though an average of 18 classes a day are cancelled because of teacher absences, the facility has only one substitute teacher available to fill in. This problem is reflected in the decline in the high school's effectiveness rating between fiscal year 2002-03 and fiscal year 2003-04. The effectiveness rating, which measures actual instruction time as a percentage of available instruction time, dropped from 70 percent to 65 percent during that period.

- Notwithstanding the problem with teacher vacancies and substitute teacher shortages, wards' cumulative standardized test scores increased from 2003 to 2004. Whereas 71 percent of wards had cumulative subject scores below the 25th national percentile rate in 2003, only 54 percent of the wards had cumulative subject scores below the 25th national percentile rate in 2004. The 54 percent rate is the institution's best since 1998 and may have resulted in part from an increase in per-ward spending and a boost in the staff-to-ward ratio following the removal of male wards from the facility. The school absenteeism rate during the same period increased slightly from 13 percent to 14 percent.

- Nearly all of the recommendations relating to investigation practices and procedures have been fully or substantially implemented.

- Thirteen of the seventeen recommendations pertaining to security deficiencies have been fully or substantially implemented, while two others have been partially

implemented and one is no longer applicable. The remaining recommendation is awaiting action by the department.

- Most of the recommendations pertaining to the disciplinary decision-making system have been fully implemented.

- All but two of the recommendations pertaining to the ward grievance system have been fully or substantially implemented.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the management of the Ventura Youth Correctional Facility take 30 additional actions to address the deficiencies. The most significant of the recommendations are the following:

- **The California Youth Authority and the Ventura Youth Correctional Facility management should promptly fill teaching vacancies and work with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive teacher compensation by upgrading pay scales using compensation exceptions provided for by law and other suitable methods, such as recruitment and retention pay incentives.**

- **The Ventura Youth Correctional Facility management should compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.**

- **To help coordinate ward education and treatment programming, the California Youth Authority and the Ventura Youth Correctional Facility management should develop policies to facilitate the attendance of teachers at ward case conferences without the need to cancel classes.**

- **The Ventura Youth correctional Facility management should ensure that treatment needs assessments are conducted for all wards within three weeks of admission to the facility.**

- **The Ventura Youth Correctional Facility management should ensure that treatment needs assessment test booklets are scanned and scored no later than the next working day.**

- **The Ventura Youth Correctional Facility management should ensure that the senior psychologist is notified before the end of the next working day if a treatment needs assessment scoring report shows a "red flag," indicating the need for immediate action by the mental health staff.**

- **The Ventura Youth Correctional Facility management should ensure that the treatment needs assessment profile and scoring report is filed in the mental health section of the unified health record.**

- **The California Youth Authority and the chief medical officer should develop comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general.**

- **The California Youth Authority should provide the Ventura Youth Correctional Facility with pertinent and timely information for tracking investigations, regardless of whether the new case management system is ready for use. The information should include the internal affairs or Education Services Branch case number, the subject name, the allegation, the incident date, the discovery date, the investigator's name, the case closure date, and the conclusions.**

- **The Ventura Youth Correctional Facility management should continue to reduce expenditures wherever possible and to track costs and reasons for unforeseen or unbudgeted expenditures.**

- **The California Youth Authority should track unforeseen or unbudgeted expenditures to support additional funding requests.**

INTENSIVE TREATMENT PROGRAM

Of ten recommendations issued by the Office of the Inspector General following a November 2002 review of the Intensive Treatment Program, two have been fully implemented, one has been substantially implemented, five have been partially implemented, and two have not been implemented. Several of the 2002 recommendations were not acted upon until 2004, when action was taken as a result of the *Farrell v. Allen* remedial plan.

In November 2002, the Office of the Inspector General conducted a review of the California Youth Authority's intensive treatment program, which is intended to provide treatment to wards who have significant mental health disorders. One of the three principal components of the department's mental health treatment system, the intensive treatment program provides sub-acute care to wards suffering from moderate to severe mental illness, including schizophrenia, psychosis, depression, and bipolar disorder. The November 2002 review determined that the intensive treatment program was serving only a small percentage of wards suffering from severe mental illness and that the treatment provided was generally substandard.

The 2004 Accountability Audit found that the California Youth Authority has made improvements to its intensive treatment program, but is still failing to ensure that newly committed wards and parole violators receive the required treatment needs assessment. California Youth Authority Institutions and Camps Branch Manual, section 6260 requires

newly committed wards and parole violators to receive treatment needs assessments within 21 days, and the department reported that a new a tracking system ensures that wards receive treatment needs assessments within 21 days of arrival. Yet, the Office of the Inspector General found that between January and November 2004, 114 newly committed wards did not receive treatment needs assessment within 21 days and that some went as long as 10 months without treatment needs assessments — delaying any needed mental health treatment and putting wards at increased risk for suicide. During the same period, 627 parole violators did not receive treatment needs assessments at all.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following additional actions:

- **Ensure that all wards—parole violators, as well as newly committed wards — receive a treatment needs assessment within the 21 days required by department policy.**
- **Implement the Office of the Inspector General's recommendation to institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing.**
- **Continue efforts to provide training to youth correctinal counselors in mental health treatment principles and methods and to provide continuing education to psychiatrists, psychologists, and other members of the mental health staff.**
- **Develop policies and procedures for providing follow-up care to wards leaving the intensive treatment program.**

OFFICE OF INTERNAL AUDITS

Of the nine recommendations issued by the Office of the Inspector General following a July 2003 audit of the Office of Internal Audits, five have not been implemented. Only one recommendation has been fully implemented; one has been substantially implemented; and two have been partially implemented.

The Office of the Inspector General conducted an audit in July 2003 of the California Youth Authority's Office of Internal Audits to determine whether the department was using its internal audit function effectively to help it fulfill its mission. The audit examined whether the management practices and procedures of the Office of Internal Audits were being carried out in accordance with applicable laws and policies and whether the office adhered to professional internal auditing standards.

The 2003 audit found that the California Youth Authority was not using the Office of Internal Audits to identify the serious problems affecting the department because it had unnecessarily restricted the work of the office to fiscal matters. Even within that limited

framework, the Office of the Inspector General found that the Office of Internal Audits was failing to accomplish its mission. The audit determined that in the most recent two-year reporting period the office had completed less than 6 percent of the 301 audits for which it was responsible. The reporting structure of the office also failed to ensure the independence of the internal audit function. The Office of the Inspector General concluded that, as a result of the deficiencies, the California Youth Authority could not properly certify that it was maintaining a system of internal accounting and administrative control as required under the Financial Integrity and State Managers Accountability Act of 1983.

The Office of the Inspector General found that the California Youth Authority is still not making effective use of the Office of Internal Audits, since re-named the Internal Audits Unit. The department reported that the changes to the internal audit function are expected to result from the *Farrell v. Allen* remedial plans, now being developed. In the meantime, the the Internal Audit Unit continues to perform the same limited fiscal audits that were being conducted at the time of the Office of the Inspector General's July 2003 audit. The department also appears to have taken no action to ensure compliance with the*Standards for the Professional Practice of Internal Auditing,* and the reporting structure continues to jeopardize the independence of the internal audit function.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General reiterates the importance of implementing the recommendations issued as a result of the July 2003 audit. The California Youth Authority should take the following actions:

- **To allow management greater control over fiscal and program functions critical to department operation, integrate the internal audit function and the program compliance function into a single office and combine staff to perform comprehensive fiscal and operational reviews.**

- **Provide for the internal audit/program compliance office to be managed by someone who can ensure that the office adheres to the *Standards for the Professional Practice of Internal Auditing.***

- **Provide for the head of the internal audit/program compliance office to report directly to the chief deputy director.**

- **Require that the head of the internal audit/program compliance office perform a comprehensive risk assessment of California Youth Authority institutions, camps, education services, treatment programs, parole operations, and headquarters to identify areas of high risk when assigning resources and developing work plans.**

- **Implement an internal quality assurance program that enables management to measure staff and office performance in the areas of fiscal and program compliance; evaluation of budgeted and expended hours; effectiveness of reports; and monitoring of findings and recommendations.**

- **In accordance with the *Standards for the Professional Practice of Internal Auditing*, arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the department director.**

YOUTH AUTHORITY BOARD

Six of the seven recommendations from a 2002 review of the process by which the California Youth Authority and the Youthful Offender Parole Board (now the Youth Authority Board) set programming requirements for wards have been fully implemented and the remaining recommendation has been substantially implemented.

In December 2002, the Office of the Inspector General reviewed the process by which the California Youth Authority and the Youthful Offender Parole Board (now the Youth Authority Board) established ward program requirements. The review found that responsibility for specifying the treatment programs wards must complete before they are released from custody rested with the Youthful Offender Parole Board, which lacked treatment expertise, while the California Youth Authority, which has the expertise and responsibility for assessing wards' treatment needs, had authority only to recommend generally what programs a ward should complete. The review also found that the Youthful Offender Parole Board often required wards to complete more treatment programs than could reasonably be completed before their scheduled release date, causing them to be retained at the institutions.

The 2004 Accountability Audit determined that significant changes have been made in the process of setting programming requirements for wards. Responsibility for recommending treatment has been shifted from the former Youthful Offender Parole Board to the California Youth Authority. The department also now provides a treatment plan for each ward and has implemented a core treatment program to promote consistency in the treatment provided to wards. An assessment of training and treatment programs has also begun. Six of the previous recommendations have been fully implemented and the remaining recommendation has been substantially implemented.

Some of the changes have resulted from the *Farrell v. Allen* litigation, while others have resulted from the passage of Senate Bill 459, which took effect on January 1, 2004. Under the provisions of the new law, the following changes have been made in the delivery of treatment, rehabilitation, and training to California Youth Authority wards:

- The Youthful Offender Parole Board was abolished and in its place the Youth Authority Board was created within the CaliforniaYouth Authority.

- T ..... he duties of the Youthful Offender Parole Board were consolidated in the CaliforniaYouth Authority and the Youth Authority Board.

- The changes set forth the membership of the Youth Authority Board and required those members to receive specified training.

- The Youth Authority Board now exercises specified powers and duties, including discharges of commitment, orders to parole and conditions thereof, revocation or suspension of parole, and disciplinary time-add appeals.

- The CaliforniaYouth Authority is required to exercise specified powers and duties, including determining offense categories, setting parole consideration dates, making decisions regarding disciplinary actions, and returning wards to the court of commitment for re-disposition by the court.

- The California Youth Authority is required to notify the probation department and the court of the parole consideration dates.

- The California Youth Authority is required to provide the court and the probation department with a treatment plan for wards and an estimated timeframe within which the treatment recommended by the court will be provided.

- The California Youth Authority is required to conduct an annual review of each ward's case and to provide copies of the review to the court and the probation department.

- The Welfare and Institutions Code now specifies that a minor may not be held in physical confinement for a period in excess of the maximum term of physical confinement set by the court.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority institute methods of assessing the effectiveness of curriculum and treatment provided to wards.

WELFARE AND INSTITUTIONS CODE SECTION 1732.8

Four of the seven recommendations from a February 2003 review of the implementation of Welfare and Institutions Code section 1732.8 pertaining to "dual-commitment" wards have been fully implemented and the remaining three have been partially implemented.

The Office of the Inspector General conducted a review in February 2003 of the Implementation of Welfare and Institutions Code section 1732.8, which allows California Youth Authority wards who have served sentences in Department of Corrections facilities to elect to also serve their remaining California Youth Authority confinement time in Department of Corrections institutions. Wards covered by the statute are termed "dual-commitment wards." At the time of the February 2003 review, there were 40 dual-commitment wards in Department of Corrections institutions throughout the state.

The February 2003 review identified a number of deficiencies in the implementation of Welfare and Institutions Code Section 1732.8. The Office of the Inspector General found that the California Youth Authority and the Youthful Offender Parole Board lacked standards and procedures for programming dual-commitment wards and that the expectations of the Youthful Offender Parole Board were not clearly explained to the wards. Dual-commitment wards also were not afforded the rights provided to other wards to attend their annual review and parole consideration date hearings and there were deficiencies in coordinating ward appeal and grievance procedures.

The 2004 Accountability Audit determined that the California Youth Authority and the Youth Authority Board have significantly improved the handling of dual-commitment wards serving California Youth Authority confinement time in Department of Corrections facilities under Welfare and Institutions Code Section 1732.8. By the time of the follow-up fieldwork in May 2004, the number of dual-commitment wards in Department of Corrections facilities had decreased from 40 to 33.

The agencies have made the following key changes in response to the previous recommendations:

- The California Youth Authority and the Youth Authority Board now allow dual-commitment wards to attend their annual reviews and parole consideration date reviews.

- The California Youth Authority and the Youth Authority Board have modified the dual-commitment consent form to clarify the programming expectations of the Youth Authority Board and the potential consequences of a ward's failure to participate in programs available at the Department of Corrections institution.

- The agencies have modified the dual-commitment consent form to include appeal and grievance procedures and the mailing address for submitting grievances.

FOLLOW-UP RECOMMENDATIONS

- **The Office of the Inspector General recommends that the California Youth Authority document review of the case files of wards who have had time added to the parole consideration date to ensure that due process rights have been fully observed.**

- **The California Youth Authority should ensure that the Department of Corrections memorandum concerning the distribution, processing, and retention of appeal/grievance forms for Welfare and Institutions Code section 1732.8 wards is submitted in final form to the inmate appeals coordinators.**

YOUTHFUL OFFENDER PROGRAM

The California Youth Authority has fully implemented the only recommendation from a previous review of the Youthful Offender Program.

In September 2003, the Office of the Inspector General conducted a special review of the Youthful Offender Program at the California Correctional Institution in Tehachapi, California. The Office of the Inspector General found from the review that the institution could not adequately accommodate the Youthful Offender Program inmates. The review determined that the limited space available at the institution, along with the need to separate youthful offenders from adult inmates, often resulted in youthful offenders being confined to cells and not receiving mandated education programming and out-of-cell exercise time. Inmates in the Youthful Offender Program also lacked access to the range of counseling, rehabilitative programs, and mental health treatment available to California Youth Authority wards.

The Office of the Inspector General recommended that the Department of Corrections and the California Youth Authority formulate an arrangement to house Youthful Offender Program inmates at a California Youth Authority facility.

The Office of the Inspector General found from the 2004 Accountability Audit that all inmates in the Youthful Offender Program were transferred from the California Correctional Institution adult prison to the Heman G. Stark Youth Correctional Facility and the N. A. Chaderjian Youth Correctional Facility in July 2004.

FOLLOW-UP RECOMMENDATIONS

None.

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INTRODUCTION

This report presents the results of a comprehensive follow-up audit of nine previous audits and reviews of California Youth Authority programs and institutions conducted by the Office of the Inspector General between April 2000 and December 2003. The purpose of the audit was to assess the progress of the Youth and Adult Correctional Agency and the California Youth Authority in implementing the Office of the Inspector General's previous recommendations. The audit was performed pursuant to California Penal Code section 6126, which assigns the Office of the Inspector General responsibility for oversight of the Youth and Adult Correctional Agency and its subordinate departments.

BACKGROUND

The California Youth Authority operates eight youth correctional facilities and three conservation camps throughout the state. At this writing, 3,589 youthful offenders are in California Youth Authority custody, and another 4,110 youths are on parole under the department's jurisdiction. Ninety-five percent of youthful offenders in California Youth Authority custody are male. The department has approximately 3,600 employees and an operating budget in fiscal year 2004-05 of $386,904,000. A new department director was appointed by the Governor in January 2004 and confirmed by the Senate Rules Committee in August 2004.

The department defines its mission as follows:

> *[T]o protect the public from criminal activity by providing education, training, and treatment services for youthful offenders committed by the courts; assisting local justice agencies with their efforts to control crime and delinquency, and encouraging the development of state and local programs to prevent crime and delinquency.*

Under state and federal law, the California Youth Authority is required to provide youths committed to its custody —who are called "wards"—with education services, medical care, counseling, and mental health treatment and to provide them with constitutionally adequate conditions of confinement. California Welfare and Institutions Code section 1120 requires the department to operate a statewide school district, and each of department's eight institutions provides academic and vocational classes to enable wards to attain a high school diploma or general education equivalent (GED) before they are released. Institutions are required to provide wards who do not have a high school diploma or GED with 240 minutes (four hours) of academic instruction per day.

In the last five years the number of youthful offenders committed to the California Youth Authority has declined by more than half, from 10,114 in June 1996 to 3,589 today. The decrease is largely the result of S.B. 681 (Chapter 66, Statutes of 1996), which discourages counties from sending non-violent offenders to the State by requiring them to pay a sliding-scale percentage of the per capita cost of housing youths in California Youth Authority facilities. In addition to causing a decline in the number of youths committed to the California Youth Authority, the

legislation has also led to a much higher percentage of violent offenders and those in need of mental health treatment comprising the Youth Authority population. Because of the declining ward population, the department has closed five of its youth correctional facilities since 2002.

The California Youth Authority has come under increasing public criticism because of violence in its institutions, suicide among wards in department custody, and failure to provide mandated education and treatment to wards. As the result of a class action lawsuit*, Farrell v. Allen,* filed against the department by the Prison Law Office, the department is presently under a consent decree to improve its operations. A formal review of California Youth Authority treatment services has been conducted by a panel of experts under the direction of the California Attorney General's Office and a comprehensive remedial plan in settlement of the lawsuit is expected to be approved in January 2005.

OBJECTIVES, SCOPE AND METHODOLOGY

To conduct the audit, the Office of the Inspector General performed the following procedures:

- Reviewed nine audits and reviews conducted by the Office of the Inspector General of California Youth Authority programs and institutions between 2000 and 2003.

- Contacted the California Youth Authority and requested information and documentation on the department's progress in implementing the Office of the Inspector General's recommendations.

- Reviewed pertinent portions of the remedial plan being developed by the California Youth Authority in response to the *Farrell v. Allen* federal court lawsuit.

- Reviewed the report, *Reforming Corrections,* issued by the Corrections Independent Review Panel, June 2004.

- Conducted site visits at all eight California Youth Authority institutions: Heman G. Stark Youth Correctional Facility; the Southern Youth Correctional Reception Center and Clinic; Ventura Youth Correctional Facility; N.J. Chaderjian Youth Correctional Facility; and Preston Youth Correctional Facility; El Paso de Robles Youth Correctional Facility; O.H. Close Youth Correctional Facility; and DeWitt Nelson Youth Correctional Facility.

- Reviewed ward and facility files, logs, records, and other documents and performed tests as necessary using audit sampling techniques.

- Evaluated the information developed from the audit procedures and classified the progress of the department and the institutions in implementing each recommendation into one of the following four categories:

  ► **Fully implemented:** The recommendation has been implemented and no further corrective action is necessary.

- **Substantially implemented:** More than half of the corrective actions necessary to fulfill the recommendation have been implemented.
- **Partially implemented:** Half or less than half of the corrective actions necessary to fulfill the recommendation have been implemented.
- **Not implemented:** The recommendation has not been implemented.

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FINDINGS

The following chapters present the results of the 2004 Accountability Audit of the California Youth Authority. Each chapter describes the findings and recommendations of the original audit or review and includes a table reporting the progress of the Youth and Adult Correctional Agency, the California Youth Authority, and California Youth Authority institutions in implementing the recommendations. Where appropriate, the Office of the Inspector General has provided additional recommendations to correct deficiencies.

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23-AND-1 CONFINEMENT

IMPLEMENTATION REPORT CARD

Previous recommendations: 4

Fully implemented: 0 (0%)

Substantially implemented:0 (0%)

Partially Implemented: 2 (50%)

Not implemented: 2 (50%)

The Office of the Inspector General found that the California Youth Authority still confines a significant number of wards to cells 23 hours per day. The review found 140 wards statewide assigned to 23-and-1 confinement and an estimated 103 additional wards on *de facto* 23-and-1 confinement because the institution lacks the resources to provide education services. The total amounts to 9 percent of the wards in the six California Youth Authority facilities examined.

In December 2000 the Office of the Inspector General conducted site reviews at six California Youth Authority institutions to examine the department's practice of confining wards with psychological and behavioral problems to their cells for 23 hours a day. The review determined that 16.4 percent of wards at those institutions — one in six — were on so-called "23-and-1" schedules. The Office of the Inspector General also found that the reasons for 23-and-1 confinement were not clearly documented; that wards did not appear to be receiving mandated services; that wards lacked necessary hygiene items; and that rooms were in disrepair, with inadequate lighting and heating.

Restriction to cells 23 hours a day over long periods of time deprives wards of academic and other programming opportunities, thereby detracting from the ultimate goal of rehabilitation and lengthening the ward's stay in California Youth Authority institutions. Long periods of isolation and the consequent lack of sensory stimuli may also increase the wards' needs for mental health services, which are in short supply. Simply put, the long-term isolation of young people entrusted to the State is both ineffective and dehumanizing. The practice of 23-and-1 confinement should cease as soon as possible.

BACKGROUND

Under normal circumstances, California Youth Authority wards are allowed to leave their cells to receive the following mandated services:

- Four hours a day of academic classes;
- At least four hours a month of individual and group counseling; and
- Three hours a day of exercise and leisure time.

Wards may also be allowed to leave their cells to participate in work assignments; for meals (although meals may be served in cells at some institutions); to obtain medical and dental care; and for telephone calls, visitations, court appearances, and religious services. Wards in drug or sex offender treatment and other specialized programs also may receive additional time outside the cell to obtain additional counseling services.

In contrast, wards who are on 23-and-1 schedules are confined to cells for all but one hour a day when they are allowed outside for one hour of exercise. Those on 23-and-1

schedules are nonetheless mandated to receive specified services, including education in the least restrictive environment possible; a daily shower; behavioral counseling; medical and dental services; visitations; telephone calls; access to legal resources; hygiene supplies; clean and sanitary living conditions; court appearances; and reasonable opportunity to participate in religious services.

Until a recent announcement by the new department director that the practice has ended, California Youth Authority policy provided for wards to be put on 23-and-1 confinement status as a result of placement in one of the three "restricted programs" listed below:

- ***Administrative lockdown.*** Administrative lockdown is the restriction to cells of all wards in a living unit or a facility due to an operational emergency that threatens the safety of wards or staff. Under department policy, administrative lockdown is to continue only as long as necessary to restore the safe operation of the facility or living unit.

- ***Temporary detention.*** Temporary detention is imposed on individual wards to ensure the ward's safety, the safety of others, or the security and orderly operation of the facility and should last only as long as the condition or behavior warrants. Wards placed on temporary detention must meet the criteria of posing a danger to self, a danger to others, being endangered (in need of protective custody), or constituting an escape risk.

- ***Special management program.*** The special management program is a segregated, structured environment that provides counseling, education, medical, psychological and psychiatric services to wards who exhibit violent and disruptive behavior. The program is intended to be short term, with the goal of returning the ward to a less restrictive programming environment as soon as possible. Department policy stipulates the average length of assignment to the special management program to be 60-90 days and provides that wards may not remain in a special management program longer than 90 days without approval of the Departmental Restricted Program Review Committee, which consists of representatives from the California Youth Authority director's office, the Institutions and Camps Branch deputy director's office, the Education Services Branch deputy director's office, and the Institutions and Camps Branch mental health programs office.

SUMMARY OF PREVIOUS FINDINGS

For the December 2000 review, the Office of the Inspector General examined 23-and-1 practices at six California Youth Authority institutions: El Paso de Robles Youth Correctional Facility; Fred C. Nelles Youth Correctional Facility; Heman G. Stark Youth Correctional Facility; Southern Youth Correctional Reception Center and Clinic; Preston Youth Correctional Facility; and N.A. Chaderjian Youth Correctional Facility.

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

- Of a total population of 4,483 wards at the six institutions, 735 (16.4 percent) were on 23-and-1 confinement status.

- A significant number of wards on 23-and-1 status said they had not received mandated services, with 36 percent reporting they were not receiving the required one hour out of their rooms in each 24-hour period and 40 percent reporting they were not receiving regular visits from the treatment team staff.
- The reasons for detention were not clearly documented.
- Living conditions for the wards were substandard. Rooms were in disrepair, with inadequate light and heating, plugged air vents, and graffiti-covered walls. Wards also lacked necessary hygiene items.
- California Youth Authority headquarters lacked timely and reliable information necessary to monitor 23-and-1 practices.

The Office of the Inspector General issued four recommendations to correct the deficiencies, including implementation of procedures to provide clear justification for isolating wards on detention; measures to ensure that the wards' mental health and medical needs were met and that the provision of mandated services was documented; and procedures to provide for cells to be inspected regularly and deficiencies rectified.

Subsequent to the Office of the Inspector General's December 2000 review, members of the Legislature and other observers also have questioned the California Youth Authority's practice of confining wards in cells for 23 hours a day. As a result, on August 4, 2004, the newly appointed director of the California Youth Authority announced during his confirmation hearing before the Senate Rules Committee that the department had ended the practice.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Office of the Inspector General conducted the 2004 follow-up review to determine whether the California Youth Authority had indeed ended 23-and-1 confinement and had implemented the four recommendations from the December 2000 review. To conduct the follow-up review, the Office of the Inspector General asked the department to report the implementation status of each of the previous recommendations and evaluated the response. The Office of the Inspector General then made simultaneous unannounced visits on September 23, 2004 to five of the six institutions covered in the 2000 review: N.A. Chaderjian Youth Correctional Facility; Heman G. Stark Youth Correctional Facility; El Paso de Robles Youth Correctional Facility; Preston Youth Correctional Facility; and the Southern Youth Correctional Reception Center and Clinic.[1] At the institutions, the auditors interviewed staff and wards; reviewed logs, documents, and records associated with restricted programs and mandated services; observed operations; inspected the rooms of wards; and conducted tests necessary to determine whether 23-and-1 confinement had been discontinued and whether the recommendations from the December 2000 review had been implemented.

[1] The sixth institution covered in the December 2000 review, Fred C. Nelles Youth Correctional Facility, is now closed and therefore was not included in the 2004 follow-up review.

SUMMARY OF THE FOLLOW-UP RESULTS

The Office of the Inspector General found that a significant number of wards at four of the five institutions reviewed were still on 23-and-1 confinement schedules on September 23, 2004. Among the five institutions, only the Southern Youth Correctional Reception Center and Clinic had ended the 23-and-1 practice. The Office of the Inspector General identified 140 wards at the remaining four facilities who were assigned to 23-and-1 confinement. In addition, the audit team estimated that another 103 wards at the Heman G. Stark Youth Correctional Facility not in restricted programs were on *de facto* 23-and-1 schedules because the institution lacks enough teachers to provide education services, with the result that wards simply remain in their cells 23 hours a day instead of attending classes. In total, the Office of the Inspector General found that out of a total population at the five facilities of 2,658 wards, an estimated 243 wards—9 percent—were on 23-and-1 confinement on September 23, 2004.

The review determined that California Youth Authority headquarters has failed to provide clear direction, resources, policies, and procedures to end 23-and-1 confinement practices. Formal direction from headquarters pertaining to 23-and-1 status appears to have been limited to one memorandum to institution superintendents, issued in July 2004, advising that 23-and-1 confinement was no longer an acceptable practice for wards in special management programs. The memorandum did not address 23-and-1 confinement for wards in other restricted programs and did not spell out implementation procedures for ending 23-and-1 status. Instead, the memorandum directed superintendents to develop their own solutions to implementing the directive. As a result, implementation has been inconsistent. The superintendent of the Southern Youth Correctional Reception Center and Clinic told the Office of the Inspector General that she relied on the director's senate testimony to end 23-and-1 confinement for all wards, while the other four superintendents said they relied strictly on the director's memorandum, which mentioned only wards in special management programs.

The Office of the Inspector General found that lack of clear direction and additional resources from department headquarters to carry out implementation may have had several unintended consequences. For example, ending 23-and-1 confinement for special management program wards, who tend to be the most disruptive and violent, may serve as a disincentive to positive behavior for wards in other restricted programs, who remain on 23-and-1. Superintendents also expressed concern about the increased risk to staff and wards from allowing potentially violent wards to spend more time out of their rooms in the absence of additional resources to address the problem.

In addition to determining that 23-and-1 confinement has not ended at the institutions, the follow-up review revealed a number of other findings. Most significantly, the review found that 27 wards who were on administrative lockdown at the Heman G. Stark Youth Correctional Facility on October 7, 2004, in fact, were not being allowed out of their rooms at all, except for five-minute daily showers. In addition, the review found that of the 46 wards on administrative lockdown at the N.A. Chaderjian Youth Correctional Facility, 39 had been on administrative lockdown status for more than 30 days and 3 had been on administrative lockdown for more than 200 days.

The review also found numerous unsafe conditions in the rooms of wards at the Heman G. Stark Youth Correctional Facility, including windows blocked with paper and towels, preventing the staff from monitoring activity inside the rooms, and in one case, a rope made from a twisted bedsheet draped over a ceiling light fixture.

The Office of the Inspector General reported the unsafe conditions to the director of the California Youth Authority on October 5, 2004, yet found that the conditions had still not been corrected eight days later, on October 13, 2004. When the audit team discussed the issue with the superintendent on October 13, 2004, he reported that he had not been notified of the problem by department headquarters and had been unaware of the unsafe conditions. On November 16, 2004, the Office of the Inspector General again visited the facility and found that the conditions had been corrected.

Of the four recommendations issued by the Office of the Inspector General as a result of the December 2000 review, none have been fully implemented; none have been substantially implemented; two have been partially implemented and two have not been implemented.

Following is a summary of the findings from the 2004 follow-up review:

- A total of 243 wards — 9 percent of wards at the institutions reviewed — were on 23-and-1 status on September 23, 2004. The total consisted of the following:

  √ 94 wards on temporary detention at the Heman G. Stark, N.A. Chaderjian, El Paso de Robles, and Preston Youth Correctional Facilities;

  √ 46 wards on administrative lockdown at the N.A. Chaderjian Youth Correctional Facility;

  √ An estimated 103 "Phase 1"[2] wards on *de facto* 23-and-1 status at the Heman G. Stark Youth Correctional Facility. Although phase-one wards are supposed to receive time outside their cells for education and counseling, along with an additional hour a day outside for large-muscle exercise, phase-one wards at Heman G. Stark are confined 23 hours a day because the institution lacks enough teachers to consistently provide education services. Of 22 phase-one Heman G. Stark wards selected for review by the audit team, 12 (55 percent) had not attended school during one or both of the two months reviewed. Of the remaining 10 wards, 5 had received fewer than 10 hours of education for the entire month. Furthermore, in one month, 10 of the 22 phase-one wards selected for review had received an average of only 14 minutes a day outside their rooms for education and counseling services combined.

- The management at the Heman G. Stark Youth Correctional Facility told the Office of the Inspector General that 27 wards on administrative lockdown at the institution

[2] "Phase 1" refers to wards in the beginning phase of a three-phase system intended to motivate wards to participate in programs and improve behavior.

on October 7, 2004 actually were on 24-hour restriction, with no time outside their cells except for a five-minute daily shower.

- At the Heman G. Stark Youth Correctional Facility, 26 of the 100 rooms of wards in the special management program (26 percent) had windows blocked with paper or towels, hampering the ability of the staff to monitor the wards.

- At the Heman G. Stark Youth Correctional Facility, the audit team found a rope made from a twisted bedsheet hanging from the ceiling light fixture in the room of one ward.

- At all five institutions, wards in special management programs now receive approximately three hours a day outside their cells instead of one hour a day. Special management program wards at the N. A. Chaderjian Youth Correctional Facility, however, spend the three hours in a 10' x 16' cyclone-fenced asphalt enclosure with no recreation equipment or toilet facilities and only a small amount of water. If a ward asks for more water or to use the restroom, the "three hours" ends and he is returned to his cell. And although the enclosures are designed for only one ward, the audit team found the facility routinely confines two wards in each enclosure.

- Of the 46 wards on administrative lockdown at the N.A. Chaderjian Youth Correctional Facility on September 23, 2004, 39 had been on administrative lockdown for more than 30 days and 3 had been on administrative lockdown for more than 200 days.

- At the N.A. Chaderjian Youth Correctional Facility, cell floors, walls, cupboard and shelf units, bed frames, inner doors, and ceilings in special management program rooms were covered to varying degrees with gang markings and graffiti.

- The department has partially implemented a previous recommendation that policies and procedures be developed to document that mandated services have been provided to wards in restricted programs, but documentation continues to be lacking. Mandated daily services, including meals and showers, appear to have been documented by the staff, but weekly and monthly mandated services, such as visiting, telephone calls, and use of religious services were not consistently documented.

- The review also found evidence that some logs documenting that mandated services have been provided were not accurate. The auditors found that the log documenting mandated services at the Heman G. Stark Youth Correctional Facility indicated that one ward had received one or more of the mandated services on 11 of the 14 days reviewed, yet a check of the computer tracking system revealed that the ward had been in court during the entire period. At El Paso de Robles Youth Correctional Facility and the N.A. Chaderjian Youth Correctional Facility, the auditors also found inconsistencies between the living unit logs initialed by the staff to document mandated services and the logs documenting services that are generated by the ward information network.

The Office of the Inspector General also noted the following area of improvement:

- The department reported that the average length of stay for wards in special management programs dropped from 158 days in September 2000 to 52 days in March 2004. The department attributes the decrease to the establishment in April 2002 of the Departmental Restricted Program Review Committee, subsequently renamed the Departmental Review Board, which monitors services to wards in special management programs, with particular attention to wards who have been in special management programs for more than 90 days.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following additional actions:

- **Determine the conditions — if any—under which it is appropriate to confine wards to cells for 23 hours a day. If these conditions are found to exist, develop clear policies and procedures to identify these conditions and the time limits that will apply. If the conditions are not found to exist, develop an implementation plan for eliminating the 23-and-1 schedule in favor of additional education, treatment, and programming services.**
- **Define confinement schedules for wards in restricted programs and promulgate and enforce uniform policies and procedures, including those governing the size of outdoor exercise enclosures and the provision of water, toilet facilities, and recreation items, to ensure consistency throughout the department.**
- **Address the inconsistency that allows wards in special management programs to receive more time out of their cells than many wards who are not in special management programs.**
- **Review methods for tracking mandated services and implement procedures to ensure that weekly and monthly, as well as daily, services are accurately documented.**
- **Direct the task force on conditions of confinement to develop and implement policies and procedures that provide clear justification for isolating wards in restricted programs.**
- **Implement the previous recommendation to hold staff accountable for failing to follow policies related to wards' living conditions, particularly those that threaten safety and security.**
- **Evaluate the reason for the extended administrative lockdown at the N.A. Chaderjian Youth Correctional Faclility and take steps to place the wards in appropriate programs.**

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

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that a significant portion of the wards interviewed said they were deprived of their rights while housed in temporary detention units.

ORIGINAL RECOMMENDATIONS		COMMENTS
The Office of the Inspector General recommended that the California Youth Authority prescribe standardized requirements for documenting activities mandated for wards held in temporary detention and other 23-and-1 programs. The recommendation suggested that consideration be given to maintaining a comprehensive compendium of information on each ward in a centralized file to ensure that issues and activities related to due process and conditions of confinement are carried out and appropriately documented. The Office of the Inspector General requested that the department implement the recommendation within 60 days.	PARTIALLY IMPLEMENTED	The department management reported to the Office of the Inspector General that the recommendation to prescribe standards has not been implemented; yet, it appears that the previous administration did implement it. The *California Youth Authority Institutions and Camps Branch Manual,* beginning at section 7270, sets forth policies and procedures developed in August 2003 for documenting the delivery of mandated services. The department pointed out that remedial plans being developed pursuant to the *Farrell v. Allen* lawsuit include a component to establish mandated services requirements, as well as a system to ensure compliance. The Office of the Inspector General found that all of the youth correctional facilities covered in the follow-up review that have wards in restricted programs have partially implemented the standards pertaining to mandated services provided in the *California Youth Authority Institutions and Camps Branch Manual.* The audit team found inconsistencies in the completion of the restricted program mandated services logs, however, at NA Chaderjian, Heman G. Stark, and El Paso De Robles Youth Correctional Facilities. The auditors found that the staff consistently completed the logs documenting daily services such as meals and showers, but did not consistently use the weekly and monthly logs to document services such as visiting, telephone calls, and use of religious services. The auditors also found evidence that the logs may not be accurate. At Heman G. Stark Youth Correctional Facility, the audit team noted that the restricted program mandated services log indicated that one ward had received one or more of the mandated services on 11 of the 14 days reviewed; yet, the computer tracking system showed that the ward had been out to court during the entire period. At El Paso de Robles Youth Correctional Facility and N.A. Chaderjian Youth

		Correctional Facility, the audit team also found inconsistencies between the living unit logs, which are initialed by the staff, and logs generated by the ward information network documenting services provided.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority review methods for tracking mandated services to wards and implement procedures to ensure that weekly and monthly, as well as daily, services are accurately documented.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the reasons for detention were not clearly documented.

ORIGINAL RECOMMENDATION		COMMENTS:
The Office of the Inspector General recommended that the authorization for detention include clear justification of the need to isolate a ward in temporary detention and that a supervisor review the report to ensure that the detention is legal and appropriate and that the ward's mental health and medical needs have been met and documented.	NOT IMPLEMENTED	Department management told the Office of the Inspector General that due process for wards placed in restricted programs will be addressed by a two-member task force on conditions of confinement formed in July 2004. Documentation provided by the department shows that the recommendations anticipated from the task force will include revisions to policies and procedures in the *California Youth Authority Institutions and Camps Branch Manual* governing restricted programs. The department also reported that as an interim measure until the task force completes its work, an e-mail was sent to all superintendents and the deputy director of education on July 23, 2004 prohibiting the placement of mental health wards in special management programs. The Office of the Inspector General reviewed the e-mail, however, and found it to be unrelated to the recommendation. Instead, the e-mail addressed changing confinement schedule for wards in the special management program from 23-and-1 to 21-and-3.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority direct the task force on conditions of confinement to develop and implement policies and procedures that provide clear justification for isolating wards in restricted programs.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that living conditions in the wards' rooms and cells were substandard.

ORIGINAL RECOMMENDATION		COMMENTS:
The Office of the Inspector General recommended that the California Youth Authority develop uniform guidelines to ensure that temporary detention rooms and cells are inspected at reasonable intervals and that deficiencies noted during the inspections are rectified.	NOT IMPLEMENTED	In response to this recommendation, department management addressed inspections that occur when the ward vacates a room, but did not address the need for inspections during the time of the ward's occupancy. The remedial plans being developed pursuant to the *Farrell v. Allen* litigation, however, will address this issue. In fieldwork at the institutions during September and October 2004, which included interviews with 45 wards and inspections of 33 ward cells, the Office of the Inspector General found the following conditions: • *N.A. Chaderjian Youth Correctional Facility*. Cell floors, walls, cupboard/shelf units, bed frames, inner doors, and ceilings were covered to varying degrees with gang markings and graffiti. Some of the wards' cells also contained large quantities of hygiene items, clothing, or towels. A treatment team supervisor told the Office of the Inspector General that some of the staff members are afraid of the wards and therefore allow them to "bend the rules," believing that those who try to enforce the rules become targets of assault. • *Heman G. Stark Youth Correctional Facility*. There were numerous unsafe conditions in the special management program living unit cells. Many of the wards had covered door windows with paper or towels, blocking visibility into the cells. On September 24, 2004, the auditors also found a rope made from a twisted bedsheet hanging from the ceiling in one ward's cell. Despite reporting these conditions to the treatment team supervisor that day and to the California Youth Authority director on October 5, 2004, the audit team found on October 13, 2004 that windows in 26 (26 percent) of the cells in the special management program were significantly blocked with paper or towels and that a rope made from a bedsheet was hanging in another cell. When the matter was discussed with the institution superintendent on October 13, 2004,

		he said he had not been contacted by department headquarters and had been unaware of the unsafe conditions. The audit team returned to the facility on November 16, 2004 and found the conditions had been corrected. • *El Paso de Robles Youth Correctional Facility*: The cells in both the temporary detention and the special management program were in good condition. • *Preston Youth Correctional Facility*: Many of the wards —42 percent of those interviewed—said that the requirement that cells be swept and mopped weekly was not consistently met. Another 42 percent also complained about the cold temperature of the rooms, especially at night. Noting that the wards were allowed only a tee shirt, boxer shorts, socks, two sheets, and one light blanket at night, the Office of the Inspector General discussed the issue with the institution staff, with the result that wards were issued a second blanket. • *Southern Youth Correctional Reception Center and Clinic*: While this facility had no wards on restricted programs, the auditors noted holes in some of the walls separating cells in the reception center living unit that would allow wards to communicate with one another and to pass contraband. The audit team also noted that the minutes of the institution's suicide prevention assessment response committee meeting of July 14, 2004 reported that Orange County judges touring the institution had reported that suicide watch rooms were "filthy and had what appeared to be blood and other material on the walls." According to the minutes, the facility's risk management officer and members of the committee confirmed the conditions and the information was communicated to department headquarters. .

FOLLOW-UP RECOMMENDATION

- **The Office of the Inspector General recommends that the California Youth Authority implement the previous recommendation to hold staff accountable for failing to follow policies relating to wards' living conditions, particularly conditions that threaten safety and security.**

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that the California Youth Authority headquarters did not have the timely and reliable information necessary to effectively monitor management of 23-and-1 programs at the facilities.

ORIGINAL RECOMMENDATION		COMMENTS:
The Office of the Inspector General recommended that the California Youth Authority director require all institutions and camps to complete a daily report justifying the continued detention of each ward in a 23-and-1 program beyond the following time limits: Special Management Unit - Four months Temporary Detention - 30 days Other 23-and-1 Programs - 30 days Lockdown - One day	PARTIALLY IMPLEMENTED	Section 7200 of the *California Youth Authority Institutions and Camps Branch Manual* provides that administrative lockdowns should last only as long as necessary to restore the safe operation of the living unit or facility. Yet, the Office of the Inspector General found from the follow-up review, that in at least one instance, wards had been kept on administrative lockdown for an extended period of time. The auditors found that 39 of 46 wards at the N.A. Chaderjian Youth Correctional Facility who were on administrative lockdown at the time of the review had been on administrative lockdown status for more than 30 days and that 3 of the wards had been on administrative lockdown for more than 200 days. The California Youth Authority told the Office of the Inspector General that it has not instituted a daily report justifying the continued detention of wards as described in the recommendation, but has taken the following actions instead to address the issue: • *Special management program:* The department reported that in April 2002, it established a Departmental Restricted Program Review Committee (later re-named the Departmental Review Board) for the purpose of monitoring day-to-day services to wards in special management programs and to ensure that wards have been appropriately placed in the programs. According to the department, the committee conducts monthly site reviews of the five special management programs statewide, devoting particular attention to wards who have been retained in special management programs for more than 90 days. Special management program cases requiring a level of review and oversight above that of the superintendent—typically those identified as mental health cases, court holds, and wards who represent a serious threat to the safety and security of the facility if placed in the general population—require review and approval by the Departmental Review Board every 30 days. According to the department, as a result of the committee's activities, the average length of stay for wards in special management programs had dropped from 158 days in

		September 2000 to 52 days in March 2004. The department told the Office of the Inspector General that the daily reporting recommendation for continued special management cases is not being implemented because the superintendents are an integral part of the Departmental Review Board process. • *Administrative lockdown.* The department reported that it has developed a protocol, not yet implemented, that will provide information on the administrative lockdown status of every institution to department management. A pilot project to test the protocol was implemented at Heman G. Stark Youth Correctional Facility in July 2004, and full implementation at all institutions is expected in December 2004.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority evaluate the reason for the extended administrative lockdown at the N.A. Chaderjian Youth Correctional Facility and take steps to place the wards in appropriate programs.

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HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

IMPLEMENTATION REPORT CARD

Previous recommendations: 25

Fully implemented: 8 (32%)

Substantially implemented: 1 (4%)

Partially implemented: 9 (36%)

Not implemented: 7 (28%)

The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility continues to fail at providing mandated education and treatment services to wards. Class cancellations have increased, instruction time has declined, and standardized test scores have dropped. Similarly, the follow-up review determined that only 33 percent of a sample of wards at the facility had received mandated counseling. Among the wards in the facility's general population, the compliance rate was zero — meaning that not a single general population ward in the sample had received the minimum individual and small-group counseling required by department policy.

The Office of the Inspector General issued a management review audit report on the Heman G. Stark Youth Correctional Facility in October 2000. The management review audit identified numerous problems with the facility's operation, including failure to consistently fulfill two of the department core functions: providing wards with education and providing them with treatment services, including individual and small-group counseling. In light of the seriousness of the findings, in July 2002 the Office of the Inspector General conducted a follow-up review of the facility's progress in implementing the recommendations from the October 2000 audit.

The 2002 follow-up review found that the Heman G. Stark Youth Correctional Facility had implemented fewer than half of the earlier recommendations and had regressed in providing individual and small-group counseling to wards, as evidenced by compliance rates significantly lower than the unsatisfactory rates revealed in the October 2000 audit. There had been marginal improvement in some areas that had been found unsatisfactory in the October 2000 management review audit. In particular, the facility's high school had become accredited, class cancellations had declined, and special education instruction time had improved.

BACKGROUND

The Heman G. Stark Youth Correctional Facility is one of eight youth correctional institutions within the California Youth Authority. The institution assists the California Youth Authority in meeting its mission of protecting the public from criminal activity by providing education, training, and treatment services for youthful offenders committed by the courts. Located on 101 acres outside Chino in Southern California, the Heman G. Stark Youth Correctional Facility houses youthful offenders aged 18 to 25, many of whom have committed serious offenses, including murder, rape, armed robbery, and assault. At present, the facility houses approximately 900 youthful offenders, a number significantly lower than the nearly 1,300 wards housed at the facility during the Office of the Inspector General's October 2000 management review audit.

For fiscal year 2004-05, the Heman G. Stark Youth Correctional Facility has a budgeted staff of 716.8 positions and an operating budget of $60,982,000. Staff positions include

administrators, medical and dental professionals, psychologists, administrative support personnel, youth correctional officers, and youth correctional counselors. In addition the staff includes academic and vocational education instructors, administrators, and support staff, all of whom report to the California Youth Authority Education Services Branch rather than to the superintendent.

Wards at Heman G. Stark Youth Correctional Facility are housed in three areas consisting of 10 team living units, each designated by two alphanumeric letters such as A/B and C/D. Within each team living unit are two "companies," each designated by one of the letters, resulting in a total of 20 companies at the facility. Most wards eat and sleep in their rooms in the team living units. They also participate in programs, including individual and small-group counseling based on individual needs. Some team living units house general population wards, while others specialize in orienting newly transferred wards, treating sex offenders and drug abusers, and providing intensive treatment and special counseling to wards with recognized needs.

Wards leave the living units to participate in other ward programs at various locations on the institution grounds. The programs include attending the facility's Lyle Egan High School, obtaining vocational training, receiving medical and dental services, and attending religious services.

As a result of the October 2000 management review audit, the Office of the Inspector General made 11 findings that encompassed nearly every aspect of the facility's operation. These findings included observations of deficiencies in the following areas: investigations of staff misconduct; ward education; ward treatment services; ward grievance processing; ward discipline and detention; facility safety and security; and information management. To correct the deficiencies, the Office of the Inspector General made a total of 44 recommendations to the facility, the Education Services Branch, and the California Youth Authority.

The seriousness of the findings prompted the Office of the Inspector General to conduct a follow-up review at the Heman G. Stark Youth Correctional Facility. As a result of that follow-up review, the Office of the Inspector General issued a July 2002 report on the facility's progress in implementing the recommendations from the October 2000 management review audit. Among the more significant findings from the 2002 follow-up review were the following:

- Heman G. Stark Youth Correctional Facility had implemented fewer than half of the Office of the Inspector General's recommendations.

- In education, the Office of the Inspector General noted marginal improvement in some areas that had been found unsatisfactory in the October 2000 management review audit. Specifically, the facility's Lyle Egan High School had received full accreditation; the superintendent and the principal had made efforts to provide a positive learning environment; there had been a decline in the number of class cancellations precipitated by a shortage of substitute teachers; and special education instruction time had improved.

- The institution had regressed in providing individual and small group counseling — the most fundamental aspect of the ward treatment program. Specifically, testing in the follow-up review found that only 31 percent of the wards sampled had received the required frequency of individual and small-group counseling. This represented a decline of 25 percentage points from the unsatisfactory compliance rate of 56 percent found in the October 2000 management review audit.

- The facility continued to fail to consistently investigate ward grievances in a timely manner. Of 44 regular ward grievances reviewed, 11 (25 percent) were more than 30 days old.

- The management and monitoring of wards in temporary detention had improved. Wards were being tracked by the ward information network (WIN 2000) system.

The Office of the Inspector General issued 44 recommendations as a result of the October 2000 management review audit. Following the July 2002 follow-up, the Office of the Inspector General issued another 25 recommendations.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2004 follow-up review was to determine the extent to which the Heman G. Stark Youth Correctional Facility, the Education Services Branch, and the California Youth Authority headquarters have implemented the 26 recommendations from the Office of the Inspector General's July 2002 follow-up review of the October 2000 management review audit. To conduct the follow-up review, the Office of the Inspector General provided Heman G. Stark Youth Correctional Facility, the Education Services Branch, and the California Youth Authority director's office 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 non-compliance with the recommendations.

As part of the evaluation, the Office of the Inspector General conducted fieldwork at the Heman G. Stark Youth Correctional Facility, during which the audit team interviewed staff and wards; reviewed logs and records; observed selected facility operations; and conducted tests necessary to formulate conclusions regarding the implementation of the Office of the Inspector General's recommendations.

SUMMARY OF THE FOLLOW-UP RESULTS

Consistent with the findings from the July 2002 follow-up review of the October 2000 management review audit, the Office of the Inspector General found again that the Heman G. Stark Youth Correctional Facility, the Education Services Branch, and California Youth Authority headquarters had implemented fewer than half of the recommendations from the July 2002 follow-up review. Of the 25 recommendations issued by the Office of the Inspector General in July 2002, 8 have been fully implemented, 1 has been substantially implemented, 9 have been partially implemented, and 7 have not been implemented.

The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility continues to fail at educating wards and at providing them with individual and small-group counseling. In the four years since the October 2000 management review audit, there has been no improvement in the unsatisfactory conditions found by that audit. These deficiencies are particularly serious, given that education and counseling are core functions of the California Youth Authority.

In summary, the Office of the Inspector General found the following:

- The effectiveness rating of the institution's high school for fiscal year 2003-04 was only 30 percent, meaning that wards received an average of only 30 percent of available instruction time during the year. This is a drop of seven percentage points from the 37 percent effectiveness rating for fiscal year 2002-03.

- Class closures averaged 540 per month for fiscal year 2003-04, compared to 460 per month the previous fiscal year. More classes are closed now than were closed during the Office of the Inspector General's management review audit in 2000.

- The Office of the Inspector General's review of standardized test scores showed that scores have continually declined in all subject areas since 1998. For example, in 2004 88 percent of Lyle Egan wards had cumulative subject scores below the 25th national percentile rate compared to 68 percent of the school's wards in 1998.

- In the past two years, the Lyle Egan High School has reported absenteeism rates of 36 percent and 45 percent, respectively. Those absenteeism rates are significantly higher than the 24 percent absenteeism rate found in the Office of the Inspector General's October 2000 management review audit.

- As a result of teacher vacancies, combined with ward absences, wards enrolled for at least 90 days during the past academic year earned an average of only 9.45 high school credits.

- Only 30 percent of the special education wards assigned to special day classes received the services prescribed in their individual education plans. That figure represents a decrease of eight percentage points from the 38 percent rate found by the Office of the Inspector General in the October 2000 management review audit.

- None of the 14 general population wards sampled by the Office of the Inspector General had received the minimum amount of weekly individual and small-group counseling. Conversely, all 7 of the wards sampled from the specialized programs had received such counseling. General population wards, however, comprise most of the facility's population. In the same tests from the 2000 management review audit and the 2002 follow-up to that audit, the Office of the Inspector General found compliance rates of 56 and 31 percent, respectively. Thus, the facility not only continues to fail, but has regressed in providing required counseling to wards.

- Many treatment team supervisors did not routinely perform the required monthly audits of ten ward files. Of seven treatment team supervisors reviewed, an average of

only one supervisor per month audited ten ward files during the ten-month period reviewed by the audit team. One treatment team supervisor acknowledged that he performed no file reviews. Some treatment team supervisors attempted to delegate their responsibilities to subordinates, in violation of institution policy.

- California Youth Authority headquarters relieved the institutions of responsibility for conducting *California Youth Authority Institutions and Camps Branch Manual* section 4000 annual treatment services self-audit reports due to the need to implement parole hearing changes at the facilities in the wake of Senate Bill 459. Thus, a proven monitoring tool has not been used for more than a year.

- To their credit, the present superintendent and deputy superintendent have attempted to monitor casework. The Office of the Inspector General obtained memoranda and other documents showing that these officials had found discrepancies in monthly small group reports and had ordered remedial action and, in some cases, progressive discipline. However, the persistent failure of the facility since 2000 to provide individual and small-group counseling indicates the facility needs to intensify its efforts.

- Of the 21 randomly selected wards reviewed, only one ward had had a teacher attend his initial case conference and no teachers attended any of the wards' progress case conferences. In addition, only three (14 percent) of the 21 wards' files showed that the ward had been assigned to an education or work program within four days of his arrival at his permanent living unit.

- A grievance filed and won by the local chapter of the California Correctional Peace Officers Association makes it difficult for supervisory staff to accurately monitor the casework of youth correctional counselors. The grievance relieves youth correctional counselors of documenting all casework in ward living unit files where it can be easily checked by supervisors. Instead, counselors document small-group counseling in records separate from ward living unit files. The grievance was granted by the labor relations unit in California Youth Authority headquarters because casework documentation requirements imposed by the facility allegedly increased the counselors' workload beyond that agreed to in a 1995 agreement.

The Office of the Inspector General found improvement in some areas of facility operations. The most noteworthy improvements include the following:

- According to the institution, as of August 1, 2004, it had filled all youth correctional counselor vacancies. In addition, the ward information network (WIN 2000) system has been updated to assist staff with tracking disciplinary decision-making system actions and administrators and treatment team supervisors reportedly monitor the living units daily to ensure that disciplinary actions are processed in a timely manner.

- The Office of the Inspector General conducted an on-site review at the facility to verify that each living unit had an up-to-date suicide risk list. In addition, the audit team asked the staff to locate the Hoffman tool, a safety knife for quickly cutting down wards who attempt to hang themselves. The audit team found that all units had an up-to-date suicide risk list and were able to present the Hoffman tool within 8 to 21 seconds.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Heman G. Stark Youth Correctional Facility take the following additional actions.

- **The California Youth Authority Education Services Branch and the facility should continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include working with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive compensation for teachers.**
- **The principal should continue to monitor the causes of ward absenteeism and make efforts to improve ward attendance and accurately report ward average daily attendance. The monitoring should include audits of the student ward attendance tracking system to ensure that absences are appropriately documented and justified.**
- **To help coordinate ward eduction and treatment programming, the superintendent and the principal should require teachers to participate in case conferences as facilitated by the alternative education schedule.**
- **The superintendent and the principal should take steps to ensure that wards are assigned to education and work programs within four days of their arrival at their permanent living units.**
- **The Education Services Branch and the principal should continue their efforts to develop trade advisory committees at the facility to guide vocational instruction.**
- **The Heman G. Stark Youth Correctional Facility should use a computerized system for tracking all requests for internal affairs investigations. The facility should explore the possibility of using the existing adverse action database for this purpose, as internal affairs investigations are presently input into this system. The system should track the originating grievance and inquiry numbers related to each investigation to allow for efficient cross-referencing and tracking of cases.**
- **The California Youth Authority should continue its efforts to integrate its computer systems to minimize education-related reporting errors and duplication of effort.**
- **The California Youth Authority should immediately take whatever steps necessary, including contract re-negotiation, to ensure efficient monitoring of weekly small group and individual counseling.**
- **The superintendent should use progressive discipline to hold treatment team supervisors accountable for performing the required audits of 10 ward files per month.**

- **The California Youth Authority should immediately resume the *California Youth Authority Institutions and Camps Branch Manual* section 4000 annual self-audit reporting requirement for all facilities.**

- **The facility management should intensify efforts to provide individual and small group counseling to wards. The efforts should include reiterating to staff the importance of counseling to the mission of the department, providing ongoing training as necessary, and using progressive discipline up to and including termination for employees who fail to meet counseling requirements.**

- **The administrative assistant responsible for tracking staff action grievances should be trained in the use of the computerized inquiry tracking system and the grievance tracking system maintained on the WIN 2000 system. The administrative assistant should perform a periodic reconciliation of the staff action grievances contained in those systems.**

- **The superintendent should continue to pursue implementing cafeteria-style feeding of wards.**

- **The superintendent should require control booth staff to have all visitors sign in and sign out of the facility.**

- **The California Youth Authority should thoroughly test the WIN 2000 system to ensure that access is controlled properly, that programming requests are assigned priority according to departmental policy, and that timely feedback on the status of service requests is provided to institutions and other users.**

- **The California Youth Authority should conduct periodic audits of the WIN 2000 system.**

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

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility did not have a system to ensure that allegations of staff misconduct were promptly and properly investigated. Moreover, management actions relative to such investigations appeared to be questionable.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution do the following:		
• Develop written policies and procedures governing internal affairs investigations for inclusion in the *Heman G. Stark Youth Correctional Facility Administrative Policy and Operation Manual.*	FULLY IMPLEMENTED	According to the institution management, policies and procedures governing internal affairs investigations have been standardized throughout the California Youth Authority by the Internal Affairs office in Sacramento. The Office of the Inspector General confirmed that the Internal Affairs office issued the Internal Affairs Unit Policy and Procedures Manual in March 2003. All facilities are responsible for adhering to the manual.
• Develop accurate, complete, and timely logs for tracking investigations and ensure the staff is properly trained.	NOT IMPLEMENTED	The institution management reported that the department's Office of Professional Standards has implemented a centralized tracking system to track and monitor open investigative cases. The superintendent's administrative assistant, in collaboration with internal affairs special agents, is responsible for tracking and monitoring the progress of each case. Each section uses two compatible databases to ensure all cases are accurately accounted for. The Office of the Inspector General found, however, that the superintendent's administrative assistant does not use a compatible database as described by the institution management, but rather uses a word processing document to track cases that have been referred to the Internal Affairs Unit. Even though the administrative assistant meets with the Internal Affairs Unit monthly to reconcile the cases, the Office of the Inspector General found numerous discrepancies between her document and other sources of information.
• Adopt clear criteria for differentiating between Level I and Level II investigations.	FULLY IMPLEMENTED	The criteria for differentiating between Level I and Level II investigations are outlined in Section 2020 of the Internal Affairs Unit Policy and Procedures Manual. Institution management reported that it applies the required criteria to each case upon requesting an investigation. The Office of the Inspector General found that the facility no longer performs

• Ensure that investigation files contain, at a minimum, signed investigation reports and documentation used to support the investigative conclusion.	**FULLY IMPLEMENTED**	internal affairs investigations. All requests for investigation are referred to the department's Internal Affairs Unit. It is the responsibility of the Internal Affairs Unit to apply the criteria provided in section 2020 of the manual. According to the institution management, the superintendent's office personally reviews each case to ensure the investigation is fully supported and signed and that due process was provided. The Office of the Inspector General reviewed four internal affairs investigative files maintained at the facility and found that each contained a signed investigative report and relevant exhibits.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Heman G. Stark Youth Correctional Facility use a computerized system for tracking all requests for internal affairs investigations. The facility should explore the possibility of using the existing adverse action database for this purpose, as internal affairs investigations are presently input into this system. The system should track the originating grievance and inquiry numbers related to each investigation to allow for efficient cross-referencing and tracking of cases.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility educational and vocational classes were poorly attended and wards' academic achievement was low in comparison to other California Youth Authority facilities.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Youth Authority Education Services Branch and the institution education administrators do the following: • Continue to recruit qualified substitute teachers to lessen the number of cancellations when an instructor is sick, takes vacation, or is otherwise absent.	**PARTIALLY IMPLEMENTED**	As part of the *Farrell v. Allen* remedial plan for the Education Services Branch, the California Youth Authority reported it has begun recruiting new academic teachers for all its school sites, with six positions now advertised in the *Employment Weekly* for Lyle Egan High School at the Heman G. Stark Youth Correctional Facility.

		According to facility management, the department submitted a budget change proposal in July 2004 to address staffing shortages in education. The proposal includes additional positions to reduce classroom size, provide additional administrative support and monitoring, and enhance information technology support. Included in this proposal is a request to provide a 15 percent relief factor to fund additional substitute teachers in order to improve classroom coverage. The Office of the Inspector General conducted a follow-up review at the Lyle Egan High School and found that the school continues to have significant problems fully staffing classrooms and that the high school is failing in its mission to provide education services to wards. Presently, 18 members of the Lyle Egan High School staff are not reporting to work. The absent staff members include an assistant principal, support staff, teachers, and a psychologist. Failure to staff the high school has contributed significantly to the following conditions: • The effectiveness rating of the high school for fiscal year 2003-04 was only 30 percent, meaning that wards received an average of only 30 percent of their available instruction time during the year. This figure represents a drop of seven percentage points from the 37 percent effectiveness rating for fiscal year 2002-03. • Class closures averaged 540 per month for fiscal year 2003-04 compared to 460 per month the previous fiscal year. More classes are closed now than were closed during the Office of the Inspector General's October 2000 management review audit. • The Office of the Inspector General found that the high school's standardized test scores have continually declined since 1998 in all subject areas. For example, 88 percent of Lyle Egan High School wards had cumulative subject scores below the 25th national percentile rate in 2004, compared to 68 percent of the school's wards in 1998. • In the past two years, Lyle Egan High School has reported absenteeism rates of 36 percent and 45 percent, respectively. Those absenteeism rates are significantly higher than the 24 percent absenteeism rate found

		in the Office of the Inspector General's October 2000 management review audit. • As a result of teacher vacancies, combined with ward absences, wards enrolled for at least 90 days during the past academic year earned an average of only 9.45 high school credits. According to the institution staff, Lyle Egan High School does not use substitute teachers in the traditional sense, wherein someone from outside is called in as needed. Instead, the school employs four retired annuitants and other teachers who are temporarily authorized to staff academic classes. The high school also designates four regular employees as relief teachers in vocational subjects. Yet, these resources are represented in the class closure statistics cited above. The result of the teacher staffing deficiency is that existing high school-eligible wards are scheduled to attend an average of only two classes per day, only one of which is in an academic subject.
• Continue to recruit special education instructors, especially for the delivery of special day classes.	**PARTIALLY IMPLEMENTED**	The institution management reported that despite the past constraints of the protracted state hiring freeze, the special education assistant principal has pursued special education candidates by submitting letters of justification to an *ad hoc* committee of the state Department of Personnel Administration. That committee is presently considering granting permission to accept applications for one resource specialist program teacher and one special education management services technician at the school. In addition, the high school is reportedly developing employment opportunity bulletins and has initiated a weekly process for scoring supplemental applications. The high school administration also stated that two retired annuitant education administrators (one north and one south) have been recently hired to work with the Education Services Branch as recruiters. These recruiters will make contacts, staff a table at conferences and job fairs, act as liaisons with universities, and perform related duties. The first job fair was August 17, 2004. In August 2004 the Lyle Egan High School administration contacted several special education teachers who had transferred out of the department because of facility closures in an effort to bring them back. The Office of the Inspector General found that the delivery of special

		education services continues to be hampered by shortages of qualified teachers, substitutes, and ward absences. From January through August 2004, only 30 percent of the special education wards assigned to special day classes received at least 90 percent of the services prescribed in their individual education plans. This figure represents a decrease of eight percentage points from the 38 percent rate found by the Office of the Inspector General in the 2000 management review audit.
• Analyze why class cancellations have increased.	**PARTIALLY IMPLEMENTED**	The Education Services Branch has implemented the Student Ward Attendance Tracking system, which is designed to collect and analyze data on each ward's attendance and the reason each absence occurs. The data is reported to the superintendent and the principal and is discussed at weekly executive staff meetings. The Office of the Inspector General verified that Lyle Egan High School has implemented the Student Ward Attendance Tracking system. The system is capable of identifying all ward absences and class closures. Although the education staff is diligent in maintaining and refining the system, absence reporting from the living units and security staff is not always accurate, thereby undermining the usefulness of the data. For example, the "NIS" code, which stands for "not in school," accounted for 3,649 (28 percent) of the recorded ward absences in September 2004. That code should be used when a staff member failed to add the ward to the School Movement Accountability Sheet, thereby precluding the ward from going to school that day. However, the living unit staff and security staff use it as a generic, catchall code. By doing so, they prevent the school from knowing the true reason a ward missed school.
• Work to provide competitive teacher compensation by upgrading pay scales, using compensation exceptions provided for by law and other suitable methods.	**PARTIALLY IMPLEMENTED**	The budget change proposal cited above proposes establishing a teacher salary and working conditions package commensurate with those of local school districts. Facility management also noted that the Corrections Independent Review Panel chaired by former Governor Deukmejian recommended a 5 percent retention pay package and a 220-day school year as part of its "Reforming Corrections" review. The Office of the Inspector General reviewed the budget change proposal and the recommendations by the Corrections Independent Review Panel and confirmed the accuracy of the information provided by the department and

		facility management.
• Ensure that the trade advisory committees are truly functioning as outlined in Sections 3410 and 3420 of the *Education Services Branch Manual.*	**NOT IMPLEMENTED**	Facility management reported that trade advisory committee activity decreased several years ago when outside advisors were unable to gain admission to the facility. Activity declined further as all remaining vocational assistant principals retired or were transferred to other positions, leaving vocational education supervised by academic assistant principals. The institution management reported that a vocational administrator currently works half-time at the Education Services Branch. One of his goals is to ensure the implementation and monitoring of a trade advisory committee at each school. He will report quarterly to the Education Services Branch on the effectiveness of these committees. The Office of the Inspector General confirmed with Lyle Egan High School's vocational administrator that the high school has not implemented trade advisory committees.
• Ensure the use of meeting agendas and minutes to develop and organize effective committee goals.	**NOT IMPLEMENTED**	This recommendation pertains to trade advisory committees. As discussed above, the Heman G. Stark Youth Correctional Facility does not have trade advisory committees.
• Work to improve the accuracy and reliability of the monthly average daily attendance report, especially those fields related to the computation of average daily attendance.	**PARTIALLY IMPLEMENTED**	According to the high school administration, the standard handwritten attendance reporting completed at the end of each month by all teachers continues to have two levels of quality: (a) handwritten forms and computations of questionable accuracy by teachers unfamiliar with electronic spreadsheets, and (b) more accurate spreadsheet forms by staff who are conversant with electronic spreadsheets and their electronic formulas. Further, since January 2004 the entire system of attendance reporting has been overlaid by a second system, the Student Ward Attendance Tracking system, which includes inputting absence slips from each period of each day using 46 specific absence codes. The new system provides significantly more detailed reports on absenteeism patterns. The Office of the Inspector General visited Lyle Egan High School and found that during September 2004, only 11 of the 26 monthly average daily attendance reports were computed by teachers using electronic spreadsheets designed by Lyle Egan High School staff. Eight members of the Lyle Egan

• Continue working on the integrated attendance-reporting project.	**PARTIALLY IMPLEMENTED**	High School staff also used electronic spreadsheets to compute daily attendance, which is in turn added to the teachers' monthly average daily attendance reports. The use of electronic spreadsheets in this manner ensures better accuracy because all computations are derived from formulas. Although data is entered into the Student Ward Attendance Tracking System daily, the system does not yield results until the end of each month. To provide an accuracy check between these two attendance systems, the Education Services Branch reportedly has begun an effort to reconcile class closure data between the two systems before submitting final average daily attendance results to the Department of Education. According to the ward information network (WIN 2000) project manager, in August 2004 the integrated attendance-reporting system was still under development, with an anticipated pilot project at DeWitt Nelson Youth Correctional Facility later this year. However, the pilot project depends on the department obtaining additional WIN 2000 programming staff. Currently, the system has only one individual performing this function. The budget change proposal cited above addresses acquiring technical support to help with the WIN 2000 enhancements. As described above, the Office of the Inspector General conducted testing of ward enrollment and attendance performance. To conduct these tests, the audit team had to use several systems, including the WIN 2000, the Student Ward Attendance Tracking system, manually prepared records, and electronic spreadsheets. The need of the audit team to access so many systems underscores the need to integrate attendance reporting.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the following additional actions be taken:

- **The California Youth Authority Education Services Branch and the facility should continue efforts to recruit and retain qualified education staff, including full-time teachers, special education instructors, and substitutes. Those efforts should include working with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive compensation for teachers.**

- **The principal should continue to monitor the causes of ward absenteeism and make efforts to improve ward attendance and accurately report ward average daily attendance. The monitoring should include audits of the Student Ward Attendance Tracking system to ensure absences are appropriately documented and justified.**
- **The Education Services Branch and the principal should continue efforts to develop trade advisory committees at the facility. The committees should use meeting agendas and minutes to develop and organize effective committee goals.**
- **The California Youth Authority should continue efforts to integrate its computer systems to minimize education-related reporting errors and duplication of effort.**

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that wards were not provided with required treatment services.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution do the following: • Develop an effective casework auditing system that requires each treatment team supervisor to audit two cases monthly from each of his or her youth correctional counselors' caseload. The audit sheet should enumerate all standards listed in Section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual* . The institution should use work improvement discussions, letters of instruction, and other progressive disciplinary measures for parole agents and counselors whose work is found to be unsatisfactory and for treatment team supervisors and senior youth correctional counselors who fail to address poor	PARTIALLY IMPLEMENTED	The institution reported that the California Youth Authority has refined the WIN 2000 database so that it captures data on casework matters such as case conferences and casework notes. Youth correctional counselors now have the capability of documenting all counseling activity for each ward into the database. This documentation allows for the permanent storage of information such as initial and progress case conference forms and anyone with access to the database can review the work conducted for each ward. According to facility management, the office of the superintendent routinely reviews the database. Facility management also reported that treatment team supervisors submit a monthly report that documents their audit of a minimum of 10 ward files during the preceding month. The facility uses these reports to update ward files and to hold youth correctional counselors and supervisory staff accountable for substandard casework. In addition, facility management reported that the parole agent III and the superintendent's office review

employee performance. In addition, the superintendent should empower the parole agent IIIs with the authority to review audit sheets and recommend corrective action and possible staff discipline to the superintendent.		treatment team files. The Office of the Inspector General visited the Heman G. Stark Youth Correctional Facility to assess the facility's progress in providing treatment services to wards. Although the audit team verified that the casework auditing system has been designed as described by the facility, the casework auditing system has been ineffective in fulfilling its purpose. Specifically, the system has not ensured that wards receive the weekly individual and small group counseling required by section 4050 of the *California Youth Authority Institutions and Camps Branch Manual.* The audit team reviewed the individual and small-group counseling provided to a random sample of 21 wards and found that only seven (33 percent) had received the required weekly counseling over the previous 12 months. None of the 14 wards sampled from the general population had received the required counseling, whereas all seven of the wards sampled from specialized programs such as the intensive treatment program had received it. In the same tests from the 2000 management review audit and the 2002 follow-up to that audit, the Office of the Inspector General found compliance rates of 56 percent and 31 percent, respectively. Thus, the facility continues to fail at providing required counseling to wards. The following factors have contributed to the facility's inability to provide required counseling to wards: • A grievance filed and won by the local chapter of the California Correctional Peace Officers Association makes it difficult for supervisory staff to accurately monitor the casework of youth correctional counselors. The grievance relieves youth correctional counselors from documenting all casework in ward living unit files where it can be easily reviewed. Instead, counselors document small group counseling in records separate from ward living unit files. The grievance was granted by the labor relations unit in California Youth Authority headquarters because casework documentation requirements imposed by the facility allegedly increased the counselors' workload beyond that agreed to in a 1995 agreement. • Many treatment team supervisors did not routinely perform their required monthly audits of ten ward files. Of seven treatment team

		supervisors reviewed, an average of only one supervisor per month audited 10 ward files during the ten-month period reviewed by the audit team. One treatment team supervisor acknowledged he did no file reviews. Some treatment team supervisors attempted to delegate their responsibilities to subordinates. • California Youth Authority headquarters relieved the institutions of responsibility for conducting the fiscal year 2003-04 *California Youth Authority Institutions and Camps Branch Manual* section 4000 annual treatment services self-audit reports due to the need for implementing parole hearing changes at the facilities in the wake of Senate Bill 459. Thus, a proven monitoring tool has not been used for more than a year. • The present superintendent and deputy superintendent, to their credit, have attempted to monitor casework. The Office of the Inspector General obtained memoranda and other documents showing these officials had found discrepancies in monthly small group reports and had ordered remedial action and, in some cases, progressive discipline. However, the persistent failure of the facility since 2000 to provide individual and small group counseling indicates the facility needs to intensify its efforts.
• The casework auditing system should generate a monthly report of the institution's compliance rates with Section 4000 requirements. This report should go to the superintendent, the assistant deputy director for the California Youth Authority's Institutions and Camps southern region, and the California Youth Authority headquarters. The assistant deputy director and the Superintendent should meet monthly to discuss trends in the compliance rates, progressive discipline against non-performing employees, staff vacancies in parole and counselor areas, ideas for improving compliance, and other	**PARTIALLY IMPLEMENTED**	Facility management reported it has developed an auditing form in direct response to the Office of the Inspector General's management review audit follow-up of July 2002. The audit form enumerates all standards listed in section 4000 of the *California Youth Authority Institutions and Camps Branch Manual* related to treatment services. Each month the facility submits a report to the Institutions and Camps Branch that includes any non-compliance that occurred in the previous month. California Youth Authority headquarters requires the superintendent to contact the Institutions and Camps Branch immediately whenever any significant matter arises that adversely affects case management compliance with section 4000. The Office of the Inspector General visited the Heman G. Stark Youth Correctional Facility and verified that the facility uses the auditing form. However, as noted above, treatment team supervisors do not always use the form. As further noted, the California Youth Authority excused the institution from producing its annual section 4000 self-audit report, which

pertinent issues.		uses the auditing form as its compliance testing instrument.
• Make every effort to fill vacant youth correctional counselor positions.	**FULLY IMPLEMENTED**	According to the facility management, as of August 1, 2004, it had filled all youth correctional counselor vacancies.
• Send teachers to case conferences.	**NOT IMPLEMENTED**	The facility management reported that it implemented an alternative education schedule in 2002 to encourage participation of teachers in the case conference process. On specific days, no instructional classes are held, specifically to allow teachers time to come to the living units and participate in case conferences. Due to a shortage of teachers, however, the facility reported that there is no consistency in participation. According to the facility, the assistant principals are responsible for overseeing the process. Each assistant principal is responsible for monitoring designated living units for faculty attendance at each conference and school consultation team meeting. At the Heman G. Stark Youth Correctional Facility, the Office of the Inspector General reviewed the extent to which teachers participated in wards' initial case conferences and progress case conferences. Of the 21 randomly selected wards reviewed, only one ward had had a teacher attend his initial case conference. No teachers attended any of the wards' progress case conferences. In addition, only three (14 percent) of the 21 wards' files showed that the ward had been assigned to an education or work program within four days of arrival at his permanent living unit.
• Convey to all staff the need for, and importance of, weekly individual and small group counseling sessions.	**NOT IMPLEMENTED**	The institution management did not provide a response to this recommendation.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Heman G. Stark Youth Correctional Facility take the following additional actions:

- **The California Youth Authority should immediately take whatever steps necessary, including contract re-negotiation, to ensure efficient monitoring of weekly small group and individual counseling.**
- **The superintendent should use progressive discipline to hold treatment team supervisors accountable for performing the required 10 audits of wards files per month.**
- **The California Youth Authority should immediately resume the annual *California Youth Authority Institutions and Camps Branch Manual* section 4000 self-audit reporting requirement for all facilities.**
- **The facility management should intensify its efforts to provide the individual and small group counseling to wards. Those efforts should include reiterating to staff the importance of counseling to the mission of the department, providing ongoing training as necessary, and using progressive discipline up to and including termination for employees who fail to meet counseling requirements.**
- **The superintendent and the principal should require teachers to participate in case conferences as facilitated by the alternative education schedule.**
- **The superintendent and the principal should take steps to ensure that wards are assigned to education and work programs within four days of arrival at their permanent living units.**

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that system deficiencies and inadequate effort resulted in ward grievances not being promptly and appropriately addressed.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution do the following: • The superintendent should hold the treatment team supervisors for the living units accountable for reconciling the pre-numbered ward grievance forms as described in the *Heman G. Stark Youth Correctional Facility Administrative*	**FULLY IMPLEMENTED**	Institution management reported that senior youth correctional counselors reconcile all ward grievances weekly. The audit team confirmed that senior youth correctional counselors work with ward grievance clerks on a daily basis to account for ward grievance forms assigned to their treatment teams. The audit team also reviewed the tracking system used by the ward rights coordinator and found it to be an effective tool for tracking all ward

Policy and Operations Manual. The superintendent should also hold staff accountable for processing ward grievances, particularly preliminary "fact-finding" investigations on staff action grievances, in a timely manner.		grievances in progress. According to institution management, inquiries into staff action grievances are due within 30 working days of the date assigned. If a case is approaching a deadline, the institution management reported that a supervisor must request an extension through the office of the superintendent detailing the reasons for the delay. Management said it is holding staff accountable through the progressive discipline process when cases have not been processed on time. The Office of the Inspector General confirmed these representations and found that the institution is presently taking adverse action against one individual who failed to process staff action grievances in a timely manner. The institution management reported that staff action grievances are processed separately by the administrative assistant, who assigns the grievances to a supervisor to complete an inquiry. Staff action grievances are tracked through the office of the superintendent. Recommendations concerning the grievances are made by the deputy director of the Institutions and Camps Branch. The chief deputy director approves all inquiry reports. The Office of the Inspector General found, however, that the superintendent, not the administrative assistant assigns staff action grievances to supervisors for inquiry. The audit team found that although the administrative assistant inputs inquiries into the inquiry tracking system, she does not use the database to track the progress of the open cases. Instead, she depends on hard files and a list created on a word processing document to make weekly reports to the superintendent. The audit team noted that the staff action grievances referred from the ward rights coordinator to the administrative assistant could not be reconciled by the administrative assistant because her tracking system is inadequate.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the administrative assistant be trained in the use of the computerized inquiry tracking system and the grievance tracking system maintained on the WIN 2000 system. The administrative assistant should perform a periodic reconciliation of the staff action grievances contained in those systems.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that all wards, including those in Phase 2 and 3, have been confined to eating in their rooms since the 1996 staff murder, hampering socialization efforts.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
• The Office of the Inspector General recommended that the institution develop a written plan with milestone dates for phasing in cafeteria dining for the institution's general population. The plan should set January 1, 2003 or earlier as the date for full implementation.	PARTIALLY IMPLEMENTED	Facility management reported that in 2002 it piloted an incentive cafeteria feeding program for Phase 3 wards, but three weeks into the program, wards filed a mass petition requesting termination of the program. The reason for the petition was loss of programming time. According to facility management, wards also stated a preference for eating in their cells because they can use their own utensils, condiments, and other items. The superintendent reported that the facility made further efforts to initiate a change to cafeteria dining but the wards again resisted the efforts. Furthermore, facility management contended that cafeteria feeding takes too long (up to two hours versus only a half hour for cell feeding). In addition, problem wards use cafeteria dining to engage in fighting or assaultive behavior. Facility management maintained that the current feeding program provides wards with more time to participate in program activities and to participate in mandated services such as school. For example, the breakfast hour overlaps the school movement, which begins at 7:30 a.m. Under a cafeteria-feeding program, treatment teams are unable to complete the feeding process before preparing the team for school. Facility management said that despite the problems identified, it planned to revisit the issue of cafeteria feeding in October 2004. According to facility management, treatment teams that program separately from the mainstream population are able to incorporate cafeteria-style feeding in accordance with section 1490 of the *California Youth Authority Institutions and Camps Branch Manual.* For example, Morrissey program wards (parolees awaiting revocation) eat breakfast and dinner in a common dining area. Although this feeding process occurs regularly, the staff contends it is time-consuming because it requires multiple sittings to

		accommodate all wards. The facility management said that the cafeteria-style setting has been successful in the Youthful Offender Program. Wards on dayroom time in that program have the opportunity to eat in an open setting. The dining arrangement does not affect wards' allotted program time and wards have been cooperative during the feeding process.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the superintendent continue to pursue implementing cafeteria-type feeding for wards.

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that Northern Hispanic wards were transferred from N. A. Chaderjian Youth Correctional Facility to the Heman G. Stark Youth Correctional Facility for punitive purposes, rather than for treatment.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
None	NOT APPLICABLE	Recommendations were found to have been implemented by the 2002 follow-up review.

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that the management and monitoring of wards in temporary detention needed improvement.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
None	NOT APPLICABLE	Recommendations found to have been implemented by the 2002 follow-up review.

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that the disciplinary decision-making system needs improvement.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the superintendent hold the appropriate staff at the living units accountable for processing disciplinary cases in a timely manner so that disciplinary actions are not lost when mandated time frames are not met.	SUBSTANTIALLY IMPLEMENTED	According to facility management, the ward information network (WIN 2000) system has been updated to assist staff with tracking disciplinary decision-making system actions. In addition, administrators and treatment team supervisors reportedly monitor the living units daily to ensure that disciplinary actions are processed in a timely manner. All staff making entries into the system are able to record specific comments and dates of receipt and to permanently record any discrepancies for particular cases. When disciplinary behavior reports are entered into the system, the program automatically generates due dates for each required procedural step. The living unit tracks the case to ensure timely completion. The Office of the Inspector General noted that the comments by the facility management are not responsive to the recommendation. The audit team did note, however, that management is holding one individual accountable for not processing disciplinary cases in a timely manner.

FOLLOW-UP RECOMMENDATION

None.

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that staff performance appraisals and probationary reports are overdue.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
None	NOT APPLICABLE	Recommendations were found to have been implemented by the 2002 follow-up review.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that facility safety and security could be enhanced.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution do the following: • Ensure that suicide risk lists are updated daily and maintained in each living unit, including intensive treatment program units.	FULLY IMPLEMENTED	According to facility management, it has appointed a suicide risk manager to identify risk management issues that pertain to suicide, to monitor managers and treatment teams in their communication with and handling of wards at suicide risk, and to inform staff of proper procedures for handling high-risk wards. The suicide risk manager will also review the WIN 2000 daily to ensure that all procedures and safeguards are properly completed for at-risk wards. According to facility management, suicide risk lists are printed no later than 6:00 a.m daily. Treatment team supervisors are responsible for ensuring that this task is accomplished and that staff members are fully aware of high-risk wards. On weekends, the executive officer on duty uses inspections to verify that the staff has a current list. The senior psychologist also disseminates a crisis call calendar so that the staff has access to a mental health professional at all times. For specialized counseling teams, special programs, and intensive treatment programs, the assigned psychologists meet weekly with wards identified as high-risk. According to the facility management, the California Youth Authority will conduct statewide training in suicide prevention procedures in November of each year. The Office of the Inspector General conducted an on-site review at the facility to verify that each living unit had an up-to-date suicide risk list. In addition, the audit team asked staff to locate the Hoffman tool, a safety knife for quickly cutting down wards who attempt to hang themselves. The audit team found that all units had an up-to-date suicide risk list and were able to present the Hoffman tool within 8 to 21 seconds.

• Begin random searches of employees.	**FULLY IMPLEMENTED**	The facility management reported it conducts random searches of staff quarterly on institution grounds. A report of findings is submitted to the superintendent upon completion of each search. In addition, during subsequent management meetings, the management staff discusses the results of the search with program managers so that staff members can be held accountable for bringing in contraband and other items not allowed in the institution. During the Office of the Inspector General's follow-up review, the facility provided the audit team with the report of findings from the last random search of the staff, which was conducted on August 13, 2004. During the same follow-up review, the Office of the Inspector General informed the deputy superintendent that the custody staff in the control booth at the facility entrance did not require the audit team to sign the visitor log when entering or exiting the facility. The deputy superintendent confirmed that security policy requires all visitors to sign in the visitor log and said he would ensure that staff members were aware of this requirement. Yet, when the audit team visited the facility a week later to conduct additional follow-up work, team members again were not required to sign the visitor log. Instead, the facility staff obtained the audit team's identification cards, gave them visitor's passes, and supplied the team with keys to the facility. When the team left the facility, the custody staff collected the keys and the visitor's passes and returned the identification cards. In addition to being against facility policy, this process provides no evidentiary record that a visitor was at the facility should an escape or another security issue arise.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the superintendent require control booth staff to have all visitors sign in and sign out of the facility.

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that the ward information network system had numerous weaknesses.

2002 FOLLOW-UP RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Youth Authority do the following:		
• Continue department-wide implementation of the WIN 2000 system.	FULLY IMPLEMENTED	The facility provided the Office of the Inspector General with a copy of the WIN 2000 migration schedule with completion dates listed by facility. Migration for the Heman G. Stark Youth Correctional Facility to the WIN 2000 system was completed in July 2003.
• Once implementation is complete, thoroughly test the system to ensure that access to the system is controlled properly, that programming requests are assigned priority according to departmental policy, and that timely feedback on the status of service requests is provided to institutions and other users.	NOT IMPLEMENTED	According to facility management, due to staffing shortages, there has been no formal testing of the WIN 2000 system. The assistant director of the information technology unit at California Youth Authority headquarters has been assigned to complete this function.
• Upon full implementation, conduct periodic audits of the WIN 2000 system.	NOT IMPLEMENTED	The institution's response referenced the WIN 2000 migration schedule, but the schedule provides no specifics concerning periodic audits of the system. The schedule lists central office "subject matter experts" and states that each of these individuals is responsible for conducting periodic reviews of the data residing in the WIN 2000. The schedule also states that there is no formal schedule established for conducting the periodic reviews. Facility management provided no documentation in its response to the Office of the Inspector General to indicate that reviews of the system have been conducted.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following additional actions:

- **Thoroughly test the WIN 2000 system to ensure that access is controlled properly, that programming requests are assigned priority according to department policy, and that timely feedback on the status of service requests is provided to institutions and other users.**
- **Conduct periodic audits of the WIN 2000 system.**

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SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

IMPLEMENTATION REPORT CARD

Previous recommendations: 77

Fully implemented: 32 (42%)

Substantially implemented:8 (10%)

Partially implemented:21 (27%)

Not implemented: 16 (21%)

The Southern Youth Correctional Reception Center and Clinic has improved some of its operations since a June 2003 audit, but numerous deficiencies remain. The institution has enhanced safety and security; improved the intensive treatment program; and improved screening for wards with communicable diseases. But wards are still not receiving mandated education services and have fallen further behind in achievement; diagnostic assessments are still not being completed on time; not all wards are receiving mandated counseling services; and required mental health and suicide prevention procedures are not consistently followed.

The Office of the Inspector General issued a management review audit report on the Southern Youth Correctional Reception Center and Clinic in June 2003. The audit identified serious problems at the institution, extending to nearly every aspect of the facility's operation. Deficiencies were found in institution security, the ward diagnostic assessment process, mental health services, suicide prevention, education, medical care, the ward disciplinary decision-making system, the ward grievance system, and employee evaluations. The Office of the Inspector General noted that the then-recently appointed superintendent had made significant improvements during his short tenure, and that some of the deficiencies, such as those relating to ward education, fell outside the superintendent's authority and required attention from California Youth Authority headquarters.

BACKGROUND

The Southern Youth Correctional Reception Center and Clinic, together with the Preston Youth Correctional Facility in Ione, receives and processes youthful offenders sent to the California Youth Authority by the county courts by providing diagnostic services, education, training and treatment. At the reception center, wards undergo academic and vocational testing, medical and dental examinations, and mental health assessments, followed if necessary by more in-depth psychological and psychiatric evaluations and treatment. The mental health clinicians at the facility perform an evaluation consisting of interviews and diagnostic testing and prepare a recommended treatment plan for each ward. The diagnostic evaluations are used in determining the ward's programming requirements, length of incarceration, and parole consideration date.

In addition to serving as a reception center for newly committed wards, the Southern Youth Correctional Reception Center and Clinic also receives wards for court evaluation, temporary detention, and parole violation disposition hearings. Among the institution's residential programs is the 25-bed Marshall intensive treatment program, which provides emotionally disturbed wards aged 13 to 24 with long-term residential treatment, crisis intervention, and transitional services. Another is a 30-bed short-term work experience

program for parole violators aged 18 to 24, who work as apprentices to the facility's maintenance staff.

The Southern Youth Correctional Reception Center and Clinic has a design capacity of 377 wards, with eight living units on the facility grounds. Wards leave the living units to obtain diagnostic and counseling services and to participate in programs at various locations on the institution grounds, including the facility's Jack B. Clarke High School and vocational training in janitorial services. Wards also leave their living units to obtain medical and dental services at the institution's hospital and clinic and to attend religious services. Located in Norwalk, California, the Southern Youth Correctional Reception Center and Clinic opened in 1954. For fiscal year 2004-05, the facility has a budgeted staff of 350.9 positions and an operating budget of $27, 808,000.

SUMMARY OF PREVIOUS FINDINGS

The Office of the Inspector General made the following specific findings as a result of the 2003 management review audit:

- The Southern Youth Correctional Reception Center and Clinic was not complying with established security requirements.

- The Southern Youth Correctional Reception Center and Clinic was not processing wards through the diagnostic assessment process within the required time limits.

- Wards in the Marshall intensive treatment program and the work experience program were not receiving required counseling and related services.

- There were deficiencies in medical procedures at the Southern Youth Correctional Reception Center and Clinic, including failure to provide required vaccinations; failure to obtain consent for treatment; and failure to screen wards with communicable diseases from working in food services.

- Wards at the Southern Youth Correctional Reception Center and Clinic did not consistently receive required mental health services and the institution did not consistently comply with required mental health procedures.

- Staff assigned to living units were not adequately informed about suicide prevention measures and the suicide prevention assessment and response committee meetings were poorly attended.

- Academic achievement at the Southern Youth Correctional Reception Center and Clinic was low compared to other California Youth Authority facilities and the institution was not providing wards with special education services in a timely manner.

- The institution was over-stating average daily attendance and misrepresenting provider service hours in reports to the Education Services Branch.

- A new building, intended to house an intensive treatment center and later modified to operate as a correctional treatment center, had design flaws affecting security and the duties and responsibilities of security employees at the building were neither documented nor well-defined.

- The disciplinary decision-making system at the Southern Youth Correctional Reception Center and Clinic did not ensure due process for wards and failed to provide management with important tools for monitoring disciplinary actions and ward grievance activity.

- The ward grievance system at the institution was ineffective and did not comply with department regulations.

- Staff performance appraisals and probationary reports were not completed on time.

The Office of the Inspector General made 77 recommendations as a result of the management review audit and also recommended that the superintendent develop a comprehensive strategic plan to correct the problems. The Office of the Inspector General urged the California Youth Authority administration to provide support and assistance to the superintendent to address issues that were outside the superintendent's control.

OBJECTIVES, SCOPE AND METHODOLOGY

The purpose of the 2004 follow-up review was to determine the extent to which the Southern Youth Correctional Reception Center and Clinic, the Education Services Branch, and California Youth Authority headquarters have implemented the 77 recommendations from the Office of the Inspector General's June 2003 management review audit. To conduct the follow-up review, the Office of the Inspector General interviewed the superintendent of the Southern Youth Correctional Reception Center and Clinic and members of the institution staff. The audit team also reviewed selected ward files, conducted physical inspections of the institution, and reviewed written responses from the institution management and department headquarters addressing the Office of the Inspector General's recommendations.

SUMMARY OF FOLLOW-UP RESULTS

The follow-up review determined that the Southern Youth Correctional Reception Center and Clinic, the Education Services Branch, and the California Youth Authority headquarters have fully implemented 32 (42 percent) of the 77 recommendations from the Office of the Inspector General's 2003 management review audit; have substantially implemented eight recommendations (10 percent); and have partially implemented 21 (27 percent). Seventeen recommendations (21 percent) have not been implemented.

Among the findings of the follow-up review are the following:

- The institution has taken several measures to improve safety and security, including repairing the perimeter fence; instituting random searches of staff, visitors, and vendors; implementing a personal alarm pilot program for employees; installing

automatic locks on classroom doors; updating the multi-hazard emergency plan; and improving control over maintenance tools.

- Significant improvements have been made to ensure that wards in the Marshall intensive treatment program receive required weekly individual and small group counseling and related services and are promptly enrolled in education classes.
- Improvements have been made to screen wards for communicable diseases and to ensure that only wards with proper medical clearance are assigned to food service or kitchen duties.
- Safety deficiencies in the building housing the intensive treatment program have been corrected.
- Improvements have been implemented in the institution's disciplinary decision-making process to help ensure due process for wards.

The Office of the Inspector General noted the following continuing deficiencies:

- Wards are still not receiving mandated education services. The effectiveness rating of the high school for fiscal year 2003-04 was only 40 percent, meaning that wards received an average of only 40 percent of available instruction time during the year. That figure represents a drop of one percentage point from the 41 percent effectiveness rating for fiscal year 2002-03.

- Wards have fallen further behind in achievement, with cumulative test scores steadily declining since 1998. Approximately 78 percent of wards at the facility's Jack B. Clarke High School had cumulative subject scores below the 25th national percentile rate in 2004, compared to 67 percent of the school's wards in 2002 and 69 percent of the school's wards in 1998.

- Ward absenteeism from school has increased from 9 percent to 13 percent over the past two years.

- Wards are still not being processed through the diagnostic assessment within required time limits. The review found that 237 (82 percent) of the 288 initial case reviews held between January and August 2004 were not conducted within the 45-day time limit. The auditors noted that in one instance, the 45-day time limit was exceeded by 93 days. Several recommendations relating to improving the timeliness of the diagnostic assessment process have still not been implemented.

- Not all wards are receiving the weekly individual and small-group counseling required by California Youth Authority policy. Nine (25 percent) of 36 randomly selected wards who had been at the facility 12 months or less had not received the required counseling. Although all 13 of the Marshall intensive treatment program wards sampled had received the required counseling services, none of the wards in the work experience program had received the counseling.

- Special program needs assessments are not consistently completed on time. Although the institution claimed that 97 percent of special program needs assessments are completed by psychologists within 10 days, the audit team's review of internal tracking records found 43 of 80 (54 percent) of special program needs assessments were late during the July through December 2003 reporting period, while 65 of 136 (48 percent) were late in the period April through August 2004. In addition, the audit team found that 4 of the 18 wards taking psychotropic medications had not received special program needs assessments prior to being administered the drugs, in violation of departmental policy.

- The mental health staff does not consistently obtain parental or guardian consent to administer psychotropic medication to wards, in violation of department policy.

- Although the institution reported that a checklist has been in use since October 2002 to ensure that wards receive timely orientations, the review found that all of the checklists in the files of wards in the work experience program were prepared immediately before the arrival of the audit team.

- Recommendations to correct deficiencies in the suicide prevention assessment and response program have been only partially implemented. Some staff members do not attend mandatory refresher training, and attendance at monthly meetings has been poor among security and medical staff.

- The institution's academic record-keeping practices rely too heavily on manual calculation of critical statistical indicators, including average daily attendance.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center and Clinic take the following additional actions:

- **Continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include working with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive compensation for teachers**.

- **Improve the thoroughness and overall quality of the annual *California Youth Authority Institutions and Camps Branch Manual* section 1800 security audits.**

- **Improve control over access to the armory and ensure that armory staff have time to accurately inventory weapons and other controlled materials.**

- **Remove discarded furniture and other items that present potential barriers to observing wards from behind the gym, commissary, and maintenance areas.**

- **Keep ward rooms locked when they are unoccupied to prevent unauthorized entry.**

- **Develop an automated process to track and monitor caseworker productivity and to ensure that the diagnostic assessment process for each ward is completed within required time limits.**

- **Conduct timely annual performance appraisals for all casework specialists, including the supervising casework specialist II.**

- **Make appropriate revisions to the supervising casework specialist II's duty statement to better ensure the quality and timeliness of the diagnostic assessment process.**

- **Ensure that the work experience program provides weekly individual and small-group counseling to wards.**

- **Monitor the casework of all living units, including the work experience program, to ensure that the casework management system is being used to manage the counseling of wards.**

- **Use progressive discipline to hold counseling staff and their supervisors accountable for failing to counsel wards.**

- **Ensure that staff use ward orientation checklists as intended.**

- **Hold the chief medical officer accountable for the continued planning and monitoring of the activities of the medical staff.**

- **Develop policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics.**

- **Ensure the timely completion of special program assessment needs evaluations.**

- **Do not administer psychotropic medications to wards who have not received treatment needs assessments.**

- **Ensure that employees obtain consent forms to administer psychotropic medication to wards under age 18.**

- **Ensure that all staff receive annual refresher training in suicide prevention assessment and response.**

- **Remind staff of the importance of the suicide prevention and response committee, and enforce attendance at committee meetings.**

- **Ensure that wards do not move from class to class without notification by staff to school security.**

- **Institute the Education Services Branch's student ward attendance tracking (SWAT) system at the facility's high school.**

- **Improve the high school's effectiveness rating by striving to make more classroom time available to wards.**

- **Require all teachers to use the electronic version of the average daily attendance report.**

- **Require supervisory review and written approval of the high school's average daily attendance forms.**

- **Notify courts that refer wards to the California Youth Authority of their obligation to provide complete special education data under *Welfare and Institutions Code* section 1742. Develop a plan with court representatives to accomplish that purpose, including a timetable for submitting special education information. If cooperation is not forthcoming, refuse to accept wards who do not have complete special education background packages.**

- **Conduct quarterly audits of a random sample of Level A and Level B ward disciplinary reports and use the results in the annual performance appraisals of living unit staff.**

- **Develop a system to identify and address delinquent annual employee appraisals and probation reports and to hold supervisors accountable for completing the reports and appraisals.**

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

ORIGINAL FINDING NUMBER 1

In the 2003 audit, the Office of the Inspector General found that the Southern Youth Correctional Reception Center and Clinic had failed to comply with established security requirements.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that institution management, in conjunction with California Youth Authority headquarters, take the following actions to improve institution security:		
• Assemble a task force of California Youth Authority security professionals to review the security findings of this report and to conduct a thorough security assessment of the Southern Clinic. Using the Office of the Inspector General's findings and its own findings, the task force should develop a corrective action plan that prioritizes deficiencies according to risk, cites specific tasks for correcting deficiencies, sets deadlines for completion, and identifies the staff responsible for each task. The corrective action plan should include the following tasks:	SUBSTANTIALLY IMPLEMENTED	Facility management reported that the compliance unit of California Youth Authority, consisting of experienced professionals, conducted an institutional security audit in June 2003. The Office of the Inspector General obtained and reviewed this report. The report addressed nearly all of the areas cited as deficient in the security component of the June 2003 management review audit. Many of the improvements cited below are the result of the cooperation between the compliance unit and facility management.
• Improve the thoroughness and overall quality of the Southern Clinic's annual Section 1800 security audits.	NOT IMPLEMENTED	Facility management reported that the institution conducted the annual audit required by section 1800 of the *California Youth Authority Institutions and Camps Branch Manual* in July 2004 and that remediation was completed by September 10, 2004. The facility could not provide the Office of the Inspector General with a completed copy of the report for the audit team's evaluation, however. Facility management said it did anticipate providing the report to the director by the November 30, 2004 deadline required by section 1800.

• Enhance accountability for wards in counts and movement.	**SUBSTANTIALLY IMPLEMENTED**	According to the institution management, as of December 1, 2002, all wards were provided with photo identification cards, and clipboards are placed outside each classroom to allow teachers and school security to monitor ward counts. The audit team confirmed that the institution has greatly enhanced accountability for wards, particularly in the education area, and noted that staff members are more visible when wards are being moved than they were before. Some of the doors in the living units are still unlocked, however, permitting wards to enter rooms to which they are not assigned.
• Improve perimeter security.	**FULLY IMPLEMENTED**	The institution reported that it submitted a budget change proposal for a perimeter fence upgrade in its five-year plan, to begin in fiscal year 2003-4. The Office of the Inspector General verified that the institution submitted a capital outlay budget change proposal for fiscal year 2003-04, that the fence upgrade was included, and that repairs to the fence have been made. The audit team saw evidence that perimeter checks are conducted weekly and fence alarm tests are conducted daily and also observed a successful test of the fence alarm.
• Enhance the range of facility radios.	**NOT IMPLEMENTED**	According to the institution management, the Federal Communications Commission controls the assignment of radio frequencies, limiting the range of the institution's system. Staff traveling beyond the limits of the institution's frequency range are issued cellular telephones.
• Improve personal alarm procedures.	**FULLY IMPLEMENTED**	The institution reported that it has implemented a new personal alarm system for employees as a pilot program. The audit team found that personal alarm procedures have been significantly enhanced and saw evidence that personal alarms are tested daily and that employees failing to test the alarms are reported to the superintendent.
• Develop accurate inventories of supplies and equipment in the armory areas.	**SUBSTANTIALLY IMPLEMENTED**	According to the institution, a lieutenant and sergeant are assigned to armory inventory control to ensure that weapons storage, access logs, firearms assignments, chemical agent counts, and reconciliation of inside and outside inventory counts meet the department's policies and regulations. A standardized

		department-wide armory audit report will be implemented by January 2005. The audit team found the firearm inventory to be accurate, but the inventory of chemical agents in both the inside and outside armories contained discrepancies that suggest improvement is still needed. The sergeant acknowledged the inventory discrepancies and commented that too many staff members have access to the armory. He further stated that he and the lieutenant perform this function as collateral duties, and that they need more time assigned to the armory.
• Implement random searches of staff, visitors, and vendors.	**FULLY IMPLEMENTED**	The institution reported that since June 2003 it has conducted routine random searches as mandated by section 5070 of the *California Youth Authority Institutions and Camps Branch Manual.* The audit team confirmed that the department implemented a random search policy for employees on June 10, 2003, and that searches of staff and visitors are being conducted and the results reported to headquarters monthly.
• Install automatic outside locks on the education classroom doors.	**FULLY IMPLEMENTED**	According to the institution, budget constraints thwarted a project to change all locks during the 2003-04 fiscal year. That project has been reactivated, and the audit team found that the automatic locks were recently installed.
• Identify all staff or visitors on institution grounds.	**FULLY IMPLEMENTED**	The audit team found that visitors are being logged and identified at both the main entrance and the sallyport located near the maintenance section. New procedures implemented in December 2002 require all those making deliveries to provide proper identification, which is logged at the sallyport entrance.
• Update the multi-hazard emergency plan.	**FULLY IMPLEMENTED**	The institution reported and the audit term verified that the multi-hazard plan was revised in November 2003.
• Conduct training for handling hostage situations.	**NOT IMPLEMENTED**	The institution reported that its former chief of security initiated discussions with the Los Angeles County Sheriff's Department for training on hostage situations, and that its current chief of security will continue to pursue securing this training. The audit team confirmed that a draft agreement with local law enforcement agencies for handling hostage situations has been completed, but found that department headquarters instructed institution management to wait until language can be drafted for the use of all institutions to achieve statewide

		consistency.
• Improve the intercom system.	**FULLY IMPLEMENTED**	The institution reported that for the past several years it has submitted an annual proposal for a new education building that includes a state-of-the-art intercom system. In the interim, standard and emergency communications occur via two-way radio, telephone systems, and the call feature in the personal alarm system. The audit team confirmed that the institution has submitted proposals for a new education building. With the elimination of some of the older portable classrooms, classes are now held in rooms with an adequate intercom system.
• Enhance key controls.	**SUBSTANTIALLY IMPLEMENTED**	The institution reported that it has established a key control committee consisting of the chief of security, chief of plant, and the business manager; that the key control sergeant and a youth correctional officer in key control conduct a key inventory and identification card audit during every shift; and that a complete inventory of all institution keys was completed in January 2004. The audit team confirmed that report, and also found that locksmith duties are shared by two maintenance workers in addition to their regular duties because the institution currently has no regular locksmith. That arrangement sometimes causes delays in inventory control. In addition, the team noted that some of the staff assigned to the main entry control need training to understand the function of each key issued to staff and official visitors by that post.
• Improve tool controls.	**FULLY IMPLEMENTED**	The institution reported that the maintenance department has constructed and installed shadow boards in its shops and an additional locking cabinet for the kitchen. The audit team confirmed those changes and also noted that staff members have been disciplined for not properly accounting for tools.
• Minimize barriers to observing wards.	**SUBSTANTIALLY IMPLEMENTED**	The institution reported that it removes all shrubs surrounding interior fencing and building perimeters on a regular trimming schedule. The audit team confirmed that information, but noted discarded furniture and other items behind the gym, commissary, and maintenance areas that present potential barriers to observing wards.

• Tether and secure dumpsters.	**FULLY IMPLEMENTED**	The audit team observed that all dumpsters are secured with locks and chained to fixed objects in accordance with department policy.
• Limit visiting to the new visiting building.	**PARTIALLY IMPLEMENTED**	The institution reported that all visiting now occurs within the visitor center located inside the institution's secured perimeter, but the audit team observed that the old visiting area is still in use because the visitor center does not have enough space to accommodate all visitors. Both areas are within the secured perimeter, however.
• Ensure that ward rooms are locked.	**PARTIALLY IMPLEMENTED**	The institution reported that watch commanders conduct random checks of living unit doors to ensure compliance with section 1832 of the *California Youth Authority Institutions and Camps Branch Manual*. The audit team found, however, that the rooms of some wards were unlocked, allowing other wards to enter. The team also noted that one ward had been placed on temporary detention for entering a room to which he was not assigned.
• Update post orders and make them available on every post.	**FULLY IMPLEMENTED**	The audit team confirmed that a binder of updated post orders is located in the offices of the major, the duty lieutenant, and the control center, and that each duty station has a record of specific post orders.
• Safeguard confidential records.	**FULLY IMPLEMENTED**	According to the institution, confidential records have been removed from the warehouse and are now stored in the administration building.
• Update, as necessary, the facility's security-related policies and procedures to reflect the findings and recommendations of the task force.	**FULLY IMPLEMENTED**	According to the institution, the chief of security has reviewed the Office of the Inspector General's June 2003 management review audit and the section 1800 compliance reports and will meet quarterly with the superintendent and assistant superintendent to assess the need to update security-related policies and procedures.
• The task force's progress should be reported periodically to the California Youth Authority executive staff and to the Office of the Inspector General.	**NOT IMPLEMENTED**	The institution maintains that this effort should be monitored through a regular review process instead of through a new separate reporting system.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic continue to improve its security procedures by taking the following actions:

- **Improve the thoroughness and overall quality of the annual *California Youth Authority Institutions and Camps Branch Manual* section 1800 audits.**
- **Improve control over access to the armory, and ensure armory staff have time to accurately inventory weapons and other controlled materials.**
- **Remove discarded furniture and other items that present potential barriers to observing wards from behind the gym, commissary, and maintenance areas.**
- **Keep ward rooms locked when they are unoccupied to prevent unauthorized entry.**

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the Southern Youth Correctional Reception Center and Clinic was not processing wards through the diagnostic assessment process within the required time limits.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Southern Youth Correctional Reception Center and Clinic take the following actions to improve the timeliness of the diagnostic assessment process: • Assign newly committed wards to a casework specialist before the actual delivery of the ward to the Southern Clinic and enter each ward into the clinical assessment process by the day after his	**FULLY IMPLEMENTED**	The institution staff reported and the Office of the Inspector General confirmed that the supervising casework specialist II assigns newly committed wards to a casework specialist upon their arrival at the institution, and that those wards enter the clinical assessment process by the day following their arrival. The supervising casework specialist II tracks ward

arrival at the facility, as required by the *California Youth Authority Institutions and Camps Branch Manual, s*ection 3265.		assignments using a spreadsheet that records each ward's name, identification number, arrival date, assignment date, due date (the date by which the ward's diagnostic assessment report is due to typing staff), assigned casework specialist, and other vital information.
• Systematically monitor the productivity of each casework specialist. The monitoring should include tracking the following information on an electronic spreadsheet: the arrival date of each newly committed ward; the date each ward receives an initial face-to-face contact with the assigned casework specialist; the date the ward receives a conference with the supervising casework specialist II and the psychologist; and the date the ward transfers out of the Southern Clinic or into a Southern Clinic residential program. The spreadsheet should calculate the elapsed time and determine compliance or non-compliance with the 45-day mandate for completion of the assessment.	**NOT IMPLEMENTED**	The institution acknowledged that this recommendation has not been implemented. Instead, the supervising casework specialist and staff manually track and monitor each newly committed ward's contact with casework specialists, dates of conferences with social workers and the psychologist, and the date of transfer out of the institution. The supervising casework specialist II told the Office of the Inspector General that there is no means of using the ward information network to monitor the productivity of casework specialists. Consequently, the institution is not processing all wards through the diagnostic assessment process within the required 45-day period.
• Using the spreadsheet described above, develop a management information system to tabulate the weekly assignments each casework specialist receives; to enable the supervising casework specialist II to identify casework specialists who are not providing timely and efficient casework services; and to flag wards in danger of exceeding the 45-day timeframe.	**NOT IMPLEMENTED**	This recommendation has not been implemented. Instead, the supervising casework specialist II tracks casework specialist productivity by hand and diagnostic assessments are still not being completed on time. The audit team found that 237 (82 percent) of the 288 initial case reviews held during the period January to August 2004 exceeded the 45-day time limit—in one instance by 93 days.
• Using the spreadsheet and the management information system, perform timely and accurate performance appraisals of casework specialists at the intervals specified by California Youth Authority	**PARTIALLY IMPLEMENTED**	The institution reported that caseworker productivity is addressed as part of performance evaluations, and the audit team confirmed that each casework specialist had annual appraisals during calendar years 2003 and 2004, with four specialists receiving critical observations concerning late diagnostic reports. However, the most recent appraisal for the supervising casework

policy and state law.		specialist II was dated March 14, 2001 and was prepared during that employee's assignment at Fred C. Nelles Youth Correctional Facility, now closed.
• Revise the supervising casework specialist II duty statement to incorporate these recommendations and monitor the supervising casework specialist II's performance.	NOT IMPLEMENTED	The institution reported that this action had been accomplished, but the audit team found that the duty statement has not been revised. The most recent duty statement in the supervising casework specialist II's personnel file was one attached to a March 14, 2001 performance appraisal related to a previous position at the Fred C. Nelles Youth Correctional Facility.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic make further improvements to its diagnostic assessment process by taking the following actions:

- **Develop an automated process to track and monitor caseworker productivity and ensure that the diagnostic assessment process for each ward is completed within the required time limits.**
- **Conduct timely annual performance appraisals for all casework specialists, including the supervising casework specialist II.**
- **Make appropriate revisions to the supervising casework specialist II's duty statement to better ensure the quality and timeliness of the diagnostic assessment process.**

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that wards in the Marshall intensive treatment program and the work experience program had not been provided with required counseling and related services.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management take the following actions to improve ward assessment and counseling:		

• Continuously emphasize to all staff members the importance of counseling and assessment service to the mission of the institution.	**PARTIALLY IMPLEMENTED**	According to facility management, a new program model uses individualized clinic plans and interactive journaling by wards to facilitate this objective. To determine whether the facility staff is providing the weekly individual and small-group counseling required by section 4050 of *the California Youth Authority Institutions and Camps Branch Manual*, the Office of the Inspector General randomly sampled 36 living unit files of wards in the Marshall intensive treatment program, the Gibbs general population unit, the Pico sex offender program, and the work experience program. Of the 36 wards, 9 (25 percent) had not received the required counseling for the 12 months or less they had been at the facility. Although all 13 of the Marshall wards had received the required counseling, none of the 8 work experience wards had received the counseling and one of the 8 Pico sex offender program wards also had not received the counseling.
• Develop a casework management system that meets the content and frequency criteria laid out in section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual.* Of particular importance is weekly individual and small group counseling and the prompt conducting of initial and progress case conferences. The system should include: (1) monthly auditing of at least five ward files per residential program by appropriate administrators; (2) the timely reporting of the audit results up and down the chain of command; and (3) the prompt administration of progressive discipline for staff failing to perform duties. The audits should be the basis of the institution's annual section 4000 report to the Institutions and Camps Branch.	**PARTIALLY IMPLEMENTED**	The institution reported that it developed an audit form to track critical events in each ward's file, and that five cases per month are reviewed to ensure that orientations are being conducted in a timely manner. The senior youth correctional counselor for the intensive treatment program created a weekly casework schedule to track casework time for each youth correctional counselor and to provide verification that casework is completed. The audit team observed that files for wards in the intensive treatment program showed that these tools were consistently used, but files for wards in the work experience program did not.

• Use annual performance appraisals and progressive discipline to hold line, supervisory, and management staff accountable for monitoring the work of casework specialists, the senior youth correctional counselor, and youth correctional counselors.	**FULLY IMPLEMENTED**	The institution reported that the superintendent, assistant superintendent, and program administrator review all performance appraisals.
• Ensure that all wards receive timely and complete orientation, and that wards acknowledge in writing that they have received such orientation.	**PARTIALLY IMPLEMENTED**	The institution reported that a comprehensive ward orientation checklist has been in use since October 2002, but the audit team found that all of the checklists in the files of wards in the work experience program were prepared immediately before the arrival of the audit team for the follow-up review, casting doubt on the institution's veracity.
• Cease placing ineligible wards into the work experience program, and transfer any wards not meeting program criteria. • • •	**FULLY IMPLEMENTED**	The institution reported that public service (work experience) program wards are screened into the program and notified that they will be given work assignments subject to treatment program priorities. Non-high school graduates must attend academic classes, while special education students continue to receive required services.
• Staff the work experience program with youth correctional counselors and a senior youth correctional counselor. One option would be to redirect two new youth correctional counselor positions budgeted for reception clinic services to the work experience program. For the senior youth correctional counselor position, the facility could redirect one of two newly budgeted casework specialist positions.	**NOT IMPLEMENTED**	According to the institution, current funding does not allow for a youth correctional counselor and senior youth correctional counselor position. Counseling is conducted by casework specialists.
• Allow visitation on both weekend days, and cease the policy of terminating visits when a ward has to visit the restroom.	**FULLY IMPLEMENTED**	The institution reported that wards assigned to the work experience program and the Marshal intensive treatment program have visiting opportunities on both weekend days. The facility no longer terminates visits when wards have to use the restroom.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic take the following additional actions:

- **Ensure that the work experience program provides weekly individual and small-group counseling to wards.**
- **Monitor the casework of all living units, including the work experience program, to ensure the casework management system is being used to manage the counseling of wards.**
- **Use progressive discipline to hold counseling staff and their supervisors accountable for failing to counsel wards.**
- **Ensure that staff use ward orientation checklists as intended.**

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found deficiencies in medical services at the Southern Youth Correctional Reception Center and Clinic.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Southern Youth Correctional Reception Center and Clinic take the following actions to improve medical services: • Develop sound policies and procedures for identifying wards with communicable diseases and communicating this information with staff members who have a need to know, while ensuring ward confidentiality. The policies and procedures should include using the ward information system's 4-D subsystem for	SUBSTANTIALLY IMPLEMENTED	According to the institution's chief medical officer, wards go through a medical intake process and a physician must medically clear a ward for food service duties. The clearance is entered into the ward 4D information system, where it is accessible to all staff. The staff is instructed to assign only wards with the proper medical clearance to food service or kitchen duties.

food services clearances.		
• Hold the chief medical officer accountable for planning and monitoring the activities of the medical staff, including (1) full compliance with the requirements of *California Youth Authority Institutions and Camps Branch Manual* section 6160 *et seq.,* (2) the prompt and thorough completion of all tasks required for inclusion in the unified health record of each ward, and (3) the use of progressive discipline for employees failing to do their jobs.	**PARTIALLY IMPLEMENTED**	The chief medical officer reported that the process for administering repeat tuberculosis tests has been changed to ensure that all wards receive the tests. The chief medical officer also reported that the medical staff has been instructed to use the problem list and the ward movement form to record any chronic medical conditions, and staff has been instructed to ensure that wards requesting HIV tests complete and sign the appropriate consent form, which is then filed in the ward's unified health record. The response to the Office of the Inspector General from the chief medical officer did not address the question of monitoring and correcting employee performance.
• Require the chief medical officer to develop and implement the auditing of a random sample of at least 30 unified health records per quarter. At a minimum, the audit should assess the accuracy, thoroughness, and timeliness of entries. The results of the audit should be reported to the superintendent and used as a basis for annual personnel appraisals.	**FULLY IMPLEMENTED**	The chief medical officer provided the audit team with evidence that he now randomly audits 30 unified health records each quarter using a special form to log the audits and report the results to the superintendent.
• Correct the unsanitary and unsafe conditions in the outpatient housing unit.	**FULLY IMPLEMENTED**	The chief medical officer reported and the audit team confirmed that the outpatient housing unit has been cleaned up.
In addition, the Office of the Inspector General recommends that the California Youth Authority Health Care Services Division take the following actions:		
• Rescind the policy memorandum of September 25, 2002 allowing wards with hepatitis B and hepatitis C to work in food	**NOT IMPLEMENTED**	The California Youth Authority headquarters said the *Farrell v. Allen* remedial plan is expected to address all aspects of the department's health care program. However, the department did not specifically respond to this recommendation.

services operations.		The department reported that it had expected to hire a new chief medical officer by November 2004, but told the Office of the Inspector General that "The first selection process did not identify an acceptable candidate for this position."
• Develop policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics and other California Youth Authority facilities. Those policies and procedures should be incorporated into the *California Youth Authority Institutions and Camps Branch Manual*.	**NOT IMPLEMENTED**	The California Youth Authority did not specifically respond to this recommendation.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic and the California Youth Authority take the following additional actions:

- **Hold the chief medical officer accountable for the continued planning and monitoring of the medical staff's activities.**
- **Develop policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics.**

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that wards at the Southern Youth Correctional Reception Center and Clinic did not consistently receive required mental health services and that the institution did not consistently comply with required mental health procedures.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Southern Youth Correctional Reception Center and Clinic take the following actions to improve the institution's mental health services:		
• Ensure that all treatment needs assessments and supporting documents are promptly filed in the mental health section of the wards' unified health records.	FULLY IMPLEMENTED	According to the institution management, casework specialists have been directed to immediately review the treatment needs assessments, note areas of concern, and send the profiles to medical records for timely filing. The audit team confirmed that treatment needs assessments are administered two weeks after the ward's arrival and are reviewed by the senior psychologist. If the procedure reveals "red flags," the ward is evaluated by a psychologist to determine the extent of his treatment needs. The treatment needs assessments are then forwarded to the medical records office and filed in the ward's unified health record**.** A newly developed recap sheet tracks the entire process.
• Ensure that the new special program assessments of needs (SPAN) policy and procedures are properly implemented. If the institution is unable to perform special program assessments of needs evaluations with the addition of two new psychologists, management should negotiate with the licensed clinical social workers on staff to obtain their services for that purpose.	PARTIALLY IMPLEMENTED	Although the institution claimed that 97 percent of special program assessments of needs are completed by psychologists within 10 days, the audit team's review of internal tracking records found 54 percent (43 of 80) of special program assessments of needs were late during the July through December 2003 reporting period, while 48 percent (65 of 136) were late in the period April through August 2004. In addition, the audit team found that 4 of the 18 wards taking psychotropic medications had not received special program assessments of needs, in violation of departmental policy.
• Provide orientation to all mental health staff on California Youth Authority policies and procedures regarding the prescribing and administering of psychotropic medication. The orientation	PARTIALLY IMPLEMENTED	According to the institution, the senior psychologist provides training to all mental health staff on policies and procedures pertaining to prescribing and administering psychotropic medications. The institution also reported that its chief medical officer has implemented a record-keeping process to ensure that a parental or guardian consent to administer psychotropic medications to

should emphasize the need for securing written consent and the need for promptly filing consent documents in the unified health record.		wards under age 18 is delivered by registered mail and that follow-up is accomplished within required time limits. However, the audit team found that an audit conducted by the chief medical officer of 27 files in September 2004 found 13 files (48 percent) without the required consent forms.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic take the following additional actions:

- **Ensure the timely completion of special program assessment needs evaluations.**
- **Do not administer psychotropic drugs to wards who have not received treatment needs assessments.**
- **Ensure that employees obtain consent forms to administer psychotropic medications to wards under the age of 18.**

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that the staff in the living units was not adequately informed about suicide prevention measures and that the suicide prevention assessment and response committee meetings were poorly attended.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Southern Youth Correctional Reception Center and Clinic take the following actions to correct the deficiencies in the suicide prevention assessment and response program:		
• Ensure that all staff members, including the risk management officer and living unit staff, receive adequate suicide prevention assessment and response program training upon appointment and as annual refresher training.	PARTIALLY IMPLEMENTED	The institution pointed out that the department has standard lesson plans for suicide prevention and assessment response as part of its academy curriculum and requires two hours of annual refresher training, but the audit team found that 43 of 224 scheduled employees (19 percent) failed to attend the most recent mandatory training. Furthermore, more than 100 employees who transferred to the Southern Youth Correctional Reception Center and Clinic from other institutions arrived without training records and the training officer has been unable to obtain them.
• Require the risk management officer to regularly monitor the suicide prevention assessment and response program.	PARTIALLY IMPLEMENTED	The institution reported that the risk management officer attends all suicide prevention assessment and response meetings. The audit team noted, however, that the risk management officer is new to the position, comes from a non-mental health background, and replaces a predecessor who did not adequately monitor this area.
• Emphasize to members of the suicide prevention assessment and response committee the importance of the	PARTIALLY IMPLEMENTED	The institution reported that the risk management officer and senior psychologist have developed a sign-in sheet to monitor attendance. The Office of the Inspector General noted a pattern of non-attendance, however, by

committee and monitor and enforce attendance at committee meetings.		security staff, who missed four of the seven most recent monthly meetings, and by medical staff, who missed three meetings.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic take the following additional actions:

- **Ensure that all staff receive annual refresher training in suicide prevention and response.**
- **Remind staff of the importance of the suicide prevention and response committee, and enforce attendance at committee meetings.**

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found that academic achievement at the Southern Youth Correctional Reception Center and Clinic was low compared to other California Youth Authority facilities and that the institution was not providing wards with special education services in a timely manner. The institution also over-stated average daily attendance and misrepresented provider service hours in reports to the Education Services Branch.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Youth Authority and the management of the Southern Youth Correctional Reception Center and Clinic take the following actions to improve education services at the institution:		The California Youth Authority noted in its response to these findings that all aspects of the department's education program were reviewed by experts as a result of the *Farrell v. Allen* lawsuit and will be addressed in the remedial plan.
• Promptly enroll Marshall intensive treatment program and work experience program wards in education programs.	FULLY IMPLEMENTED	The institution's high-school principal reported that Marshall wards are enrolled in school within five days of arrival and that all of the students deemed ready for school by their therapists from January through August 2004 were enrolled within one day of being so identified. According to the principal,

		a casework specialist identifies work experience wards who do not possess a high school diploma to the principal, who directs them to be placed in appropriate school classes. The audit team reviewed reports presented by the principal and confirmed that wards are being entered into school within five days of referral by unit staff or therapists.
• Establish security procedures that minimize class closures to provide the best learning environment possible in a reception center setting. Toward this end, the Office of the Inspector General recommended that the superintendent and the principal consult with their counterparts at the then-existing Northern Youth Correctional Reception Center and Clinic in Sacramento.	**PARTIALLY IMPLEMENTED**	According to the principal, education security and academic staff cooperate to improve the accountability of students through use of the School Area Attendance Form on which teachers note the student's presence or absence before placing it outside the classroom. The security staff then compares the form with a visual count of students in the classroom. If a student has to leave the class, that fact is noted on the School Area Attendance Form. The audit team noted that the process described above was in use at the time of the Office of the Inspector General's June 2003 audit, and that ward accountability deficiencies were first noted from the information on those forms. The Office of the Inspector General observed at that time that wards moved from class to class with teacher approval, but that attendance forms were not adjusted. Because the education area was the point of origin for a previous escape, efforts to lessen or eliminate the movement of wards from class to class without first notifying school security are critical.
• Promptly fill teaching vacancies, including those in special education, and develop a comprehensive list of substitute teachers willing to work in a youth correctional environment on short notice.	**SUBSTANTIALLY IMPLEMENTED**	The principal reported that the institution received additional teachers from the closure of Fred C. Nelles Youth Correctional Facility, which helped alleviate teacher vacancies and class closures. In reviewing the attendance reports, the audit team found few class closures resulting from the unavailability of substitute teachers, but found that class closure data is suspect. Specifically, the audit team noted that class closures for the period January 2004 through June 2004 were attributed to reasons that differed from those reported in the Monthly Report Risk Indices. The audit team noted that in numerous instances teacher rosters reported class closures resulting from "staff development," but that those closures were not included in the summary of classes closed reported in the Monthly Report Risk Indices. The audit team further noted that the Jack B. Clarke High School does not use

		the Education Services Branch's student ward attendance tracking (SWAT) system, a reliable system used at other facilities. To determine whether the corrective actions reported by the department and the facility have had a positive effect in improving ward education at Jack B. Clarke High School, the Office of the Inspector General reviewed Education Services Branch data and calculated key indicators of education performance. The audit team found that while class closures per month reportedly decreased, there was a dropoff in performance in the following areas: • The effectiveness rating of the high school for fiscal year 2003-04 was only 40 percent, meaning that wards received an average of only 40 percent of their available instruction time during the year. That figure represents a drop of one percentage point from the 41 percent effectiveness rating for fiscal year 2002-03. • Cumulative test scores have declined since 1998. Approximately 78 percent of Jack B. Clarke High School wards had cumulative subject scores below the 25th national percentile rate in 2004, compared to 67 percent of the school's wards in 2002 and 69 percent of the school's wards in 1998. • Ward absenteeism has increased from 9 percent to 13 percent over the past two years. These statistics raise serious questions about the high school's ability to educate wards.
• Establish a central repository at the institution for teacher attendance rosters. The rosters should be filed monthly and should be available to support the principal's monthly average daily attendance report.	**FULLY IMPLEMENTED**	According to the principal, there is a central repository for teacher attendance rosters and Teacher Monthly ADA Reports to support the principal's monthly average daily attendance report. The audit team confirmed that it was able to obtain teacher records from a single source.

• Use an electronic spreadsheet to automate average daily attendance calculations for the institution's monthly average daily attendance report and create a spreadsheet for teachers' monthly average daily attendance reports and monthly individual provider reports.	**SUBSTANTIALLY IMPLEMENTED**	The department's Education Services Branch developed and distributed an electronic version of the average daily attendance report for use by teachers and principals at all California Youth Authority schools. Although these tools are available for all teachers, the audit team observed several staff members at Jack B. Clarke High School still tracking and computing attendance figures manually. While converting a manual roll into electronic form at month's end is acceptable, continued manual computation of the inherently complicated and inter-dependent calculations of statistical indicators, such as effectiveness rate, absence factor, student-to-teacher ratio, and the average daily attendance, is not acceptable. Previous management review audits identified a high error rate in such manually computed reports.
• Implement supervisory sign-off on teachers' average daily attendance monthly reports to improve the accuracy of average daily attendance and related attendance figures.	**NOT IMPLEMENTED**	While the new electronic average daily attendance forms provide for a signature on one of the three attendance forms, the audit team noted that no teacher attendance forms require supervisory approval. The purpose of that control is to provide accountability over teachers. The audit team observed that certain class closures were left off the teacher attendance sheets, but without supervisory sign off, could not identify who authorized the adjustments.
• Provide for a prompt and thorough review by the Education Services Branch of monthly average daily attendance reports from principals at the institutions so that corrections can be made in a timely manner.	**NOT IMPLEMENTED**	The Office of the Inspector General has requested fiscal year 2003-04 average daily attendance schedules from the department's Education Services Branch on several occasions, but has encountered delays because the schedules are compiled months after California Youth Authority schools submit them. Although the recommendation has not been implemented, the Office of the Inspector General's comparative evaluation of the compiled average daily attendance reports for 2002-03 and 2003-04 revealed improvement over those of previous years.
• Correct the deficiencies in the existing service provider reporting database or acquire a new system.	**FULLY IMPLEMENTED**	The principal reported that procedures designed to identify any reporting errors before the monthly service provider reports are finalized are in place. A review of the March 2004 report revealed none of the deficiencies found during audits of the reports in 2003.
• Separate the duties of staff members responsible for attendance recording from those responsible for entering attendance data, generating reports, and reviewing.	**FULLY IMPLEMENTED**	The system for preparing, reviewing, and approving the special education service reports is adequate as long as staff members avoid performing incompatible duties.

• Notify courts that refer wards to the California Youth Authority of their obligation to provide complete special education data under *Welfare and Institutions Code* section 1742. Develop a plan with court representatives to accomplish that purpose, including a timetable for submitting special education information. If cooperation is not forthcoming, refuse to accept wards who do not have complete special education background packages.	**NOT IMPLEMENTED**	The institution principal has only recently begun to address this issue by requesting assistance from the department through a memorandum dated August 2004.
• With the assistance of an electronic spreadsheet, monitor the timeliness of each ward's entry into special education classes. Elapsed times should be calculated based on the following: the ward's arrival date; the date the ward is confirmed as having special education status; and the date of the ward's first day of class following confirmation of special education status.	**FULLY IMPLEMENTED**	The principal reported that students are entered into special education classes within either five days of arrival at the institution or five days after identification as special education students, whichever applies. The audit team noted that the institution uses a special education tracking report containing all recommended fields.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic take the following additional actions:

- **Ensure that wards do not move from class to class without notification by the staff to school security.**
- **Continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include working with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive compensation for teachers.**
- **Institute the Education Services Branch's student ward attendance tracking (SWAT) system at the facility.**
- **Improve the high school's effectiveness rating by striving to make more classroom time available to wards.**

- **Require all teachers to use the electronic version of the average daily attendance report.**
- **Require supervisory review and written approval of teachers' average daily attendance forms.**
- **Notify courts that refer wards to the California Youth Authority of their obligation to provide complete special education data under *Welfare and Institutions Code* section 1742. Develop a plan with court representatives to accomplish that purpose, including a timetable for submitting special education information. If cooperation is not forthcoming, refuse to accept wards who do not have complete special education background packages.**

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that a new building, which was intended to house an intensive treatment program and was later modified to operate as a correctional treatment center, had design flaws affecting security and that the duties and responsibilities of security employees at the building were neither documented nor well-defined.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Youth Authority take the following actions:		
• Fully investigate and quantify the reasons for the flaws in the design and construction of the correctional treatment center and take appropriate measures to prevent such occurrences in the future.	NOT IMPLEMENTED	In its response, the department noted that the institution had no control over design and construction of its correctional treatment center. While this may be true, it does not respond to the recommendation to identify the reasons for the flaws and take measures to prevent such occurrences in the future.
• In future construction projects, assign security staff to design committees with access to scale models of the proposed building to identify flaws in security layouts before construction begins.	FULLY IMPLEMENTED	The department reported that its Facilities Planning and Construction Services Bureau will use security staff in future design processes.

• If a building must remain idle for a significant period, instruct the facility staff to inspect the building and test its mechanical features daily to expose potential problems while warranty protection is still available.	**FULLY IMPLEMENTED**	According to the department, in future construction projects, local administration will ensure that plant operation staff monitor mechanical features to identify potential problems while warranty protections remain available.
• Although the building in question is structurally complete and changing the location of the control center without extensive reconstruction costs is impractical, lessen the remaining security problems by closing the gaps between the corridor floors, the door frames, and the room doors.	**FULLY IMPLEMENTED**	The institution reported and the audit team confirmed that extensive post-construction work was done to seal doorframes, particularly at the top and near the floor.
• Establish and publish post orders and procedural manuals for all security positions at the correctional treatment center.	**FULLY IMPLEMENTED**	The institution reported and the audit team confirmed that this has been accomplished.
• Revise section 1802 of the *California Youth Authority Institutions and Camps Branch Manual* to resolve conflicts with the Americans with Disabilities Act.	**NOT IMPLEMENTED**	The department reported that all aspects of its health care program underwent extensive review as the result of the *Farrell v. Allen* lawsuit. The Office of the Inspector General confirmed that Americans with Disabilities Act deficiencies are expected to be addressed in the remedial plan resulting from the lawsuit .

FOLLOW-UP RECOMMENDATIONS

- None

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that the disciplinary decision-making system at the Southern Youth Correctional Reception Center and Clinic did not ensure due process for wards and failed to provide management with important tools for monitoring disciplinary actions and ward grievance activity.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Southern Youth Correctional Reception Center and Clinic management take the following actions to improve the disciplinary decision-making system:		
• Issue a memorandum to inform all employees of the importance of wards' due process rights under the disciplinary decision-making system. The memorandum should stress the importance of completely filling out the appeals section of the Level A and Level B behavior reports, including the dates and times necessary to demonstrate compliance with timeliness requirements.	FULLY IMPLEMENTED	According to the institution, these policies and procedures have been communicated at briefings. The institution reported that copies of the policies have been given to unit sergeants and staff and have been placed on read-and-initial boards. The institution reported and the audit team confirmed that all staff members were provided with training on the new disciplinary decision-making policy in August 2003.
• Conduct quarterly audits of a random sample of Level A and Level B reports covering the work of staff in each living unit. Use the audit results as part of the annual performance appraisal of each member of the living unit staff.	NOT IMPLEMENTED	The institution reported that a full-time ward rights coordinator has been assigned oversight duties since November 2002 and that a comprehensive information packet on the process for filling out disciplinary appeals has been distributed to the staff. The audit team noted that these measures do not address the recommendation to monitor and hold employees accountable.

• Provide training as necessary to keep staff informed about policies and procedures pertaining to the disciplinary decision-making system.	**FULLY IMPLEMENTED**	The institution reported that when the disciplinary decision-making system was revised in September 2003, all staff members were trained in the process, including the new designations for the various levels of violations.
• Require the ward rights coordinator to perform a quarterly review of the accuracy and completeness of disciplinary decision-making system data entered by living unit sergeants, report the results to the sergeants' supervisors, and include the information in the sergeants' annual performance appraisals.	**PARTIALLY IMPLEMENTED**	The institution reported and the audit team confirmed that the disciplinary decision-making system coordinator provides the superintendent with a report by the first day of each month. That information does not fully address the recommendation with respect to employee performance appraisals, however.
• Require monthly management reports on disciplinary rule violations and ward grievance activity.	**FULLY IMPLEMENTED**	The institution reported that monthly reports on disciplinary and ward grievance activities are required by policy and that timely processing of these actions has been part of the department risk management plan for the last two years.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the management of the Southern Youth Correctional Reception Center and Clinic monitor the ward disciplinary process by conducting quarterly audits of a random sample of Level A and Level B reports covering the work of staff in each living unit. The facility should use the audit results as part of the annual performance appraisal of each member of the living unit staff.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that the ward grievance system at the Southern Youth Correctional Reception Center and Clinic was ineffective and did not comply with department regulations.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the management of the Southern Youth Correctional Reception Center and Clinic take the following actions to improve the ward grievance system:		
• Assign a higher priority to the ward grievance system and announce that policy to all staff and wards. Ensure that members of the staff are provided with training at least annually on the ward grievance process, including the correct disposition of a ward grievance.	PARTIALLY IMPLEMENTED	In a blanket response to these recommendations, the department reported that all aspects of the department's ward grievance system underwent expert review as the result of the *Farrell v. Allen* lawsuit. The remedial plan resulting from the lawsuit is expected to address the ward grievance system. The institution reported that it has taken certain actions independent of the pending remedial plan. These actions include providing grievance training to all staff, modifying the ward information network 2000 system to permit it to track ward grievance information, and holding monthly meetings of the grievance clerks.
• Provide the ward grievance coordinator with either an office assistant or institutional ward grievance clerk, and provide the ward rights office with adequate physical workspace and storage space.	PARTIALLY IMPLEMENTED	See above.
• Continue to monitor the ward grievance process and accurately report overdue grievances on monthly reports.	PARTIALLY IMPLEMENTED	See above.
• Enable the ward grievance coordinator to work a day shift comparable to other managers at the facility and to stay in that position for at least two years.	PARTIALLY IMPLEMENTED	See above.
• Require the ward grievance coordinator to	PARTIALLY IMPLEMENTED	See above.

hold monthly ward grievance clerk meetings and ensure that the assistant superintendent is invited and that formal notes are taken during the meetings.		

FOLLOW-UP RECOMMENDATIONS

- None

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that staff performance appraisals and probationary reports at the Southern Youth Correctional Reception Center and Clinic were not completed on time.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the superintendent take the following actions to ensure prompt evaluation of employee performance:		
• Notify every staff member of the importance of performance appraisals and probationary reports to the mission of the Southern Youth Correctional Reception Center and Clinic.	FULLY IMPLEMENTED	The institution reported that by October 10, 2004, every staff member will have been notified of the importance of appraisals.
• Instruct the personnel officer to develop a system that systematically logs the due dates for all performance appraisals and probationary reports, notifies supervisors when appraisals and reports are due, and identifies supervisors who are delinquent in completing appraisals and reports. The log should be submitted to the superintendent monthly and made a	PARTIALLY IMPLEMENTED	The institution reported and the audit team confirmed that the personnel office has developed a system that logs the due dates for all performance appraisals and probation reports and routes pending reports through the superintendent's office. The Office of the Inspector General noted, however, that the system identifies only employees whose annual appraisal dates are imminent and does not provide for follow-up of delinquent appraisals. The audit team noted that more than 100 annual appraisals were overdue at the time of the follow-up review, with due dates ranging from January through September 2004.

regular topic of management meetings. • Include the responsibility for timely performance appraisals and probationary reports in the performance appraisals of supervisors and managers.	**PARTIALLY IMPLEMENTED**	The institution reported that its personnel services supervisor provides regular updates on overdue reports to the superintendent and that managers are notified by the superintendent's office of overdue reports.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Southern Youth Correctional Reception Center and Clinic develop a system to identify and address delinquent annual employee appraisals and probation reports and to hold accountable supervisors responsible for completing the reports and appraisals.

VENTURA YOUTH CORRECTIONAL FACILITY

The Office of the Inspector General found that the Ventura Youth Correctional Facility has improved its operations since a June 2002 management review audit. Treatment services, mental health assessments, medical care, security, aspects of education, employee investigations, ward discipline, and the ward grievance process have all improved. A number of the problems were solved by converting the facility to an all-female institution, making it easier to provide wards with services. Education services continue to be hampered by not having enough teachers, however, with an average of 18 classes a day cancelled because teachers are out and there is no one available to fill in.

IMPLEMENTATION REPORT CARD

Previous recommendations: 101

Fully implemented: 49 (48%)

Substantially implemented: 22 (22%)

Partially implemented: 16 (16%)

Not implemented: 10 (10%)*

No longer applicable: 4 (4%)

In June 2002, the Office of the Inspector General issued a "baseline" management review audit report on the Ventura Youth Correctional Facility, which at the time was the California Youth Authority's only coeducational youth correctional facility. The audit was conducted following the appointment of a new superintendent and identified a number of serious problems at the institution, many of which stemmed from the difficulty of providing education, treatment, and other services to male and female wards while keeping the genders separated. The audit determined that operating the institution as a coeducational facility disrupted programs, caused services to be duplicated, and in some cases prevented Ventura Youth Correctional Facility wards from receiving the services provided to wards at other institutions. The Office of the Inspector General found that only 47 percent of a sample of wards had received required weekly counseling sessions and that only 54 percent had received timely case conferences. Only 29 percent of a sample of female wards had received treatment needs assessments within the required three weeks of arrival at the institution. Pregnancy care for female wards was inadequate; wards with communicable diseases were not adequately screened from working in food services; and the segregation of male and female wards limited access to medical services for both genders. The academic achievement of wards at the institution also was low compared to that of wards at other California Youth Authority institutions. The Office of the Inspector General found that a number of the deficiencies identified in education and medical care resulted from a shortage of resources and inadequate policy direction from California Youth Authority management.

BACKGROUND

Located in Camarillo, California, the Ventura Youth Correctional Facility is one of nine youth correctional facilities operated by the California Youth Authority. At the time of the 2002 management review audit, the facility housed 302 male wards—73 of whom resided at the Sylvester Carraway Public Service and Fire Center camp outside the institution's secured perimeter — and 278 female wards. In March 2004, the department removed all of the male wards from the institution, with the exception of those at the Sylvester Carraway Public Service and Fire Center camp, and converted the Ventura Youth Correctional Facility to an all-female institution. The facility presently houses all of the female wards in California

Youth Authority custody—a population totaling 157 at the time of the follow-up review. For fiscal year 2004-05, the facility and the fire camp (which has a separate population of 46 wards) have a combined budgeted staff of 373.4 positions and a combined operating budget of $31,375,000. As a result of the conversion to an all-female institution, with a relatively small ward population, the budgeted cost per ward at the Ventura Youth Correctional Facility is now among the highest of all California Youth Authority institutions.

SUMMARY OF PREVIOUS FINDINGS

The June 2002 management review audit was conducted as a "baseline" audit following the appointment of a new superintendent. The Office of the Inspector General made the following specific findings as a result of the audit:

- Operating the facility as a coeducational institution limited the ability of the institution to provide programs and services to wards and resulted in wards not receiving the services provided at other California Youth Authority institutions.

- Wards were not receiving required treatment services.

- Female wards were not receiving required mental health assessment services in a timely manner.

- The health of pregnant female wards, their infants, and male and female wards in general were being jeopardized by institution practices and medical services at the facility.

- The academic achievement of wards at the facility was low compared to that of other California Youth Authority institutions.

- Fundraising activities by the institution staff were not properly administered.

- Investigation practices and procedures were significantly deficient.

- The institution was not complying with security requirements.

- The disciplinary decision-making system at the institution had serious defects.

- The ward grievance system failed to hold staff accountable.

- A projected budget deficit of $2 million in fiscal year 2001-02 was largely attributable to costs for overtime pay, external contract expenditures, and high utility expenses.

- There were inadequate controls over access to the institution warehouse.

- Despite the limited number of paid jobs at the institution, some wards held more than one job.

- Staff performance appraisals and probationary reports were not being completed on time.

The Office of the Inspector General issued 101 recommendations as a result of the 2002 management review audit and recommended that the superintendent develop a comprehensive strategic plan to correct the problems. The Office of the Inspector General also recommended that the California Youth Authority convert the Ventura Youth Correctional Facility (or another facility) to an all-female institution, rather than continue to operate the facility as a coeducational institution.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2004 follow-up review was to determine the extent to which the Ventura Youth Correctional Facility, the Education Services Branch of the California Youth Authority, and the California Youth Authority headquarters have implemented the 101 recommendations from the June 2002 management review audit. To conduct the follow-up review, the Office of the Inspector General provided the Ventura Youth Correctional Facility, the Education Services Branch, and the California Youth Authority director's office with a table listing the June 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 non-compliance with the recommendations.

As part of the evaluation, the Office of the Inspector General conducted fieldwork at the Ventura Youth Correctional Facility, during which the audit team interviewed the superintendent, staff, and wards; reviewed logs and records; observed selected facility operations; and conducted tests necessary to formulate conclusions regarding the implementation of the Office of the Inspector General's recommendations.

SUMMARY OF FOLLOW-UP RESULTS

The Office of the Inspector General determined that the institution has significantly improved most of its operations and has made considerable progress in implementing the recommendations from the June 2002 management review audit. Forty-nine (48 percent) of the 101 previous recommendations have been fully implemented; twenty-two (22 percent) have been substantially implemented; sixteen (16 percent) have been partially implemented; and ten (10 percent) have not been implemented. Another four (4 percent) are no longer applicable. The superintendent has also implemented a number of successful programs involving community volunteers to benefit the wards. The facility is no longer operated as a coeducational facility and now houses only a relatively small population of female wards. The superintendent of the facility was removed on September 30, 2004.

Among the findings of the follow-up review are the following:

- The institution has significantly improved treatment services for wards. For example, the 2002 audit found that only 47 percent of a sample of wards had received the weekly individual and small group counseling required by section 4050 of *the California Youth*

Authority Institutions and Camps Branch Manual, while the 2004 follow-up review found that 44 (94 percent) of a similar sample of 47 wards had received the counseling. Most of the recommendations pertaining to treatment services have been implemented.

- The institution has either fully or substantially implemented most of the recommendations pertaining to mental health assessment services.

- The institution has improved medical services for pregnant wards; has improved procedures for handling wards with communicable diseases; and has eliminated barriers to medical care caused by operating the facility as a coeducational institution.

- Although three of the seven recommendations pertaining to education have been fully implemented, problems resulting from teacher vacancies and the inadequacy of the substitute teacher pool remain. From April 2004 through August 2004, 30 percent of classes at the facility's Mary B. Perry High School were cancelled because teachers were not available. Even though an average of 18 classes a day are cancelled, primarily because of teacher absences, the facility has only one substitute teacher available to fill in. This problem is reflected in the decline in the high school's effectiveness rating between fiscal year 2002-03 and fiscal year 2003-04. The effectiveness rating, which measures actual instruction time as a percentage of available instruction time, dropped from 70 percent to 65 percent during that period.

- Notwithstanding the problem with teacher vacancies and substitute teacher shortages, wards' cumulative standardized test scores increased from 2003 to 2004. Whereas 71 percent of wards had cumulative subject scores below the 25th national percentile rate in 2003, only 54 percent of the wards had cumulative subject scores below the 25th national percentile rate in 2004. Further, the 54 percent rate is the institution's best since 1998. The improvement from 2003 to 2004 may be partly attributable to the facility's ceasing operation as a coeducational facility during that period. The ward absenteeism rate during the same period increased slightly from 13 percent to 14 percent.

- Fundraising activities formerly conducted for the sole benefit of the staff have ceased, but money that should have been returned to the ward benefit fund has not been returned and the facility did not review the activities of employees who were engaged in the fundraising activities for possible disciplinary action.

- Nearly all of the recommendations relating to investigation practices and procedures have been fully or substantially implemented.

- Thirteen of the seventeen recommendations pertaining to security deficiencies have been fully or substantially implemented, while two others have been partially implemented and one is no longer applicable. The remaining recommendation is awaiting action by the department.

- Most of the recommendations pertaining to the disciplinary decision-making system have been fully implemented.

- All but two of the recommendations pertaining to the ward grievance system have been fully or substantially implemented.

- All of the recommendations pertaining to the institution warehouse have been fully or substantially implemented.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the management of the Ventura Youth Correctional Facility take the following additional actions:

- **The Ventura Youth Correctional Facility management should ensure that treatment needs assessment test booklets are scanned and scored no later than the next working day.**

- **The Ventura Youth Correctional Facility management should ensure that the senior psychologist is notified before the end of the next working day if a treatment needs assessment scoring report shows a "red flag."**

- **Conduct treatment needs assessments for all wards within three weeks of admission to the facility.**

- **The Ventura Youth Correctional Facility management should ensure that the treatment needs assessment profile and scoring report is filed in the mental health section of the unified health record.**

- **The California Youth Authority and the chief medical officer should develop comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general.**

- **The California Youth Authority and the Ventura Youth Correctional Facility management should develop policies to facilitate the attendance of teachers at ward case conferences without the need to cancel classes.**

- **The California Youth Authority and the Ventura Youth Correctional Facility management should promptly fill teaching vacancies and work with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive teacher compensation by upgrading pay scales using compensation exceptions provided for by law, and other suitable methods.**

- **The Ventura Youth Correctional Facility management should compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.**

- **Explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid reasons, and that all alternatives to cancellation have been explored.**

- **Study the factors contributing to the frequent cancellation of classes and the need for substitute teachers. These factors should include the impact of alternative work schedules on class cancellations.**

- **Continue to seek an integrated attendance system that automates daily classroom attendance to minimize reporting errors and to better utlilize staffing resources.**

- **The Ventura Youth Correctional Facility management should update the Ventura Youth Correctional Facility operations manual to specify the type of fundraisers acceptable for participation by staff or wards.**

- **The California Youth Authority should update the *California Youth Authority Institutions and Camps Branch Manual* to provide clear guidance to institutions on the types of fundraising and financial transactions allowed between staff and wards.**

- **The California Youth Authority should provide training to Institutions and Camps Branch administrators in the proper use of ward benefit funds.**

- **The Ventura Youth Correctional Facility should exert a stronger effort to ensure that wards are assigned to only one paid job to increase the number of wards capable of earning money that can be used for canteen purchases. The institution should also document instances in which potentially capable wards decline the offer to work in a paid position. The ward should be required to sign a form declining the offer.**

- **The Ventura Youth Correctional Facility management should determine why managers and supevisors continue not to complete timely performance appraisals despite the improvements reported and hold staff accountable as appropriate.**

- **The California Youth Authority should provide the Ventura Youth Correctional Facility with pertinent and timely information for tracking investigations, regardless of whether the new case management system is ready for use. The information should include the internal affairs or Education Services Branch case number, the subject name, the allegation, the incident date, the discovery date, the investigator's name, the case closure date, and the conclusions.**

- **The Ventura Youth Correctional Facility management should continue to pursue a mutual aid agreement with a local law enforcement agency and should develop procedures for handling hostage situations, rather than waiting for the department to develop a standardized mutual aid agreement.**

- **The Ventura Youth Correctional Facility should trim back the vegetation growing against the fence near the maintenance area and tarp the fence to provide both a visual barrier and security containment.**

- **The facility should ensure that all video pictures on security monitors are clear.**

- **The facility should replace chemical agent canisters lacking durable serial numbers.**

- **The Ventura Youth Correctional Facility management should continue efforts to obtain funds to install bulletproof glass to protect the youth correctional officer stationed at the reception desk.**

- **The California Youth Authority should consider the advisability of relying on local law enforcement to handle potential hostage situations and either amend or follow section 1809 of the *California Youth Authority Institutions and Camps Branch Manual* accordingly.**

- **The Ventura Youth Correctional Facility should provide annual disciplinary decision-making system refresher training to all staff members responsible for the custody and treatment of wards.**

- **The Ventura Youth Correctional Facility management should immediately investigate the cause of "withdrawn" fast track, staff action grievances and document the reason each grievance was withdrawn in the ward information network 2000.**

- **The Ventura Youth Correctional Facility should research the overdue grievances in the ward information network 2000 and close out those that have already been addressed. Staff members responsible for the remaining overdue ward grievances should be held accountable for completing the grievances within mandated time frames.**

- **The Ventura Youth Correctional Facility should provide annual training to staff on ward grievance procedures, including hands-on training on how to input the required data into the ward information network 2000.**

- **The Ventura Youth Correctional Facility management should continue to reduce expenditures wherever possible and to track costs and reasons for unforeseen or unbudgeted expenditures.**

- **The California Youth Authority should track unforeseen or unbudgeted expenditures to support additional funding requests.**

- **The Ventura Youth Correctional Facility management should require all staff to arrange for the retrieval of items from the warehouse with prior notification.**

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

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that operating the Ventura Youth Correctional Facility as a coeducational institution significantly limits the ability of the institution to provide programs and services for wards and results in wards at the facility not receiving the services provided to wards at other institutions.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the director of the department consider converting the Ventura Youth Correctional Facility (or another facility within the Youth and Adult Correctional Agency) into a female-only institution. The Office of the Inspector General suggested that in addition to other scenarios, the following be considered: • One approach is to make the Ventura Youth Correctional Facility a female-only institution. This scenario would significantly increase the per capita costs of housing wards. It would also entail the closure of at least four living units and significantly reduce staff levels. However, this scenario would significantly increase services to female wards. Male wards would have to be housed at other institutions. The male wards currently in the college program would need to be transferred to institutions that provide that level of education. The Department would have to determine whether or not to close the Sylvester Carraway Public Service and Fire Center to male wards because they currently receive medical services inside the institution.	FULLY IMPLEMENTED	The California Youth Authority reported that all male wards were transferred from the Ventura Youth Correctional Facility as of March 1, 2004. The review confirmed that the facility now houses only female wards. The Sylvester Carraway Public Service and Fire Center adjacent to the facility is still in operation and continues to use the medical services at the Ventura Youth Correctional Facility for its male wards.

FOLLOW-UP RECOMMENDATIONS

- None

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that Ventura Youth Correctional Facility wards were not provided with required treatment services.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management take the following actions to improve ward assessment and counseling:		
• Continuously emphasize to all staff members the importance of counseling, case management, and testing to the mission of the institution.	FULLY IMPLEMENTED	The institution staff reported that case audits are performed each month by the unit supervisors, parole agents, and program managers and that the results are provided to the treatment team and administrative staff for review. The Office of the Inspector General confirmed that the case audits are being conducted. According to the staff, casework and treatment issues also are discussed at the weekly management meetings. The staff reported that a 16-week Ventura Youth Correctional Facility parole agent academy at which case management and treatment issues were emphasized was completed in January 2004. Attendees at the academy included parole agents, casework specialists, program managers, and the assistant superintendent. According to the institution staff, a Focus on Education and Treatment audit process was implemented during the first quarter of 2003. In that audit process, treatment team members and administrative staff review quarterly treatment/education audit data for each living unit. Focus on Education and Treatment audits are conducted at the end of each quarter.
• Develop a casework management system that meets the content and frequency	FULLY IMPLEMENTED	According to the institution staff, in 2002 the Ventura Youth Correctional Facility implemented a requirement that each senior youth correctional

criteria laid out in Section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual.* Of particular importance is weekly individual and small group counseling and the prompt conducting of initial and progress case conferences. This system should include: (1) the treatment team supervisors' monthly auditing of at least five ward files per living unit; (2) the timely reporting of the audit results up and down the chain of command; and (3) the prompt administration of progressive discipline for staff failing to perform duties. The audits should be the basis of the institution's annual Section 4000 report to the Institutions and Camps Branch.		counselor, parole agent, casework specialist, and program manager conduct monthly case file audits. Parole agents and casework specialists must complete ten case audits per month, and Senior youth correctional counselors and program managers are required to complete a minimum of six case audits each month. Audit areas encompass *California Youth Authority Institutions and Camps Branch Manual* section 4000 criteria, including assignment to school/work, orientation, case conferences, and the delivery of documented individual/group counseling services. The staff reported that the case management system emphasizes reinforcing good work and best practices, with progressive discipline a key element. According to the institution staff, the institution management established a requirement that each staff member with responsibility for ward treatment be rated on progress in conducting case record audits in his or her performance evaluation. Progressive discipline taken against staff members is reviewed at each quarterly Focus on Education and Treatment audit. The institution management reported that managers and supervisors are required to nominate parole agents, casework specialists, and youth correctional counselors for recognition at the quarterly Focus on Education and Treatment celebrations held at the facility as a means of acknowledging good work. The staff responsible for ward treatment has been successful in improving the level of compliance in providing mandated treatment services. For example, the percentage of wards attending weekly structured counseling sessions has greatly improved. The Office of the Inspector General reported in 2002 that 47 percent of Ventura Youth Correctional Facility wards attended weekly structured counseling sessions. In contrast, the Ventura Youth Correctional Facility's case audits indicated that by June 2004 that figure had risen to 99 percent. The institution staff reported the current case management/treatment audit data as follows: • Orientation completed first quarter: 96 percent • Orientation completed second quarter: 96 percent • Initial case conference first quarter: 99 percent • Initial case conference second quarter: 100 percent • Progress case conference first quarter: 97 percent • Progress case conference second quarter: 94 percent;

		• One-hour counseling individual/small group first quarter: 97 percent • One-hour counseling individual/small group second quarter: 98 percent. The Office of the Inspector General reviewed a random sample of 47 ward living unit files to independently verify the above data. The audit team found the following compliance rates: • Orientation completed in timely manner: 92 percent compliant; • Initial case conference completed 94 percent of the time, and of those completed, 81 percent were completed on time; • Progress case conferences completed 96 percent of the time; of those completed, 98 percent were completed on time; • Weekly individual and small-group counseling performed 94 percent of the required time.
• Use annual performance appraisals and progressive discipline to hold treatment team supervisors, the parole agent III, and the program administrator accountable for monitoring the work of parole agents, senior youth correctional counselors, and youth correctional counselors, and for ensuring proper redistribution of workload when staff members are absent and positions are vacant.	**FULLY IMPLEMENTED**	The Office of the Inspector General verified that monthly case audits are being conducted by supervisors at the facility. In addition to reviewing monthly audit statistics provided to the superintendent, the audit team found evidence of completed case audit sheets while reviewing treatment services. According to the institution, performance appraisals and progressive discipline are used to hold treatment team supervisors, the parole agent III, and the program administrator accountable for monitoring the work of subordinates. This area is reviewed during the quarterly Focus on Education and Treatment audits conducted by the assistant superintendent and parole agent III/program administrator. The Office of the Inspector General verified that casework is strongly emphasized and that the monthly audits help to ensure that the staff is held accountable for its work.
• Provide subject matter training to the youth drug counselor so she can properly carry out her duties under the residential	**SUBSTANTIALLY IMPLEMENTED**	According to the institution staff, the staff member assigned to the Mira Loma substance abuse treatment program was provided with two weeks of updated substance abuse treatment training at the Youth Training Center in Stockton in

substance abuse treatment program contract.		January 2004. Also, the duty statement for the correctional counselor, (revised September 13, 2002) continues to ensure that the only function of the residential substance abuse treatment counselor is to provide direct services to wards. The Office of the Inspector General obtained documents that verified that one of the two counselors assigned to the Mira Loma substance abuse treatment program was provided with 56 hours of formalized substance abuse treatment training in January 2004. The latest duty statement for the correctional counselor, which was signed on April 2, 2004, describes the general duties required of youth correctional counselors, but fails to provide specific duties for counselors assigned to the substance abuse treatment program.
• Provide guidance to the drug program coordinators on how to randomly select wards for drug testing and how to provide the proper chain of custody for the samples collected.	**PARTIALLY IMPLEMENTED**	According to the institution staff, the drug program coordinator and other staff members were trained in random drug testing with emphasis on the chain of custody procedures for the residential substance abuse program in January 2004. The training was designed to ensure a high degree of accountability for ward urine samples. The Office of the Inspector General found, however, that the regular unit staff, not the drug program coordinator, conducts the random drug testing. The drug treatment counselor said the unit staff was trained on randomly selecting subjects for testing. But a review of the training logs found no evidence that training was conducted in January 2004 or thereafter. The training officer suggested that perhaps informal training was conducted on the unit and not reported to the training office.
• The school principal should require the school assignment officer to enroll wards at least twice a week in education programs.	**SUBSTANTIALLY IMPLEMENTED**	The institution staff reported that the ward information network system accomplishes this task and that program managers and administrators also closely monitor this area during the quarterly Focus on Education and Treatment audits. Class adds/drops and new assignments are conducted weekly. New students entering the facility are assigned to education programs within three days.

FOLLOW-UP RECOMMENDATIONS

- None.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that female wards at the Ventura Youth Correctional Facility were not receiving required mental health assessment services or did not receive these necessary services in a timely manner.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Ventura Youth Correctional Facility take the following actions to improve its mental health and suicide prevention programs: Develop a tracking system to monitor the treatment needs assessment process to ensure that:		
• All incoming female wards are scheduled for a treatment needs assessment within three weeks of admission.	SUBSTANTIALLY IMPLEMENTED	According to Ventura Youth Correctional Facility staff members, the intake casework specialist I, monitored by the senior psychologist, is responsible for tracking and administering treatment needs assessments to all wards within the three-week time frame required by department policy. The Office of the Inspector General reviewed 18 files and found three files that did not have a treatment needs assessment and three other files in which assessments were late, for a compliance level in this area of 67 percent.
• The treatment needs assessment test booklets are scanned and scored no later than the next working day.	NOT IMPLEMENTED	According to the institution staff, procedures mandate that the test booklets be scanned and scored by the end of the next working day. A review by the Office of the Inspector General of 18 test booklets found this to still be a significant problem, however. Only one out of 18 test booklets (6 percent) was scored within the next working day. The low compliance rate indicates that this recommendation has not been implemented.

• If a treatment needs assessment scoring report shows a "red flag," that the senior psychologist is notified before the end of the next workday.	**PARTIALLY IMPLEMENTED**	According to the institution staff, all treatment needs assessment profiles are submitted to the senior psychologist and reviewed within one working day. The profiles are signed and appropriate referrals are made. The Office of the Inspector General found, however, that treatment assessment profiles were reviewed by the senior psychologist within one working day in only 39 percent of the files sampled.
• The treatment needs assessment profile and scoring report is filed in the mental health section of the unified health record.	**PARTIALLY IMPLEMENTED**	According to the staff at Ventura Youth Correctional Facility, completed treatment needs assessment data are filed in the mental health section of the unified health record. The Office of the Inspector General found, however, that none of the 18 unified health records reviewed included the treatment needs assessments. The audit team learned that instead they had been mistakenly placed in the wards' field files. The senior psychologist corrected this error and the treatment needs assessments were moved to the unified health record. Wards with "red flags" signaling elevated treatment needs assessment scores were correctly referred for further screening and follow-up through a special program assessment of needs.
• The treatment needs assessment data is transmitted to the Ward Information Section of the California Youth Authority Research Division.	**FULLY IMPLEMENTED**	According to the staff, the treatment needs assessment results are forwarded to the California Youth Authority Research Division on a weekly basis according to policy. The Research Division is responsible for adding the data to the ward information network. The Office of the Inspector General found the department to be in compliance with the policy.
The senior psychologist should provide adequate oversight over the treatment needs assessment process by:		
• Ensuring that all equipment, such as the Scantron machine, is fully functional.	**FULLY IMPLEMENTED**	According to the institution staff, the Scantron equipment and software were installed on May 28, 2002. The Research Division provides assistance as needed. The Office of the Inspector General confirmed that the Scantron equipment was operating properly.
• Ensuring consistent screening for treatment programs through the use of the	**FULLY IMPLEMENTED**	The Ventura Youth Correctional Facility staff noted that the California Youth Authority global assessment of functioning is no longer in use and that the

standardized California Youth Authority global assessment of functioning screening report (California Youth Authority Form 8.218).		special program assessment of needs was implemented in its place. The special program assessment of needs helps identify the mental health needs of wards and enables the mental health team to ensure consistent screening for treatment programs. The screening process for treatment begins with the treatment needs assessment conducted for all wards entering the Ventura Youth Correctional Reception Center. A special program assessment may be requested based on data from the treatment needs assessment and an evaluation of the ward by the intake casework specialist I. The assessment is conducted by a psychologist and forwarded to the Health Care Services Division for review and approval. The Office of the Inspector General confirmed that the institution staff is properly using the special program assessment of needs for wards identified during the reception center treatment needs assessment screening as having "red flags." These flags indicated a history of suicidal behavior or symptoms of mental illness that resulted in treatment with psychotropic medications or hospitalization.
• Reviewing the treatment needs assessment scoring report and referring any ward with "red flags" for additional mental health evaluation, such as a global assessment of functioning.	**SUBSTANTIALLY IMPLEMENTED**	The institution staff noted that the function of the mental health management team is to ensure that the treatment needs of wards are properly met. The senior psychologist reviews the treatment needs assessment and makes referrals as needed. To assess compliance, the Office of the Inspector General reviewed the unified health records of all 16 of the wards on psychotropic medication to determine whether a special program assessment of needs had been requested. The review determined that 15 of the 16 wards had received a special program assessment of needs. (As explained above, the special program assessment of needs process succeeded the California Youth Authority global assessment of functioning.) The Office of the Inspector General reviewed eight (25 percent) of the special program assessments of needs completed during calendar year 2004 and found that the senior psychologist received seven of the eight requests (88 percent) within three working days and correctly assigned them to clinicians within three working days. Four of eight special program assessments of needs (50 percent) were completed within 10 working days. The Office of the Inspector General's review revealed that the due date provided to clinicians was

		"ASAP," leaving the due date vague. That deficiency was corrected, however, and clinicians are now assigned a due date within the 10-day requirement.
• Establishing a global assessment of functioning review panel to review the results of a random sample of the global assessment of functioning screening reports on a monthly basis. To distribute workload equitably, the mental health professionals should participate on the review panel on a rotational basis. The panel should consist of a psychiatrist, a psychologist, and a related mental health professional.	**(NO LONGER APPLICABLE)**	The Office of the Inspector General verified that the California Youth Authority global assessment of functioning has been succeeded by the special program assessment of needs. Therefore, a review panel is not required and the recommendation is no longer applicable.
• Identifying wards who would receive the most benefit from the intensive treatment and specialized counseling programs.	**SUBSTANTIALLY IMPLEMENTED**	The institution staff noted that the function of the mental health management team is to ensure that the treatment needs of wards are properly met. The senior psychologist reviews the treatment needs assessment and makes referrals as needed. As noted above, the Office of the Inspector General reviewed the unified health records of all 16 of the wards on psychotropic medication to determine whether a special program assessment of needs had been requested. The review determined that 15 of the 16 wards had received a special program assessment of needs.
Correct the deficiencies in the Suicide Prevention Assessment and Response Program by:		
• Appointing a chaplain and a representative from the California Correctional Peace Officers Association to the facility's suicide prevention and response committee.	**FULLY IMPLEMENTED**	According to the institution staff, the senior psychologist is responsible for reviewing the special program assessment of needs results. The staff reported that the establishment of a panel such as the one suggested is being explored. The Office of the Inspector General found that the recommendation was addressed by the appointment of both a chaplain and a representative from the

		California Correctional Peace Officers Association. A review of attendance figures, however, revealed that the California Correctional Peace Officers Association representative attended only two meetings in 2003 and only one of seven meetings in 2004. The chaplain attended all meetings in 2004.
• Ensuring that all staff members, including teachers, receive suicide prevention and response program training at the time of appointment and refresher training annually.	**FULLY IMPLEMENTED**	The *Farrell v. Allen* remedial plan has a component that addresses suicide prevention. The plan is expected to require initial training and refresher training to be completed by November of each year. The Office of the Inspector General found that all 30 teachers attended this required training on October 30, 2003. Other employee groups attended consistent with policy.
• Having the local area network manager or another computer support staff member develop a daily suicide risk list that differentiates the level of suicide risk for each ward.	**FULLY IMPLEMENTED**	According to the staff at Ventura Youth Correctional Facility, the department's Information Technology Office completed the transfer of historical data into the ward information network system in March 2004. The transfer allowed the system to generate a suicide risk list that differentiates the level of suicide risk for each ward. The senior psychologist reviews these referrals daily. Wards who are seen as needing a higher level of care (additional services) are referred to the mental health team for a special program assessment of needs. The process determines appropriateness for referral to the intensive treatment or specialized counseling program. Enhanced casework in the intensive treatment program is available for emergencies. The Office of the Inspector General found from a review of all the living units that all ward histories have been entered into the suicide risk list. The review determined that the list is updated daily and that all living unit staff had initialed the list every day.
• Having the first watch control sergeant print, review, and update the suicide risk list daily.	**FULLY IMPLEMENTED**	According to the institution staff, the first watch youth correctional officer of each living unit continues to download the daily suicide list, which is regularly updated on the ward information network. All living unit staff continue to initial the daily list, with the program managers responsible for ensuring compliance. The Office of the Inspector General review of all the living units revealed that all wards' histories have been entered into the suicide risk list. It was found that this list is updated daily and that all living unit staff initialed the list daily.

• Having the risk management officer hold the duty lieutenant responsible for visiting all wards on suicide watch at least once daily during each shift and documenting any exceptions in the daily operation report.	**SUBSTANTIALLY IMPLEMENTED**	According to the institution staff, on August 12, 2004, the chief of security issued a reminder memorandum to duty lieutenants to visit all wards on suicide watch at least once a day during each shift and to document the visit on the mandated service form, along with signing the unit log. The risk manager reviews the lieutenant's signatures daily and reports exceptions to the chief of security on a daily basis. The Office of the Inspector General found that an August 13, 2004 memorandum from the chief of security directed lieutenants to sign the 23-and-1 temporary detention status report for each watch to indicate that the lieutenant conducted a visit to wards on restricted programs, including suicide watch. A review by the audit team of the restricted program reports found that the lieutenants had substantially complied with the memorandum, but that there were instances in which the lieutenants did not make the mandatory visit.
• Providing instruction and training to living unit security staff and the youth correctional counselors regarding policies and procedures for administering the suicide risk screening questionnaire (California Youth Authority 8.281) when temporary detention is extended.	**FULLY IMPLEMENTED**	According to the institution staff, training was provided to all Ventura Youth Correctional Facility staff on the suicide prevention and response policy that was revised in October 2003. That session provided instruction and training to living unit security staff and youth correctional counselors regarding policies and procedures for administering the suicide risk screening questionnaire. Training is provided to all staff who have contact with wards, including volunteers. The Office of the Inspector General found that all teachers and other employee groups attended this training as required on October 30, 2003.
• Acquiring and using Part C of the suicide prevention and response referral and disposition report (California Youth Authority 8.282) when wards are discontinued from suicide watch.	**FULLY IMPLEMENTED**	The institution staff reported that they have been completing Part C of the suicide prevention and response referral and disposition report since September 2002. Senior psychologists continue to monitor completion of the required forms.
• Using progressive discipline, hold the senior psychologist accountable for managing the mental health program and supervising the psychologists under his	**FULLY IMPLEMENTED**	According to the staff at Ventura Youth Correctional Facility, senior psychologists are held accountable for managing the mental health programs and their subordinates through the use of the progressive discipline system. The chief medical officer is responsible for the supervision of senior

direction.		psychologists. The Office of the Inspector General found that the institution has a new chief medical officer and two newly appointed senior psychologists. All reported positive working relationships and expressed the belief that they are receiving support and direction as they learn their new duties.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the management of the Ventura Youth Correctional Facility take the following actions:

- **Conduct treatment needs assessments for all wards within three weeks of admission to the facility.**
- **Ensure that treatment needs assessment test booklets are scanned and scored no later than the next workday.**
- **Ensure that the senior psychologist is notified before the end of the next workday if a treatment needs assessment scoring report shows a "red flag".**
- **Ensure that the treatment needs assessment profile and scoring report is filed in the mental health section of the unified health record.**

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found that some institution practices jeopardized the health of female wards, the infants of female wards, and wards in general by failing to provide timely access to quality medical care and providing inadequate protection against communicable diseases.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that California Youth Authority and institution management take the following actions to improve medical care to female wards and to wards in general:		
• The Institutions and Camps Branch and the chief medical officer should develop comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general. At a minimum, these policies and procedures should do the following:	PARTIALLY IMPLEMENTED	All aspects of the department's health care program were reviewed as a result of the *Farrell v. Allen* court action and are expected to be addressed in the forthcoming remedial plan.
• Assign high priority to the obstetrical care of wards.	FULLY IMPLEMENTED	According the institution staff, all female wards are screened in the clinic when they arrive at the Ventura Youth Correctional Facility. The lab screening includes test for pregnancy, anemia, and hepatitis. All female wards are then scheduled for an intake physical exam. At the time of the physical examination, a breast and pelvic exam is performed, which includes a Pap smear, and other screening tests. Nurses teach the ward how to perform breast self-examination. Wards who have not received Hepatitis A and B immunizations are scheduled for immunization. If a ward is pregnant, she is immediately referred to a medical provider and placed in the next obstetrical clinic and is given prenatal vitamins and a snack at night. A special obstetrical panel is sent to the lab.

• Ensure that contingency plans exist so that appointments canceled by obstetricians and other specialists do not result in unreasonable delays in care. Options to be explored should include contracting with backup specialists or modifying contracts to require priority rescheduling of canceled appointments.	**FULLY IMPLEMENTED**	According to the staff at the Ventura Youth Correctional Facility, an on-site obstetrical clinic is held once a month. The registered nurse screens all pregnant female wards the night before the clinic, and if the clinic has to be cancelled at the last minute, either the nurse practitioner or the physician reviews all charts for the pregnant wards. Any necessary orders are written, and if needed, the ward is scheduled to see the obstetrician in an off-site office for follow-up. If necessary, the providers consult with the obstetrician by phone. A schedule for frequency of needed prenatal visits depending on the stage in the pregnancy has been established. Wards needing visits before the next obstetrical clinic are sent to the obstetrician's off-site office. The Office of the Inspector General reviewed the unified health records of pregnant wards and confirmed the information provided by the institution. The review found that in addition to the obstetrical clinic, pregnant wards are seen frequently by the medical staff throughout the month.
• Ensure that the transportation of wards to medical appointments receives proper priority and that available transportation hours reflect that priority.	**FULLY IMPLEMENTED**	The institution staff reported that pregnant wards receive high priority for appointments and transportation. According to the staff, the chief of security distributed a memorandum to that effect on July 2002 and the transportation officer's shift was changed to be more consistent with medical office hours. The Office of the Inspector General found that a memorandum from the chief medical officer dated July 16, 2002 set forth the policy for transporting pregnant wards, but did not address the priority of the transportation in relation to other purposes. The transportation officer's shift is from 7 a.m. to 3 p.m., but the transportation officer stays later if medical transportation is needed at a later time. The chief medical officer said the institution has not experienced problems or delays when medical transportation is needed for a pregnant ward. A review of unified health records verified that off-grounds medical transportation does occur and revealed no evidence of delays in transportation.
• While protecting the privacy of wards with communicable diseases, the institution should review and, if necessary, modify its policies and procedures for informing the staff about wards who cannot perform food service and other duties. Once this has	**FULLY IMPLEMENTED**	The institution staff reported that they are provided with information regarding wards with communicable diseases in a confidential manner and in accordance with provisions of the *California Youth Authority Institutions and Camps Branch Manual* and bargaining unit contracts. The Office of the Inspector General found that the chief medical officer

been accomplished, the facility should inform the staff about the policies and procedures. If the ward information network or a similar system is to be used, the staff should be provided orientation. • If the facility continues to incarcerate both female and male wards, the Institutions and Camps Branch, the superintendent, and the chief medical officer should explore alternatives for increasing the sick call opportunities for female wards. These alternatives should include, but should not be limited to, extending hours of daily operation as well as extending opportunities to weekends.	**(NO LONGER APPLICABLE)**	provides a medical clearance for wards to be allowed to work in food services. No evidence was found to indicate that wards listed on the communicable disease list were working in food service areas, including the living units, the main kitchen, or the culinary arts program of the vocational education program. As noted earlier, as of March 2004, all male wards were removed from Ventura Youth Correctional Facility. The medical department conducts scheduled appointments, as well as sick call, five days a week, Monday through Friday. Wards fill out sick call requests and place them inside locked boxes on each living unit. Sick call requests are reviewed daily and triaged as needed.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Institutions and Camps Branch and the chief medical officer develop comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found that the academic achievement of Ventura Youth Correctional Facility's wards was low compared to that of other California Youth Authority facilities.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to improve attendance and academic and vocational achievement at the Ventura Youth Correctional Facility, the Office of the Inspector General recommended that the institution management take the following actions:		

• Work with ward representatives and institution education administrators as well as Education Services Branch administrators to provide the best possible learning environment. The superintendent should encourage the exchange of ideas through regular meetings between living unit staff, security, institution administration, and teachers. Focus on understanding roles and teamwork should be emphasized between these groups.	**FULLY IMPLEMENTED**	The institution staff reported that Mary B. Perry High School involves all staff and students in a variety of meetings and activities designed to improve the learning and therapeutic environment. These activities include the ward advisory committee, the student council, scheduled student advisement, the student consultation team process, Western Association of Schools and Colleges meetings (where focus and leadership meetings always include students), and the school site plan process. The superintendent is involved in the coordination of Focus on Education and Treatment and Western Association of Schools and Colleges Leadership Team activities, which include advisement, homework, and study hall policies and ensuring support for student attendance in the classrooms. The superintendent is also responsible for maintaining a safe environment for learning. The Office of the Inspector General confirmed that regular meetings involving wards, education, and institution staff are conducted.
The management of the Education Services Branch of the California Youth Authority and the institution's education administrators should: • Promptly fill teaching vacancies. Work to provide competitive teacher compensation by upgrading pay scales, using compensation exceptions provided for by law, and other suitable methods.	**PARTIALLY IMPLEMENTED**	The staff at Mary B. Perry High School reported that the institution was not able to fill teaching positions in the two-year period following the Office of the Inspector General's 2002 audit because of a statewide hiring freeze that prevented the hiring of teachers who were not already state employees. Consequently, recruiting activities were non-existent. The hiring freeze was lifted on July 1, 2004, but the school continues to have hiring difficulties. One reason is that teacher compensation in the local public school district is among the highest in the state, with the result that the disparity between compensation for Ventura Youth Correctional Facility teachers and teachers employed by the local school district is greater than the disparity at other youth correctional facilities. The Education Services Branch of the California Youth Authority reported that the department submitted a budget change proposal in July 2004 to address the teacher shortage. The proposal requested a sufficient number of positions for

		credentialed teachers, specialists, technology staff, education support staff, and administrative support staff to achieve compliance with applicable laws, mandates, and consent decrees. Specifically, the proposal requested the resources to accomplish the following: • Establish current staffing levels at 12:1 for regular education teachers, 10:1 for special programs teachers, and 5:1 for restricted programs teachers. • Establish current staffing levels for specialists based on service time needed. • Establish minimum staffing levels of one credentialed teacher/specialist for each required content area/specialty at each site. • Provide in the funding formula a relief factor of 15 percent (substitute teachers). • Add one staff information technology analyst per site and three staff services analysts by site to perform required non-instructional activities. • Add one assistant principal to each of the five high schools, which currently have only one or two assistant principals. • Add one senior information technology specialist to the California Youth Authority headquarters to perform education network support. • Align credentialed staff with the courses they teach. • Add one associate governmental program analyst to the district office to perform grant funding management, program analysis, and policy analysis. • Establish a teacher salary and working conditions package commensurate with that of local school districts. • Develop a teacher induction program for new teachers attempting to complete credential requirements. The department reported that efforts to hire more teachers are underway. According to the department, personnel from the California Youth Authority's Examinations Unit established priorities and needs for ongoing testing in the

		teacher classifications. Examination bulletins and a weekly process for scoring supplemental job applications are being developed. A retired education administrator has agreed to work with the Education Services Branch as a recruiter and will make contacts, staff a table at conferences, act as a liaison with universities, and perform other functions. The Office of the Inspector General verified that the department has twelve teacher examination bulletins posted for open recruitment. Despite the department's efforts to recruit teachers, however, teacher staffing difficulties continue to plague Mary B. Perry High School. In September 2004, Mary B. Perry had several teacher vacancies. Yet during the same period, the institution's position reconciliation report indicated the school had seven employees in excess of its budgeted and funding level. These over-hire slots included social science, high school general education, and language, speech, and hearing positions. The result is a mismatch of employed credentialed staff and school credentialed staffing needs. Complicating the staffing situation is the continued high-end salary disparity. According to the California Department of Education, teachers in Ventura County can earn $77,915 per year —an amount that far exceeds the highest salary for correctional institution teachers (Range F), which is $68,928. The Office of the Inspector General reviewed the department's budget change proposal and verified that it includes provisions for teacher compensation enhancements. The need for these enhancements was also acknowledged and endorsed by the California Performance Review. According to the institution staff, in August 2004, the high school and the facility personnel office made efforts to include teachers in statewide recruitment plans. To enable school administrators to plan more effectively, an annual leave calendar has been developed that will provide better coverage for teachers on leave status and vacations are being scheduled on the basis of coverage availability. According to the Education Services Branch, ward attendance and class cancellations are also being addressed in the *Farrell v. Allen* remedial plan. In addition, the Education Services Branch has implemented the student/ward attendance tracking system, which is designed to collect and analyze data on

		each ward's attendance in school and the reason for any absence. The data is presented at a weekly meeting of institution managers, education, and custody staff and used by the superintendent and principal to improve school attendance. The Education Services Branch is providing technical support to the Mary B. Perry High School at Ventura to implement and maintain that process.
• Make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.	**NOT IMPLEMENTED**	The Office of the Inspector General found from a review of data provided by Mary B. Perry High School that the school has only one substitute teacher available to fill teacher absences. The shortage of substitute teachers is partly responsible for the high number of class cancellations. According to the student/ward attendance tracking system 1,757 classes were closed because no substitute was available for the months of April through August 2004, meaning that approximately 16 periods per school day were closed because no substitute teachers were available. This problem is also reflected in the decline in the high school's effectiveness rating between fiscal years 2002-2003 and 2003-2004. The effectiveness rating, which measures actual instruction time as a percentage of available instruction time, dropped from 70 percent to 65 percent during that period. Notwithstanding the above problem with teacher vacancies and substitute teacher shortages, wards' cumulative standardized test scores increased from 2003 to 2004. Whereas 71 percent of wards had cumulative subject scores below the 25th percentile rate in 2003, only 54 percent of the wards had cumulative subject scores below the 25th national percentile rate in 2004. (This improvement may be in part attributable to the facility's ceasing operation as a coeducational institution during the period.) Further, the 54 percent rate is the best going back to 1998. The ward absenteeism rate increased slightly from 13 percent to 14 percent from 2003 to 2004.
• Explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid reasons, and that all alternatives to cancellation have been explored.	**PARTIALLY IMPLEMENTED**	The Ventura Youth Correctional Facility staff reported that the institution has begun scheduling one half-day a week for ward case conferences to allow teachers to attend ward case conferences without canceling classes and affecting the delivery of required instructional minutes. The Office of the Inspector General verified that the institution has attempted to reduce ward absences and class cancellations by closing classes for one half day a week (two 75-minute periods) to allow wards, teachers, and counselors to attend case conferences. The schedule rotates each week between Tuesday,

• Insist on the accurate and timely reporting of ward attendance by the school principal and instructors. Provide training as necessary and implement supervisory review and signature controls.	**FULLY IMPLEMENTED**	Wednesday, and Thursday and between mornings and afternoons. The schedule is prepared each month and disseminated to the living units to give staff the opportunity to schedule caseloads and report back to the education department. The living unit list identifies the case conferences scheduled to allow teachers to schedule their attendance. The Office of the Inspector General found, however, that the schedule is not working. A review of ward files revealed that teachers are not participating in ward case conferences. Initial estimates found that teacher participation is in the 10 percent range. The audit team determined that class cancellations resulted in the equivalent of 851 ward absences per *month,* yet the same ward population requires a maximum of only 685 case conferences per *year.* Thus, the absences associated with the scheduled class cancellations far exceed the need. Based upon this analysis, it appears that the cost (loss of classroom time) exceeds the benefit (teacher attendance at case conferences.) Consequently, it appears that the solution imposed to minimize class cancellations and disruptions may actually result in more school absences than the original problem. The institution staff reported that several measures have been taken to improve the accurate and timely reporting of ward attendance. According to the staff, a new student/ward attendance tracking system, which enables managers to pinpoint unauthorized absences and make appropriate corrections, was implemented in April 2004. In addition, an anticipated update to the ward information network system will enable teachers to prepare average daily attendance reports electronically. Monthly average daily attendance reports are also submitted to the appropriate supervisor before compilation. The Office of the Inspector General found that the Education Services Branch issued a memorandum on October 15, 2002 describing problems with average daily attendance data received from California Youth Authority schools. To remedy the deficiencies, new spreadsheets and instructions were issued to all of the schools. The instructions describe the nature of the data collected and in some cases the need for the data. The spreadsheets accompanying the instructions include formulas to help decrease errors and improve the consistency and accuracy of data submitted to the Education Services Branch for analysis and funding support. The Office of the Inspector General found that the average duration between the end of month and completion of the average daily attendance report was 23 days.

		The Office of the Inspector General found, however, that the student/ward attendance tracking system is not compatible with either the ward information network or the spreadsheets used to prepare average daily attendance figures. Efforts are underway to consolidate education reporting into the ward information system. While having three separate but overlapping systems is inefficient, the output from the systems has nonetheless improved the extent and reliability of data available for evaluating school performance.
• Comply with all recommendations of the Western Association of Schools and Colleges in order to obtain full accreditation for Mary B. Perry High School.	**FULLY IMPLEMENTED**	The Education Services Branch reported, and the Office of the Inspector General verified, that Mary B. Perry High School was granted a three-year accreditation by the Western Association of Schools and Colleges on February 6, 2003. The accreditation is valid until June 30, 2006. According to the Education Services Branch, the Western Association of Schools and Colleges visited Mary B. Perry High School/Ventura Youth Correctional Facility November 17 through November 20, 2002. Mary B. Perry High School completed the Western Association of Schools and Colleges self-study and complied with all recommendations. The visiting team will return during 2006. The school is continuing to develop and work on completing action plans to maintain Western Association of Schools and Colleges accreditation.
• Study the factors contributing to the frequent cancellation of classes and the need for substitutes. These factors should include the impact of alternative work schedules on class cancellations.	**PARTIALLY IMPLEMENTED**	Identifying specific causes for class cancellations and ward absences are key objectives of the student/ward attendance tracking system, which has now been fully implemented at Mary B. Perry High School. Although the student/ward attendance tracking system is not integrated with the ward information system and inefficiencies exist, the system is nonetheless capable of tracking reasons for ward absences. The system found that in the period April through August 2004, 30 percent of classes at Mary B. Perry High School—1,935 classes out of 6,347 classroom periods— were cancelled. According to the institution staff, class cancellations have increased because of teachers retiring and leaving for other job opportunities. Teachers who were formerly unassigned have now been given classroom or unit educational assignments. Mary B. Perry High School also has an inadequate number of substitute teachers available. Although the school is canceling an average of 18 classes a day, only one teacher is on the substitute list. Teacher recruitment is underway at the development level, but according to the Ventura education staff, the focus

		of those efforts has been in the southern and northern regions. The principal told the Office of the Inspector General that the schools at the El Paso de Robles and Ventura Youth Correctional Facilities may be overlooked because of their distance from the recruiters.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Ventura Youth Correctional Facility take the following actions:

- **Promptly fill teaching vacancies and work with the Youth and Adult Correctional Agency and the Department of Personnel Administration to provide competitive teacher compensation by upgrading pay scales using compensation exceptions provided for by law, and other suitable methods.**
- **Make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.**
- **Explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid reasons, and that all alternatives to cancellation have been explored.**
- **Develop policies and procedures to facilitate the attendance of teachers at ward case conferences without the need to cancel classes.**
- **Study the factors contributing to the frequent cancellation of classes and the need for substitute teachers. These factors should include the impact of alternative work schedules on class cancellations.**
- **Continue to seek an integrated attendance system that automates daily classroom attendance to minimize reporting errors and to better utilize staffing resources.**

ORIGINAL FINDING NUMBER 6

The Office of the Inspector General found that certain fundraising activities conducted by staff at the Ventura Youth Correctional Facility were not properly administered.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management take the following actions regarding fundraising activities:		
• Discontinue fundraising sales to wards when proceeds are to be used to benefit staff members. While the institution may use other methods such as donations from local businesses, the time required to secure these donations should be volunteered by staff without incurring overtime pay or compensating time off hours. If fundraising activity that benefits staff conducted under these terms conflicts with applicable collective bargaining agreements, the activity should be discontinued.	FULLY IMPLEMENTED	The Office of the Inspector General found that fundraising activities benefiting staff have ceased. According to the institution staff, the superintendent stopped all fundraising sales to wards to benefit staff members on June 7, 2002.
• Immediately close the Bank of America checking account used for the Ventura Youth Correctional Facility staff recognition fund. Any account balance should be deposited into the ward benefit fund.	PARTIALLY IMPLEMENTED	The institution staff told the Office of the Inspector General that the Bank of America checking account holding funds for the staff recognition committee was closed on July 30, 2002, with the account showing deposits through June 10, 2002. The staff said that the balance of $151.63 from the account was deposited into the general ward benefit trust account held in the institution accounting office. The Office of the Inspector General verified that the Bank of America account was closed, but found that more than $1,100 remained in the account at the time it was closed. Moreover, instead of reverting to the ward benefit fund, most of the money was used for staff functions during peace officer week festivities.
• Update the facility's operational manual to define acceptable financial transactions between wards and staff, such as those involving canteen purchases or fundraisers	SUBSTANTIALLY IMPLEMENTED	The Office of the Inspector General found that section 9010 of the Ventura Youth Correctional Facility operations manual has been updated to read, "No financial transactions, will be permitted between wards, wards and staff, or wards and volunteers." The manual still does not define the type of fundraisers

for the sole benefit of wards, and provide training to business office staff, accounting staff, and other employees involved in fundraising activities.		that are acceptable, however.
• Deliver cash revenues from car washes to the accounting office weekly to facilitate deposit to a bank within ten working days. The safe at the camp should be used to store cash only until it is delivered to the accounting office.	**FULLY IMPLEMENTED**	According to the institution staff, effective July 29, 2002, revenues from fire camp car washes are delivered to the accounting office on a daily basis.
• Develop procedures to purchase supplies for the car wash program or other ward benefits through the procurement section of the institution. This would separate the duties of staff members who purchase items from those who have custody of the revenues.	**FULLY IMPLEMENTED**	According to the institution staff, the car wash project now uses established accounting procedures to request funds from the camp ward benefit fund.
• Reimburse the ward benefit fund for $1,950 to correct the erroneous use of the funds, and explore obtaining reimbursement of those funds from the State Board of Control. (It is possible in certain cases to submit claims up to 12 months after the date of the incident.)	**PARTIALLY IMPLEMENTED**	According to the institution staff, the State Board of Control claims were submitted on July 23, 2002. The Office of the Inspector General verified that the Board of Control claims were submitted, but found that the claims were not approved and the funds were not reverted back to the ward benefit fund.
• Provide training for the institution's business management and staff in the proper use of ward benefit funds.	**FULLY IMPLEMENTED**	According to the institution staff, accounting staff continue to receive in-service training from central office staff regarding the management of ward benefit funds.
• Review the actions of members of the Ventura Youth Correctional Facility staff in participating in fundraising activities for the staff recognition committee for possible disciplinary action.	**NOT IMPLEMENTED**	According to the institution staff, since the new guidelines were established, staff personnel have followed the procedure and there has not been a need for progressive discipline.

		This recommendation was intended to encourage the institution management to review the past actions of those who participated in the fundraising activities for the staff recognition committee. That was not done.
In addition, the Institutions and Camps Branch should take the following actions: • Update the *California Youth Authority Institutions and Camps Branch Manual* to provide clear guidance to institutions on fundraising and financial transactions between staff and wards.	**NOT IMPLEMENTED**	According to the California Youth Authority, a department-wide fundraising policy task force has been developed. The first report is due December 1, 2004.
• Provide training to branch administrators in the proper use of ward benefit funds.	**NOT IMPLEMENTED**	Documentation was not provided to the Office of the Inspector General to show that this recommendation was implemented.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Ventura Youth Correctional Facility take the following actions:

- **Update the Ventura Youth Correctional Facility operations manual to specify the type of fundraisers that are acceptable for participation by staff or wards.**
- **Update the *California Youth Authority Institutions and Camps Branch Manual* to provide clear guidance to institutions on the types of fundraising and financial transactions allowed between staff and wards.**
- **Provide training to Institutions and Camps Branch administrators in the proper use of ward benefit funds.**

ORIGINAL FINDING NUMBER 7

The Office of the Inspector General found significant deficiencies in the institution's practices and procedures in conducting investigations.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management take the following actions to improve institutional investigations:		
• In the short term, the superintendent should request the director of the California Youth Authority to allow the institution to refer all preliminary investigations and Level I investigations, as well as Level II investigations, to the California Youth Authority Internal Affairs unit until the institution is prepared to conduct them.	FULLY IMPLEMENTED	After the 2002 management review audit, the institution did begin referring its cases to the Internal Affairs Unit. Now, however, the department provides the superintendent with the authority to conduct an inquiry, also termed a "preliminary investigation" to determine whether the complaint or allegation should be moved forward to the Internal Affairs Unit for formal investigation. Key elements of an inquiry are determining whether the alleged activity took place; what happened; when it occurred; who was involved; and who witnessed the activity.
• In the long term, the superintendent and her staff should develop an institutional plan for conducting well-planned, diligently conducted investigations. At a minimum, this plan should require the following:	FULLY IMPLEMENTED	According to the Ventura Youth Correctional Facility staff, a rotational system to assign inquiries to managers has been developed. Only managers who have completed the California Youth Authority's required Internal Affairs investigation training are assigned inquiries. Refresher training was given on August 11, 2004. All formal investigations are referred to the Department's Internal Affairs Unit.
• Thorough screening of investigator candidates using supplemental background investigations and psychological tests.	(NO LONGER APPLICABLE)	According to the institution staff, this recommendation is not applicable. At Ventura Youth Correctional Facility, middle managers and two lieutenants conduct inquiries and the thorough background screening outlined in California Penal Code, section 6065, is not required.
• Signed conflict of interest statements for investigators and all staff in a position to affect the outcome of an investigation.	SUBSTANTIALLY IMPLEMENTED	The administrative assistant at the facility told the Office of the Inspector General that the institution had not been consistently using conflict of interest statements because those conducting inquiries did not realize the statements were required for every assignment. Recent Internal Affairs training, however, addressed the need for conflict of interest statements for all inquiries.
• Use of well-developed, written investigative plans.	FULLY IMPLEMENTED	According to the institution staff, all Ventura Youth Correctional Facility managers and lieutenants attended training for conducting Internal Affairs

		inquiries on August 11, 2004. Standardized procedures and guide forms for planning and conducting inquiries were distributed at the training.
• Use of confidential employees for clerical and other support services.	**FULLY IMPLEMENTED**	According to the institution staff, effective October 1, 2002, the administrative assistant, who is a confidential employee, transcribes all reports.
• Proper securing of investigation case files, including the use of locking file cabinets and other devices as appropriate.	**SUBSTANTIALLY IMPLEMENTED**	According to the institution staff, effective October 1, 2002, investigation case files are required to be sorted and properly secured in the office of the administrative assistant. The Office of the Inspector General confirmed that inquiry files dated after 2001 are properly secured and that all current inquiries are locked in filing cabinets. Older inquiries and investigation files, however, are still located in a less-secure closet accessible to various members of the staff.
• Prompt disqualification of any investigator found to be the subject of a sustained, serious disciplinary action.	**NOT IMPLEMENTED**	The institution staff reported that no investigators have been disqualified at the Ventura Youth Correctional Facility. The Office of the Inspector General identified one lieutenant currently listed as an institution investigator who was the subject of a sustained allegation of discourteous treatment toward a ward in 2001. The case was conducted by the Internal Affairs Unit and classified as a Level II investigation. As a result, the investigator should be disqualified from conducting inquiries and investigations.
• Careful supervision of investigators' work by their supervisors.	**FULLY IMPLEMENTED**	According to the institution staff, the superintendent provides in-service training to investigators on an individual basis to correct deficiencies when necessary.
• Timely feedback to investigators on their performance.	**SUBSTANTIALLY IMPLEMENTED**	According to the institution staff, the assistant superintendent reviews all inquiries before the superintendent receives them. Effective June 1, 2004, the chief deputy director reviews all inquiries before closure.
• High-level monitoring of all cases by the superintendent to ensure their accurate and timely disposition.	**FULLY IMPLEMENTED**	According to the Ventura Youth Correctional Facility staff, the superintendent and assistant superintendent review all investigations. The Office of the Inspector General confirmed that inquiries conducted by the facility staff are reviewed at the institutional level by the assistant superintendent, who is presently the acting superintendent). Inquiries referred for investigation are also reviewed at the deputy director level before being forwarded to the Internal Affairs Unit for investigation. The Internal Affairs Unit is responsible for

The Office of the Inspector General also recommended that the Education Services Branch provide the institution with pertinent and timely case information for tracking in institutional investigation logs. This case information should include the following: • Internal Affairs unit or Education Services Branch case number • Subject name • Allegations • Incident date • Discovery date • Investigator name • Case closure date • Case conclusions	**PARTIALLY IMPLEMENTED**	monitoring inquiries at the institutional level to ensure that those not referred to investigation were properly conducted. According to the California Youth Authority, the Office of Professional Standards has assumed the tracking of all cases. The Education Services Branch reported that a system has been designed to track inquiries and investigations and was scheduled be implemented on September 1, 2004. The system would serve as an interim measure until the Youth and Adult Correctional Agency implements an employee disciplinary matrix. The assistant director of program compliance and internal affairs told the Office of the Inspector General, however, that the interim tracking system has not yet been implemented. The Office of the Inspector General was not able to test the investigation tracking function because no Level II Education Services Branch investigations have been posted at the Ventura Youth Correctional Facility since the June 2002 management review audit. The audit team did find periodic memoranda from the former southern regional administrator for the Education Services Branch advising superintendents of the status of investigations, but was unable to determine whether that function has continued since the regional administrator positions were eliminated in June 2004.

FOLLOW-UP RECOMMENDATION

- **The Office of the Inspector General recommends that the California Youth Authority provide the Ventura Youth Correctional Facility with pertinent and timely information for tracking investigations regardless of whether the case management system is ready for use. The information should include the Internal Affairs or Education Services Branch case number, the subject name, the allegation, the incident date, the discovery date, the investigator name, the case closure date, and the conclusions.**

ORIGINAL FINDING NUMBER 8

The Office of the Inspector General found that the California Youth Authority and the Ventura Youth Correctional Facility failed to comply with established security requirements.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management take the following actions to improve institution security:		
• Include deadlines for completing deficiencies found in annual security evaluations, and ensure that the deadlines are met.	SUBSTANTIALLY IMPLEMENTED	The institution staff reported that the chief of security prepares a quarterly report advising the superintendent of security needs. The institution also provided a copy of the institution's most recent annual security audit, required by *California Youth Authority Institutions and Camps Branch Manual* section 1800, which was completed on November 1, 2004. The Office of the Inspector General confirmed that the institution is preparing quarterly security evaluations for its own use and noted that one section of the institution's section 1800 security audit was not in compliance and did not have a deadline for compliance because the corrective measure required significant fiscal resources.
• Install automatic outside locks for the education classrooms. In the interim, issue a written directive for teachers to lock their classroom doors from the outside.	SUBSTANTIALLY IMPLEMENTED	The education staff reported and the Office of the Inspector General confirmed that the department has submitted budget change proposals to have automatic locks installed on classroom doors. The Office of the Inspector General also found that the problem of unauthorized wards entering classrooms has diminished since male wards were transferred from the institution.
• Request departmental approval to use local law enforcement during hostage situations. Develop written procedures for handling hostage situations that include the use of outside law enforcement.	PARTIALLY IMPLEMENTED	The institution staff reported that representatives from the Ventura Youth Correctional Facility and local law enforcement met on April 23, 2003 to discuss a mutual aid agreement and that the California Youth Authority will finalize a memorandum of understanding with local law enforcement by December 1, 2004. The Office of the Inspector General found that department headquarters is drafting a standardized mutual aid agreement for use by all institutions and that the Ventura Youth Correctional Facility is waiting for the standardized agreement before proceeding.

• Install intercom systems in portable classrooms.	**(NO LONGER APPLICABLE)**	The institution staff reported and the Office of the Inspector General confirmed that an intercom system is no longer needed. Because of the drop in the ward population after male wards were removed from the institution, portable classrooms are no longer used.
• Establish a key control committee and develop policies and procedures to ensure that the chief of security and the locksmith conduct quarterly key inventories and account for broken and blank keys.	**FULLY IMPLEMENTED**	The institution staff reported that a key control committee consisting of the locksmith, chief of security, and assistant superintendent has been established and that the most recent key audit was conducted in May 2004. The Office of the Inspector General confirmed that key audits are being conducted.
• Install bulletproof glass to protect the youth correctional officer at the reception desk.	**PARTIALLY IMPLEMENTED**	The institution staff reported and the Office of the Inspector General confirmed that the department submitted a budget change proposal to fund the installation of bulletproof glass in the reception area, but that the funds have not been approved.
• Weigh the risks, benefits, and costs of the second pedestrian entry point in the maintenance area, and either justify keeping it or close it.	**FULLY IMPLEMENTED**	The institution staff reported and the Office of the Inspector General confirmed that the second pedestrian gate has been welded closed and is equipped with the appropriate fence alarms.
• Consider welding the second vehicle gate to strengthen it against forced vehicle entry.	**FULLY IMPLEMENTED**	The institution staff maintains that the second vehicle gate is a necessary point of entry, that future projects on the institutional grounds can be accomplished only by using this entry point, and that the gate has been chained closed, which provides adequate security.
• Cut back the vegetation growing against the perimeter fence and work with the owner of the eucalyptus trees to ensure that they are properly trimmed. Old or unstable trees should be removed to prevent them from falling on the fence.	**SUBSTANTIALLY IMPLEMENTED**	The institution staff reported and the Office of the Inspector General confirmed that the trees in question have been trimmed. The institution has chosen to retain some of the vegetation surrounding the outside fence as a visual barrier to provide added security.
• Install razor wire on the roof of the central kitchen and locate a camera on the roof. Ensure that the boiler room outer door is shut.	**SUBSTANTIALLY IMPLEMENTED**	The institution staff reported that there is razor wire on the roof of the central kitchen and that institution management has mandated that the sally-port area outside the boiler room remain secured at all times. The staff also reported and the Office of the Inspector General confirmed that a budget request has been

		submitted to cover the cost of installing a camera on the roof. The Office of the Inspector General noted that a tree near the kitchen has been substantially trimmed so that the razor wire on the front part of the central kitchen is no longer an absolute necessity. The audit team confirmed that the boiler room outer door was closed and locked.
• Ensure that all pallets, tables, wheeled dumpsters, and similar items are secured far enough from the perimeter fence to preclude their use as escape aids.	**FULLY IMPLEMENTED**	The institution staff reported that security personnel routinely inspect the areas surrounding the perimeter fence and that the areas adjacent to the kitchen and warehouse are the responsibility of the youth correctional officer assigned to the vehicle gate. An addendum to the post order reflecting the vehicle gate responsibility was to be issued by August 31, 2004. The Office of the Inspector General confirmed that there were no items near the perimeter fence that could aid in an escape.
• Ensure that ancillary security devices related to the perimeter fence, including the fence alarm system and the camera system, are operating as designed.	**FULLY IMPLEMENTED**	A joint inspection by the Office of the Inspector General and the assistant superintendent of the institution April 29, 2003 found the fence alarm and cameras to be operating properly. Maintenance area work orders verified that the security staff regularly tests the devices.
• Enhance the reliability of the fence alarm system by: keeping debris away from the fence; correcting the problem with resetting the alarm in zone 17; repairing inoperable fence cameras; redirecting fence cameras, such as the one in zone 10; and correcting the wiring and display problems hampering the effectiveness of the monitors in the communications center.	**SUBSTANTIALLY IMPLEMENTED**	The institution staff reported that all of the problems cited have been corrected. The Office of the Inspector General confirmed that most of the problems have been corrected, but found that some of the video pictures on a control room monitor were not clear.
• Use shadow boards and inventory sheets for tool control in the maintenance shops. Modify Section 3270 of the *Ventura Operational Manual* to make it consistent with Section 1821 of the *California Youth Authority Institutions and Camps Branch*	**FULLY IMPLEMENTED**	According to the institution staff, wards are not allowed to work in the maintenance area where tool accountability could be a problem. The staff reported and the Office of the Inspector General confirmed that the maintenance staff now uses a color-code system and shadow boards to account for tools.

Manual.		
• Ensure that the inventory of supplies and equipment stored in the armory is all-inclusive and accurate, that chemical agent canisters are carefully controlled and have durable serial numbers, and that the firearm serial number discrepancy is resolved.	**SUBSTANTIALLY IMPLEMENTED**	The staff reported and the Office of the Inspector General confirmed that the institution has implemented a system of accounting for non-lethal weapons stored in the armory in which the weapons are numbered, entered into a database, and accounted for quarterly. The Office of the Inspector General found, however, that not all of the chemical agent canisters have durable serial numbers.
In addition, the Office of the Inspector General recommended that the Department of the Youth Authority do the following:		
• The deputy director of the Institutions and Camps Branch should resume the annual security audits of the Ventura Youth Correctional Facility as required by Section 1800 of the *Institutions and Camps Branch Manual.*	**FULLY IMPLEMENTED**	As stated previously, the facility completed an annual section 1800 security audit on November 1, 2004.
• Determine the advisability of relying on local law enforcement to handle all potential hostage situations. Once this determination has been made either review and modify Section 1809 accordingly or reiterate to the institutions and camps that Section 1809 is to be complied with as is.	**NOT IMPLEMENTED**	According to the department, the Office of Professional Standards will develop a standardized mutual aid memorandum of understanding by December 1, 2004.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Ventura Youth Correctional Facility take the following additional actions.

- **The Ventura Youth Correctional Facility should continue to pursue a mutual aid agreement with a local law enforcement agency and develop procedures for handling hostage situations, rather than waiting for the department to develop a standardized mutual aid agreement.**
- **The California Youth Authority should consider the advisability of relying on local law enforcement to handle potential hostage situations and either amend or follow section 1809 of the *California Youth Authority Institutions and Camps Branch Manual* accordingly.**
- **The Ventura Youth Correctional Facility should continue efforts to obtain funds to install bulletproof glass to protect the youth correctional officer stationed at the reception desk.**
- **The Ventura Youth Correctional Facility should trim back the vegetation growing against the fence near the maintenance area and tarp the fence to provide both a visual barrier and security containment.**
- **The facility should ensure that the resolution of video pictures on all security monitors is clear.**
- **The facility should replace chemical agent canisters not having durable serial numbers.**

ORIGINAL FINDING NUMBER 9

The Office of the Inspector General found that the disciplinary decision-making system at the Ventura Youth Correctional Facility had serious defects.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the Ventura Youth Correctional Facility management take the following actions to improve the disciplinary decision-making system:		
• Until technological improvements can be made to the Ward Information Network 2000, require each living unit to manually record each initiated Level A and Level B	FULLY IMPLEMENTED	According the institution staff, effective March 2004, the ward information network (WIN 2000) system now allows staff members to generate level 2 and 3 disciplinary reports and to track a report from start to finish. The staff reported that the ward rights coordinator generates detailed disciplinary decision-making

behavior report, with appropriate details of the rule violation, and report this information to the superintendent, assistant superintendents, and the Ward Rights Office at least monthly. The outcome and disposition of the behavior report should also be listed, including whether time limits were exceeded in processing the behavior report. Details of each case, such as the Ward Information Network case number, the ward's name, the date of the incident, the date of the behavior report, and the name of the staff writing the behavior report, should be listed.		system reports on all cases each month and submits them to the superintendent, the assistant superintendent, and treatment team supervisors. The Office of the Inspector General verified that the institution uses the WIN 2000 system to process and monitor ward disciplinary actions. The ward rights coordinator was able to generate numerous reports from the system used for monitoring and reporting purposes.
• Require the facility local area network manager, with the assistance of the California Youth Authority headquarters staff responsible for the Ward Information Network 2000 database, to help program useful reports for database users.	**FULLY IMPLEMENTED**	The institution staff reported that the local area network manager has given senior youth correctional counselors and treatment team supervisors the user access necessary to generate disciplinary decision-making system reports. The reports include the following information: the total number of level 2 and 3 cases; allegations; incident locations; number of disposition hearings held; case status; and cases with reduced disciplinary actions. The wards rights coordinator received training for trainers and assisted in training staff.
• Migrate all historical information on ward disciplinary decision-making system activity from the former database to the current database.	**FULLY IMPLEMENTED**	According to the institution staff, migration of historical information was completed in March 2004. The Office of the Inspector General verified that historical information has been migrated to the WIN 2000 system.
• Train all staff members involved in the ward disciplinary decision-making system process. The training should cover the procedures recommended above, items identified in the *Institutions and Camps Branch Manual,* and specific procedures unique to the Ventura Youth Correctional Facility or described in its operations manual. Specifically, the superintendent	**PARTIALLY IMPLEMENTED**	The institution reported that all members of the staff had been trained in the disciplinary decision-making system on the ward information network by August 2002. According to the institution staff, training on revised disciplinary decision-making system policy and on ward information network updates was provided in June 2003 and the most recent training was conducted during April, May, and June 2004. New staff members are trained in the disciplinary decision-making system during orientation and revised training is provided at least annually.

should ensure that:		The Office of the Inspector General reviewed 20 staff training files for evidence of disciplinary decision-making system training, however, and found that the last training was completed in July 2003. The ward rights coordinator acknowledged that not all staff members completed 2004 disciplinary decision-making system training and reported that only a few managers had received disciplinary decision-making system training in 2004.
• All members of the staff are provided with training on the disciplinary decision-making system process at least annually.	**NOT IMPLEMENTED**	The institution reported that all staff members are given training in the disciplinary decision-making system at least annually and that the most recent training was conducted in April, May, and June 2004. As noted above, the Office of the Inspector General found, however, that none of the 20 staff training files reviewed showed evidence of disciplinary decision-making system training in 2004.
• Hands-on training is offered on how to navigate through the Ward Information Network 2000 database and how to use it for the disciplinary decision-making system process.	**FULLY IMPLEMENTED**	The institution reported that training in revised disciplinary decision-making system policy and on ward information network updates was provided in June 2003. According to the institution, all staff members received hands-on training on how to access the disciplinary decision-making system and navigate through the ward information network 2000 database in April, May, and June 2004.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the Ventura Youth Correctional Facility provide annual disciplinary decision-making system refresher training to all staff members responsible for the custody and treatment of wards.

ORIGINAL FINDING NUMBER 10

The Office of the Inspector General found that the Ventura Youth Correctional Facility had a good working system for ward grievance monitoring and tracking, but some aspects of the process prevented management from holding facility staff accountable.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
In order to improve the ward grievance process, the facility management should take		

the following actions:		
• Immediately investigate the cause of "withdrawn" fast track, staff action grievances.	**NOT IMPLEMENTED**	According the institution staff, improvements to the ward information network have assisted in the proper tracking of the grievances. Additional training has been provided to grievance clerks, senior youth correctional counselors, and treatment team supervisors on the proper responses to reduce the number of "withdrawn" grievances. The Office of the Inspector General found that all staff action grievances are tracked by the superintendent's office and that they are rarely withdrawn. The audit team was able to find only one instance of a withdrawn staff action grievance for 2004. The ward information network did not provide a clear explanation for the ward withdrawing the grievance, but the audit team did review the original ward grievance, which contained an explanation and was signed by the ward. There was no evidence that the institution investigates the reasons staff action grievances are withdrawn.
• Require the ward rights coordinator to report overdue grievances to the superintendent, assistant superintendents, and all staff involved in the grievance process at least monthly.	**FULLY IMPLEMENTED**	The institution told the Office of the Inspector General that a report listing overdue grievances is generated weekly and monthly and that the ward rights coordinator distributes the report to the superintendent and the assistant superintendent on a weekly and monthly basis and it is discussed at weekly management meetings. The Office of the Inspector General verified that the ward rights coordinator has been providing weekly and monthly reports on overdue ward grievances to the superintendent, assistant superintendent, and supervisory staff. But the audit team found that the reports may not be accurate because the ward information network 2000 contains significant amounts of erroneous information. When asked to produce a current overdue list for the Office of the Inspector General, the ward information network generated a list of more than 200 entries. The ward rights coordinator explained that she has to ignore most of the entries because they have actually been completed, but have not been officially closed out since the migration from the old system. The ward rights coordinator said that the local area network manager is able to provide her with a report that excludes these entries. The Office of the Inspector General also found that some of the overdue grievances may be caused by staff members being unfamiliar with how to enter all of the required data into the ward information network. As a result, a grievance may have been completed, but the system may not have

		been updated to reflect its completion. The ward rights coordinator agreed that additional training is needed, as is research to close out grievances still listed as overdue even though they have been closed.
• Establish an oversight function to monitor the ward grievance process, regularly report any deficiencies directly to the superintendent, and hold staff members accountable for their responsibilities. Within this framework, the ward rights coordinator should report directly to the superintendent.	**SUBSTANTIALLY IMPLEMENTED**	The institution staff noted that the ward information network includes a numbering system that the wards rights office uses to track grievances. The numbering system includes the grievance number, grievant's name, California Youth Authority number, ward's cottage, date filed, type of grievance, staff member's response, appeal response, due dates, and resolution. A block of numbered grievances is assigned to each living unit and must be reconciled. Ward grievance clerks meet weekly with the unit supervisor to conduct audits and meet once a month with the ward rights coordinator. The Office of the Inspector General confirmed that the ward rights coordinator reports directly to the superintendent.
• Implement a "lock-box" near the watch office for wards and ward grievance clerks to ensure that for every ward grievance submitted, a copy is forwarded to either the Ward Rights Office or the superintendent's office.	**FULLY IMPLEMENTED**	The institution staff reported that a lock box was installed outside the communication center on July 31, 2002 into which wards and ward grievance clerks deposit staff action grievances and that the superintendent's office checks the box daily. The Office of the Inspector General verified that the institution installed a lock box for ward grievance clerks to use to submit staff action grievances.
• Train all staff members involved in the ward grievance process. The training should cover the procedures recommended above, items required by California Youth Authority policy as identified in the *Institutions and Camps Branch Manual,* and specific procedures unique to Ventura Youth Correctional Facility or described in its operations manual. The superintendent should ensure that the staff is provided with training on the ward grievance process, including the correct disposition of a ward grievance, at least annually.	**NOT IMPLEMENTED**	The institution reported that all Ventura Youth Correctional Facility staff members receive annual training on the ward grievance process. The Office of the Inspector General was unable to substantiate that report, however. The audit team found from reviewing 20 staff training files for evidence of ward grievance training for 2003 and 2004 that none contained evidence of training in 2004 and that only one of the files contained evidence of ward grievance training in 2003.

Implement an online database or electronic spreadsheet and tracking system that includes the following information: • Grievance number • Grievant's name (last and first) • Grievant's California Youth Authority number • Cottage • Date filed • Type of grievance • Staff member responsible for action • Due date for response • Appeal status • Due date for appeal • Resolution status	**FULLY IMPLEMENTED**	According to the institution staff, the ward grievance tracking system includes all of the information recommended by the Office of the Inspector General. The staff noted that the *Farrell v. Allen* remedial plan includes a major revision to the grievance system, including implementation of a headquarters tracking system to ensure timely response to grievances at all levels of review. The Office of the Inspector General confirmed that the data fields for tracking and monitoring ward grievances are included in the ward information network 2000.
• This tracking system should be established either on the Ward Information Network 2000 system, or, in the short run, on a stand-alone system developed by the facility.	**FULLY IMPLEMENTED**	The institution staff reported that the ward grievance tracking information is available on the ward information network 2000 and the staff was trained on the various functions in April 2004. The superintendent, assistant superintendent, living unit managers, and supervisors can access ward grievance information through the ward information network. The ward rights coordinator reviews the ward information network reports with the program managers on a weekly basis. The Office of the Inspector General confirmed that the institution is using the ward information network 2000 system to process and track ward grievances.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Ventura Youth Correctional Facility take the following additional actions:

- **Immediately investigate the cause of "withdrawn" fast track staff action grievances and document the reason the ward withdrew the grievance in the ward information network 2000 system as noted in the Office of the Inspector General's review.**
- **Research the overdue grievances in the ward information network 2000 and close out those that have already been addressed. Staff members responsible for the remaining overdue ward grievances should be held accountable for completing the grievances within mandated time frames.**
- **Provide annual training to staff on ward grievance procedures, including hands-on training on how to input the required data into the ward information network 2000.**

ORIGINAL FINDING NUMBER 11

The Office of the Inspector General found that a large portion of the institution's projected budget deficit of $2 million for fiscal year 2001-2002 was attributable to high costs of overtime, external contracts, and increased utility expenditures.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management and the California Youth Authority take the following actions to reduce the budget deficit: • Although the end of the 2001-2002 fiscal year is near, the superintendent should continue to reduce expenditures wherever possible, while developing a plan to prevent a deficit from re-occurring in subsequent years. While the California Youth Authority has already submitted Section 27.00 Deficiency Notifications seeking current year funding to cover increased utility costs and the increasing costs of care for pregnant wards, it should continue to seek an increase in its base budget to offset the effects of unforeseen	SUBSTANTIALLY IMPLEMENTED	According to the staff at the Ventura Youth Correctional Facility, the department continues to have a funding gap due to the underfunding of posted positions and the extraordinary use of sick leave statewide. The department requested an augmentation to the post relief factor through the budget change proposal process. The request was partially approved by the Department of Finance for the 2004-05 fiscal year. The Office of the Inspector General found that the California Youth Authority received a total of $3,474,000 and authority for 44.4 positions in the fiscal year 2004-05 Budget Act to fund relief coverage for posted positions. The institution management is unsure how much of that funding the institution will be allocated because the department's budget office has not provided management with that figure.

items that create an added fiscal burden, such as the effects of eliminating the Extraordinary Use of Sick Leave sanctions from the new Bargaining Unit 6 contract.		
• The institution, working in conjunction with headquarters, should update and correct the post assignment schedule so that the expenditures authorized in the Supplementary Schedule of Salaries and Wages in the Governor's budget reconcile with the institution's master roster detailing the security and counseling positions required to operate the institution.	**SUBSTANTIALLY IMPLEMENTED**	According to the staff, the institution has worked in conjunction with headquarters to reconcile the post assignment schedule to the master schedule and to the authorized positions listed in the Supplementary Schedule of Salaries and Wages. The Office of the Inspector General found that the institution received an updated post assignment schedule dated August 24, 2004 from the department's budget office, but since that time, the facility has closed two living units. Therefore, the master roster and the post assignment schedule will have to be updated again.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority and the Ventura Youth Correctional Facility take the following additional actions:

- **The institution should continue to reduce expenditures wherever possible and to track costs and reasons for unforeseen or unbudgeted expenditures.**
- **The California Youth Authority also should track unforeseen or unbudgeted expenditures to support additional funding requests.**

ORIGINAL FINDING NUMBER 12

The Office of the Inspector General found deficiencies in the operation of the Ventura Youth Correctional Facility warehouse.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution management take the following actions to improve warehouse controls:		
• Restrict access to the warehouse to warehouse staff, the superintendent, and the control center (for emergency use).	SUBSTANTIALLY IMPLEMENTED	According to the Ventura Youth Correctional Facility staff, the locks were changed on all exterior doors of the warehouse and new keys were issued only to the superintendent and warehouse personnel. An additional key is kept in a box in the communication center under glass protection to be used only in an emergency. The Office of the Inspector General verified that keys to the warehouse have been restricted, improving warehouse security, but noted that the doors remain open during hours of operation, which still allows for physical entry.
• Re-key the locks with keys that cannot be duplicated and distribute the keys only to the personnel identified above.	FULLY IMPLEMENTED	As noted above, the institution staff reported that the locks were changed on all exterior doors of the warehouse and new keys were issued only to the superintendent and warehouse personnel. The Office of the Inspector General determined that warehouse personnel have keys to the box in the communication center that holds the keys to the warehouse. The only other staff members who have access to the keys in that box are those with access to the communication center, who obtain the keys for emergency access to the warehouse.
• Require that all staff, including those from headquarters, arrange for the retrieval of items through the warehouse, with prior notification.	SUBSTANTIALLY IMPLEMENTED	The institution staff reported that an accountability system has been implemented in which the Business Services Office contacts headquarters once a week to request purchase orders in advance of any delivery. According to the staff, the Business Services Office logs the time, the day of the call, and the person contacted at headquarters. The institution reported that the warehouse supervisor and Business Services Office personnel were trained in the new

• Require that only orders that can match a purchase order (including orders initiated from headquarters) be accepted by the warehouse staff. All other orders should be rejected.	**SUBSTANTIALLY IMPLEMENTED**	procedure on July 16, 2002 and that a new schedule now in place also allows for a receiving clerk to be available for every delivery. The Office of the Inspector General found that the institution has improved its method of operations for retrieving items from the warehouse as well as the availability of the warehouse for retrieving items. The warehouse has a staff person available throughout the day, beginning at 6 a.m. and another staff member who comes on at 3 p.m. for a later shift. The institution staff reported that warehouse personnel have been instructed not to accept deliveries that have not gone through the proper approval procedure. The Office of the Inspector General found, however, that warehouse personnel continue to receive deliveries without the benefit of a purchase order before shipment. According to the staff, these types of shipments occur only a few times a month, which is an improvement over the previous situation, but are still time-consuming for the staff, who must verify that the order should be received and that the shipment is correct.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the institution require all staff to arrange for the retrieval of items from the warehouse with prior notification.

ORIGINAL FINDING NUMBER 13

The Office of the Inspector General found that the Ventura Youth Correctional Facility assigned some wards to more than one paid job.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the institution and the California Youth Authority Facilities Planning Division take the following actions to comply		

with *California Code of Regulations* Title 15, section 4725 and to increase the number of wards with paid jobs:		
• The business manager should ensure that alternate positions go to wards on the waiting list rather than to wards already assigned to regular paid assignments.	**PARTIALLY IMPLEMENTED**	According to the Ventura Youth Correctional Facility staff, the ward work application has been revised to ensure that wards are assigned to only one paid job. A work roster of all paid positions is maintained for proper monitoring. The ward trust technician notifies the work program coordinator if a ward receives compensation for more than one job. If that occurs, corrective action is taken. The Office of the Inspector General found, however, that seven wards were each assigned to two paid jobs out of the 52 paid jobs at the facility. The facility management said that because the ward population is so low, it is difficult to find capable wards to place in paid positions and that the facility has been operating without a business manager for several months, hampering compliance.
• The business manager should ensure that wards assigned to a "direct construction" position are not also assigned to another paid job assignment.	**PARTIALLY IMPLEMENTED**	According to the institution staff, the ward trust account technician is responsible for notifying the work coordinator if a ward receives compensation from more than one job. Since the establishment of the Southern Regional Accounting Office, the local business office, which is under the guidance of the regional office, now monitors the process. As noted above, the Office of the Inspector General found from the follow-up review that seven wards were each assigned to two paid jobs out of the 52 paid jobs at the facility.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the Ventura Youth Correctional Facility exert a stronger effort to ensure that wards are assigned to only one paid job to increase the number of wards capable of earning money that can be used for canteen purchases. The institution should also document instances in which potentially capable wards decline the offer to work in a paid position. The ward should be required to sign a form declining the offer.

ORIGINAL FINDING NUMBER 14

The Office of the Inspector General found that staff performance appraisals and probationary reports were not completed on time.

ORIGINAL RECOMMENDATION(S)	STATUS	COMMENTS
The Office of the Inspector General recommended that the superintendent take the following actions to ensure prompt evaluation of employee performance:		
• Notify every staff member of the importance of performance appraisals and probationary reports to the mission of the Ventura Youth Correctional Facility.	FULLY IMPLEMENTED	According to the institution staff, all managers and supervisors have been provided with a Ventura Youth Correctional Facility operations manual and have been reminded of the importance of performance appraisals. Facility management reported that the issue is routinely addressed at all levels and is part of performance evaluations for managers and supervisors.
• Instruct the personnel officer to develop a system that does the following: systematically logs the due dates for all performance appraisals and probationary reports, notifies supervisors when such appraisals and reports are due, and compiles information on supervisors who are delinquent in completing appraisals and reports. This log should be submitted to the superintendent monthly and made a regular topic of management meetings.	PARTIALLY IMPLEMENTED	The institution staff reported that reminders are sent to the appropriate staff member one month before the due date for annual performance reports and probationary reports. A list of delinquent annual performance appraisals and probationary reports is sent to the superintendent for review and distributed to supervisors and managers, who are required to ensure completion by a specified date. The personnel staff reports the compliance rate to the superintendent. The Office of the Inspector General verified that systems have been developed to remind supervisors and managers of upcoming due dates and to notify the superintendent if those due dates are not met. The audit team found, however, that from a randomly selected sample of 10 employees, 50 percent (5 out of 10) had not received their annual performance appraisal as required. Moreover, 3 of the 5 employees who had not received current performance appraisals did not appear on the report the superintendent uses for follow-up.
• Include the responsibility for timely performance appraisals and probationary reports in supervisors' and managers' own performance expectations and performance	FULLY IMPLEMENTED	According to the Ventura Youth Correctional Facility staff, timely completion of performance appraisals is a fundamental performance expectation for managers and supervisors and is evaluated in their own performance appraisals.

appraisals.		

FOLLOW-UP RECOMMENDATIONS

- **The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management determine why managers and supervisors continue not to complete timely performance appraisals despite the improvements reported above. Facility management should hold staff accountable as appropriate.**

INTENSIVE TREATMENT PROGRAM

IMPLEMENTATION REPORT CARD

Previous recommendations: 10

Fully implemented: 2 (20%)

Substantially implemented: 1 (10%)

Partially implemented: 5 (50%)

Not implemented: 2 (20%)

The Office of the Inspector General found that the California Youth Authority has made improvements to its intensive treatment program, which serves wards, who are acutely suicidal or who have significant mental health disorders. The department is still failing, however, to ensure that newly committed wards and parole violators receive the required treatment needs assessment.

In November 2002, the Office of the Inspector General conducted a review of the California Youth Authority's intensive treatment program, which is intended to provide treatment to wards who have significant mental health disorders. One of the three principal components of the department's mental health treatment system, the intensive treatment program provides sub-acute care to wards who are acutely suicidal or who are suffering from moderate to severe mental illness, including schizophrenia, psychosis, depression, and bipolar disorder. The November 2002 review determined that the intensive treatment program was serving only a small percentage of wards suffering from severe mental illness and that the treatment provided was generally substandard.

BACKGROUND

Providing mental health services to wards is one of the department's core responsibilities. Studies have found that mental illness is pervasive among incarcerated youths. A 2001 study of California Youth Authority wards found that 97 percent suffered from at least one mental health disorder and that most exhibited numerous mental health problems.[1] The percentage of California Youth Authority wards with serious mental health problems and treatment needs has steadily increased since the introduction in 1997 of a sliding fee scale intended to encourage counties to find alternatives to California Youth Authority commitment for non-violent offenders.

The California Youth Authority operates intensive treatment programs at five institutions: the Southern Youth Correctional Reception Center and Clinic, Preston Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, Ventura Youth Correctional Facility, and Heman G. Stark Youth Correctional Facility. At the time of the November 2002 review, the department was operating 273 intensive treatment program beds, but was planning to decrease the number of beds to 210 in an effort to improve treatment by increasing staff-to-ward ratios.

In addition to the intensive treatment program, the California Youth Authority operates the following other programs for wards with mental health problems: a specialized counseling

[1] "The Assessment of the Mental Health System of the California Youth Authority: Report to Governor Gray Davis," prepared by Principal Investigator: Hans Steiner, M.D., Co-Principal Investigator: Keith Humphreys, PhD., and Project Manager: Allison Redlich, Ph.D., Department of Psychiatry, Stanford University School of Medicine, December 31, 2001.

program at five facilities for wards who generally do not require the full array of medical services required by the intensive treatment program; the intermediate care program at the Southern Youth Correctional Reception Center and Clinic, a short-term program operated jointly with the Department of Mental Health for wards who have severe and persistent mental illness; and a specialized behavioral treatment program at the Preston Youth Correctional Facility for wards who are aggressively mentally ill. The department also operates treatment programs for substance abusers and sex offenders, and is mandated to provide individual, small-group, and large-group counseling to wards in the general population.

California Youth Authority Institutions and Camps Branch Manual, section 6260, requires that all newly committed wards and wards who have violated parole receive a treatment needs assessment—the department's initial mental health screening test—within 21 days of arrival at the California Youth Authority. The assessment is critical to the timely and accurate assignment of wards to the general population or to one of the treatment programs described above.

As a result of the November 2002 review the Office of the Inspector General made the following specific findings:

- Under then-existing practices, the intensive treatment program was not able to accommodate all wards needing intensive mental health services.

- The process used by the California Youth Authority to screen wards for placement in the intensive treatment program failed to ensure that all wards needing intensive treatment were identified and received the necessary treatment.

- Treatment services provided to wards in the intensive treatment program were limited in scope, lacking in planning, poorly documented, and generally deficient in quality.

- There were serious deficiencies in the handling by mental health clinicians of suicidal wards in the intensive treatment program.

- There was a lack of follow-up care for wards leaving the intensive treatment program.

The November 2002 findings were consistent with those of subsequent studies, including a December 2003 review of the department's mental health treatment services by a panel of mental health experts under the direction of the California Attorney General's Office. Among other findings, the Attorney General's panel concluded that the California Youth Authority was not meeting recognized standards of care for youth with mental health disorders, that

intensive treatment programs "varied markedly across CYA," and that the intensive treatment program beds were "not being used appropriately."[2]

The Office of the Inspector General issued ten recommendations as a result of the November 2002 review.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2004 follow-up review was to determine the extent to which the California Youth Authority has implemented the ten recommendations from the Office of the Inspector General's November 2002 review of the intensive treatment program. To conduct the follow-up review, the Office of the Inspector General provided the California Youth Authority with a table listing the November 2002 findings and recommendations and asked the department to provide the implementation status of each recommendation. The Office of the Inspector General reviewed the response, along with documentation provided by the department and evaluated the degree of compliance or non-compliance with the recommendations.

As part of the evaluation, the Office of the Inspector General conducted fieldwork at the five facilities that have intensive treatment programs: Southern Youth Correctional Reception Center and Clinic, Preston Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, Ventura Youth Correctional Facility, and Heman G. Stark Youth Correctional Facility. In addition, the audit team visited the O.H. Close Youth Correctional Facility and the Dewitt Nelson Youth Correctional Facility to review their administration of treatment needs assessments. During the fieldwork, the audit team interviewed staff, reviewed records, observed selected program operations, and conducted tests necessary to formulate conclusions regarding the implementation of the Office of the Inspector General's recommendations.

SUMMARY OF THE FOLLOW-UP RESULTS

The California Youth Authority reported that it has made improvements in tracking the delivery of services to wards; in ensuring that wards receive treatment needs assessments within required time limits; and in providing training to youth correctional counselors in mental health treatment. The Office of the Inspector General verified that the department is providing training in mental health treatment to youth correctional counselors. Other improvements in the intensive treatment program are in the process of being implemented as a result of the *Farrell v. Allen* remedial plan. But the Office of the Inspector General determined that the California Youth Authority is not providing timely treatment needs assessments to wards who violate parole and to newly arrived wards. The follow-up review also found that the department still has not developed a formal process for admitting wards to

[2] "Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Youth Authority Facilities," Eric W. Trupin, Ph.D. and Raymond Patterson, M.D., December 2003.

the intensive treatment program who are not identified as needing intensive treatment during intake processing.

Of the ten recommendations issued by the Office of the Inspector General in November 2002, two have been fully implemented, one has been substantially implemented, five have been partially implemented, and two have not been implemented. Several of the 2002 recommendations were not acted upon until 2004, when action was taken as a result of the remedial plan.

Among the findings from the 2004 follow-up review are the following:

627 parole violators who were received at various California Youth Authority facilities between January 1, 2004 and November 14, 2004 had never received a treatment needs assessment as required by California Youth Authority policy

- A mental health level-of-care designation has been added to the ward information network system to track the delivery of mental health services to wards in specialized programs. The Office of the Inspector General found, however, that the mental health section of the ward information network system does not capture all of the mental health services provided to wards.

- The department reported that a tracking system at the reception centers ensures that wards receive treatment needs assessments within 21 days of arrival. The Office of the Inspector General found, however, that between January and November 2004, 627 parole violators did not receive treatment needs assessment as required by *California Youth Authority Institutions and Camps Branch Manual*, section 6260. In addition, 114 newly committed wards did not receive the treatment needs assessment within the 21 days required by the manual. Some newly committed wards went as long as 10 months without treatment needs assessments—delaying needed mental health treatment and putting wards at increased risk for suicide.

- Youth correctional counselors received training in mental health treatment during fiscal year 2003-2004.

- The department has established procedures for obtaining parental consent for minors to receive medication.

- Mental health assessment and treatment protocols being implemented as part of the *Farrell v. Allen* remedial plan will standardize the intensive treatment program at the various institutions and provide comprehensive treatment plans for intensive treatment program wards.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following additional actions:

- **Ensure that all wards—parole violators, as well as newly committed wards — receive a treatment needs assessment within the 21 days required by department policy.**
- **Implement the Office of the Inspector General's previous recommendation to institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing.**
- **Continue efforts to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education to psychiatrists, psychologists, and other members of the mental health staff.**
- **Develop policies and procedures for providing follow-up care to wards leaving the intensive treatment program.**

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

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that under then-existing practices the California Youth Authority's intensive treatment program did not accommodate all wards needing intensive mental health services/treatment.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
None		See second follow-up recommendation following Finding 2, below.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the process used by the California Youth Authority to screen wards for placement in the intensive treatment program failed to ensure that all wards needing intensive treatment were identified and receive the necessary treatment.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Youth Authority take the following actions: Require the reception centers to develop computerized tracking systems to ensure that every ward receives a treatment needs assessment within specified time limits.	NOT IMPLEMENTED	The California Youth Authority reported that the ward information network system tracks program and treatment information on each ward. The department told the Office of the Inspector General that in August 2004 a mental health level of care designation that identifies and tracks the delivery of services to wards in specialized programs was added to the ward information network. The department also reported that reception centers have a tracking system to ensure that treatment needs assessments are completed within 21 days. The audit team verified that the ward information network has a mental health level-of-care designation that records a ward's suicide risk screening questionnaire rating and the completion of a Special Program Assessment Needs evaluation. But the network does not track whether a treatment needs assessment was completed or whether the ward received the assessment within the required timeframe. The ward information section of the department's Research Division

		has the capacity to monitor administration of the treatment needs assessment to each ward, but has not performed the monitoring in a consistent or timely manner. For example, on November 4, 2004, a Research Division memorandum alerted the Preston Youth Correctional Facility that 114 wards admitted to Preston Youth Correctional Facility during calendar year 2004, some of them as early as January 2004, had not received a treatment needs assessment.
Institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing.	**NOT IMPLEMENTED**	In its response to this recommendation, the California Youth Authority reported that in 2003 it implemented the special program assessment of needs system to identify initial and subsequent treatment needs of wards placed in the intensive treatment program. The department also reported that positions have been added to mental health intervention programs in the reception centers to assess and treat wards in need of mental health care. The department's response did not address the recommendation to develop a formal and uniform process for admitting wards, including those in the general population, to the intensive treatment program subsequent to intake processing.
• After the first six months of operation, conduct a thorough evaluation of the Special Program Assessment Needs system to assess its efficacy in identifying wards with specific mental health treatment needs.	**PARTIALLY IMPLEMENTED**	The California Youth Authority provided the Office of the Inspector General with the report of an evaluation performed of the special program assessment of needs system by the department's Compliance Unit in January 2004. The report identified two risk management issues requiring corrective action. The department reported that it has established a team to review the special needs assessment process. The department further reported it would prepare a corrective action plan at the conclusion of its report, which was anticipated in November 2004 — approximately two years after the Inspector General's recommendation.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority make further improvements to the intensive treatment program by taking the following actions.

- **Implement the Office of the Inspector General's previous recommendation to institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing.**
- **Ensure that all wards—parole violators, as well as newly committed wards —receive a treatment needs assessment within the 21 days required by department policy.**

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that treatment services provided to wards in the intensive treatment program were limited in scope, lacking in planning, poorly documented, and generally deficient in quality.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Youth Authority take the following actions: • Continue to pursue efforts to institute mental health treatment according to the continuum of care model, including extending treatment services to all California Youth Authority wards, with treatment levels closely tied to mental health treatment needs.	PARTIALLY IMPLEMENTED	The California Youth Authority reported that reception center clinics have a tracking system to ensure that treatment needs assessments are completed within 21 days. According to the department, the casework specialist is responsible for evaluating mental health data to ensure that wards are placed in the appropriate continuum of care model. The department also reported that the team reviewing the special needs assessment process is also reviewing the treatment needs assessment aspect of the program. The department noted and the Office of the Inspector General confirmed that the *Farrell v. Allen* remedial plan includes a program to ensure continuum of care to wards with mental health needs. The audit team found that the reception center clinics have developed manual tracking systems to monitor the administration of treatment needs assessments to wards. But the audit team also found that not all of the tracking systems are effective. As noted above, the department notified Preston Youth Correctional Facility in November 2004 that 114 wards—some of whom had been at the

		facility for as long as ten months— had not received treatment needs assessments within the required 21 days. The audit team also found that 627 parole violators who were received at various California Youth Authority facilities between January 1, 2004 and November 14, 2004 had never received a treatment needs assessment as required by California Youth Authority policy.
• Continue efforts to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education training for psychiatrists, psychologists and other members of the mental health staff.	**PARTIALLY IMPLEMENTED**	The California Youth Authority reported and the Office of the Inspector General confirmed that youth correctional counselors received various types of training during fiscal year 2003-2004, including training in the signs and symptoms of mental illness. The department reported that a minimum of two staff members from each intensive treatment program participated in a cognitive behavioral training session in 2003. The amount of training described by the department is minimal, however, and does not meet the intent of the recommendation.
• Institute quality control procedures and monitoring to ensure that constitutional standards of mental health treatment and documentation are met.	**PARTIALLY IMPLEMENTED**	The California Youth Authority told the Office of the Inspector General that the quality control procedures recommended by the Inspector General were not implemented. But the department reported and the Office of the Inspector General confirmed that the *Farrell v. Allen* remedial plan contains a quality assurance program component to ensure that constitutional standards are met.
• Require the development of comprehensive treatment plans for all intensive treatment program wards.	**PARTIALLY IMPLEMENTED**	According to the California Youth Authority, a standardized individualized change plan was developed and implemented in the ward information network in January 2004. The department reported that the *Farrell v. Allen* remedial plan incorporated the individualized change plan to help the California Youth Authority staff identify treatment and develop a comprehensive treatment plan for wards in the intensive treatment program. The audit team verified that the ward information network contains the standardized individualized change plan for wards assigned to an intensive treatment program during calendar year 2004. The Office of the Inspector General also confirmed that the remedial plan contains a standardized change plan to assist in identifying the appropriate treatment for wards in the intensive treatment program.

• Standardize the process and forms for obtaining parental consent to administer psychotropic medication to minors.	**FULLY IMPLEMENTED**	The California Youth Authority reported that the department's Health Care Services Division has established procedures for parental consent of medications for minors. The department also told the Office of the Inspector General that *Keyhea*[3] procedures have been implemented for adults requiring medication. The department provided the Office of the Inspector with copies of the procedures for parental consent of medications for minors and the *Keyhea* procedures for adults requiring medications.
• Standardize the intensive treatment program at the various institutions to ensure that the most effective treatment modalities are used consistent with differences in age groups, wards with special problems, and DSM-IV diagnoses.	**SUBSTANTIALLY IMPLEMENTED**	According to the California Youth Authority, the integrated treatment delivery of care system, as well as the mental health assessment protocol, was established in March 2004 as part of the *Farrell v. Allen* remedial plan. The department provided the Office of the Inspector with copies of the mental health assessment protocol. The Office of the Inspector General confirmed that the remedial plan contains the integrated delivery of care system and the mental health assessment protocol.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority continue efforts to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education to psychiatrists, psychologists, and other members of the mental health staff.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found serious deficiencies in the handling by mental health clinicians of suicidal wards in the intensive treatment program.

[3] Keyhea procedures refer to findings by the court in *Keyhea v. Rushen* ([1986] 178 Cal.App.3d) that inmates and wards have the right to refuse antipsychotic drugs absent a judicial determination of incompetence.

ORIGINAL RECOMMENDATION	STATUS	COMMENTS
The Office of the Inspector General recommended that the California Youth Authority provide specific training to staff psychologists and psychiatrists in the proper completion of the standard referral and disposition report to ensure that the forms specify the custody and treatment recommended for wards exhibiting suicidal behavior.	FULLY IMPLEMENTED	The California Youth Authority reported that a mental health assessment policy was developed in March 2004 to ensure that assessments of wards by psychologists and psychiatrists are thorough. The department provided the Office of the Inspector General with a copy of the policy outlining custody and treatment recommended for wards exhibiting suicidal behavior. In addition, the department reported that its procedures ensure that proper documentation is placed in the ward's unit health record.

FOLLOW-UP RECOMMENDATIONS

None.

ORIGINAL FINDING NUMBER 5

The Office of the Inspector General found a lack of follow-up care for wards leaving the intensive treatment program.

ORIGINAL RECOMMENDATIONS	STATUS	COMMENTS
None		See recommendation below.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority develop policies and procedures for providing follow-up care to wards leaving the intensive treatment program.

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OFFICE OF INTERNAL AUDITS

IMPLEMENTATION REPORT CARD

Previous recommendations: 9

Fully implemented: 1 (11%)

Substantially implemented: 1 (11%)

Partially implemented: 2 (22%)

Not implemented: 5 (56%)

The California Youth Authority is still not effectively using internal audits to identify problems affecting the department and has fully implemented only one of the nine recommendations from a July 2003 audit.

The Office of the Inspector General conducted an audit in July 2003 to assess the effectiveness of the California Youth Authority's Office of Internal Audits in helping the department fulfill its mission. The audit also sought to determine whether the management practices and administrative procedures of the Office of Internal Audits were being carried out in accordance with applicable laws, regulations, and policies and to measure the performance of the Office of Internal Audits in relation to professional internal auditing standards.

The management audit found that the California Youth Authority was not effectively using the Office of Internal Audits to identify the serious problems affecting the department because it had unnecessarily restricted the work of the office to fiscal matters. Even within that limited framework, the Office of the Inspector General found that the Office of Internal Audits was failing to fully accomplish its mission. The audit determined that in the most recent two-year reporting period, and despite a staffing increase, the office had completed less than 6 percent of the 301 audits for which it was responsible. The Office of the Inspector General concluded that, as a result of the deficiencies, the California Youth Authority could not properly certify that it was maintaining a system of internal accounting and administrative control as required under the Financial Integrity and State Managers Accountability Act of 1983.

BACKGROUND

The Financial Integrity and State Manager's Accountability Act of 1983, California Government Code section 13400, *et seq.,* requires every state agency to maintain effective internal accounting and administrative control systems as an integral part of its management practices. The act also requires state agency directors to prepare and submit a report certifying the adequacy of the agency's internal accounting and administrative control systems to the Governor, the Legislature, the Bureau of State Audits (formerly the Office of the Auditor General), and the Department of Finance at the end of every odd-numbered fiscal year. Consistent with the act, the Office of Internal Audits was established within the California Youth Authority to review the department's internal accounting and administrative controls. Section 8500 of the *Department of the Youth Authority Administrative Manual* provides as follows:

> *In accordance with the Financial Integrity and State Managers Accountability Act of 1983 (Sections 13405 (a) and (b) of the Government Code), the Director is required to certify to the Governor, the Legislature, the Auditor General, and the Director of Finance that an effective system of internal accounting and administrative control is in effect and functioning to safeguard the State's assets, provide reliable accounting data, promote operational efficiency, and ensure*

adherence to prescribed managerial policies. The Office of Internal Audits reviews the internal accounting and administrative controls throughout the Department and issues reports to the Director.

At the time of the 2003 audit, the Office of Internal Audits had a staff of seven, including one senior management auditor, one staff management auditor, and five associate management auditors. Its budget for the 2002-03 fiscal year was approximately $850,000. Although the department had proposed a reorganization that could change its reporting structure, at the time of the audit the Office of Internal Audits reported directly to the assistant director of the Office of Internal Affairs and Internal Audits, who reported to the chief deputy director within the Office of the Director of the California Youth Authority.

SUMMARY OF PREVIOUS FINDINGS

In the July 2003 audit, the Office of the Inspector General found that the Office of Internal Audits was providing minimum value to the department and that the findings resulting from the work of the Office of Internal Audits were insignificant in relation to the dollars expended in staff resources and the liability to the department posed by deficiencies in California Youth Authority programs and operations.

The Office of the Inspector General made the following specific findings as a result of the 2003 audit:

- The California Youth Authority was not making effective use of the Office of Internal Audits as a tool for identifying problems needing corrective action because the work of the Office of Internal Audits was unnecessarily limited to fiscal matters. Even within the limited scope of fiscal audit activity, the office was performing its work in an ineffective, piecemeal fashion that failed to target high-risk areas or to provide management with a comprehensive assessment of systems and operations.

- The failure of the Office of Internal Audits to fulfill its responsibilities resulted from poor management, inadequate supervision of the audit staff, the absence of a quality control program, and the failure of management to use risk assessment in planning audit activities. The audit found that the office completed less than 6 percent of the audits for which it was responsible in the two-year reporting period ending December 31, 2001.

- The reporting structure of the Office of Internal Audits did not adequately protect the independence of the internal audit function and impeded communication between the Office of Internal Audits and the department director.

The Office of the Inspector General issued nine recommendations to correct the deficiencies. The recommendations included integrating the department's internal audit and program compliance functions into a single office; combining staff to perform comprehensive fiscal and operational reviews; and taking steps to ensure that the work of the office adheres to the *Standards for the Professional Practice of Internal Auditing.*

OBJECTIVES, SCOPE, AND METHODOLOGY

The Office of the Inspector General conducted the 2004 follow-up review to determine the extent to which the California Youth Authority had implemented the recommendations from the July 2003 audit. To conduct the follow-up review, the Office of the Inspector General asked the California Youth Authority to report the implementation status of each of the nine recommendations from the earlier audit. The audit team reviewed the department's response, along with documentation provided by the department, to evaluate the degree of compliance or non-compliance. The results are presented in the tables following this narrative.

SUMMARY OF THE FOLLOW-UP RESULTS

The Office of the Inspector General found that the California Youth Authority is still not making effective use of the Office of Internal Audits, since re-named the Internal Audits Unit. The department reported that the changes to the internal audit function are expected to result from the *Farrell v. Allen* remedial plans, now being developed. In the meantime, the department has not integrated the internal audit and program compliance functions into a single office and has not combined staff for the purpose of performing comprehensive fiscal and operational reviews using a comprehensive risk assessment process. Instead, the Internal Audit Unit continues to perform the same piecemeal fiscal audits that were being conducted at the time of the Office of the Inspector General's July 2003 audit. The department also appears to have taken no action to ensure compliance with the *Standards for the Professional Practice of Internal Auditing,* and the reporting structure continues to jeopardize the independence of the internal audit function.

Of the nine recommendations issued by the Office of the Inspector General in July 2003, five have not been implemented. Only one recommendation has been fully implemented; one has been substantially implemented; and two have been partially implemented.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General reiterates the importance of implementing the recommendations issued as a result of the July 2003 audit. The California Youth Authority should take the following actions:

- **To allow management greater control over fiscal and program functions critical to department operation, integrate the internal audit function and the program compliance function into a single office and combine staff to perform comprehensive fiscal and operational reviews.**

- **Provide for the internal audit/program compliance office to be managed by someone who can ensure that the office adheres to the *Standards for the Professional Practice of Internal Auditing.***

- **Provide for the head of the internal audit/program compliance office to report directly to the chief deputy director in the office of the department director.**

- **Require that the head of the internal audit/program compliance office perform a comprehensive risk assessment of California Youth Authority institutions, camps, education services, treatment programs, parole operations, and headquarters to identify areas of high risk when assigning resources and developing work plans.**

- **Implement an internal quality assurance program that enables management to measure staff and office performance in the areas of fiscal and program compliance; evaluation of budgeted and expended hours; effectiveness of reports; and monitoring of findings and recommendations.**

- **In accordance with the *Standards for the Professional Practice of Internal Auditing*, arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the department director.**

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

ORIGINAL FINDING NUMBER 1
The Office of the Inspector General found that the California Youth Authority was not making effective use of the Office of Internal Audits as a tool for identifying problems needing corrective action.

ORIGINAL FINDING NUMBER 2
The Office of the Inspector General found that the Office of Internal Audits was poorly managed and inadequately supervised and was not fulfilling its audit responsibilities.

ORIGINAL FINDING NUMBER 3
The Office of the Inspector General found that the reporting structure of the Office of Internal Audits did not adequately protect the independence of the internal audit function and impeded communication between the Office of Internal Audits and the department director.

The Office of the Inspector General made the following recommendations as a result of the three findings:

ORIGINAL RECOMMENDATIONS		COMMENTS
To allow management greater control over fiscal and program functions critical to department operation, the Office of the Inspector General recommended that the California Youth Authority integrate the internal audit function and the program compliance function into a single office and combine staff to perform comprehensive fiscal and operational reviews.	NOT IMPLEMENTED	The department reported that it is planning to combine the internal audit and program compliance functions, but is awaiting development of the *Farrell v. Allen* remedial plans. The department said it anticipates it will begin to conduct combined audits in January 2005. The department acknowledged that in the meantime it has not integrated the internal audit and the program compliance functions into a single office and has not combined staff from the two units to perform comprehensive fiscal and operational reviews.

The Office of the Inspector General recommended that the California Youth Authority provide for the internal audit/program compliance office to be managed by a person who can ensure that the office adheres to *Standards for the Professional Practice of Internal Auditing.*	**NOT IMPLEMENTED**	The department reported no changes in the management of the Internal Audit Unit. When asked whether the managers and staff of the unit had received additional training since the 2003 audit, the department reported that staff from the Internal Audits and Compliance Review units had attended a course in risk management in anticipation of the planned merger of the two offices. According to the department, the audit manager and audit supervisor have received routine continuing education, but the Office of the Inspector General noted that they have not received training specific to managing an internal audit operation according to the *Standards for the Professional Practice of Internal Auditing* The department reported that the assistant director of the Office of Internal Affairs and Internal Audits, to whom the manager of the Internal Audits Unit reports, and who is the same person who was in position at the time of the earlier audit, took an Internet course in June 2003 entitled: "Basic Skills Used in Auditing." The Office of the Inspector General noted from a review of the department's organization chart that the Compliance Review Unit, which remains separate from the Internal Audits Unit, is made up of employees with custody, treatment, and analytical backgrounds and has no positions requiring audit education or experience. It appears that no significant action has been taken to ensure that the Internal Audits Unit and the Compliance Review Unit include employees who have the education and experience necessary to ensure that the office complies with the *Standards for the Professional Practice of Internal Auditing*.

The Office of the Inspector General recommended that the California Youth Authority provide for the head of the internal audit/program compliance office to report directly to the chief deputy director within the Office of the Director of the California Youth Authority.	**PARTIALLY IMPLEMENTED**	The California Youth Authority told the Office of the Inspector General that the heads of the internal audit and program compliance offices report to the assistant director of the Office of Professional Standards, who in turn reports directly to the department director. The department's organization chart, however, shows that another administrative position is situated between the assistant director and the heads of the Internal Audits and Compliance Review units. The assistant director told the Office of the Inspector General that the administrative position does not have the authority over the Internal Audits and Compliance Review Units implied by the organization chart and that structural changes to the organization are planned. The department told the Office of the Inspector General that the reporting structure will be discussed at the next meeting of the executive audit review team to decide whether the Office of the Inspector General's recommendation should be implemented.
The Office of the Inspector General recommended that the California Youth Authority require the head of the internal audit/program compliance office to perform a comprehensive risk assessment of California Youth Authority institutions, camps, parole operations and headquarters to identify areas of high risk when assigning resources and developing work plans.	**NOT IMPLEMENTED**	The department provided the Office of the Inspector General with a proposed three-year audit plan, prioritized according to a risk assessment of the entities to be audited, but the Office of the Inspector General found that the risk assessment covered only fiscal issues, not program issues. The department reported that the proposed plan would be used as a comprehensive risk assessment tool when the department's compliance audits begin in January 2005 in conjunction with the remedial plans expected to result from the *Farrell v. Allen* litigation. The department also provided the Office of the Inspector General with an interim 15-month audit plan identifying audits being conducted while the department awaits finalization of the remedial plans. The Office of the Inspector General found these to be the same piecemeal fiscal audits that were being performed by the Office of Internal Audits at the time of the July 2003 audit. The department reported that after the remedial plans are approved by the court, the department staff will develop a comprehensive risk assessment to direct the resources of the Compliance Review and Internal Audits Units to areas of highest risk.

The Office of the Inspector General recommended that the California Youth Authority ensure adequate supervision of staff in the field by combining experienced and inexperienced staff into teams and ensure that managers and supervisors provide fieldwork supervision.	**SUBSTANTIALLY IMPLEMENTED**	The department told the Office of the Inspector General that the audit chief and supervisor provide supervision in the field. The department further reported that auditors in the Internal Audits Unit work in teams of two whenever appropriate. That information is supported by the Office of the Inspector General's review of the interim 15-month audit plan and sample audit plans submitted by the department. The department also reported that it has employed a group audit approach, which provides the opportunity for each member to review the audit process, the findings and the proposed recommendations. Auditors are required to clear the peer review before review by the supervisor. The Office of the Inspector General noted from the information provided that although the Compliance Review Unit conducts compliance audits, staff is not supervised by individuals with auditing expertise.

The Office of the Inspector General recommended that the department ensure that reports are issued promptly and communicate the relative importance of the findings and recommendations.	**PARTIALLY IMPLEMENTED**	The department reported that the new department director provided specific directions to the Office of Professional Standards in January 2004 about the areas upon which he wanted to focus. According to the department, a new schedule and tracking system was implemented as a result, along with the expectation that audit reports be finalized within 30 days of the draft report. The Office of the Inspector General asked the department to provide documentation of the specific directions provided by the new director, but the department was unable to provide that documentation. A schedule of current audit assignments as of October 1, 2004, supplied by the department, indicates that the Internal Audits Unit currently has 13 audits in progress and that the oldest audit was 65 days old as of October 1, 2004. That report indicates a dramatic improvement over the findings of the July 2003 audit, when the Office of the Inspector General determined that the Office of Internal Audits took nearly a year from the audit start date to issue a standard audit report. The Office of the Inspector General requested that the department provide information about the issue of ensuring that reports communicate the relative importance of the findings and recommendations, but the department did not provide that information.
Develop a tracking system to ensure that corrective action is implemented by auditees and that the status of the corrective action is submitted for management review.	**FULLY IMPLEMENTED**	The department reported that it implemented a system for tracking corrective action in January 2004 and provided a sample report from the tracking system. The Office of the Inspector General found that tracking system appears to adequately report the status of corrective action being taken by auditees.

Implement an internal quality assurance program that enables management to measure staff and office performance in the areas of fiscal and program compliance, evaluation of budgeted and expended hours, effectiveness of reports, and monitoring of findings and recommendations.	**NOT IMPLEMENTED**	The California Youth Authority told the Office of the Inspector General that the department director established an executive audit review team consisting of the chief deputy director, the deputy directors, and the assistant directors in September 2004. The first meeting of the review team was scheduled for September 22, 2004. According to the department, the executive audit review team will meet quarterly to review audit reports and corrective action plans and to evaluate the quality of the audit reports. The Office of the Inspector General noted, however, that the establishment of the executive audit review team was initiated with a memorandum from the department director dated September 1, 2004—just two days after the Office of the Inspector General initiated this follow-up review. In the opinion of the Office of the Inspector General, establishment of an executive audit review team is unlikely to satisfy the internal assessment requirement specified by the *Standards for the Professional Practice of Internal Auditing*. The standards require that periodic reviews be "performed through self-assessment or by other persons within the organization, with knowledge of internal auditing practices and the *Standards*." Internal assessments are an integral part of a quality assurance and improvement program, and it is doubtful that the positions specified as members of the audit review team would have the knowledge required to perform this function. Involvement of an executive review team is nonetheless valuable. In addition to contributing to the quality assurance and improvement program, the executive review team can provide the input of senior management in the risk-based plan of engagements for the internal audit activity, as required by section 2010 of the *Standards for the Professional Practice of Internal Auditing.*

In accordance with the *Standards for the Professional Practice of Internal Auditing,* arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the Office of the Director.	NOT IMPLEMENTED	The department told the Office of the Inspector General that the California Youth Authority director will request the first external assessment in July 2006 and every five years thereafter.

FOLLOW-UP RECOMMENDATIONS

The Office of the Inspector General reiterates the importance of implementing the recommendations issued as a result of the July 2003 audit. The Office of the Inspector General therefore recommends that the California Youth Authority take the following actions:

- **To allow management greater control over fiscal and program functions critical to department operation, integrate the internal audit function and the program compliance function into a single office and combine staff to perform comprehensive fiscal and operational reviews.**

- **Provide for the internal audit/program compliance office to be managed by someone who can ensure that the office adheres to the *Standards for the Professional Practice of Internal Auditing.***

- **Provide for the head of the internal audit/program compliance office to report directly to the chief deputy director in the office of the department director.**

- **Require that the head of the internal audit/program compliance office perform a comprehensive risk assessment of California Youth Authority institutions, camps, education services, treatment programs, parole operations, and headquarters to identify areas of high risk when assigning resources and developing work plans.**

- **Implement an internal quality assurance program that enables management to measure staff and office performance in the areas of fiscal and program compliance; evaluation of budgeted and expended hours; effectiveness of reports; and monitoring of findings and recommendations.**

- **In accordance with the *Standards for the Professional Practice of Internal Auditing*, arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the department director.**

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YOUTH AUTHORITY BOARD

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 6 (86%)

Substantially implemented: 1 (14%)

Partly as a result of legislation that took effect in January 2004, the process used to establish programming requirements for California Youth Authority wards has been significantly improved. All but one of the recommendations from a 2002 review have been fully implemented and the remaining recommendation has been substantially implemented.

In December 2002, the Office of the Inspector General reviewed the process by which the California Youth Authority and the Youthful Offender Parole Board (now the Youth Authority Board) established ward program requirements.The review found that responsibility for specifying the treatment programs wards must complete before they are released from custody rested with the Youthful Offender Parole Board, which lacked treatment expertise, while the California Youth Authority, which has the expertise and responsibility for assessing wards' treatment needs, had authority only to recommend generally what programs a ward should complete. The review also found that the Youthful Offender Parole Board often required wards to complete more treatment programs than could reasonably be completed before their scheduled release date, causing them to be retained.

BACKGROUND

At the time of the 2002 review, the seven-member Youthful Offender Parole Board was responsible for setting the length of a ward's commitment and for ordering wards to complete specified treatment programs before they could be paroled. Under the process, wards committed to the state by the courts underwent an assessment by the California Youth Authority of education background, mental health needs, and other factors to determine what training and treatment would be beneficial to rehabilitation. On the basis of the assessment, the California Youth Authority submitted a packet containing a discussion of the ward's treatment needs to the Youthful Offender Parole Board, included a recommendation about what institutions might be suitable for the ward's placement, and sometimes, but not always made a formal recommendation for treatment programs to be completed.

The Youthful Offender Parole Board staff reviewed the packet and developed a list of programs for the ward to complete before parole. The board then conducted an initial hearing on each case, issued an order specifying the programs the ward was required to complete before parole, and set a "parole consideration date" — the earliest date the ward might be released on parole depending on his or her behavior during confinement and completion of all recommended programs. Thereafter, the board was required to review each case annually to determine whether the program requirements should be modified or continued and whether the parole consideration date should be changed.

SUMMARY OF PREVIOUS FINDINGS

As a result of the December 2002 review, the Office of the Inspector General made the following findings.

- Having the Youthful Offender Parole Board conduct initial hearings added little value; frequently resulted in parole consideration dates that exceeded regulatory guidelines; and often resulted in requirements that the ward complete more treatment programs than could reasonably be accomplished.

- The California Youth Authority did not develop plans to enable wards to complete treatment programs before the parole consideration date, thereby jeopardizing wards' scheduled release.

- Despite incurring significant expense in providing a broad array of treatment programs for wards, the State had not sought to measure the effectiveness of the programs.

The Office of the Inspector General issued seven recommendations to address the deficiencies.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the follow-up review was to determine the extent to which the California Youth Authority has implemented the recommendations from the December 2002 review. To conduct the follow-up review, the Office of the Inspector General asked the California Youth Authority to report the implementation status of each of the seven recommendations from the December 2002 review. The auditors reviewed the department's response, spoke by telephone with managers responsible for drafting the response, reviewed documentation relating to changes implemented by the department, and reviewed changes resulting from legislative and court actions affecting the way the California Youth Authority provides treatment and rehabilitative services to wards. The audit team also visited three facilities— Heman G. Stark Youth Correctional Facility, Southern Youth Correctional Reception Center and Clinic, and the Ventura Youth Correctional Facility— to confirm information reported by the department.

SUMMARY OF FOLLOW-UP RESULTS

The Office of the Inspector General found that significant changes have been made in the process of setting programming requirements for wards. Responsibility for recommending treatment has been shifted from the former Youthful Offender Parole Board to the California Youth Authority. The department also now provides a treatment plan for each ward and has implemented a core treatment program to promote consistency in the treatment provided to wards. An assessment of training and treatment programs has also begun. Six of the previous recommendations have been fully implemented and the remaining recommendation has been substantially implemented.

Some of the changes have resulted from the *Farrell v. Allen* litigation, while others have resulted from the passage of Senate Bill 459, which took effect on January 1, 2004. Under the provisions of the new law, the following changes have been made in the delivery of treatment, rehabilitation, and training to California Youth Authority wards:

- The Youthful Offender Parole Board was abolished and in its place the Youth Authority Board was created within the CaliforniaYouth Authority.
- The duties of the Youthful Offender Parole Board were consolidated in the CaliforniaYouth Authority and the Youth Authority Board.
- The changes set forth the membership of the Youth Authority Board and required those members to receive specified training.
- The Youth Authority Board now exercises specified powers and duties, including discharges of commitment, orders to parole and conditions thereof, revocation or suspension of parole, and disciplinary appeals.
- The CaliforniaYouth Authority is required to exercise specified powers and duties, including determining offense categories, setting parole consideration dates, making decisions regarding disciplinary actions, and returning wards to the court of commitment for re-disposition by the court.
- The California Youth Authority is required to notify the probation department and the court of the parole consideration dates.
- The CaliforniaYouth Authority is required to provide the court and the probation department with a treatment plan for wards and an estimated timeframe within which the treatment recommended by the court will be provided.
- The California Youth Authority is required to conduct an annual review of each ward's case and to provide copies of the review to the court and the probation department.
- The Welfare and Institutions Code now specifies that a minor may not be held in physical confinement for a period in excess of the maximum term of physical confinement set by the court.

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority institute methods of assessing the effectiveness of curriculum and treatment provided to wards.

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

ORIGINAL FINDING NUMBER 1

The Office of the Inspector General found that having the Youthful Offender Parole Board conduct initial hearings added little value to the process and frequently resulted in parole consideration dates exceeding regulatory guidelines and requirements that the ward complete more treatment programs than could reasonably be accomplished.

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that the California Youth Authority did not develop plans defining how each ward would complete his or her treatment programs before the parole consideration date, thereby jeopardizing the ward's scheduled release.

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found that despite incurring significant expense in providing a broad array of treatment programs for wards, the State had not sought to measure the effectiveness of the programs.

The following recommendations resulted from the three findings:

ORIGINAL RECOMMENDATIONS		COMMENTS
The Office of the Inspector General recommended the following: • The California Youth Authority should take responsibility for making formal recommendations for treatment programs to be completed by wards based on assessments of wards completed during the intake process and on consideration of the time required to complete the programs during the ward's expected confinement period.	FULLY IMPLEMENTED	A regulation change published on June 20, 2003 following passage of S.B. 459 describes the new role of the Youth Authority Board, formerly the Youthful Offender Parole Board, in the initial review of new cases committed to the California Youth Authority. Under that change, responsibility for establishing case categories, treatment recommendations, and parole consideration dates (now called "projected board dates") is shifted to the California Youth Authority. The Youth Authority Board serves in an advisory and affirming capacity to facilitate early brokering of differences on specific cases and to avoid potential conflicts during parole consideration proceedings.

• The Youthful Offender Parole Board, in coordination with the California Youth Authority, should immediately discontinue conducting initial hearings.	**FULLY IMPLEMENTED**	According to the California Youth Authority, the Youthful Offender Parole Board (now the Youth Authority Board) ceased conducting initial hearings effective November 2002. A regulation change, published June 20, 2003, outlined the change and identified the board's new role in the initial review of new cases committed to the California Youth Authority.
• The California Youth Authority, in consultation with the Youthful Offender Parole Board, should review the various programs currently being offered at the institutions and eliminate those found to be least effective.	**FULLY IMPLEMENTED**	The California Youth Authority provided a November 18, 2002 memorandum from the former chief deputy director of the California Youth Authority, who wrote: "The Department has begun the process of reviewing all treatment programs currently offered at its institutions and camps and will eliminate programs that are nonessential." The California Youth Authority also reported that the department has reviewed and evaluated the treatment and training programs in conjunction with the Youth Authority Board. In addition, the department reported that the *Farrell v. Allen* remedial plans, still in development, will address the development of a more evidence-based program component. Notwithstanding these developments, the department reported that it has developed and implemented a standardized basic core program consisting of 14 treatment modules for California Youth Authority wards. According to the department, California Youth Authority staff received 24 hours of training in the spring of 2004 addressing the methods to be used in presenting the modules. The department reported that the basic core program was fully implemented at all institutions on July 1, 2004. To confirm the department's report, the Office of the Inspector General visited three California Youth Authority facilities—Heman G. Stark Youth Correctional Facility, Southern Youth Correctional Reception Center and Clinic, and the Ventura Youth Correctional Facility— and found that all three had implemented the basic core program in the general population units and in some of the specialized program units, such as the special management program and substance abuse treatment units. The Office of the Inspector General confirmed that the basic core program consists of 14 treatment modules, but found that the program is being introduced into the facilities in phases. The first phase is currently in progress and encompasses approximately the first three modules. On October 1, 2004, general population wards began the first module,

		entitled "substance abuse." Each subsequent month, the wards will be introduced to a new module. The Office of the Inspector General found that although staff at each of the three facilities had received training in presenting the program, the claim that each staff member had received 24 hours of training was not confirmed at all facilities. Staff at one facility said they recalled receiving between four and eight hours of training, and the auditors found from reviewing documentation at another facility that some staff members had received the 24 hours, but others had received less.
• The California Youth Authority should immediately initiate an effort to promote consistency and uniformity in the curriculum and content of programs being offered to wards and devise means to fully assess their effectiveness.	**SUBSTANTIALLY IMPLEMENTED**	The department reported that it has restructured its treatment and training programs to ensure statewide consistency and uniformity throughout the institutions and camps. The *Farrell V. Allen* remedial plan also addresses continuum of care and delivery of services for wards and will address devising methods to assess the effectiveness of the curriculum and content of programs presented to wards. Although the department reports that the California Youth Authority staff has discussed how to make these assessments, no plan will be implemented until issues relating to the remedial plan have been resolved. As noted above, the Office of the Inspector General verified that the basic core program is being implemented at the three facilities visited. The audit team also confirmed that a training program has been developed and implemented to introduce the facility staff to the program content and methodology for presenting the program to wards. According to the California Youth Authority, standardized training was developed following the Office of the Inspector General's 2002 report and is now being provided by staff who work in specialized programs, including the sex offender and substance abuse programs. The department reported that the training is based on national models and provided the audit team with copies of a "program organizational model," which describes four evidence-based approaches to behavior change.
• The Youthful Offender Parole Board should develop a training program specifically designed to enable the board	**FULLY IMPLEMENTED**	According to the California Youth Authority, as revised or emerging treatment and training programs are developed, board members, hearing officers, and staff are deployed on a routine basis to be briefed on and attend the programs

staff to fully understand the board's role and responsibilities in the hearings and to ensure that the hearing staff is thoroughly familiar with California Youth Authority programs and requirements.		available within the department. The training includes visits to various treatment and training programs at regular intervals to provide staff with current knowledge of programs, curriculum, and modalities. Board members also receive orientation on all institution and parole programs upon initial appointment to the board. They observe hearings and programs and are involved in reviews and discussions of the various training manuals. Thereafter, they commence board case hearing responsibilities, working with trained veteran hearing officer colleagues, who function as "field training officers." The Office of the Inspector General reviewed a copy of the training and orientation form used by the Youth Authority Board for new board members and hearing officers to document exposure to program areas and board processes. The form lists 14 areas and provides for the date and time to be recorded to indicate the areas covered. The Office of the Inspector General also reviewed a copy of a hearing calendar on which new member and officer "tours" and observations are documented. According to the calendar for February 2004, observations or tours were documented on 14 days.
• The California Youth Authority should develop a standardized format for a ward treatment plan and require such plan to be prepared as a part of the ward's initial assessment. Training should be provided to the staff to ensure consistency in the preparation of the treatment plan.	**FULLY IMPLEMENTED**	The California Youth Authority reported that the individualized treatment plan for wards has been revised and standardized and is now known as the "individualized change plan." Section 3282 of the *California Youth Authority Institutions and Camps Branch Manual* provides for an individualized treatment plan to be developed for all new commitments and to be reviewed at the initial case review. All wards receive a copy of the individualized treatment plan during their initial assessment. The Office of the Inspector General noted that according to the instructions on the plan, Part I is to be completed at the reception center-clinic, while Part II is to be completed at the program facility. According to the department, all staff members received training in the spring of 2004 to ensure consistency in the preparation of the plan.
• The Youthful Offender Parole Board should function in an oversight capacity by reviewing the California Youth Authority's recommended program and formal treatment plan for wards and	**FULLY IMPLEMENTED**	Under the provisions of Welfare and Institutions Code section 1719 *et seq.* (S.B. 459, effective January 1, 2004), the Youthful Offender Parole Board was renamed the Youth Authority Board and the authority to conduct annual review hearings was transferred to the California Youth Authority. The annual review hearings are now performed by the department's Youth Authority

evaluating the ward's behavior and progress at the first annual and subsequent annual hearings.		Administrative Committee, which includes a Youth Authority Board hearing officer, who functions in an oversight capacity. The hearing officer reviews the department's recommended programs and formal treatment plans for wards and evaluates ward behavior and progress at the first annual review hearing and at subsequent annual review hearings preceding the department's referral of the case to the board for parole consideration. The Office of the Inspector General noted that Welfare and Institutions Code section 1719 provides that the powers and duties of the Youth Authority Board "may be delegated to a panel, member, or case hearing representative as provided in Section 1721." These powers and duties include "discharges of commitment, orders to parole and conditions thereof, revocation or suspension of parole, and disciplinary appeals." Section 1720(e) provides in part, "Reviews conducted by the department…shall include…the following:…a review of the ward's disciplinary history and response to disciplinary sanctions; an updated individualized treatment plan for the ward that makes adjustments based on the review required by this subdivision." .

FOLLOW-UP RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority institute methods of assessing the effectiveness of curriculum and treatment provided to wards.

WELFARE AND INSTITUTIONS CODE SECTION 1732.8

IMPLEMENTATION REPORT CARD

Previous recommendations: 7

Fully implemented: 4 (57%)

Substantially implemented: 0 (0%)

Partially implemented: 3 (43%)

Not implemented: 0 (0%)

The Office of the Inspector General found that the California Youth Authority and the Youth Authority Board have significantly improved the handling of dual-commitment wards serving California Youth Authority confinement time in Department of Corrections facilities under Welfare and Institutions Code section 1732.8.

The Office of the Inspector General conducted a review in February 2003 of the implementation of Welfare and Institutions Code section 1732.8, which allows California Youth Authority wards who have served sentences in Department of Corrections facilities to elect to also serve their remaining California Youth Authority confinement time in Department of Corrections institutions.[1] Wards covered by the statute are termed "dual-commitment wards." At the time of the February 2003 review, there were 40 dual-commitment wards in Department of Corrections institutions throughout the state.

The February 2003 review identified a number of deficiencies in the implementation of Welfare and Institutions Code section 1732.8. The Office of the Inspector General found that the California Youth Authority and the Youthful Offender Parole Board lacked standards and procedures for programming dual-commitment wards and that the expectations of the Youthful Offender Parole Board were not clearly explained to the wards. Dual-commitment wards also were not afforded the rights provided to other wards to attend their annual review and parole consideration date hearings and there were deficiencies in coordinating ward appeal and grievance procedures.

BACKGROUND

Chapter 476, Statutes of 2001 (SB 768, McPherson) added section 1732.8 to the *California Welfare and Institutions Code*. The provision established a program allowing certain California Youth Authority wards to choose to be confined in Department of Corrections facilities until they are released from custody. The program affects those commonly referred to as "dual commitment" or "dual jurisdiction" wards. These are wards over the age of 18 who have committed felonies while housed in a California Youth Authority facility or while on California Youth Authority parole; who have served court-imposed time for those felonies in the California Department of Corrections; and who have confinement time remaining with the California Youth Authority. Dual commitment wards often have assaulted other wards, staff, or members of the public and frequently have failed to program effectively at the California Youth Authority. They are generally disruptive and unsuited to the California Youth Authority's mission of treatment and training.

Approximately 60 days before the end of their Department of Corrections sentence, the wards are provided with a consent form allowing them to exercise their option to either remain in Department of Corrections custody or return to the California Youth Authority.

[1] The review was conducted at the request of Senator Gloria Romero.

The statute requires that a California Youth Authority representative meet with the ward and explain the provisions of the statute before the ward exercises the option. The provisions of the statute are articulated in the consent form, which requires the ward's initials beside each provision. The ward must also check the option he or she has selected and sign the consent form. The ward's decision is irrevocable once the consent form is signed, but the director of the Department of Corrections has discretionary authority to return any ward to the California Youth Authority.

Dual commitment wards may exercise the Department of Corrections option for a variety of reasons, including distaste for the programming required under the Youthful Offender Parole Board (now the Youth Authority Board) orders, perceived treatment in the California Youth Authority as children rather than adults, or a desire to be housed closer to their families. Since the statute became law on January 1, 2002, the California Youth Authority has offered the program to 81 wards. Of these, 55 had opted to accept confinement in Department of Corrections facilities at the time of the 2003 review, while the remaining 26 had exercised their right to return to the California Youth Authority.

Wards who choose to remain in Department of Corrections custody may still be subject to Youthful Offender Parole Board/Youth Authority Board orders requiring that they complete a range of programs, such as anger management, victim awareness, or gang awareness. The ward also may be required to earn a high school diploma or a general educational development certificate. When a ward is sentenced to the Department of Corrections, the maximum sentence runs concurrently with his or her available confinement time, which is established by law and represents the last date the ward can be held by the California Youth Authority. The available confinement time is based on the type of crime committed and generally cannot exceed the ward's 25th birthday. If a ward's Department of Corrections sentence exceeds his or her California Youth Authority available confinement time, the Youth Authority Board may dishonorably discharge the ward from the California Youth Authority; but if the Department of Corrections sentence is less than the available confinement time, the ward is left with California Youth Authority confinement time remaining. Under those circumstances, the Youth Authority Board can require the ward to abide by the programming requirements of his or her board orders. However, there is no requirement for the Department of Corrections to provide dual commitment wards with the programs necessary for them to fulfill the board orders. Neither is the Department of Corrections obligated to provide a ward with academic or vocational education. Such education is to be provided only to the extent that the appropriate programs are available.

The effect of not completing programs ordered by the Youthful Offender Parole Board/Youth Authority Board, in turn, may be to lengthen the ward's sentence. As long as a ward has not completed his or her California Youth Authority available confinement time, the Youth Authority Board has authority to add time to a ward's confinement in either the California Youth Authority or the Department of Corrections. In making the decision, the board considers a case report on the ward prepared by the California Youth Authority and logged into the ward master file from information obtained from the Department of Corrections. The information is to include the ward's history of disciplinary actions such as CDC-115 rules violations, programming efforts, and in-

prison jobs the ward may have held. Even if a ward has incurred no disciplinary actions, the absence of programming efforts may be grounds for added time.

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

- Dual-commitment wards were not allowed to attend their annual reviews and parole consideration date reviews and had little contact with the California Youth Authority and the Youthful Offender Parole Board.

- In making parole decisions, the Youthful Offender Parole Board did not adequately take into account that dual-commitment wards do not have access to the equivalent of board-ordered programs at Department of Corrections institutions and the board had not developed programming standards for the wards.

- The agencies had not developed appeal and grievance procedures for dual-commitment wards.

The Office of the Inspector General made seven recommendations to correct the deficiencies.

OBJECTIVES, SCOPE, AND METHODOLOGY

To conduct the follow-up review, the Office of the Inspector General interviewed officials of the California Youth Authority, including managers and staff responsible for implementing and monitoring the Welfare and Institutions Code section 1732.8 program. The Office of the Inspector General also reviewed memoranda and documents relating to policy and procedural changes implemented as a result of the original report, reviewed ward files, and performed audit tests to verify compliance with the Office of the Inspector General's recommendations.

SUMMARY OF THE FOLLOW-UP RESULTS

By the time of the follow-up field work in May 2004, the number of dual-commitment wards in Department of Corrections facilities had decreased from 40 to 33, and the follow-up review revealed that the California Youth Authority and the Youthful Offender Parole Board (now the Youth Authority Board) had made significant progress in implementing the Office of the Inspector General's recommendations. Four of the seven recommendations have been fully implemented and the remaining three have been partially implemented.

The agencies have made the following key changes in response to the recommendations:

- The California Youth Authority and the Youth Authority Board now allow dual-commitment wards to attend their annual reviews and parole consideration date reviews.

- The California Youth Authority and the Youth Authority Board have modified the dual-commitment consent form to clarify the programming expectations of the Youth Authority Board and the potential consequences of a ward's failure to participate in programs available at the Department of Corrections institution.

- The agencies have modified the dual-commitment consent form to include appeal and grievance procedures and the address for submitting grievances.

FOLLOW-UP RECOMMENDATIONS

- **The Office of the Inspector General recommends that the California Youth Authority document review of the case files of wards who have had time added to the parole consideration date to ensure that due process rights have been fully observed.**

- **The California Youth Authority should ensure that the Department of Corrections memorandum concerning the distribution, processing, and retention of appeal/grievance forms for Welfare and Institutions Code section 1732.8 wards is submitted in final form to the inmate appeals coordinators.**

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

ORIGINAL FINDING NUMBER 1:

The Office of the Inspector General found that dual-commitment wards were not allowed to attend their annual reviews and parole consideration date reviews and had little contact with the California Youth Authority and the Youthful Offender Parole Board.

ORIGINAL RECOMMENDATIONS	STATUS:	COMMENTS:
The Office of the Inspector General recommended that the California Youth Authority and the Youthful Offender Parole Board reevaluate the Youth and Adult Correctional Agency legal opinion concerning whether California Welfare and Institutions Code section 1732.8 (e) mandates that wards be given appearance hearings. If appearance hearings are indeed required by law, which is the view of the Office of Inspector General, the department must either provide the wards with appearance hearings or pursue legislation to amend section 1732.8(e). On the other hand, if it is determined that appearance hearings are not required under the statute, the department should revise the consent form to clearly address the issue of non-appearance hearings.	FULLY IMPLEMENTED	The California Youth Authority informed the Office of the Inspector General that, as the result of a legal opinion by the Youth and Adult Correctional Agency, the director of the California Youth Authority on February 24, 2003 ordered all Welfare and Institutions Code section 1732.8 wards be given the option of appearing at their Youthful Offender Parole Board (Youth Authority Board) hearing or submitting a written statement. If the ward waives the right, the hearing will go on as scheduled. If he or she elects to appear, arrangements for the appearance will be made with the board. The Office of the Inspector General reviewed the files of five wards and found the California Youth Authority had afforded all of them the opportunity to attend their Youthful Offender Parole Board (Youth Authority Board) hearings.

The California Youth Authority should send representatives to prisons at designated intervals to communicate with dual-commitment wards or should provide orientation to correctional counselors on Welfare and Institutions Code section 1732.8 requirements.	**FULLY IMPLEMENTED**	According to the California Youth Authority staff, the California Youth Authority provided training on Welfare and Institutions Code section 1732.8 requirements to more than 200 Department of Corrections employees, including classification and parole representatives (correctional counselor IIIs), on February 24-27, 2003. The California Youth Authority staff reported that the Department of Corrections employees who attended the training received written procedures governing dual jurisdiction cases. California Youth Authority officials were unable to provide the Office of the Inspector General with the written procedures, but they did provide two letters of appreciation from the Department of Corrections for the training. The Office of the Inspector General reviewed the field files of three wards and listened to audiotapes of the formal meetings at which California Youth Authority representatives explained the purpose of the dual-commitment consent form, described the options available to the ward, and documented the ward's decision to remain at the Department of Corrections institution.
Even though the ward's decision is irrevocable once he or she has signed the waiver form, the California Youth Authority should provide the current dual-commitment wards with an opportunity to reconsider their decisions in light of the fact that some wards may have signed the consent form without a clear understanding of its provisions.	**PARTIALLY IMPLEMENTED**	The California Youth Authority disagreed with this recommendation, contending that the director of the California Youth Authority does not have the authority to grant wards the opportunity to reconsider the decision to remain at the Department of Corrections under Welfare and Institutions Code section 1732.8. The California Youth Authority also contends that giving dual-commitment wards the opportunity to attend their Youthful Offender Parole Board (Youth Authority Board) hearings should clear up the wards' confusion about the board's programming expectations and give wards the opportunity to present their cases to the Youthful Offender Parole Board (Youth Authority Board). California Youth Authority officials provided the Office of the Inspector General with a copy of a June 9, 2003 memorandum, which they said was distributed to all dual-commitment wards. The memorandum informed the wards they could appeal to the director of the Department of Corrections if they wish to return to the California Youth Authority.

FOLLOW-UP RECOMMENDATIONS

None

ORIGINAL FINDING NUMBER 2

The Office of the Inspector General found that in making parole decisions, the Youthful Offender Parole Board did not adequately take into account that dual-commitment wards do not have access to the equivalent of board-ordered programs at Department of Corrections institutions and did not develop programming standards for these wards.

ORIGINAL RECOMMENDATIONS	STATUS:	COMMENTS:
The Office of the Inspector General recommended that the California Youth Authority and the Youthful Offender Parole Board jointly review the case files of the 14 wards who have had time added to the parole consideration date for additional treatment and training to ensure that due process rights have been fully observed.	PARTIALLY IMPLEMENTED	The California Youth Authority and the Youthful Offender Parole Board (Youth Authority Board) reported they performed a joint review of seven of the 14 cases and that the other seven wards had already paroled. The Office of the Inspector General verified the parole dates of the latter wards and reviewed three of the remaining seven files for evidence of the joint review. Although none of the files contained evidence of the review, a California Youth Authority representative reiterated that the reviews did take place, but reported that neither the California Youth Authority nor the Youthful Offender Parole Board (Youth Authority Board) documented the reviews in the wards' files.
The Office of the Inspector General also recommended that the California Youth Authority modify the dual-commitment consent form to clearly articulate (1) the programming expectations of the Youthful Offender Parole Board, and (2) the potential consequences of a ward's failure to avail himself of programs at the Department of Corrections institution.	FULLY IMPLEMENTED	The California Youth Authority revised the consent form (YA 1.207) in May 2003 in accordance with the Office of the Inspector General's recommendations.

FOLLOW-UP RECOMMENDATION:

- **The California Youth Authority should document review of the case files of wards who have had time added to the parole consideration date to ensure that due process rights have been fully observed.**

ORIGINAL FINDING NUMBER 3

The Office of the Inspector General found no evidence that the California Youth Authority and the Youthful Offender Parole Board had a "blanket policy" of automatically denying parole to dual-commitment wards.

ORIGINAL RECOMMENDATIONS	STATUS:	COMMENTS:
None.	NOT APPLICABLE	None.

ORIGINAL FINDING NUMBER 4

The Office of the Inspector General found no evidence that dual-commitment wards had been purposely denied a means of appealing actions or grieving department policies, but did find that the agencies had not developed appeal and grievance procedures to meet the needs of these wards.

ORIGINAL RECOMMENDATIONS	STATUS:	COMMENTS:
The Office of the Inspector General recommended that the agencies administering Welfare and Institutions Code section 1732.8 modify the memorandum of understanding to specify the agencies' respective responsibilities for handling dual-commitment ward grievances and to establish reasonable time limits for filing and responding to grievances.	PARTIALLY IMPLEMENTED	The California Youth Authority did not modify the memorandum of understanding, contending that it does not need revision because it is broad enough to allow for the required program modifications. Instead, the California Youth Authority provided the Department of Corrections with copies of the Youth Authority Appeal Form and Ward Grievance Form for distribution to institution inmate appeals coordinators. The California Youth Authority provided the Office of the Inspector General with an undated draft memorandum written by the Department of Corrections Inmate Appeals Branch concerning the distribution, processing, and retention of appeal/grievance forms for Welfare and Institutions Code section 1732.8 wards.
The dual-commitment consent form should be modified to incorporate the process and procedures governing appeals and should fully explain the process to the wards. The	FULLY IMPLEMENTED	The California Youth Authority revised the consent form (YA 1.207) in May 2003 to incorporate the grievance procedures. The form includes the following statement:

consent form should also include the agency's address for mailing ward inquiries and grievances.		"[A]ny grievances pertaining to CYA issues are to be referred to: Program Administrator, Wards Rights/Grievance, 4241 Williamsbourgh Drive, Suite 230, Sacramento, CA 95823-2088.

FOLLOW-UP RECOMMENDATION:

The Office of the Inspector General recommends that the California Youth Authority ensure that the Department of Corrections memorandum concerning the distribution, processing, and retention of appeal/grievance forms for Welfare and Institutions Code section 1732.8 wards is submitted in final form to the inmate appeals coordinators.

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YOUTHFUL OFFENDER PROGRAM

IMPLEMENTATION REPORT CARD

Previous recommendations: 1

Fully implemented: 1 (100%)

The Office of the Inspector General found that all inmates in the Youthful Offender Program were transferred from the California Correctional Institution adult prison to the Heman G. Stark Youth Correctional Facility and the N. A. Chaderjian Youth Correctional Facility in July 2004. That action fully implemented the Office of the Inspector General's previous recommendation.

In September 2003, the Office of the Inspector General conducted a special review of the Youthful Offender Program at the California Correctional Institution in Tehachapi, California. The review, which was conducted at the request of Senator Gloria Romero, Chair of the Senate Select Committee on the California Correctional System, was prompted by the suicide of a 17-year-old inmate at the institution who was a participant in the Youthful Offender Program. Senator Romero requested that the Office of the Inspector General examine the operation of the Youthful Offender Program to identify any systemic problems.

The Office of the Inspector General found from the review that the facilities at the California Correctional Institution could not adequately accommodate the Youthful Offender Program inmates. The review determined that the limited space available at the institution, along with the need to separate youthful offenders from adult inmates, often resulted in youthful offenders being confined to cells and not receiving mandated education programming and out-of-cell exercise time. Inmates in the Youthful Offender Program also lacked access to the range of counseling, rehabilitative programs, and mental health treatment available to California Youth Authority wards.

BACKGROUND

The Youthful Offender Program resulted from the March 2000 passage of Proposition 21, the "Gang Violence and Juvenile Crime Prevention Act." The act increased penalties for gang-related felonies and other specified serious and violent crimes; required that juveniles 14 or older charged with specific offenses be tried in adult court; and required that any juvenile 16 years and older who was convicted in adult court be sentenced to the California Department of Corrections.

All minors sentenced under the provisions of Proposition 21 were incarcerated in the Youthful Offender Program at the California Correctional Institution in Tehachapi, a Level IV adult correctional facility. The institution was intended to house the Youthful Offender Program for a period of only three years pending the retrofitting of another Department of Corrections institution or the completion of a new prison at Delano, California. At the time of the Office of the Inspector General's special review, almost four years later, however, the department had still not developed a permanent site for the Youthful Offender Program. Little progress had been made in retrofitting another institution to house the program and construction of the new prison at Delano had been halted for budgetary reasons.

At the time of the review, the Youthful Offender Program inmates numbered 142. All were either 16 or 17 years of age; 75 percent were gang-affiliated; and they represented a diverse mix of custody levels and ethnic backgrounds. Because state law requires that juveniles be separated from the adult inmate population, the Youthful Offender Program inmates were confined to one facility at the institution — a Level IV adult maximum security facility with two small enclosed concrete outdoor exercise areas originally designed for adult administrative segregation inmates. Whenever they left the housing unit they had to be escorted by custody staff, while adult inmates were much less restricted. Youthful offenders also had to be separated from one another according to custody level, ethnicity, and gang affiliation.

SUMMARY OF PREVIOUS FINDINGS

As a result of the September 2003 review, the Office of the Inspector General found that the facilities at the California Correctional Institution could not adequately accommodate Youthful Offender Program inmates. The limited space available at the institution for the program, along with the need to separate youthful offenders by custody level, ethnicity, and gang affiliation and to keep them separate from the adult inmates, often resulted in youthful offenders being confined to cells and receiving less than the mandated education programming and out-of-cell exercise time. Youthful Offender Program inmates did not have access to the range of counseling and rehabilitative programs available to juveniles committed to the California Youth Authority, and the institution was not licensed or equipped to provide them with required mental health treatment. As a result, youthful offenders needing placement in a mental health crisis bed or in an enhanced outpatient program often had to be transferred to other institutions, sometimes repeatedly, imposing a significant logistical and financial burden on the institution. Meanwhile, juveniles convicted of identical offenses who had not been tried as adults or who were not 16 at the time of the conviction offense, were held in California Youth Authority institutions with greater access to counseling, mental health, education, and rehabilitative programs.

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

- The facilities at the California Correctional Institution could not adequately accommodate the Youthful Offender Program inmates.

- The juvenile offenders charged with or convicted of offenses identical to those of the Youthful Offender Program inmates incarcerated at the Department of Corrections were being held in California Youth Authority facilities, which were better equipped to handle them.

- The Department of Corrections had made little progress in developing an appropriate facility to accommodate the Youthful Offender Program.

The Office of the Inspector General determined from a review of state law that although minors convicted under the provisions of Proposition 21 must be sentenced to state prison, the Department of Corrections and the California Youth Authority could nonetheless develop

an agreement to house juveniles sentenced to state prison in a California Youth Authority institution until their 18th birthday. The Office of the Inspector General recommended that the departments take that action.

OBJECTIVES, SCOPE, AND METHODOLOGY

The purpose of the 2004 follow-up review was to determine the extent to which the California Youth Authority and the Department of Corrections have implemented the recommendations from Office of the Inspector General's September 2003 special review. To conduct the 2004 follow-up review, the Office of the Inspector General asked the California Youth Authority to report the implementation status of the previous recommendation and reviewed the department's response, along with additional information supplied by the department.

SUMMARY OF THE FOLLOW-UP RESULTS

The California Youth Authority reported that it has implemented the recommendation to house Youthful Offender Program inmates at a California Youth Authority facility. In July 2004, all Youthful Offender Program inmates were transferred to the Heman G. Stark Youth Correctional Facility and the N. A. Chaderjian Youth Correctional Facility.

FOLLOW-UP RECOMMENDATIONS

None.

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

ORIGINAL OBSERVATION NUMBER 1

The Office of the Inspector General found that the facilities at the California Correctional Institution cannot adequately accommodate Youthful Offender Program inmates.

ORIGINAL OBSERVATION NUMBER 2

The Office of the Inspector General found that juvenile offenders charged with or convicted of offenses identical to those of the Youthful Offender Program inmates incarcerated at the Department of Corrections were being held in California Youth Authority facilities, which were better equipped to handle them.

ORIGINAL OBSERVATION NUMBER 3:

The Office of the Inspector General found that the Department of Corrections had made little progress in developing an appropriate facility to accommodate the Youthful Offender Program.

The following recommendation resulted from the three observations:

ORIGINAL RECOMMENDATION	STATUS:	COMMENTS:
• The Office of the Inspector General recommended that the Department of Corrections and the California Youth Authority formulate an arrangement to house Youthful Offender Program inmates at a California Youth Authority facility.	FULLY IMPLEMENTED	The California Youth Authority reported and the Office of the Inspector General confirmed that all Youthful Offender Program wards were transferred from the California Correctional Institution to the Heman G. Stark Youth Correctional Facility and the N.A. Chaderjian Youth Correctional Facility in July 2004.

FOLLOW-UP RECOMMENDATIONS

None.

ATTACHMENT

RESPONSE FROM THE CALIFORNIA YOUTH AUTHORITY

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State of California

Youth and Adult Correctional Agency

Memorandum

Date : December 21, 2004

To : Matthew L. Cate
Inspector General

Subject: **DEPARTMENT OF THE YOUTH AUTHORITY ACCOUNTABILITY AUDIT**

Attached for your consideration is the response from the Department of the Youth Authority regarding the Accountability Audit conducted by the Office of the Inspector General (OIG). The accountability audit encompassed follow-up information and recommendations on nine separate audits conducted by the OIG during 2002 and 2003. Those audits included:

- 23-and-1 Confinement
- Heman G. Stark Youth Correctional Facility
- Southern Youth Correctional Reception Center and Clinic
- Ventura Youth Correctional Facility
- Intensive Treatment Program
- Office of Internal Audits
- Youth Authority Board
- Welfare and Institutions Code Section 1732.8
- Youthful Offender Program

Not surprisingly, the findings contained in these audits were generally consistent with the findings from the Department's experts who reviewed departmental operations as a result of the Farrell v. Allen III taxpayer lawsuit filed by the Prison Law Office. Where these recommendations overlapped, the Department was guided by its proposed remedial plans in terms of planned program improvements, accountability, and compliance strategies and target dates.

Two major issues, 23-and-1 confinement and educational services, will be addressed extensively in our remedial plans, and it is expected that there will be budgetary issues included in our recommendations that will need to be addressed.

Thank you for your continued assistance in the Agency's efforts to improve its operations. Should you have any questions or concerns, call me at 323-6001.

RODERICK Q. HICKMAN
Secretary

Attachment

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The following pages present the California Youth Authority's responses to the Accountability Audit of the Office of the Inspector General. The responses are organized by the individual audits and reviews included in the Accountability Audit, and are presented in a matrix format. The first column of the matrix summarizes the previous audit findings of the Office of the Inspector General. The second column identifies the new recommendations issued by the Office of the Inspector General from this follow-up review. The third column of the matrix presents the California Youth Authority's responses to the recommendations.

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Matrix OIG Response

HEMAN G STARK YOUTH CORRECTIONAL FACILITY

ORIGINAL Finding 1 ***The Office of the Inspector General found that the Heman G. Stark Youth Facility did not have a system to ensure that allegations of staff misconduct were promptly and properly investigated. Moreover, management actions relative to such investigations appeared to be questionable.***	**CURRENT OIG Recommendation: #1 Under Original Finding 1** ***The Office of the Inspector General recommends that Heman G. Stark Youth Correctional Facility should use a computerized system for tracking all requests for internal affairs investigations. The facility should explore the possibility of using the existing adverse action database for this purpose, as internal affairs investigations are presently inputting into this system. The system should track the originating grievances and inquiry numbers related to each investigation to allow for efficient cross-referencing and tracking of cases.***	**Response to Recommendation #1 Under Finding 1.** The Department is reviewing this recommendation as part of the plan by the Youth and Adult Correctional Agency to structurally reorganize the Agency and its subordinate departments during 2005.
ORIGINAL Finding 2 ***The Office of the Inspector General found that the Heman G. Stark Youth Correctional Facility educational and vocational classes were poorly attended and wards' academic achievement was low in comparison to other California Youth Authority Facilities.***	**CURRENT OIG Recommendation: #1 Under Original Finding 2** ***The Office of the Inspector General recommends that the California Youth Authority Education Services Branch and the facility continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include providing competitive compensation for teachers.***	**Response to Recommendation #1 Under Finding 2.** The Department partially agrees. • The Department instituted focused recruitment for select, hard-to-fill positions including teachers beginning in September 2004. • Compensation exceptions or other means of increasing compensation are not available.
	CURRENT OIG Recommendation: #2 Under Original Finding 2 ***The Office of the Inspector General recommends that the principal should continue to monitor the causes of ward absenteeism and make efforts to improve ward attendance and accurately report ward average daily attendance. The monitoring should include audits of the Student Ward Attendance Tracking system to ensure that absences are appropriately documented and justified.***	**Response to Recommendation #2 Under Finding 2.** The Department complied with this recommendation in April 2004.

	CURRENT OIG Recommendation: #3 Under Original Finding 2 ***The Office of the Inspector General recommends that the Education Services Branch and the principal should continue their efforts to develop trade advisory committees at the facility. The committees should use meeting agendas and minutes to develop and organize effective committee goals.***	**Response to Recommendation #3 Under Finding 2.** The Department agrees. ▪ The Site Principal has been directed to reinstate the Trade Advisory Committee by May 2005. This effort will be evaluated quarterly thereafter. The Vocational Assistant Principal at HGSYCF will coordinate the effort of contacting interested community vendors for participation. The Committee will use meeting agendas and minutes to develop and organize effective committee goals, and will retain these documents as official records. ▪ A statewide plan to reinstate all Trade Advisory Committees will be completed by July 2005.
	CURRENT OIG Recommendation: #4 Under Original Finding 2 ***The Office of the Inspector General recommends that the California Youth Authority should continue its efforts to integrate its computer systems to minimize education-related reporting errors and duplication of effort.***	**Response to Recommendation #4 Under Finding 2.** See above response to Recommendation #1 Under Finding 1.

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HEMAN G STARK YOUTH CORRECTIONAL FACILITY

ORIGINAL Finding 3 ***The Office of the Inspector General found that wards were not provided with required treatment services.***	**CURRENT OIG Recommendation: #1 Under Original Finding 3** ***The Office of the Inspector General recommends that the California Youth Authority should immediately take whatever steps necessary, including contract re-negotiation, to ensure efficient monitoring of weekly small group and individual counseling.***	**Response to Recommendation #1 Under Finding 3.** The Department agrees. • The Deputy Director of the Institutions and Camps Branch will develop a plan to reinstate the casework mandates of the Youth Correctional Counselors (space, scheduling) to include monitoring of casework services. The plan will be completed by February 2005. • The plan will include a memorandum to all staff for required training. • Staff who fails to meet the counseling requirements will be held accountable.
	CURRENT OIG Recommendation: #2 Under Original Finding 3 ***The Office of the Inspector General recommends that the Superintendent should use progressive discipline to hold treatment team supervisors accountable for performing the required audits of 10 ward files per month.***	**Response to Recommendation #2 Under Finding 3.** **THIS NEEDS REVIEW** The Department agrees. • The Superintendent will reiterate the requirement regarding the monthly auditing of ward files by December 31, 2004. • The supervisors will conduct file reviews monthly to ensure compliance. • Appropriate corrective action shall be taken by the Superintendent as necessary.
	CURRENT OIG Recommendation: #3 Under Original Finding 3 ***The Office of the Inspector General recommends that the California Youth Authority should immediately resume the annual California Youth Authority Institutions and Camps Branch Manual Section 4000 self-audit reporting requirement for all facilities.***	**Response to Recommendation #3 Under Finding 3.** The Department agrees. A directive was issued by the Deputy Director of the Institutions and Camps Branch on December 15, 2004 to reinstate the Section 4000 self-audit by April 2005.

	CURRENT OIG Recommendation: #4 Under Original Finding 3 ***The Office of the Inspector General recommends that the facility management should intensify its efforts to provide individual and small group counseling to wards. The efforts should include reiterating to staff the importance of counseling to the mission of the department, providing ongoing training as necessary, and using progressive discipline up to and including termination for employees who fail to meet counseling requirements.***	**Response to Recommendation #4 Under Finding 3.** The Department agrees. • The Deputy Director of the Institutions and Camps Branch will develop a plan to reinstate the casework mandates of the Youth Correctional Counselors (space, scheduling) to include monitoring of casework services. The plan will be completed by February 2005. • The plan will include a memorandum to all staff for required training. • Staff who fails to meet the counseling requirements will be held accountable.
	CURRENT OIG Recommendation: #5 Under Original Finding 3 ***The Office of the Inspector General recommends that to help coordinate ward education and treatment programming, the superintendent and the principal should require teachers to participate in case conferences as facilitated by the alternative education schedule.***	**Response to Recommendation #5 Under Finding 3** The Department agrees. ▪ The revised guidelines for case conference will be formalized by the Department by April 2005. ▪ The institution has developed a monthly school schedule that includes allotted time for teachers to attend case conferences, student advisements and special events. The institution and school schedules are coordinated at weekly management meetings.

	CURRENT OIG Recommendation: #6 Under Original Finding 3 ***The Office of the Inspector General recommends that the Superintendent and the principal should take steps to ensure that wards are assigned to education and work programs within 4 days of their arrival at their permanent living units.***	**Response to Recommendation #6 Under Finding 3.** The Department agrees. • The Department will ensure that wards are assigned to education and work programs within 4 days of their arrival at their permanent living units by developing and implementing procedures to that effect by January 2005. • The superintendent will review compliance on a monthly basis and take appropriate action, as necessary. • The Department will develop and implement a quarterly reporting system

		for all institutions by March 2005.
ORIGINAL Finding 4 ***The Office of the Inspector General found that system deficiencies and inadequate effort resulted in ward grievances not being promptly and appropriately addressed.***	**CURRENT OIG Recommendation: #1 Under Original Finding 4** ***The Office of the Inspector General recommends that the administrative assistant be trained in the use of the computerized inquiry tracking system and the grievance tracking system maintained on the WIN 2000 system. The administrative assistant should perform a periodic reconciliation of the staff action grievances contained in those systems.***	**Response to Recommendation #1 Under Finding 4.** The Department agrees. • The HGSYCF administrative assistant will be trained in the use of the computerized inquiry tracking system and the grievance tracking system maintained on the WIN 2000 system, by March 2005. • The Ward's Rights' Coordinator and/or the Administrative Assistant will reconcile staff action grievances monthly. Quarterly reports will be provided to the Superintendent beginning March 2005.
ORIGINAL Finding 5 ***The Office of the Inspector General found that all wards, including those in Phase II and III, have been confined to eating in their rooms since the 1996 staff murder, hampering socialization efforts.***	**CURRENT OIG Recommendation: #1 Under Original Finding 5** ***The Office of the Inspector General recommends that the superintendent should continue to pursue implementing cafeteria-style feeding of wards.***	**Response to Recommendation #1 Under Finding 5.** The Department agrees. The Deputy Director of the Institutions and Camps Branch will develop a plan by March 2005 to reinstitute cafeteria style feeding.
ORIGINAL Finding 10 ***The Office of the Inspector General found that facility safety and security could be enhanced.***	**CURRENT OIG Recommendation: #1 Under Original Finding 10** ***The Office of the Inspector General recommends that the Superintendent require control booth staff to have all visitors sign in and sign out of the facility.***	**Response to Recommendation #1 Under Finding 10.** The Department agrees. ▪ A workgroup was established on December 2004 to develop a statewide protocol on housing unit security. ▪ Protocols will be implemented by February 2005.

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ORIGINAL Finding 11 ***The Office of the Inspector General found that the ward information network system had numerous weaknesses.***	**CURRENT OIG Recommendation: #1 Under Original Finding 11** ***The Office of the Inspector General recommends that California Youth Authority should thoroughly test the WIN 2000 system to ensure that access is controlled properly, that programming requests are assigned priority according to departmental policy, and that timely feedback on the status of service requests is provided to institutions and other users.***	**Response to Recommendation #1 Under Finding 11.** The Department agrees. • The CYA Information Security Officer will implement the appropriate security policies by February 2005. A pilot program at the Preston facility will be conducted in March 2005. ▪ YACA is in the process of implementing a structural reorganization, which will incorporate the CYA and CDC Information Services Divisions. YACA will be responsible for this function in the future.
	CURRENT OIG Recommendation: #2 Under Original Finding 11 ***The Office of the Inspector General recommends that the California Youth Authority should conduct periodic audits of the WIN 2000 system.***	**Response to Recommendation #2 Under Finding 11.** The Department agrees to audit WIN 2000 beginning May 2005 to ensure that access is controlled. • The CYA Information Security Officer will implement the appropriate security policies by February 2005. A pilot program at the Preston facility will be conducted in March 2005. ▪ YACA is in the process of implementing a structural reorganization, which will incorporate the CYA and CDC Information Services Divisions. YACA will be responsible for this function in the future.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

ORIGINAL Finding	CURRENT OIG Recommendation: #1 Under Original Finding ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic continue efforts to recruit and retain qualified educational staff, including full-time teachers, special education instructors, and substitutes. The efforts should include providing competitive compensation for teachers.***	**Response to Recommendation #1 Under Finding.** The Department partially agrees. • The Department instituted focused recruitment for select, hard-to-fill positions including teachers beginning in September 2004. • Compensation exceptions or other means of increasing compensation are not available.
	CURRENT OIG Recommendation: #2 Under Original Finding #1 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic improve the thoroughness and overall quality of the annual California Youth Authority Institutions and Camps Branch Manual section 1800-security audits.***	**Response to Recommendation #2 Under Finding 1.** The Department agrees. ▪ The entire Section 1800 was reviewed by the Chief of Security to ensure compliance. Only two areas were found not to be in compliance. The Chief of Security and the Superintendent met the week of November 15, 2004 to review the Section 1800 report and discuss the action plan for compliance. ▪ The completed report will be provided to the OIG in the Department's March 31, 2005 progress report. ▪ The Deputy Director of the Institutions and Camps (I&C) Branch will ensure that all institutions are complying with the requirements concerning Section 1800 security audits.
	CURRENT OIG Recommendation: #3 Under Original Finding #1 ***The Office of the Inspector General recommends that the CYA and the Southern Youth Correctional Reception Center & Clinic improve control over access to the armory and ensure that armory staff has time to accurately inventory weapons and other controlled materials.***	**Response to Recommendation #3 Under Finding 1.** The Department agrees. ▪ The institution complied with this recommendation starting in August 2004; the last OIG audit was completed in October 2004. ▪ Since this is a statewide issue, the Compliance Unit will conduct a standardized armory security audit by September 2005, and annually thereafter.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

	CURRENT OIG Recommendation: #4 Under Original Finding #1 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic remove discarded furniture and other items that present potential barriers to observing wards from behind the gym, commissary, and maintenance areas.***	**Response to Recommendation #4 Under Finding 1.** The Department agrees. All items that present potential barriers to observing wards from behind the gym and commissary were removed in December 2004.
	CURRENT OIG Recommendation: #5 Under Original Finding #1 ***"The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic keep ward rooms locked when they are unoccupied to prevent unauthorized entry."***	**Response to Recommendation #5 Under Finding 1.** The Department agrees. ▪ Through memorandum, e-mail, and administrative notation in logs, all living unit staff has been made aware of the expectation that all wardroom doors remain locked. ▪ Since this is a statewide issue, the Department will reissue the Section 1832 of I&C Manual to all facilities in January 2005. The Department will develop internal audit procedures by April 2005 to ensure compliance.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

ORIGINAL Finding #2 *The Office of the Inspector General found that the Southern Youth Correctional Reception Center and Clinic was not processing wards through the diagnostic assessment process within the required time limits.*	**CURRENT OIG Recommendation: #1 Under Original Finding #2** *The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic develop an automated process to track and monitor caseworker productivity and to ensure that the diagnostic assessment process for each ward is completed within required time*.	**Response to Recommendation #1 Under Finding 2.** The Department agrees. In the interim, a manual system is being used to track and monitor caseworker productivity and to ensure that the diagnostic assessment process for each ward is completed within the required timeframes.
	CURRENT OIG Recommendation: #2 Under Original Finding #2 *The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic conduct timely annual performance appraisals for all casework specialists, including the Supervising Casework Specialist II.*	**Response to Recommendation #2 Under Finding 2.** The Department agrees. ▪ The Personnel Supervisor will continue to provide the Office of the Superintendent with a list of overdue performance reports, every month. ▪ Reasons for the late report are documented and submitted to the Office of the Superintendent for review and appropriate action. ▪ The Administrative Services Branch (ASB), Deputy Director, is in the process of revising the tracking of performance reports to improve timely completion of these reports as well as accurate reporting of overdue performance appraisals. The tracking system will be revised by July 2005.
	CURRENT OIG Recommendation: #3 Under Original Finding #2 *The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic make appropriate revisions to the Supervising Casework Specialist II's duty statement to better ensure the quality and timeliness of the diagnostic assessment process.*	**Response to Recommendation #3 Under Finding 2.** The Department agrees. ▪ The Supervising Casework Specialists II's duty statement has been revised; however, the revised language needs to be reviewed by Labor Relations and Personnel to determine if and when it can be changed. We will report quarterly until resolution is known.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

ORIGINAL Finding #3 ***The Office of Inspector General found that wards in the Marshall intensive treatment program and the work experience program had not been provided with required counseling and related services.***	**CURRENT OIG Recommendation: #1 Under Original Finding #3** ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic ensure that the work experience program provides weekly individual and small group counseling to wards.***	**Response to Recommendation #1 Under Finding 3.** The Department agrees to assess the recommendation. The Deputy Director of Institutions and Camps Branch will assess this recommendation by May 2005 and if appropriate, develop a plan by August 2005.
	CURRENT OIG Recommendation: #2 Under Original Finding #3 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic monitor the casework of all living units, including the work experience program, to ensure that the casework management system is being used to manage the counseling of wards.***	**Response to Recommendation #2 Under Finding 3.** The Department agrees. In accordance with existing policy (Section 4000), each program unit Treat Team Supervisor or Supervising Casework Specialist is required to complete monthly casework audits to ensure that the casework management system is being used to manage the counseling of wards.
	CURRENT OIG Recommendation: #3 Under Original Finding #3 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic use progressive discipline to hold counseling staff and their supervisors accountable for failing to counsel wards.***	**Response to Recommendation #3 Under Finding 3.** The Department agrees. • The Superintendent will reiterate by January 2005 the requirement of effective documentation on counseling wards. • The program administrator/treatment team supervisor will conduct file reviews monthly to ensure compliance as required by existing policy. • Appropriate corrective action shall be taken by the Superintendent as necessary.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

	CURRENT OIG Recommendation: #4 Under Original Finding #3 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic ensure that staff uses ward orientation checklists as intended.***	**Response to Recommendation #4 Under Finding 3.** The Department agrees. ▪ In order to ensure compliance with the current policy, the Supervising Casework Specialist II will retain a copy of each checklist in the ward's file. ▪ The Program Administrator/Treatment Team Supervisor will conduct monthly file reviews to ensure compliance as required by existing policy.
ORIGINAL Finding #4 ***The Office of Inspector General found deficiencies in medical services at the Southern Youth Correctional Reception Center and Clinic.***	**CURRENT OIG Recommendation: #1 Under Original Finding #4** ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic hold the Chief Medical Officer accountable for the continued planning and monitoring of the medical staffs' activities.***	**Response to Recommendation #1 Under Finding 4.** The Department agrees. • A peer review process will be implemented in conjunction with the Health Care Services Division Remedial Plan. In the interim, the Department will perform peer reviews quarterly at each facility beginning April 2005, including reception centers, and shall provide a mechanism by which professional performance in a correctional facility is reviewed by internal and external physicians to assess appropriateness of decision-making and overall quality of care.
	CURRENT OIG Recommendation: #3 Under Original Finding #4 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic develop policies and procedures for periodic peer reviews of the medical programs at reception centers and clinics.***	**Response to Recommendation #3 Under Finding 4.** The Department agrees. • A peer review process will be implemented in conjunction with the Health Care Services Division Remedial Plan. • In the interim, the Department will perform peer review quarterly at each facility beginning April 2005, including reception centers, and shall provide a mechanism by which professional performance in a correctional facility is reviewed by internal and external physicians to assess appropriateness of decision-making and overall quality of care.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

ORIGINAL Finding #5 ***The Office of Inspector General found that wards at the Southern Youth Correctional Reception Center and Clinic did not consistently receive required mental health services and that the institution did not consistently comply with required mental health procedures.***	**CURRENT OIG Recommendation: #1 Under Original Finding #5** ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic ensure the timely completion of special program assessment needs evaluations.***	**Response to Recommendation #1 Under Finding 5.** The Department agrees. ▪ Two full-time Staff Psychologists were hired in November 2004. The full staffing pattern at SYCRCC should resolve the previously documented delays in completing SPANs. ▪ The Department will develop a monitoring and compliance tool by March 2005.
	CURRENT OIG Recommendation: #2 Under Original Finding #5 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic do not administer psychotropic medications to wards that have not received treatment needs assessments.***	**Response to Recommendation #2 Under Finding 5.** The Department disagrees. Quite often wards arriving to SYCRCC from the juvenile halls are already on prescribed psychotropic medications; it is medically dangerous and inappropriate to stop those medications suddenly while waiting for the Treatment Needs Assessments to be done.
	CURRENT OIG Recommendation: #3 Under Original Finding #5 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic ensure that employees obtain consent forms to administer psychotropic medication to wards under age 18.***	**Response to Recommendation #3 Under Finding 5.** The Department agrees. Health Care Services/ Legal Unit chair a work group to revise procedures for obtaining consent forms to administer psychotropic medication to wards under age 18 by March 2005. The existing policy will be revised to include a tracking and follow-up component to ensure compliance
ORIGINAL Finding #6 ***The Office of Inspector General found that the staff in the living units was not adequately informed about suicide prevention measures and that the suicide prevention assessment and response committee meetings were poorly attended.***	**CURRENT OIG Recommendation: #1 Under Original Finding #6** ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic ensure that all staff receives annual refresher training in suicide prevention assessment and response.***	**Response to Recommendation #1 Under Finding 6.** The Department agrees. Annual refresher training in suicide prevention assessment and response was provided to all staff from October thru December 2004. The completion of this annual training will be documented in staff files by the Training Office. The superintendent will be responsible for insuring compliance with this requirement.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

	CURRENT OIG Recommendation: #2 Under Original Finding #6 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic remind staff of the importance of the suicide prevention and response committee, and enforce attendance at committee meetings.***	**Response to Recommendation #2 Under Finding 6.** The Department agrees. The Deputy Director of the Institutions and Camps Branch will mandate attendance at suicide prevention committee meetings through a written memorandum by January 2005. Staff failing to attend meetings without proper justification will be held accountable. The suicide prevention committee minutes will be forwarded to the Superintendent as part of the compliance process, including a list of attendees, and those absent (including reasons for absence).
ORIGINAL Finding #7 ***The Office of Inspector General found that academic achievement at the Southern Youth Correctional Reception Center and Clinic was low compared to the other California Youth Authority facilities and that the institution was not providing wards with special education services in a timely manner. The institution also over-stated average daily attendance and misrepresented provider service hours in reports to the Education Services Branch.***	**CURRENT OIG Recommendation: #1 Under Original Finding #7** ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic ensure that wards do not move from class to class without notification by staff to school security.***	**Response to Recommendation #1 Under Finding 7.** The Department agrees. The Deputy Director of the Institutions and Camps Branch will issue a department wide policy addressing the issue of wards moving from class to class, and the requirement that school security be notified, by June 2005.
	CURRENT OIG Recommendation: #2 Under Original Finding #7 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic institute the Education Services Branch's student ward attendance tracking (SWAT) system at the facility's high school.***	**Response to Recommendation #2 Under Finding 7.** The Department complied with this recommendation in April 2004.
	CURRENT OIG Recommendation: #3 Under Original Finding #7 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic improve the high school's effectiveness rating by striving to make more classroom time available to wards.***	**Response to Recommendation #3 Under Finding 7.** The Department agrees. This issue will be addressed through the Department's remedial plan. The Department will provide the OIG with a progress report by the end of March 2005.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

	CURRENT OIG Recommendation: #4 Under Original Finding #7 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic require all teachers to use the electronic version of the average daily attendance report.***	**Response to Recommendation #4 Under Finding 7.** The Department complied with this recommendation in April 2004.
	CURRENT OIG Recommendation: #5 Under Original Finding #7 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic require supervisory review and written approval of the high school's average daily attendance forms.***	**Response to Recommendation #5 Under Finding 7.** The Department agrees. The ADA forms will be revised by March 2005 to include the supervisor's approval. The sampling of forms will be reviewed by the Education Services Branch to verify supervisory review and approval.
	CURRENT OIG Recommendation: #6 Under Original Finding #7 ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic notify courts that refer wards to the California Youth Authority of their obligation to provide complete special education data under Welfare and Institutions Code section 1742. Develop a plan with court representatives to accomplish that purpose, including a timetable for submitting special education information. If cooperation is not forthcoming, refuse to accept wards that do not have complete special education background packages.***	**Response to Recommendation #6 Under Finding 7.** The Department agrees. ▪ The Department's Intake and Court Services Division will continue to require special education information in court documents. ▪ The Department will work with the Administrative Office of the Courts to develop a plan to notify the court/county that CYA will not accept wards without appropriate special education documentation.
ORIGINAL Finding #9 ***The Office of Inspector General found the disciplinary decision-making system at the Southern Youth Correctional Reception Center and Clinic did not ensure due process for wards and failed to provide management with important tools for monitoring disciplinary actions and ward grievance activity.***	**CURRENT OIG Recommendation: #1 Under Original Finding #9** ***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic conduct quarterly audits of a random sample of Level A and Level B ward disciplinary reports and use the results in the annual performance appraisals of living unit staff.***	**Response to Recommendation #1 Under Finding 9.** The Department disagrees. Supervisors should hold staff accountable based on a person's entire work performance and not a "sample." In addition, staff will be held accountable where they have violated departmental policies and procedures.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

ORIGINAL Finding #11	**CURRENT OIG Recommendation: #1 Under Original Finding #11**	**Response to Recommendation #1 Under Finding 11.**
The Office of Inspector General found that staff performance appraisals and probationary reports at the Southern Youth Correctional Reception Center and Clinic were not completed on time.	***The Office of the Inspector General recommends that the California Youth Authority and the Southern Youth Correctional Reception Center & Clinic develop a system to identify and address delinquent annual employee appraisals and probation reports and to hold supervisors accountable for completing the reports and appraisals.***	The Department agrees. ▪ The Personnel Supervisor will continue to provide the Office of the Superintendent with a list of overdue performance reports, every month. ▪ Reasons for the late report are documented and submitted to the Office of the Superintendent for review and appropriate action. ▪ The Administrative Services Branch (ASB), Deputy Director, is in the process of revising the tracking of performance reports to improve timely completion of these reports as well as accurate reporting of overdue performance appraisals. The tracking system will be revised by July 2005.

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VENTURA YOUTH CORRECTIONAL FACILITY

ORIGINAL Finding 3 ***The Office of the Inspector General found that female wards at the Ventura Youth Correctional Facility were not receiving required mental health assessment services or did not receive these necessary services in a timely manner.***	**CURRENT OIG Recommendation: #1 Under Original Finding 3** ***The Office of the Inspector General recommends that Ventura Youth Correctional Facility conduct treatment needs assessment for all wards within 3 weeks of admission to the facility.***	**Response to Recommendation #1 Under Finding 3.** The Department agrees. ▪ The institution is in compliance with the policy as written in the Institution and Camps (I&C) manual (reference #6260 dated 10/11/02) that requires a Treatment Needs Assessment (TNA) to be conducted within 3 weeks of a ward's admission to the facility. ▪ The Department will complete a random audit of records quarterly, beginning March 2005, to insure continued compliance. Findings and corrective action will be addressed by the Superintendents and provided to the Deputy Director of the I&C and the Department Director as a routine part of this process.
	CURRENT OIG Recommendation: #2 Under Original Finding 3 ***The Office of the Inspector General recommends that Ventura Youth Correctional Facility management ensure that treatment needs assessment test booklets are scanned and scored no later than the next working day.***	**Response to Recommendation #2 Under Finding 3.** The Department agrees. A random audit of test booklets will be completed quarterly, beginning March 2005, to ensure compliance. Findings and corrective action will be addressed by the Superintendent and shared with the Department Director as a routine part of this process.
	CURRENT OIG Recommendation: #3 Under Original Finding 3 ***The Office of the Inspector General recommends that Ventura Youth Correctional Facility management ensure that the senior psychologist is notified before the end of the next working day if a treatment needs assessment scoring report shows a "red flag."***	**Response to Recommendation #3 Under Finding 3.** The Department agrees. A random audit of records will be completed quarterly, beginning March 2005, to ensure compliance. Findings and corrective action will be addressed by the Superintendents and shared with the Department Director as a routine part of this process.

VENTURA YOUTH CORRECTIONAL FACILITY

	CURRENT OIG Recommendation: #4 Under Original Finding 3 ***The Office of the Inspector General recommends that Ventura Youth Correctional Facility management ensure that the treatment needs assessment profile and scoring report is filed in the mental health section of the unified health record.***	**Response to Recommendation #4 Under Finding 3.** The Department agrees. ▪ Procedures were implemented in October 2004 to ensure that the TNA profile and scoring report is filed in the mental health section of the Unified Health Record. ▪ A random audit of records will be completed quarterly, beginning March 2005, to ensure compliance. Findings and corrective action will be addressed by the Superintendents and shared with the Department Director as a routine part of this process. ▪
ORIGINAL Finding 4 ***The Office of the Inspector General found that some institution practices jeopardized the health of female wards, the infants of female wards, and wards in general by failing to provide timely access to quality medical care and providing inadequate protection against communicable diseases.***	**CURRENT OIG Recommendation: #1 Under Original Finding 4** ***The Office of the Inspector General recommends that the Institutions and Camps Branch and the chief medical officer develop comprehensive policies and procedures governing the medical care of female wards and the medical transportation of wards in general.***	**Response to Recommendation #1 Under Finding 4.** The Department agrees. • In November 2004, the Department issued policies and procedures governing the medical care of female wards. The Department will develop the policy for medical transportation of wards, in general, and issue the policy by February 2005. • The Department will issue policy and procedures by March 2005 for Emergency Response Review Committee.

VENTURA YOUTH CORRECTIONAL FACILITY

ORIGINAL Finding 5 ***The Office of the Inspector General found that the academic achievement of Ventura Youth Correctional Facility's wards was low compared to that of other California Youth Authority facilities."***	**CURRENT OIG Recommendation: #1 Under Original Finding 5** ***The Office of the Inspector General recommends that the California Youth Authority and the Ventura Youth Correctional Facility management promptly fill teaching vacancies and work to provide competitive teacher compensation by upgrading pay scales using compensation exceptions provided for by law and other suitable methods.***	**Response to Recommendation #1 Under Finding 5.** The Department partially agrees. • The Department instituted focused recruitment for select, hard-to-fill positions including teachers beginning in September 2004. • Compensation exceptions or other means of increasing compensation are not available.
	CURRENT OIG Recommendation: #2 Under Original Finding 5 ***The OIG recommends that the Ventura Youth Correctional Facility management make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.***	**Response to Recommendation #2 Under Finding 5.** The Department agrees. ▪ The VYCF Principal will continue to work to compile a list of qualified substitute instructors for use when regular instructors are unable to conduct classes. The list will be updated and provided to the Deputy Director of Education Services on a quarterly basis, beginning March 2005, for review and appropriate action. ▪ This issue will be addressed through the Department's remedial plan.
	CURRENT OIG Recommendation: #3 Under Original Finding 5 ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility explore ways to lessen the disruption or cancellation of classes, ensure that all class cancellations are for valid reasons, and that all alternatives to cancellation have been explored.***	**Response to Recommendation #3 Under Finding 5** The Department agrees. Each institution has been directed to submit weekly reports to the Director indicating the number of classes cancelled along with the reasons for cancellation. An analysis of these reports, along with the institutions' corrective action plans, will be included in the progress report submitted to the OIG on March 31, 2005.
	CURRENT OIG Recommendation: #4 Under Original Finding 5 ***The Office of the Inspector General recommends that the California Youth Authority and Ventura Youth Correctional Facility management develop policies and procedures to facilitate the attendance of teachers at ward case conferences without the need to cancel classes.***	**Response to Recommendation #4 Under Finding 5** The Department agrees. • The institution has developed a monthly school schedule that includes allotted time for teachers to attend case conferences, student advisements and special events. The institution and school schedules are coordinated at weekly management meetings. • Each institution has been directed to submit weekly reports to the Director indicating the number of classes cancelled along with the reasons for cancellation. An analysis of these reports, along with the institutions' corrective action plans, will be included in the progress report submitted to the OIG on March 31, 2005. •

VENTURA YOUTH CORRECTIONAL FACILITY

	CURRENT OIG Recommendation: #5 Under Original Finding 5 ***The Office of the Inspector General recommends that Ventura Youth Correctional Facility study the factors contributing to the frequent cancellation of classes and the need for substitute teachers. These factors should include the impact of alternative works schedules on class cancellations.***	**Response to Recommendation #5 Under Finding 5.** The Department agrees. Each institution has been directed to submit weekly reports to the Director indicating the number of classes cancelled along with the reasons for cancellation. An analysis of these reports, along with the institutions' corrective action plans, will be included in the progress report submitted to the OIG on March 31, 2005.
	CURRENT OIG Recommendation: #6 Under Original Finding 5 ***The Office of the Inspector General recommends that Ventura Youth Correctional Facility continue to seek integrated attendance system that automates daily classroom attendance to minimize reporting errors and to better utilize staffing resources.***	**Response to Recommendation #6 Under Finding 5.** The Department complied with this recommendation in April 2004.
ORIGINAL Finding 6 ***The Office of the Inspector General found that certain fundraising activities conducted by staff at the Ventura Youth Correctional Facility were not properly administered.***	**CURRENT OIG Recommendation: #1 Under Original Finding 6** ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management update the Ventura Youth Correctional Facility's operations manual to specify the type of fundraisers that are acceptable for participation by staff or wards.***	**Response to Recommendation #1 Under Finding 6.** The Department agrees. ▪ A Temporary Institutional Procedure (TIP) dated August 17, 2004 was distributed to all institution staff regarding fund raising activities. A policy will be distributed by April 2005 on this issue. The Department will ensure that all institution manuals are consistent. ▪ A VYCF Business Manager was hired on December 1, 2004. The Business Manager will train Accounting Personnel on the fundraising portion of the TIP no later than March 2005.
	CURRENT OIG Recommendation: #2 Under Original Finding 6 ***The Office of the Inspector General recommends that the California Youth Authority update the Institutions and Camps Branch Manual to provide clear guidance to institutions on the types of fundraising and financial transactions allowed between staff and wards.***	**Response to Recommendation #2 Under Finding 6.** The Department agrees. See above response to Recommendation #1 Under Finding 6.
	CURRENT OIG Recommendation: #3 Under Original Finding 6 ***The Office of the Inspector General recommends that the California Youth Authority provide training to Institutions and Camps Branch administrators in the proper use of ward benefit funds.***	**Response to Recommendation #3 Under Finding 6.** The Department agrees. The Department will develop and provide training to I&C Branch administrators in the proper use of ward benefit funds by June 2005.

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ORIGINAL Finding 7 ***The Office of the Inspector General found significant deficiencies in the institution's practices and procedures in conducting investigations.***	**CURRENT OIG Recommendation: #1 Under Original Finding 7** ***The Office of the Inspector General recommends that California Youth Authority provide the Ventura Youth Correctional Facility with pertinent and timely information for tracking investigations regardless of whether the case management system is ready for use. The information should include the Internal Affairs or Education Services Branch case number, the subject name, the allegation, the incident date, the discovery date, the investigator name, the case closure date, and the conclusions.***	**Response to Recommendation #1 Under Finding 7.** The Department disagrees with this recommendation. • The tracking system was installed at VYCF in October 2004. • Staff training will be completed in January 2005 with full compliance expected by February 2005.
ORIGINAL Finding 8 ***The Office of the Inspector General found that the California Youth Authority and the Ventura Youth Correctional Facility failed to comply with established security requirements.***	**CURRENT OIG Recommendation: #1 Under Original Finding 8** ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management should continue to pursue a mutual aid agreement with a local law enforcement agency and should develop procedures for handling hostage situations, rather than waiting for the department to develop a standardized mutual aid agreement.***	**Response to Recommendation #1 Under Finding 8.** The Department agrees. The Department has drafted a mutual aid agreement for use by all institutions and expects the Superintendents to have the agreements in place by March 2005. The Office of Professional Standards (OPS) will develop procedures for handling hostage situations by June 2005.
	CURRENT OIG Recommendation: #2 Under Original Finding 8 ***The Office of the Inspector General recommends that the California Youth Authority should consider the advisability of relying on local law enforcement to handle potential hostage situations and either amend or follow Section 1809 of the California Youth Authority Institutions and Camps Branch Manual accordingly.***	**Response to Recommendation # 2 Under Finding 8.** The Department agrees. The Assistant Director for Professional Standards (OPS) has been directed to contact local law enforcement to determine the feasibility of entering into MOUs and agreements for hostage negotiations. The Department will submit a progress report to the OIG in March 31, 2005.

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	CURRENT OIG Recommendation: #3 Under Original Finding 8 ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management should continue efforts to obtain funds to install bulletproof glass to protect the youth correctional officer stationed at the reception desk.***	**Response to Recommendation #3 Under Finding 8.** The Department agrees to assess this issue. The CYA Facilities Planning Branch will conduct a review and determine the necessary enhancements to protect the entrance security. If additional funding is required, the Department will pursue these resources through the annual Capital Outlay budget process.
	CURRENT OIG Recommendation: #4 Under Original Finding 8 ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility should trim back the vegetation growing against the fence near the maintenance area and tarp the fence to provide both a visual barrier and security containment.***	**Response to Recommendation #4 Under Finding 8.** The Department agrees. The facility has already trimmed back vegetation. A type of visual barrier will be put in place by January 2005. The Chiefs of Security will inspect the area quarterly beginning March 2005.
	CURRENT OIG Recommendation: #5 Under Original Finding 8 ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility should ensure that all video pictures on security monitors are clear.***	**Response to Recommendation #5 Under Finding 8.** The Department agrees. • The Department will issue policies and procedures by January 2005. ▪ The Chiefs of Security will conduct and document monthly reviews of security, monitor clarity and necessary repairs and will report in writing to the Superintendent by February 2005.
	CURRENT OIG Recommendation: #6 Under Original Finding 8 ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility should replace chemical agent canisters not having durable serial numbers.***	**Response to Recommendation #6 Under Finding 8.** The Department agrees. ▪ An Armory Inventory procedure will be developed by July 2005 to address inventory/disposal of all chemical agents. ▪ In the interim, the institution will locate an appropriate vendor to replace the canisters without durable serial numbers, by March 2005.

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ORIGINAL Finding 9 ***The Office of the Inspector General found that the disciplinary decision-making system at the Ventura Youth Correctional Facility had serious defects.***	**CURRENT OIG Recommendation: #1 Under Original Finding 9** ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility should provide annual disciplinary decision-making system refresher training to all staff members responsible for the custody and treatment of wards.***	**Response to Recommendation #1 Under Finding 9.** The Department agrees. Training on DDMS will be completed for all staff members responsible for the custody and treatment of wards by December 2005, and annually thereafter. Department procedures will be developed by March 2005 to ensure that the training sessions are documented in the staff training files. The Office of Administrative Services Branch is responsible for this training.
ORIGINAL Finding 10 ***The Office of the Inspector General found that the Ventura Youth Correctional Facility had a good working system for ward grievance monitoring and tracking, but some aspects of the process prevented management from holding facility staff accountable.***	**CURRENT OIG Recommendation: #1 Under Original Finding 10** ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management immediately investigate the cause of "withdrawn" fast track, staff action grievances and document the reason the ward withdrew the grievance in the Ward Information Network 2000 System as noted in the Office of the Inspection General's review.***	**Response to Recommendation #1 Under Finding 10.** The Department agrees. Effective immediately, the Deputy Director of I&C will issue a memorandum to all superintendents that wards will be allowed to withdraw grievances; however, the Superintendent's Office must complete the inquiry process and report to the Deputy Director of I&C.
	CURRENT OIG Recommendation: #2 Under Original Finding 10 ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility should research the overdue grievances in the Ward Information Network 2000 and close out those that have already been addressed. Staff members responsible for the remaining overdue ward grievances should be held accountable for completing the grievances within mandated time frames.***	**Response to Recommendation #2 Under Finding 10.** The Department agrees. ▪ The VYCF Ward's Rights Coordinator will review all overdue grievances in WIN 2000 and will officially close out those that have already been completed, by December 18, 2005. ▪ Names of staff responsible for the overdue grievances will be provided to respective program managers and the Superintendent's Office. The Superintendent will submit a quarterly report, beginning March 2005, to the Deputy Director noting corrective steps taken to address overdue grievances.
	CURRENT OIG Recommendation: #3 Under Original Finding 10 ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility should provide annual training to staff on ward grievance procedures, including hands-on training on how to input the required data into the Ward Information Network 2000.***	**Response to Recommendation #3. Under Finding 10.** The Department agrees. ▪ The Department will complete annual training for staff by December 2005, and annually thereafter, on appropriate use of WIN 2000 to ensure accurate and timely data entry. The training will be documented in the staff training files.
ORIGINAL Finding 11	**CURRENT OIG Recommendation: #1**	**Response to Recommendation #1 Under Finding 11.**

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The Office of the Inspector General found that a large portion of the institution's projected budget deficit of $2 million for fiscal year 2001-2002 was attributable to high costs of overtime, external contracts, and increased utility expenditures.	**Under Original Finding 11** ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management should continue to reduce expenditures wherever possible and to track costs and reasons for unforeseen or unbudgeted expenditures.***	The Department agrees. ▪ The Department will develop and implement a monthly budget plan process by July 2005 that will require each superintendent to address facility budget issues, including those identified by the OIG. This process will require facilities to develop and report corrective action plans to the Directorate, as necessary. • This process will be coordinated with the Chief of Fiscal Programs at YACA.
	CURRENT OIG Recommendation: #2 Under Original Finding 11 ***The Office of the Inspector General recommends that the California Youth Authority should track unforeseen or unbudgeted expenditures to support additional funding requests.***	**Response to Recommendation #2 Under Finding 11.** The Department agrees. Please refer to the above response to Recommendation #1 Under Finding 11.
ORIGINAL Finding 12 ***The Office of the Inspector General found deficiencies in the operation of the Ventura Youth Correctional Facility warehouse.***	**CURRENT OIG Recommendation: #1 Under Original Finding 12** ***The Office of the Inspector General recommends that the institution require all staff to arrange for the retrieval of items from the warehouse with prior notification.***	**Response to Recommendation #1 Under Finding 12.** The Department agrees. The Deputy Director of I&C will develop policies and procedures to address this issue by March 2005.

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ORIGINAL Finding 13 ***The Office of the Inspector General found that the Ventura Youth Correctional Facility assigned some wards to more than one paid job.***	**CURRENT OIG Recommendation: #1 Under Original Finding 13** ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility exert a stronger effort to ensure that wards are assigned to only one paid job to increase the number of wards capable of earning money that can be used for canteen purchases. The institution should also document instances in which potentially capable wards decline the offer to work in a paid position. The ward should be required to sign a form declining the offer.***	**Response to Recommendation #1 Under Finding 13.** The Department partially agrees. ▪ There is no policy that precludes wards from holding two jobs. Title 15, Section 4275 simply refers to the Department's efforts to increase the number of wards with paid jobs. Since the number of jobs is larger than the current ward population, assigning wards to two paid jobs is not in violation of Title 15. Programmatically this provides wards the opportunity to develop social skills and stronger work ethics. ▪ The institution shall document instances in which potentially capable wards declined the offer to work in a paid position by requiring such wards to sign a form to that effect, beginning January 2005.
ORIGINAL Finding 14 ***The Office of the Inspector General found that staff performance appraisals and probationary reports were not completed on time.***	**CURRENT OIG Recommendation: #1 Under Original Finding 14** ***The Office of the Inspector General recommends that the Ventura Youth Correctional Facility management determine why managers and supervisors continue not to complete timely performance appraisals despite the improvements reported above. Facility management should hold staff accountable as appropriate.***	**Response to Recommendation #1 Under Finding 14.** The Department agrees. ▪ The Personnel Supervisor will continue to provide the Office of the Superintendent with a list of overdue performance reports, every month. ▪ Reasons for the late report are documented and submitted to the Office of the Superintendent for review and appropriate action. ▪ The Administrative Services Branch (ASB), Deputy Director, is in the process of revising the tracking of performance reports to improve timely completion of these reports as well as accurate reporting of overdue performance appraisals. The tracking system will be revised by July 2005.

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INTENSIVE TREATMENT PROGRAM

ORIGINAL Finding 2 ***The Office of the Inspector General found that the process used by the California Youth Authority to screen wards for placement in the intensive treatment program failed to ensure that all wards needing intensive treatment were identified and receive the necessary treatment.***	**CURRENT OIG Recommendation: #1 Under Original Finding 2** ***The Office of the Inspector General recommends that the California Youth Authority institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing.***	**Response to Recommendation #1 Under Finding 2.** The Department agrees. • The Department has instituted a formal and uniform process for identification and placement of wards into an ITP. The Special Program Assessment Needs (SPAN) is a web-based program utilized statewide that became effective April 1, 2003. The SPAN is used at any time during a ward's incarceration to determine the appropriate level of mental health care needed, including the ITP. • The Department established a work group in the Fall 2004 to review problem areas identified with the current process and to formalize a uniform admission process. A report on the group's findings and recommendations is expected to be completed by February 2005 and will be included in the March 31, 2005 progress report.
	CURRENT OIG Recommendation: #2 Under Original Finding 2 ***The Office of the Inspector General recommends that the California Youth Authority ensure that all wards, parole violators, as well as newly committed ward, receive a treatment needs assessment within the 21 days required by department policy***	**Response to Recommendation #2 Under Finding 2.** The Department agrees. ▪ Expectations for compliance and timely completion are being implemented at the appropriate institutions. The Deputy Director of the Institutions and Camps Branch will issue a memorandum by December 31, 2004 clarifying existing policy, including how the policy will be audited quarterly and how compliance will be reported in writing to the Deputy Director for action, if necessary. ▪ The Department is pursuing funding for necessary staff and equipment to insure the parole violators TNA's are completed in an efficient and timely manner. ▪ TNA training is being developed and will be scheduled in February 2005 for the staff responsible for completing and monitoring the TNA process.
ORIGINAL Finding 5 ***The Office of the Inspector General found a lack of follow-up care for wards leaving the intensive treatment program.***	**CURRENT OIG Recommendation: #1 Under Original Finding 5** ***The Office of the Inspector General recommends that the California Youth Authority develop policies and procedures for providing follow-up care to wards leaving the intensive treatment program.***	**Response to Recommendation #1 Under Finding 5.** The Department will develop Statewide policies and procedures by June 2005 for providing follow-up care to wards leaving the intensive treatment program

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OFFICE OF INTERNAL AUDITS

ORIGINAL Finding #1 *The Office of the Inspector General found that the California Youth Authority was not making effective use of the Office of Internal Audits as a tool for identifying problems needing corrective action.*	**CURRENT OIG Recommendation: #1 Under Original Finding #1-3** *The Office of the Inspector General recommends to allow management greater control over fiscal and program functions critical to department operation, integrate the internal audit function and the program compliance function into a single office and combine staff to perform comprehensive fiscal and operational reviews.*	**Response to Recommendation #1 Under Finding#1-3.** The Department is reviewing this recommendation as part of the plan by the Youth and Adult Correctional Agency to structurally reorganize the Agency and its subordinate departments during 2005. The Department will submit a progress report to the OIG by March 31, 2005.
ORIGINAL Finding #2 *The Office of the Inspector General found that the Office of Internal Audits was poorly managed and inadequately supervised and was not fulfilling its audit responsibilities.*	**CURRENT OIG Recommendation: #2 Under Original Finding #1-3** *The Office of the Inspector General recommends provisions for the internal audit/program compliance office to be managed by someone who can ensure that the office adheres to the Standards for the Professional Practice of Internal Auditing.*	**Response to Recommendation #2 Under Finding #1-3.** The restructuring of the audit and program compliance functions is a major priority in the Agency's reorganization efforts. Until these changes are made, the Department will ensure that the administrators and staff of these two functions are provided with training by March 2005 to understand and adhere to the Standards for the Professional Practice of Internal Auditing.
ORIGINAL Finding #3 *The Office of the Inspector General found that the reporting structure of the Office of Internal Audits did not adequately protect the independence of the internal audit function and impeded communication between the Office of Internal Audits and the department director.*	**CURRENT OIG Recommendation: #3 Under Original Finding #1-3** *The Office of the Inspector General recommends provisions for the head of the internal audit/program compliance office to report directly to the Chief Deputy Director in the office of the department director.*	**Response to Recommendation #3 Under Finding #1-3.** The Department will review this recommendation as part of the plan by the Youth and Adult Correctional Agency to structurally reorganize the Agency and its subordinate departments during 2005.
	CURRENT OIG Recommendation: #4 Under Original Finding #1-3 *The Office of the Inspector General recommends that California Youth Authority require that the head of the internal audit/program compliance office perform a comprehensive risk assessment of California Youth Authority institutions, camps, education services, treatment programs, parole operations, and headquarters to identify areas of high risk when assigning resources and developing work plans.*	**Response to Recommendation #4 Under Finding #1-3.** The Department agrees. A comprehensive risk assessment of the Department's operations will be performed by March 2005 to identify and address areas of high risk when assessing resources and developing work plans.
	CURRENT OIG Recommendation: #5 Under Original Finding #1-3 *The Office of the Inspector General recommends that California Youth Authority implement an internal quality assurance program that enables management to measure staff and office*	**Response to Recommendation #5 Under Finding #1-3.** The Department will review this recommendation as part of the plan by the Youth and Adult Correctional Agency to structurally reorganize the Agency and its subordinate departments during 2005.

OFFICE OF INTERNAL AUDITS

	performance in the areas of fiscal and program compliance; evaluation of budgeted and expended hours; effectiveness of reports; and monitoring of findings and recommendations.	
	CURRENT OIG Recommendation: #6 Under Finding #1-3 ***The Office of the Inspector General recommends that in accordance with the Standards for the Professional Practice of Internal Auditing, that the California Youth Authority arrange for external assessments of the office at least every five years and communicate the results of the external assessments to the department director.***	**Response to Recommendation #6 Under Finding #1-3.** The department agrees, provided funding is appropriated to complete such an assessment. The Department plans to complete its first assessment in July 2006, and every five years thereafter, contingent on the availability of funding.

YOUTH AUTHORITY BOARD

ORIGINAL Finding #3	**CURRENT OIG Recommendation: #1 Under Original Finding 1-3**	**Response to Recommendation #1 Under Finding 1-3.**
The Office of the Inspector General found that despite incurring significant expense in providing a broad array of treatment programs for wards, the State had not sought to measure the effectiveness of the programs.	***The Office of Inspector General recommends that the California Youth Authority institute methods of assessing the effectiveness of curriculum and treatment provided to wards.***	The Department agrees. The Youth and Adult Correctional Agency (YACA) is establishing a Policy, Planning, and Research function that will be responsible for measuring the effectiveness of programs throughout the Agency, including programs within the California Youth Authority. Through this reorganization, YACA will be responsible for this function in the future. The reorganization will be effective on July 1, 2005.

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WELFARE AND INSTITUTIONS CODE SECTION 1732.8

ORIGINAL Finding #2 ***The Office of the Inspector General found that in making parole decisions, the Youthful Offender Parole Board did not adequately take into account that dual-commitment wards do not have access to the equivalent of board-ordered programs at Department of Corrections institutions and did not develop programming standards for these wards.***	**CURRENT OIG Recommendation: #1 Under Original Finding #2** ***The Office of the Inspector General recommends that the California Youth Authority document review of the case files of wards who have had time added to the parole consideration date to ensure that due process rights have been fully observed.***	**Response to Recommendation #1 Under Finding 2.** The Department agrees. • In July 2003, Department and the YAB jointly reviewed ward case files to ensure due process had been provided. Unfortunately, these reviews were not documented; therefore, the Department and the YAB will conduct a current review of these files by July 2005. • The Department will develop a due process audit instrument for use to complete each case review. The audit instrument will be completed in January 2005; training completed by March 2005; and implemented by June 2005.
ORIGINAL Finding #4 ***The Office of the Inspector General found no evidence that dual-commitment wards had been purposely denied a means of appealing actions or grieving department policies, but did find that the agencies had not developed appeal and grievance procedures to meet the needs of these wards.***	**CURRENT OIG Recommendation: #1 Under Original Finding #4** ***The Office of the Inspector General recommends that the California Youth Authority should ensure that the Department of Corrections memorandum concerning the distribution, processing, and retention of appeal/grievance forms for Welfare and Institutions Code section 1732.8 wards is submitted in final form to the inmate appeals coordinators.***	**Response to Recommendation #1 Under Finding 4.** The Department agrees. The Department took the following actions to address the finding in August 2004. The Department: ▪ Compiled a packet of information outlining the ward's rights/appeals and due process regarding placement options. Each ward in CDC was mailed a packet in August 2004. ▪ Developed procedures so that each ward given the option under Section 1732.8 is provided a similar packet. ▪ In addition, the Department of Corrections provided the inmate appeals coordinators with a final copy of a memorandum dated July 1, 2004, which outlines the procedures.

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