



July 2018

## **INVESTIGATIONS OF IMPROPER ACTIVITIES BY STATE AGENCIES AND EMPLOYEES**

Misuse of State Time, Economically Wasteful Activities,  
and Misuse of State Property

Report I2018-1



**INVESTIGATIONS**

COMMITMENT  
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**CALIFORNIA STATE AUDITOR**

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Elaine M. Howle State Auditor

July 24, 2018

Investigative Report I2018-1

The Governor of California  
President pro Tempore of the Senate  
Speaker of the Assembly  
State Capitol  
Sacramento, California 95814

Dear Governor and Legislative Leaders:

Pursuant to the California Whistleblower Protection Act, the California State Auditor's Office (State Auditor) presents this investigative report summarizing investigations concerning allegations of improper governmental activities that were completed between July 2017 and June 2018. During this time period, the office received 1,331 calls or inquiries within its investigative jurisdiction and conducted investigative work on 1,481 cases that we opened either in previous periods or in the current period. We determined that 1,018 of these cases lacked sufficient information for investigation or are pending preliminary review. We conducted additional work on the remaining 463, of which 86 resulted in either an independent investigation by our office or a referral to the involved state agency for further investigation.

This report details seven substantiated allegations involving several state agencies and two university campuses. Through our investigations, we found misuse of state time and property and economically wasteful activities. In total, we identified an estimated \$200,000 in inappropriate expenditures.

For example, two employees at California State University, Fresno failed to perform their work duties for thousands of hours during a period of at least five years. From 2013 through 2017, these two employees failed to account for more than 5,100 hours by taking extended breaks and leaving campus without permission. This misuse of state time cost the State more than \$111,000 in salary paid for work not performed. In addition, the employees' managers failed to ensure that these two employees performed their work.

In another investigation, we determined that a director of nursing at one of California's adult prisons violated state law by removing a licensed vocational nurse (LVN) from patient care duties and assigning her to perform the duties of an office technician. This resulted in nearly \$30,000 of unnecessary salary payments from May 2015 through July 2016, including overtime payments to other nurses who covered the LVN's assigned post.

State agencies must report to the State Auditor any corrective or disciplinary action taken in response to recommendations made by the State Auditor. Their first report is due no later than 60 days after we notify the agency or authority of the improper activity and monthly thereafter until corrective action is completed.

Respectfully submitted,

ELAINE M. HOWLE, CPA  
California State Auditor

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# SUMMARY

## Results in Brief

The California Whistleblower Protection Act (Whistleblower Act) empowers the California State Auditor's Office (State Auditor) to investigate and report on improper governmental activities by agencies and employees of the State. Under the Whistleblower Act, an improper governmental activity includes any action by a state agency or employee related to state government that violates a law; is economically wasteful; or involves gross misconduct, incompetence, or inefficiency.<sup>1</sup>

From July 1, 2017, through June 30, 2018, the State Auditor conducted investigative work on 1,481 cases. This report contains seven examples of investigations that substantiated improper governmental activities, including misuse of state time and inaccurate attendance records, economically wasteful activities, and misuse of government property. In addition, during the past year, the State Auditor issued nonpublic reports regarding nepotism, bad-faith hires, improper promotions, and other misconduct by executive management within two state entities. It provided these reports to those who could remediate the problems and ensure that the management teams involved did not retaliate against perceived whistleblowers.

### California State University, Fresno

Two facilities operations employees at California State University, Fresno engaged in egregious and continued time and attendance abuse by taking extended breaks or leaving campus without accounting for their time. From 2013 through 2017, two employees failed to account for more than 5,100 hours of work, costing the State more than \$111,000 in salary paid for work not performed. Furthermore, the employees were dishonest in their attempts to conceal their time and attendance abuse.

### California Department of Corrections and Rehabilitation, Kern Valley State Prison

For about two years, an employee at Kern Valley State Prison misused state time by regularly leaving work up to 45 minutes early as a result of inadequate supervision. We estimated that the employee failed to account for 312 hours of missed work time, costing the State nearly \$9,000.

## Investigative Highlights . . .

*State employees and agencies engaged in various improper governmental activities, including the following:*

- » *Four employees at several agencies misused state time and cost the State approximately \$160,000.*
- *Two employees either took extended breaks or left the premises over a five-year period.*
- *One employee regularly left early from work over two years.*
- *One employee slept at her desk for extended periods of time during work hours.*
- » *A nursing director removed an LVN, who was her personal friend, from her assigned nursing position to perform duties typically performed by an office technician.*
- » *An official built an unauthorized structure on state property with the help of on-duty staff under his command.*

<sup>1</sup> For more information about the State Auditor's investigations program, please refer to the Appendix.

### **Department of Motor Vehicles**

A key data operator at the Department of Motor Vehicles failed to perform her essential duties over a period of nearly four years because she slept at her desk for extended periods of time during work hours. From February 2014 through December 2017, the employee misused more than 2,200 hours of work time as a result of sleeping on the job, costing the State more than \$40,000.

### **California Correctional Health Care Services**

From May 2015 through July 2016, a director of nursing (nursing director) at a Southern California adult prison removed a licensed vocational nurse (LVN), who was her personal friend, from her assigned nursing position—or post—providing patient care and reassigned her to perform nurse scheduling duties typically performed by an office technician. During this period, the LVN continued to receive her pay as a nurse even though she provided patient care only when she worked occasional overtime shifts, causing California Correctional Health Care Services (Correctional Health Care) to waste \$10,500 in unnecessary salary payments. Furthermore, the nursing director's decision cost the State an additional \$18,700 in unnecessary overtime payments that Correctional Health Care paid to other nurses to cover the LVN's originally assigned post, resulting in total waste of nearly \$30,000.

### **California Department of Corrections and Rehabilitation**

The California Department of Corrections and Rehabilitation (CDCR) overpaid a staff services analyst (analyst) at one of its prisons nearly \$3,000 from July 2016 through March 2017. The analyst, her manager, an associate warden, and a personnel specialist all failed to follow CDCR procedure and the California Department of Human Resources' policy regarding inmate supervision pay, which resulted in the overpayments. In addition, the associate warden violated state law by choosing not to initiate any collection efforts after two internal audits in 2017 documented the error in pay and recommended the recovery of the overpayments.

### **California State University, Dominguez Hills**

In March 2013, a manager at California State University, Dominguez Hills directed a member of his staff to purchase a Nissan-manufactured electric vehicle quick charger for nearly \$7,000 before the manager had performed the due diligence necessary to ensure that the equipment was compatible with

the energy resource plan for the campus. The quick charger has remained unused for five years, its warranty lapsed in 2014, and Nissan is no longer manufacturing replacement parts. As of February 2018, the campus told us it will be unable to install the quick charger before 2020 or 2021, if at all.

### **California Department of Forestry and Fire Protection**

A California Department of Forestry and Fire Protection (CAL FIRE) assistant chief misused state resources when he violated his rental agreement by building an unauthorized structure on state property using on-duty staff under his command. In 2016 the assistant chief built a 16-foot-by-20-foot structure with plumbing, electrical, and sewer connections in the backyard of the state residence he rented from CAL FIRE without written approval from CAL FIRE to build the structure as his rental agreement required. He also did not have approval from the Office of the State Fire Marshal, which is responsible for inspecting state-owned buildings.

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# INTRODUCTION

## The California Whistleblower Protection Act

The California Whistleblower Protection Act (Whistleblower Act) empowers the California State Auditor's Office (State Auditor) to investigate and report on improper governmental activities by agencies and employees of the State. Under the Whistleblower Act, an improper governmental activity includes any action by a state agency or employee related to state government that violates a law; is economically wasteful; or involves gross misconduct, incompetence, or inefficiency.<sup>2</sup>

Since 1993, when the State Auditor activated its whistleblower hotline, it has identified improper governmental activities that have cost the State a total of \$577.7 million. These improper activities include gross inefficiency, theft of state property, conflicts of interest, and personal use of state resources, among many others. For example, the State Auditor reported in March 2014 that the Employment Development Department failed to participate in a key aspect of a federal program that would have allowed it to collect an estimated \$516 million owed to the State in unemployment benefit overpayments. In addition, the investigations have substantiated improper activities that cannot be quantified monetarily but still have had negative impacts on state government.

## The State Auditor's Investigative Work From July 2017 Through June 2018

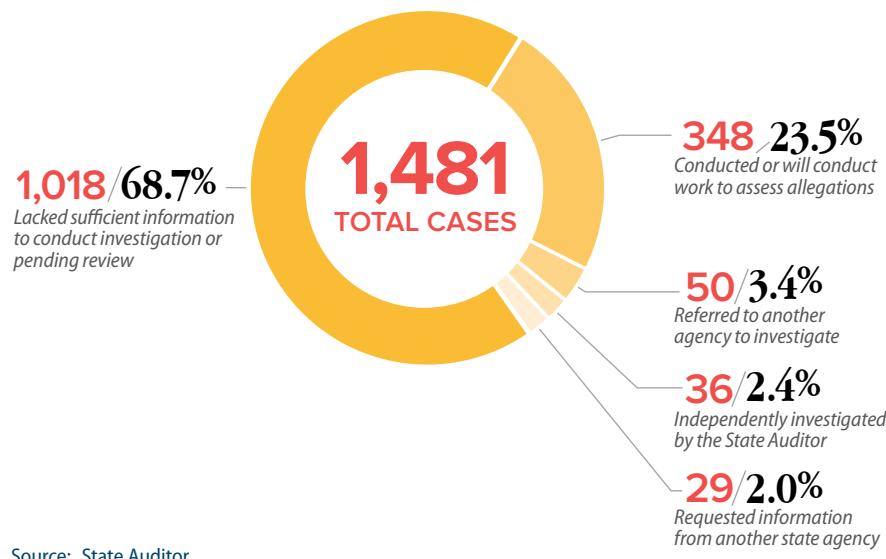
As the Appendix discusses, the State Auditor receives allegations of improper governmental activities in several ways. From July 1, 2017, through June 30, 2018, the State Auditor received 1,331 calls or inquiries that fell within its jurisdiction. Of these, 698 came through the State Auditor's website, 359 through the mail, 228 through the hotline, 38 via facsimile, five through internal sources, and three through individuals who visited the State Auditor's office. In addition, the State Auditor received hundreds of allegations outside its jurisdiction and it referred these callers and inquirers to the appropriate federal, local, or state agencies, when possible.

During this one-year period, the State Auditor conducted investigative work on 1,481 cases that it opened either in previous periods or in the current period. As Figure 1 on the following page shows, the State Auditor's investigative staff determined that 1,018 of the 1,481 cases either lacked sufficient information for

<sup>2</sup> For more information about the State Auditor's investigations program, please refer to the Appendix.

investigation or are pending preliminary review. For another 348 cases, the staff conducted or will conduct additional work—such as analyzing available evidence and contacting witnesses—to assess the allegations. The State Auditor’s staff notified the respective departments for another 50 cases so they could investigate the matters further and independently initiated investigations for another 36 cases. Some of these investigations may still be ongoing. In addition, the staff requested that state agencies gather information for 29 cases to assist the State Auditor in assessing the validity of the allegations.

**Figure 1**  
**Status of 1,481 Cases From July 2017 Through June 2018**



Source: State Auditor.

Under the Whistleblower Act, the State Auditor may issue public reports when investigations substantiate improper governmental activities. This report contains seven examples of investigations that substantiated improper governmental activities, including misuse of state time and inaccurate attendance records, economically wasteful activities, and misuse of government property. The State Auditor may also issue nonpublic reports to the head of the agencies involved and, if appropriate, to the Office of the Attorney General (Attorney General) and the appropriate policy committees. During the past year, the State Auditor issued nonpublic reports regarding nepotism, bad-faith hires, improper promotions, and other misconduct by executive management within two state entities. It provided these reports to those who could remediate the problems and ensure that the management teams involved did not retaliate against perceived whistleblowers.

# CHAPTER 1

## MISUSE OF STATE TIME AND INACCURATE ATTENDANCE RECORDS

This chapter includes certain investigations in which we have substantiated allegations involving misuse of state time and inaccurate attendance records. The employees in these investigations regularly arrived late, left early, wasted time, or had other substantial absences during their workdays for which they did not account on their timesheets. State employees are required by law to be honest and accurate in the reporting of their attendance on timesheets. Further, state laws prohibit employees from using state-compensated time for personal purposes and require them to devote their full time, attention, and efforts to their jobs during hours of duty. Employees who fail to comply with these requirements may be subject to disciplinary action. For example, in 2016 we reported on our investigation of a group of psychiatrists with the Department of State Hospitals, whom we found regularly worked between 22 and 29 hours per week instead of the required 40 hours, costing the State nearly \$300,000 during a one-year period. As a result of our investigation, all of the involved psychiatrists resigned rather than face disciplinary action.

In addition to these cases that follow, we reviewed 294 other cases that involved misuse of state time from July 2017 through June 2018. We conducted preliminary investigative work on 137 of the cases, and in 41 of these instances, we obtained sufficient evidence to request additional information from the respective departments, notify the respective departments so they could look into the matters further, or launch investigations of our own, some of which may still be ongoing.

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## CALIFORNIA STATE UNIVERSITY, FRESNO: TWO EMPLOYEES FAILED TO PERFORM THEIR WORK FOR THOUSANDS OF HOURS DURING A PERIOD OF AT LEAST FIVE YEARS

CASE I2017-0276

### Results in Brief

During a five-year period, two facilities operations employees at California State University, Fresno (Fresno State) engaged in egregious and continued time and attendance abuse by taking extended breaks or leaving campus without accounting for their time. As a result, they failed to perform the normal and reasonable duties of their positions. We estimate that from 2013 through 2017, the employees failed to account for more than 5,100 hours of work, costing the State more than \$111,000 in salary paid for work not performed. During this period, the employees' management failed to ensure that these two employees performed their work. Furthermore, Fresno State determined that the employees were dishonest in their attempts to conceal their time and attendance abuse.

#### About the University

Fresno State is one of 23 campuses of the California State University (CSU) system. Fresno State employs 25 grounds staff to maintain its 388-acre main campus.

#### Relevant Criteria

Education Code section 89535 provides that a permanent CSU employee may be dismissed, demoted, or suspended for reasons that include dishonesty and failure to perform the normal and reasonable duties of his or her position.

### Background

The two employees have worked at Fresno State for more than 20 years as groundskeepers in the facilities operations department and are responsible primarily for operating small tractors, backhoes, and mowers. They report directly to a supervisor, whereas other groundskeepers report to lead employees who then report to the supervisor. Their department requires that employees notify their supervisors whenever they need to leave work early. Until recently, the two employees in question were scheduled to begin work one hour before the other groundskeepers.

In response to an allegation we received that these employees for years regularly took extended breaks, we initiated an investigation and requested Fresno State's assistance in conducting it.

### Two Employees Failed to Perform Their Work for Multiple Hours Daily During an Estimated Five-Year Period, Costing the State More Than \$111,000

From January 2013 through December 2017, the two employees at Fresno State each missed thousands of hours of work without accounting for their time. Specifically, Employee A engaged in

severe time and attendance abuse when he missed two hours of work each workday by driving off campus or by sitting either in his personal vehicle or in campus buildings during his work hours. Three witnesses reported that their shifts began one hour after Employee A's shift and that when they arrived for work, they generally either observed Employee A coming out of buildings on campus or noticed that none of his assigned work area had been mowed. These witnesses added that they also observed Employee A leaving campus in his personal vehicle for at least one hour every workday. Two of the witnesses explained that because of Employee A's attendance abuse, he did not complete mowing his assigned work area and that other employees, including themselves, needed to complete his unfinished work. Witnesses said that Employee A engaged in this type of behavior for at least five years.

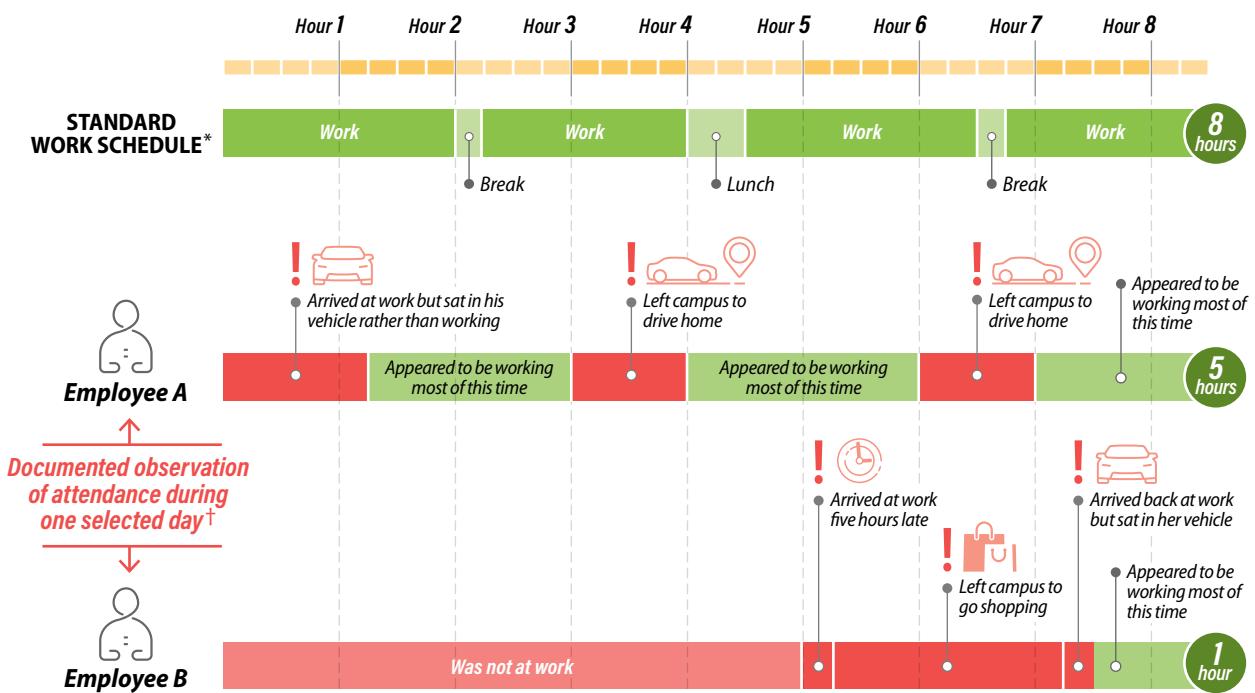
As part of Fresno State's review of this allegation, it conducted surveillance of Employee A for three randomly selected days, and the investigator's observations support the witnesses' statements. On each of these three days, the investigator saw that Employee A missed between three and four hours of work either by sitting in his vehicle or inside a building or by leaving campus to drive to his home. Figure 2 illustrates the hours Employee A was away from work on one of the three days observed. Based on the witnesses' statements and its own three-day surveillance, Fresno State concluded that Employee A likely missed at least two hours of work every workday for at least the past five years. We estimated that from January 2013 through December 2017, Employee A missed more than 2,100 hours of work time without reporting his absences, costing the State more than \$45,000.

Similarly, Employee B also engaged in extreme time and attendance abuse by leaving the campus for at least three hours daily. Four witnesses reported frequently observing Employee B leaving campus with a relative, who is also a Fresno State employee, for hours at a time during work hours. In fact, a witness even estimated that during a five-day workweek, Employee B worked only about a day and a half. Two witnesses added that Employee B did not complete mowing her assigned work area because of her time abuse, causing other employees to finish her work. Witnesses also mentioned that Employee B had engaged in this behavior for at least five years.

Fresno State's surveillance of Employee B for three randomly selected days corroborated the witnesses' statements that Employee B frequently missed many hours of work. Specifically, the investigator observed that on these three days, Employee B missed four, five, and seven hours of work, respectively, because she either arrived to work late or left campus with her relative. In fact, during the day on which Employee B missed seven hours

of work, the investigator observed her shopping at four different locations. Figure 2 illustrates the hours Employee B missed on that day. Based on the number of hours Employee B was observed away from campus on these three days and the witness statements that we discuss previously, we determined that she likely missed at least three hours of work daily for at least the past five years. Thus, we estimated that from January 2013 through December 2017, Employee B missed more than 3,000 hours of work time without reporting her absences, costing the State more than \$66,000.

**Figure 2**  
Observed Misuse of Work Time by Employees A and B



Source: State Auditor's analysis of surveillance records.

\* The employees are allowed one hour total per day for breaks, which includes two 15-minute paid breaks and a 30-minute unpaid lunch break.

† Employees A and B were observed on different days.

### Management Failed to Provide Adequate Supervision to Ensure That These Two Employees Performed Their Work

Management failed to ensure that Employees A and B performed their work. As we mentioned in the Background, Employees A and B are the only groundskeepers who report directly to the supervisor rather than to a lead employee. The employees'

supervisor explained that the facilities operations department previously assigned Employees A and B to a lead employee, but their lead employee was reassigned to a different work area in August 2015. According to the supervisor, he attempted at that time to reassign them to one of the two other lead employees. However, he added that Employees A and B both informed him that they had past problems with the two lead employees. Thus, the supervisor stated that his superiors did not want to assign Employees A and B to any lead employee and instead required them to report directly to him. However, he conceded that his other responsibilities prevented him from being able to closely supervise Employees A and B.

Management failed to ensure adequate oversight of Employees A and B even after it became aware of their significant attendance problems. The supervisor admitted that he received complaints about Employee A not attending to his work but stated that he assumed that Employee A was on break during the times in question. In addition, he acknowledged that he frequently personally observed Employee B leaving campus with her relative during work hours. In fact, he reported that he has been unable to locate Employee B on campus on several occasions. Despite receiving complaints about Employee A failing to work and having personal knowledge about Employee B leaving campus, the supervisor took limited action to ensure that these employees performed their work duties and accounted for their missed work time. Specifically, in March 2017, nearly two years after these employees began reporting to him, the supervisor informed one of his superiors that he believed these employees should report to a lead employee because the nature of his responsibilities prevented him from effectively supervising them. Despite being made aware of this issue, the superior failed to take sufficient actions to ensure that these employees received the appropriate level of supervision.

As a result of this investigation, Fresno State has taken or plans to take certain steps to address the two employees' behavior; nevertheless, we are concerned that these steps may not fully resolve their time and attendance abuse. Specifically, following the investigation, Fresno State required Employees A and B to start their shifts at the same time as the other groundskeepers. However, we noted that these employees engaged in time and attendance abuse even when their shifts overlapped with the shifts of other groundskeepers. In addition, the supervisor stated that his superiors have approved his plan to hire another lead employee who can oversee both of these employees and ensure they perform their duties. However, these two employees engaged in time and attendance abuse even during times when they reported to a lead employee.

*Despite being made aware that the supervisor was unable to effectively monitor the employees' attendance, the superior failed to take sufficient actions to ensure that these employees received the appropriate level of supervision.*

### **The Two Employees Were Dishonest When Attempting to Conceal Their Time and Attendance Abuse**

Fresno State reported that these two employees were dishonest when they attempted to conceal their time and attendance abuse. Specifically, two witnesses stated that they observed Employee A driving his mower an unnecessary longer distance across campus to add time to its meter to make it appear that he spent more time performing his duties than he actually did. Additionally, when an investigator initially asked Employee A during his interview if he left campus during work hours, Employee A denied leaving campus. When he was subsequently confronted with evidence to the contrary, Employee A stated he could not recall whether he left campus. He also said that he notified his supervisor of his departures from campus and accounted for any missed work time when he expected to be away beyond his established break and lunch times. However, the supervisor stated he had no record of Employee A submitting any requests for time off for any of the days on which he was observed leaving campus.

Similarly, Employee B attempted to conceal her time and attendance abuse. When asked if she left campus during work hours, she first denied leaving campus. After she was provided with evidence demonstrating that she left campus during work hours to shop at four different stores, Employee B admitted that she left campus on that day but insisted that she only went to one store during her lunch break. She also said that she informed her supervisor when she expected to be away from campus and that she accounted for any missed work time when reporting her hours. However, the supervisor stated he had no record of Employee B submitting any requests for time off for any of the days on which she was observed leaving campus.

### **Recommendations**

To address the improper governmental activities we identified in this investigation, Fresno State should take the following actions:

- Take appropriate disciplinary actions against Employee A for his continued time and attendance abuse and for his dishonesty when attempting to conceal his actions.
- Take appropriate disciplinary actions against Employee B for her continued time and attendance abuse and for her dishonesty when attempting to conceal her actions.

- Investigate Employee B's relative for potential time and attendance abuse because the relative, who also works at Fresno State, was observed leaving campus for long periods of time.
- Assign Employees A and B to a lead employee who is trained regarding his or her responsibility to ensure that these two employees perform their duties and report any time away from their assigned duties.
- Take appropriate corrective actions against the supervisor and other relevant managers for failing to adequately address these employees' substantial time and attendance abuse.
- Determine the amount of time Employees A and B can be charged to account for their missed work hours, reduce their leave balances accordingly, and, if applicable, seek to recover from them any wages paid to them for time they did not work.

### **Agency Response**

In March 2018, Fresno State reported that since January 2018, it has required Employees A and B to report to a lead employee who will ensure that they perform their duties and account for their time. It also informed us that it issued 12-week unpaid suspensions to both Employees A and B. In addition, it stated that it investigated Employee B's relative for time and attendance abuse and also issued a 12-week suspension to the relative after the investigation substantiated the time abuse. In May 2018, Fresno State stated that it was exploring its legal options for recovering funds paid to the employees for time they did not work.

Fresno State reported that it had counseled the supervisor in March 2018 to ensure that he properly documents any future concerns with employees' time abuse and that he reports those concerns to his superiors and human resources. Nonetheless, Fresno State stated that it believed our report placed too much accountability on the supervisor. Instead, it asserted that the ultimate responsibility fell on the entire management team, most of whom have since retired. However, we maintain that the supervisor's limited actions were inadequate to address his subordinates' misconduct.

## CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, KERN VALLEY STATE PRISON: AN EMPLOYEE MISUSED STATE TIME BY CONSISTENTLY LEAVING WORK EARLY

CASE I2016-1265

### Results in Brief

For about two years, an employee at Kern Valley State Prison (KVSP) misused state time by regularly leaving work up to 45 minutes early as a result of inadequate supervision. We estimated that the employee failed to account for 312 hours of missed work time, costing the State \$8,850.

### Background

The employee has worked in service operations at KVSP since 2012. He is classified as an hourly employee and is required to account for any partial day absences. Before June 2017, the employee worked from 7 a.m. to 5 p.m., four days a week. In June 2017, he began working from 6 a.m. to 4 p.m., four days a week. The employee's supervisor gives his staff the last 15 minutes of their shifts to lock up their work areas and to turn in their work keys. However, he stated that he does not allow his staff to leave KVSP before their shifts end.

In response to the allegation we received that the employee regularly left early from work for years, we initiated an investigation and requested KVSP's assistance to conduct it.

### About the Department

The California Department of Corrections and Rehabilitation (CDCR) enhances public safety through safe and secure incarceration of offenders, effective parole supervision, and rehabilitative strategies to successfully reintegrate offenders into communities. CDCR operates 35 adult institutions, including KVSP, which is located on more than 600 acres in Delano, California.

### Relevant Criteria

Government Code section 8314 prohibits state employees from using state resources, such as state-compensated time, for personal purposes that exceed minimal and incidental use.

Government Code section 19990, subdivision (g), prohibits state employees from engaging in activities that are clearly inconsistent or incompatible with their state employment, including failing to devote their full time, attention, and efforts to state employment during work hours.

Government Code section 19572 identifies various causes for discipline of state employees, including violations of the prohibitions set forth in section 19990.

### The Employee Consistently Left Work Early and Did Not Account for His Early Departures

The employee engaged in time and attendance abuse by leaving KVSP up to 45 minutes early every workday for up to two years without accounting for his missed work time. When interviewed by KVSP staff about leaving early, the employee provided inconsistent and contradictory statements. Specifically, during his first interview, the employee stated that he and his colleagues probably all left early as a group. However, during the employee's second interview, he stated that he and his colleagues left their assigned posts the allotted 15 minutes before their shifts ended. By contrast, when

interviewed by KVSP staff, four witnesses each reported observing the employee leaving up to 45 minutes before the end of his shift every workday. In addition, two of these witnesses stated that the employee had engaged in this behavior for about two years. Based on the consistent statements made by these witnesses and the contradictory statements made by the employee, we concluded that the employee left KVSP early.

Despite leaving KVSP early, the employee submitted timesheets in which he claimed to have worked his entire shift. Thus, he did not charge any leave to account for the work time he missed by leaving early. We estimated that from July 2015 through June 2017, the employee missed 312 hours of work time without accounting for it, costing the State \$8,850.

### **Inadequate Supervision Resulted in the Employee Leaving Work Early Without Detection**

The employee's supervisor did not provide adequate supervision to ensure that the employee and his colleagues completed their full shifts. The supervisor acknowledged that he allows his staff to leave their work post up to 15 minutes before their shifts end so they have sufficient time to lock up their work areas and turn in their work keys. However, the supervisor clarified that he never gave his staff permission to leave KVSP before the end of their shifts. Until June 2017, the supervisor's shift ended one hour prior to the end of the employee's shift; therefore, the supervisor could not monitor the employee during that last hour. In addition, the supervisor did not have a process in place to confirm when his employees left KVSP in his absence. The supervisor's manager stated that in June 2017, he changed the work schedules for the employee and his colleagues to coincide with the supervisor's shift to ensure that the employees were supervised until the end of their shifts. However, during the investigation, the supervisor admitted that, even with the revised work schedule, he still would not have been aware if any of his staff left early without approval because he splits his work time between different areas of KVSP.

### **Recommendations**

To address the improper governmental activity we identified in this investigation, KVSP should take the following actions:

- Take appropriate corrective action against the employee, including documenting his attendance abuse in his personnel or supervisory file.

- Require the supervisor to implement policies and procedures to ensure his subordinates account for all of their missed work hours.

#### **Agency Response**

In March 2018, KVSP reported that it has served the employee with a counseling letter and implemented a procedure to ensure its employees account for all leave. This procedure includes accountability sign-in logs.

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## DEPARTMENT OF MOTOR VEHICLES: AN EMPLOYEE CONSISTENTLY SLEPT ON THE JOB YET HER SUPERVISORS FAILED TO DISCIPLINE HER

CASE I2017-0414

### Results in Brief

A key data operator at the Department of Motor Vehicles (DMV) failed to perform her essential duties over a period of nearly four years because she slept at her desk for extended periods of time during work hours. We estimated that from February 2014 through December 2017, the employee misused more than 2,200 hours of work time as a result of sleeping on the job, costing the State more than \$40,000. In addition, the employee's supervisors failed to take disciplinary or medical action against the employee after initial efforts to address her conduct proved unsuccessful.

### Background

Key data operators are responsible for performing routine data entry for change of address and new vehicle ownership forms. The employee's unit expects key data operators to process an average of 560 documents daily. Supervisory staff are responsible for addressing the failure of employees to meet expectations. The State's three-phase progressive discipline process provides supervisory staff with ample opportunity to address and correct unacceptable conduct and performance issues. Table 1 on the following page describes the three phases of the progressive discipline process.

Some employees may be unable to perform all of their duties due to disabilities. State and federal disability laws require state agencies to provide these employees with reasonable accommodations that enable them to perform their essential job functions and enjoy equal employment opportunities. An agency that receives a request for reasonable accommodation is required to engage in an interactive process with the employee to determine an effective reasonable accommodation. However, an agency is neither required to provide an accommodation that would cause it undue hardship nor must it exempt the employee from performing his or her essential job duties.

### About the Department

The DMV is primarily responsible for issuing licenses to the State's 26.5 million drivers and issuing registrations for more than 34.7 million vehicles. It employs key data operators to help process these transactions.

### Relevant Criteria

Government Code section 8314 prohibits state employees from using state resources, such as state-compensated time, for personal purposes that exceed minimal and incidental use.

Government Code section 19990, subdivision (g), prohibits state employees from engaging in activities that are clearly inconsistent or incompatible with their state employment, which include the failure to devote their full time, attention, and efforts to state employment during work hours.

Government Code section 19572 identifies inefficiency, inexcusable neglect of duty, discourteous treatment of the public or other employees, and other failure of good behavior that causes discredit to the appointing authority as causes for discipline of a state employee.

Government Code section 19253.5 states that an appointing power may require an employee to submit to a medical examination by a physician or physicians designated by the appointing power to evaluate the capacity of the employee to perform the work of his or her position.

**Table 1**  
**The Three Phases of the Progressive Discipline Process**

PHASE	DESCRIPTION
1. <i>Preventive</i>	Gives supervisors an opportunity to ensure that employees are aware of the supervisors' expectations. For example, a supervisor should communicate to an employee what constitutes acceptable and unacceptable conduct at work and should provide feedback on job performance.
2. <i>Corrective</i>	Allows supervisors and employees to address performance or behavior issues that the supervisors have deemed unacceptable and in need of correction. This phase involves holding informal counseling meetings and formal corrective interviews to outline in writing the changes that employees must make. During this phase, supervisors give verbal instruction when assigning tasks and increase their monitoring of employee activity. For example, a supervisor may document unacceptable behavior and meet with an employee to discuss any problems.
3. <i>Disciplinary</i>	Allows supervisors to implement any disciplinary actions, also known as <i>adverse actions</i> , against employees if necessary. Adverse actions include discipline such as an official letter of reprimand, reduction in salary, suspension without pay, demotion, or dismissal from state service.

Source: *State of California Supervisor's Handbook*.

In response to an allegation we received that the employee regularly slept on the job, we initiated an investigation and requested DMV's assistance to conduct it.

#### **The Employee Misused Work Time Daily for Almost Four Years, Costing the State More Than \$40,000**

Since February 2014, the employee failed to perform the essential duties of her position for at least three hours each workday because she continually fell asleep at work. Specifically, the employee's signed performance evaluations (evaluations) state that she has been sleeping at work daily since February 2014. During the investigation, the employee's supervisor stated that because she woke up the employee three to four times each day, she believed the employee missed only 20 to 30 minutes of work time daily. However, four witnesses reported consistently observing the employee sleeping at her desk for hours at a time during work hours, rather than the 20 to 30 minutes estimated by the supervisor. In fact, two of these witnesses estimated that the employee slept for a minimum of three hours each workday because the supervisor did not consistently wake up the employee even when the supervisor was aware that the employee was sleeping. In addition, the employee's evaluations also indicate that she processed on average less than half the number of documents key data operators in the

unit are expected to process. Based on the consistent statements from witnesses and the employee's significantly low production levels compared to the unit's expectation, we found the supervisor's estimate that the employee slept for only 20 to 30 minutes a day not credible. Instead, we believe that the employee likely slept for at least three hours each day. Thus, we estimated that from February 2014 through December 2017, the employee misused more than 2,200 hours of work, costing the State more than \$40,000 in salary for her wasted work time.

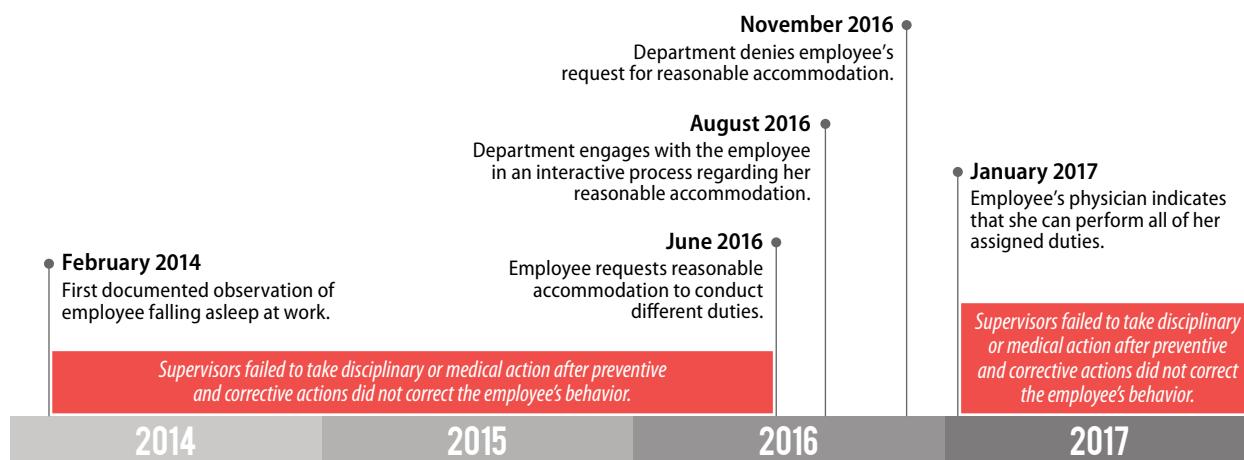
In addition to this financial cost, the employee's behavior negatively affected her colleagues and the public. Her annual evaluations state that she processed an average of only 200 documents daily despite the unit's expectation that key data operators process 560 documents each day. Witnesses explained that because the employee did not process the expected number of documents, other key data operators had to take on her unfinished workload. Further, the employee's evaluations mention that she made mistakes when entering data. In fact, during the investigation, a witness explained that the employee's work was often so inaccurate that the witness would not trust the employee to accurately enter the witness's own address or vehicle ownership change. Thus, the employee's behavior may have prevented DMV from providing the public with an appropriate level of service.

#### **The Employee's Supervisors Failed to Take Disciplinary or Medical Action to Prevent the Employee's Behavior From Continuing**

The employee's supervisors failed to take disciplinary action, also known as *adverse action*, against the employee when they saw that the preventive and corrective phases had not remedied the problem. As discussed in the Background, a supervisor should follow the State's progressive discipline process by initiating adverse action, such as reprimand, demotion, or suspension, if an employee's poor or unacceptable behavior does not improve through the preventive and corrective phases. From February 2015 through August 2017, the supervisors provided the employee with annual evaluations, which covered her job performance dating back to February 2014, and several memorandums indicating that her pattern of sleeping on the job and failing to meet the unit's production standard was not acceptable. Even after the supervisors provided the employee with these corrective memorandums, she continued to sleep on the job and failed to meet the unit's production expectations. However, despite the employee failing to correct her behavior, the employee's supervisors did not initiate adverse action within the State's progressive discipline process to ensure that her behavior did not continue.

As Figure 3 shows, the employee's supervisors also failed to take medical action during this time despite their belief that the employee had a medical condition. Specifically, during the investigation, the supervisors stated they were reluctant to take further steps to address the employee's sleeping and poor production because they speculated that a medical condition could be causing the employee to fall asleep. State law allows appointing powers to require employees to submit to medical examinations to evaluate their capacity to perform their work. However, rather than taking this action, the supervisors instead repeatedly provided the employee with a resource that confidentially assists employees with any behavioral health concerns. The employee did not request a reasonable accommodation for a medical condition until June 2016, about two years after she began sleeping during work hours in 2014. Thus, if the supervisors suspected that a medical condition could be causing the employee to fall asleep, they had ample time to require that the employee submit to a medical examination or otherwise engage in the interactive process for a reasonable accommodation. However, they failed to do so.

**Figure 3**  
**Supervisors' Failure to Take Adequate Disciplinary or Medical Action**



Source: The DMV's review of employee's personnel records.

Figure 3 also shows that the supervisors failed to take disciplinary or medical action after the DMV denied the employee's request for a reasonable accommodation. In June 2016, the employee requested a reasonable accommodation, and the DMV engaged with her in the interactive process for at least two months. Ultimately, however, the employee's physician informed the DMV that she could not perform any of the duties of a key data operator. The DMV then tried to locate a suitable vacant position

with duties the employee could perform but was unsuccessful. In November 2016, after exhausting its options, the DMV finally denied the employee's reasonable accommodation request and informed her that she could retire, resign, or return to work as a key data operator with a release from her physician indicating that she could perform her duties. The employee chose to return to work as a key data operator with a release from her physician in January 2017; nonetheless, she continued to sleep at work and failed to meet the unit's production standards. Therefore, from January 2017 through December 2017, the supervisors once again had sufficient time to issue adverse action because the employee did not have a reasonable accommodation in place. Moreover, if the supervisors still believed that the employee had a medical condition that caused her to fall asleep, they could have required the employee to submit to a medical examination by a physician selected by the DMV, as state law allows. However, the supervisors also failed to take this course of action.

As a result of this investigation, the DMV reported that it is now consulting with its human resources office to determine the appropriate steps to take with the employee. In addition, it reported that it is training the employee's supervisors on the importance of following the State's progressive discipline process.

### **Recommendations**

To address the improper governmental activity we identified in this investigation, the DMV should take the following actions:

- Take appropriate disciplinary action against the employee for sleeping on the job for hours each day and failing to adequately perform her duties.
- Take appropriate corrective or disciplinary actions against the supervisors for failing to adequately address the employee's consistent pattern of sleeping during work hours and failing to perform her duties.

### **Agency Response**

In May 2018, the DMV reported that it was unable to proceed with adverse action against the employee without a proper documented history of problems with past performance. Specifically, the DMV stated that its legal and human resources staff determined that the previous corrective memorandums the supervisors had issued to the employee did not contain the appropriate language necessary for such disciplinary action. Thus, the DMV stated that

in March 2018—after the completion of this investigation—it issued to the employee a corrective memorandum that contains the necessary language that will allow it to issue an adverse action to her if she does not correct her behavior.

The DMV's current efforts to ensure that it documents the employee's sleeping on the job and performance issues with appropriate language will assist it in taking disciplinary action in the future, if necessary. However, as we stated in this report, the employee's supervisors provided her with annual evaluations and corrective memorandums regarding these same issues for more than two years. We are concerned that the employee's supervisors failed to inform human resources and legal staff of the ongoing issues with the employee during this period. Doing so would have ensured the actions the employee's supervisors took were sufficient to implement the preventive and corrective phases of the State's progressive discipline process.

In response to our recommendation that the DMV take appropriate corrective or disciplinary actions against the supervisors for their failure to address the employee's sleeping and performance issues, the DMV reported that neither of them had previous performance issues in similar situations. Therefore, in accordance with the progressive discipline process, the DMV stated that it had provided training to the supervisors to ensure that similar situations do not occur in the future.

## CHAPTER 2

### ECONOMICALLY WASTEFUL ACTIVITIES

This chapter describes some of the economically wasteful activities that we identified and investigated during the past year. We have defined such activities as the careless or reckless use of state or university funds for which the State ultimately received no benefit. In the past, we have identified numerous instances of economically wasteful activities. For example, in August 2015, we reported that California Correctional Health Care Services (Correctional Health Care) wasted state funds totaling at least \$3.2 million that it paid to a contractor for electrical goods and services because the contractor used a subcontractor to perform all the work. The contractor generally charged Correctional Health Care an administrative fee of 25 percent of what the contractor paid to the subcontractor, even though the contractor did not perform any additional work or add any value to the contract.

In addition to these cases that follow, we reviewed 169 other cases that involved economically wasteful activities. We conducted preliminary investigative work on 89 of the cases, and in 28 of these instances, we obtained sufficient evidence to request additional information from the respective departments, notify the respective departments so they could look into the matters further, or launch investigations of our own, some of which may still be ongoing.

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## CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES: IT WASTED STATE FUNDS WHEN A NURSING DIRECTOR PERMITTED A LICENSED VOCATIONAL NURSE TO PERFORM NON-PATIENT CARE DUTIES

CASE I2015-1129

### Results in Brief

From May 2015 through July 2016, a director of nursing (nursing director) at a Southern California adult prison removed a licensed vocational nurse (LVN), who was her personal friend, from her assigned nursing position—or post—providing patient care and reassigned her to perform nurse scheduling duties typically done by an office technician. During this period, the LVN continued to receive her pay as a nurse even though she provided patient care only when she worked occasional overtime shifts, causing Correctional Health Care to waste \$10,543 in unnecessary salary payments. Compounding this wastefulness, the nursing director’s decision cost the State an additional \$18,741 in unnecessary overtime payments that Correctional Health Care paid to other nurses to cover the LVN’s originally assigned post, resulting in a total waste of \$29,284. In June 2016, Correctional Health Care hired a full-time office technician to perform nurse scheduling; however, the LVN continued to provide occasional assistance with scheduling. Further, from August 2016 through at least May 2017, the LVN performed newly created duties that did not include patient care, such as training staff to use the electronic health records system and auditing staff entries in that system. The LVN reported her time in a general ad hoc post, allowing her to obscure the fact that she was not working in a patient care post.

### Background

Correctional Health Care’s executive and nursing staff are responsible for upholding its mission to protect public health by providing inmate patients with timely access to safe and efficient medical care. Each California prison has a chief executive officer (CEO) who is responsible for ensuring that the prison has the appropriate resources in place to support health care functions, specifically adequate staffing. A chief nurse executive (chief nurse)

#### About the Department

Correctional Health Care, under the direction of a federal court-appointed receiver, is responsible for providing health care services to inmate patients at each of California’s 35 state prisons. It oversees more than 7,000 prison health care professionals, including doctors, nurses, pharmacists, and administrative staff.

#### Relevant Criteria

Government Code section 19818.8 mandates that a state employee must not be assigned to perform the duties of any class other than that to which his or her position is allocated, except in specific, limited circumstances.

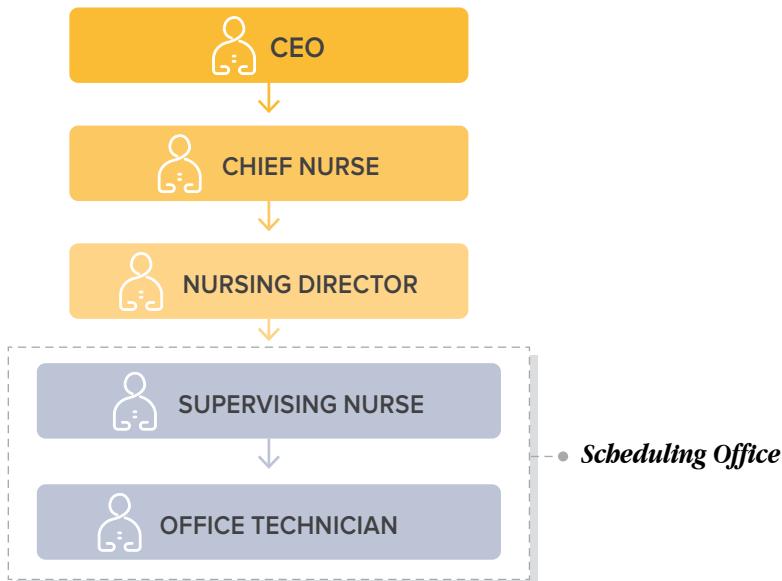
Government Code section 19572, subdivision (f), provides that dishonesty constitutes a cause for employee discipline.

California Code of Regulations, title 2, section 426, requires written documentation for any temporary assignment or loan that specifies the duration and duties of the assignment and provides a valid justification for the action.

is responsible for directing and coordinating nursing care services within each prison, while a nursing director is responsible for organizing, developing, and managing nursing services. Those in the classification of LVN provide inmates with a basic level of general nursing care, such as administering medication and immunizations, providing basic wound care and treatment, performing disease and infection prevention, obtaining and documenting inmates' clinical data, and obtaining specimens for testing.

The nurse scheduling office (scheduling office) at each prison plays an important role in ensuring adequate clinical staffing, which has a direct impact on Correctional Health Care's ability to fulfill its mission. As Figure 4 illustrates, until May 2015, the scheduling office at the prison involved in this investigation was staffed by a supervising registered nurse II (supervising nurse) who reported to the prison's nursing director and who supervised one or two scheduling office technicians. The office technicians are responsible for, among other things, scheduling nurses to ensure adequate coverage for all allocated nursing posts.

**Figure 4**  
**Reporting Structure for the Prison's Scheduling Office Until May 2015**



Source: Witness statements and Correctional Health Care's organization charts.

Another key factor for ensuring adequate clinical staffing is the accurate accounting of all allocated posts and the work the nurses perform in those posts, including overtime. Around May 2014, Correctional Health Care implemented new scheduling and

timekeeping software (scheduling software) at the prison in question. Nurse scheduling staff use the scheduling software to create nursing schedules based on the prison's shift requirements and the fiscal year's specific number of budgeted and allocated posts. The scheduling office's task of assigning nursing staff to the appropriate posts in the scheduling software is critical because it helps establish the need for additional nurse posts in future fiscal years.

### **A Nursing Director Failed to Comply With Civil Service Rules When She Removed a Nurse From Providing Patient Care and Reassigned Her to Perform Nurse Scheduling**

In May 2015, the nursing director shuffled the staff in the scheduling office and decided to remove an LVN from providing patient care and reassign her to perform nurse scheduling duties, which were the type of duties generally performed by an office technician. Not only did the nursing director fail to formally document the LVN's change in duties, but the change also did not meet the regulatory criteria for a temporary assignment. Further, the nursing director's action violated state law because she allowed the LVN to perform work duties that were inconsistent with her classification.

As part of this staffing shuffle, the nursing director removed the supervising nurse from the scheduling office, and the office technician and the LVN then began reporting to the nursing director. In October or early November 2015, about six months after the staffing shuffle, the nursing director assigned the office technician to work at another location within the prison. Shortly thereafter she pulled a replacement office technician from another area in the prison to perform scheduling duties until February 2016. The LVN continued performing nurse scheduling duties during this period. After February 2016, the LVN remained in the scheduling office by herself until the nursing director hired a second replacement office technician in June 2016.

Despite hiring the office technician in June 2016 to perform nurse scheduling duties, the nursing director continued to assign the LVN to the nursing administration office, where she assisted with scheduling and other administrative duties and seldom provided patient care. From August 2016 through at least May 2017, the nursing director, who Correctional Health Care promoted to be the new chief nurse, allowed the LVN to continue to assist with scheduling in addition to providing training and auditing staff entries in the new electronic health records system.

When interviewed, the nursing director provided several justifications for reassigning the LVN to assist in the scheduling office. However, these justifications lacked credibility. The nursing

director contended that she reassigned the LVN only after she began to notice performance issues with the office technician, but we found no evidence that she ever formally documented any performance deficiencies related to the office technician. The nursing director further asserted that she reassigned the LVN because the LVN had previous scheduling experience from working as an office technician performing nurse scheduling at the prison a few years earlier. Notwithstanding that assertion, the nursing director acknowledged that the LVN was not familiar with the prison's new scheduling software and had to travel to another prison to be trained. The nursing director stated that she moved the initial office technician to another area of the prison without formally documenting the move because she determined that the scheduling office was not the best fit for the office technician. However, multiple witnesses stated that the office technician was moved after personality conflicts ensued between the LVN and the office technician.

The nursing director also justified the decision to reassign the LVN to the scheduling office by explaining that there were no other supervising nurses or office technicians available to assist. Nevertheless, we found that the prison conducted four different recruitment efforts between May 2015 and early June 2016, from which it hired 12 office technicians. The prison assigned three of those 12 office technicians to work in other areas of nursing and could have assigned them instead to the scheduling office. Furthermore, the then-chief nurse stated in an interview that if she (referring to herself) had "put her foot down," she could have had an office technician transferred from the prison's main clinic.

Around the spring of 2015, the then-chief nurse verbally approved the nursing director's decision to reassign the LVN to assist in nurse scheduling but gave two clear directives to the nursing director: the reassignment should be a temporary fix and the LVN should return to her post once a replacement was found. The chief nurse informed us that she anticipated the temporary assignment would last about a month. The chief nurse also explained that she had dual responsibility between two prisons and thus only spent one or two days each week at this prison. Witnesses told us that the LVN hid her presence in the scheduling office from the chief nurse on the days she was there. For this reason, the chief nurse did not notice the LVN was still in scheduling until sometime after January 2016, at which point she asked the nursing director about it. The nursing director assured the chief nurse that the LVN would soon return to her regular post providing patient care. However, the chief nurse told us that she became sidetracked with other issues at the prison and never followed up. She further stated that she trusted the nursing director to "do the right thing."

***The prison assigned three of 12 newly hired office technicians to work in other areas of nursing and could have assigned them instead to the scheduling office.***

Despite the nursing director's acknowledgment that she knew the LVN's assignment was supposed to be temporary, the nursing director justified keeping the LVN in the scheduling office by stating that she needed to cover the gap between office technicians and that the LVN was needed to train the new office technicians. This argument lacks merit since the nursing director helped create the situation whereby the scheduling office no longer had an office technician to perform nurse scheduling duties. Moreover, even after the LVN had had two to six months to train the new office technicians, she did not return to her regular duties of providing patient care. A statewide chief nurse stated that Correctional Health Care expects that nurses should work as nurses and that administrative staff should handle scheduling. Other alternatives existed to ensuring adequate staffing in the scheduling office, including borrowing office technicians from other areas of the prison, which the scheduling office had done previously.

Moreover, evidence supports that the nursing director's decision to allow the LVN to work in scheduling was based on favoritism. This decision allowed the LVN to work a favorable schedule that otherwise would likely not have been available to her. The prison's staffing system generally allows nurses with the most seniority to have priority when bidding for the most desirable schedules and duties except for certain posts that management selects from interested candidates. The LVN was selected by management to work a relief post that would have required her to work a varied schedule based on when the prison needed her to cover for other nurses, including holidays. When the LVN was not needed to provide coverage at other times, her schedule should have been from 6 a.m. to 2 p.m., with her days off on Tuesdays and Wednesdays. However, she never worked this schedule. From January 2016 through May 2017, she worked in the scheduling office from 7 a.m. to 3 p.m., with weekends and holidays off, a schedule that nurses consider very desirable and that would not generally have been available to the LVN given her low seniority score. The nursing director's preferential treatment of the LVN was likely based on their friendship. When interviewed by an investigator, they both denied being friends. However, many witnesses stated that they are close friends who socialize regularly outside of work. Our review of their social media accounts corroborated the witnesses' statements.

The nursing director's favoritism and preferential treatment also played a role in the number of complaints we received and continue to receive on this and other issues. From October 2015 through October 2017, we received 25 complaints against the nursing director and the LVN, as well as other employees in the nursing division. Nine of these complaints related to the LVN performing scheduling and other administrative duties while being paid as a nurse. We were unable to substantiate improper governmental activities for the remaining 16 complaints.

*Evidence supports that the nursing director's decision to allow the LVN to work in scheduling was based on favoritism.*

### **The Nursing Director's Decision to Remove the LVN From Patient Care Cost the State at Least \$29,284**

The nursing director's decision to allow the LVN to perform scheduling duties instead of caring for patients was wasteful. As Table 2 illustrates, the State paid the LVN at a higher rate than it would have paid an office technician to perform scheduling duties, resulting in a waste of \$10,543 from May 2015 through July 2016.

**Table 2**  
**Wasteful Salary Payments From May 2015 Through July 2016**

FISCAL YEAR	TOTAL PAY FOR LVN TO WORK IN SCHEDULING	TOTAL PAY FOR OFFICE TECHNICIAN TO WORK IN SCHEDULING	PAY DIFFERENCE
<b>2014–15</b>	\$4,059	\$3,432	\$627
<b>2015–16</b>	42,292	33,151	9,140
<b>2016–17</b>	3,333	2,557	776
<b>Totals</b>	<b>\$49,683</b>	<b>\$39,140</b>	<b>\$10,543</b>

Source: State Auditor's analysis of the LVN's pay compared to the maximum pay for an office technician.

In addition, the nursing director's decision caused the State to pay other nurses overtime to cover the LVN's assigned post. During this period, the LVN spent 1,934 hours performing duties in nursing administration rather than in her assigned post providing patient care. At the same time, other nurses at the prison worked more than 10,000 hours of voluntary overtime, some of which covered the shifts the LVN should have been working to provide patient care. In fact, one witness reported that after noting the amount of overtime the other nurses were working, she asked the nursing director when the LVN would return to her post providing care. She stated that the nursing director told her "to quit asking because [the LVN] was not going anywhere." The decision to assign the LVN to scheduling duties instead of patient care cost the State \$18,741 in unnecessary overtime payments, bringing the total cost of the LVN's inappropriate assignment to \$29,284.

### **The LVN Misrepresented How She Spent Her Work Hours, Which Further Obscured That She Was Not Working in Her Assigned Post**

When completing her daily attendance records, the LVN misrepresented how she spent her work time on daily attendance records by assigning herself to a general ad hoc post in the

scheduling software. General ad hoc posts are a subcategory of incident event posts within Correctional Health Care's scheduling software. Incident event posts allow nurses to account for incidents or events that might require them to attend to duties outside their normal assigned posts. According to Correctional Health Care's advanced guide for nursing schedulers, such incidents include emergency response, hunger strikes, medical transports, and suicide prevention. If an incident does not fit within one of the several predefined categories, the scheduler can place staff in a general ad hoc post. However, according to nursing services branch staff, the general ad hoc post should be used sparingly, and the scheduler should also insert a note indicating the duties the employee was assigned to perform while in the post. During the months she assisted in the scheduling office, the LVN consistently placed herself in a general ad hoc post and never inserted an explanatory note, thereby obscuring the fact that her schedule did not match her assigned post and that she was actually performing scheduling duties instead of nursing duties. The nursing director stated that she did not have a sufficient understanding of the scheduling software to understand why the LVN assigned herself to the general ad hoc post. However, when the nursing director reviewed and approved the LVN's daily attendance records, she should have realized that the LVN's hours listed under the general ad hoc post did not accurately reflect how she spent her time. Nonetheless, the nursing director still approved the records.

### **Recommendations**

To remedy the effects of the improper governmental activities identified by this investigation and to prevent them from recurring, Correctional Health Care should take the following actions:

- Ensure that the LVN begins performing duties appropriate for her classification as a nurse who provides patient care.
- Remove the LVN's scheduler access to the scheduling software.
- Utilize appropriate administrative staff to perform scheduling duties.
- Ensure that scheduling staff use the appropriate post codes in the scheduling software for all nursing staff so their time is accurately reported.
- Ensure that all other nursing staff assignments to ad hoc posts are appropriate, and require schedulers to enter a note in the scheduling software indicating an employee's duties while in a general ad hoc post.

- Provide training to the nursing director regarding the requirements for temporary employee reassignments, including proper documentation.
- Provide training to the nursing director and the LVN on Correctional Health Care's policy on personal relationships in the employment setting.
- Consider disciplinary action against the nursing director and the LVN for being dishonest when interviewed and for violating Correctional Health Care's policy on personal relationships in the employment setting.

### **Agency Response**

In March 2018, Correctional Health Care stated that it disputed the findings in each section of our report. In July 2018, it informed us that it was still determining whether it will implement our recommendations. After further inquiry, we found that Correctional Health Care relied heavily on information from the prison CEO in preparing its response. The CEO admitted that not only did she share the confidential report with the subjects of the investigation, but that they assisted the CEO in preparing her response to Correctional Health Care. In addition, the CEO asked a witness who was interviewed as part of our investigation to write a memorandum documenting her confidential discussion with our investigator. Based on state law prohibiting any employee from divulging information relating to a confidential whistleblower investigation without the prior approval of the State Auditor, we find these actions to be inappropriate.

Correctional Health Care incorrectly asserted that the nursing director did not violate any state laws and stated that the reassignment of the LVN met the regulatory criteria under Government Code section 19050.8. This law simply allows the State Personnel Board (Personnel Board) to prescribe rules (or regulations) governing the temporary assignment or loan of employees for specific purposes, including the two purposes that Correctional Health Care cited as applicable: (a) to provide training to employees, and (b) to enable an agency to obtain expertise needed to meet a compelling program or management need. However, California Code of Regulations, title 2, section 426, requires agencies to formally document and justify any such assignments and receive approval from the Personnel Board's executive officer before making the assignments. Although management acknowledged awareness of the LVN's temporary assignment, we did not find any of the required documentation or justification, and the Personnel Board's approval was never sought.

Moreover, the LVN's assignment to scheduling duties did not meet the criteria for a temporary assignment resulting from a training and development need or a compelling management need, as provided in sections 438 and 442 of the regulations, respectively.

As noted in our report, the LVN performed office technician duties when she scheduled nurses—duties that had historically been performed by an office technician and that are still primarily performed by an office technician to this day. This assignment did not meet the criteria for allowable exceptions and therefore violated the state law that prohibits employees from being assigned to perform the duties of any class other than the class to which their positions are allocated.

Correctional Health Care also disputed that the nursing director's decision cost the State \$29,284 and asserted that the LVN's assignment actually resulted in cost savings due to increased staffing efficiencies and decreased use of overtime to cover staff positions. To support its claim, Correctional Health Care provided reports to show that the prison nursing staff had shifted from being understaffed in fiscal year 2015–16 to being overstaffed in fiscal year 2016–17, as well as other reports to demonstrate that overtime hours worked by nurses at the prison during an arbitrary date range in 2016 were less than the overtime hours worked during the same date range for the previous year. Despite this information, Correctional Health Care did not provide any evidence to suggest that the LVN's efforts contributed to these reported staffing improvements. Further, although we have not verified the accuracy of the data that were used to create these staffing reports, which were comingled with registered nurses' overtime hours, the data supports our position that the prison was understaffed during the time when the LVN was removed from patient care duties to perform nurse scheduling. The fact remains that during the time when the LVN was removed from treating patients and was performing scheduling duties, other LVNs throughout the prison were working thousands of overtime hours, including hours to cover the LVN's assigned post.

Correctional Health Care disputed the third section of the report and asserted that it does not have a policy regarding the use of general ad hoc posts in its scheduling software. Correctional Health Care cited a reference guide stating that it has no directive regarding why and when a staff member would be reassigned to a different post. However, its Nursing Master Scheduler Advanced Guide provides information on when a general ad hoc post should be used for specific events as described on page 33 of our report. Correctional Health Care also stated that the reference guide does not provide a directive for the scheduler to enter a note in the scheduling software indicating the duties the employee was

assigned to perform while in the post. Although Correctional Health Care is correct that this is not a written directive, nursing services branch staff told us that the scheduler should include a note to define the duties being performed. Thus, when the LVN placed herself in a general ad hoc post and did not insert an explanatory note, she obscured that she was not performing nursing duties and misrepresented how she spent her work hours, which could have had an impact on Correctional Health Care's budgetary and staffing decisions.

Correctional Health Care also stated that the LVN never documented time that she did not work and that the nursing director signed and submitted only true and accurate timesheets. Our report did not conclude that the LVN inaccurately recorded the number of hours she worked. Instead, we found that the LVN did not accurately represent in the timekeeping system the actual duties she was performing: scheduling in lieu of the nursing duties affiliated with her state classification.

## CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION: IT IMPROPERLY PAID AN ANALYST FOR INMATE WORKER SUPERVISION AND FAILED TO SEEK REPAYMENT

CASE I2017-0453

### Results in Brief

The California Department of Corrections and Rehabilitation (CDCR) overpaid a staff services analyst (analyst) at one of its prisons nearly \$3,000 from July 2016 through March 2017. CDCR provides extra pay—known as Institutional Worker Supervision Pay (inmate supervision pay)—to employees in eligible positions who supervise inmate workers in addition to performing their regular duties. The analyst had been entitled to and received inmate supervision pay in her former position as an office technician. However, CDCR began providing the inmate supervision pay to her again after it promoted her to a position that was not eligible to receive it.

The analyst, her manager, an associate warden, and a personnel specialist all failed to follow CDCR procedure and California Department of Human Resources (CalHR) policy regarding inmate supervision pay. Had they followed established processes, they would have recognized that the analyst no longer qualified for the inmate supervision pay in her new position. Moreover, after two internal audits in 2017 documented the error in pay and recommended the recovery of the overpayments, the associate warden chose not to initiate any collection efforts, which violated state law.

Based on our past investigations and on audits conducted by the State Controller's Office, we determined that CDCR has an ongoing, systemic problem with improperly paying employees inmate supervision pay.

### Background

As part of its rehabilitation process, CDCR employs inmates in a variety of positions inside its prisons. CDCR regularly assigns noncustody staff to supervise inmates when those inmates are performing their work obligations. State employees in certain

#### About the Department

CDCR's mission is to enhance public safety through safe and secure incarceration of offenders, effective parole supervision, and rehabilitative strategies that help offenders successfully reintegrate into communities upon their release.

#### Relevant Criteria

Government Code section 19838 requires the State to recoup employee overpayments and prescribes the methods for recovery. Administrative action to recover an overpayment must be initiated within three years from the date of overpayment.

State Civil Service Pay Scales section 14, Pay Differential 67, in conjunction with certain union bargaining agreements, provides for inmate supervision pay to state employees in specified positions when they are assigned to supervise inmate workers in addition to performing their regular duties. To qualify each month, an eligible employee must supervise at least two inmates for a minimum number of hours during the pay period. Depending on the employee's position, the monthly amount of inmate supervision pay can range from \$190 to \$400.

positions who are assigned to supervise inmate workers in addition to performing their regular responsibilities are entitled to inmate supervision pay, a type of pay differential, ranging from \$190 to \$400 per month, provided they meet specific requirements. The amount of inmate supervision pay an employee receives is dependent on the employee's position. For example, office technicians at a prison who meet the necessary criteria and who act as inmate supervisors receive \$190 of inmate supervision pay each month.

CDCR's inmate supervision pay procedure requires the personnel office at each prison to conduct yearly audits of its inmate supervision pay program. During 2017, personnel staff at the prison in question completed audits for fiscal years 2015–16 and 2016–17.

### **CDCR Improperly Paid the Analyst Nearly \$3,000 After Her Promotion Made Her Ineligible for Inmate Supervision Pay**

For most of July 2013 through June 2015, the analyst in question was in the office technician classification, supervised inmate workers, and appropriately received the monthly inmate supervision pay of \$190. In July 2015, CDCR promoted the employee to her current position as an analyst, which is not eligible to receive inmate supervision pay. For the first year following her promotion, the analyst did not supervise inmate workers and did not receive any extra pay.

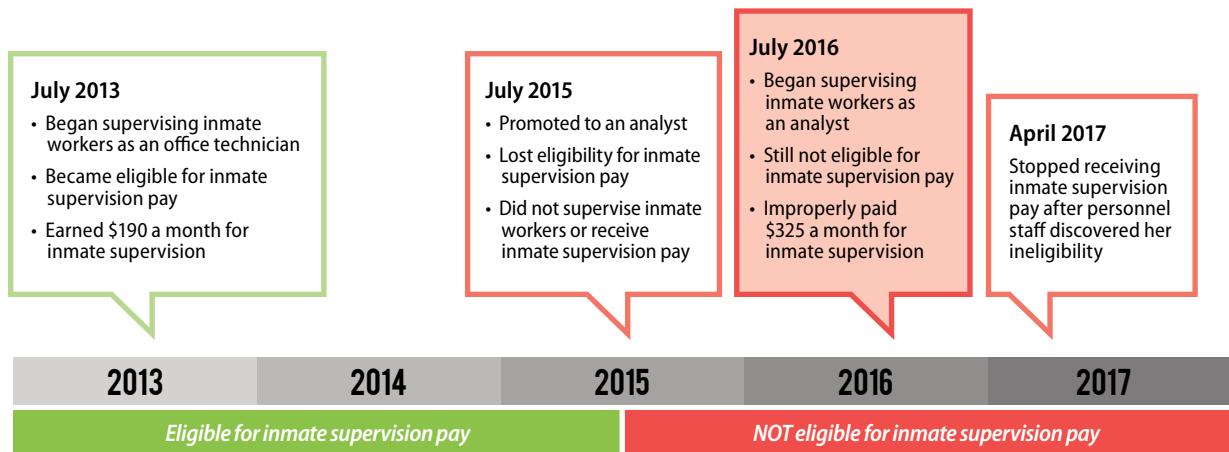
In July 2016, the analyst began to again supervise inmate workers. Although the analyst was now employed in a position that was ineligible to receive inmate supervision pay, CDCR improperly paid her at an increased rate of \$325 per month in extra pay from July 2016 through March 2017, for a total of \$2,925. According to the analyst and associate warden, the analyst began supervising inmate workers again because the office technician who had been supervising the inmates transferred to another facility and the analyst was the only staff member available to perform that task until a new office technician was hired. Nevertheless, after CDCR appointed another office technician in December 2016, the analyst continued supervising inmate workers and receiving the inmate supervision pay for several more months. Figure 5 presents a timeline of when the analyst supervised inmates from July 2013 through April 2017 and identifies the periods during which her job classification made her ineligible to receive inmate supervision pay.

Management and personnel staff allowed the analyst to receive inmate supervision pay because they failed to recognize that she was not eligible to do so. Each of those nine months, the analyst filled out the monthly inmate supervision pay documentation, and her manager approved and submitted it to an experienced personnel specialist for processing.<sup>3</sup>

<sup>3</sup> In one of the nine months, another manager approved the analyst's inmate supervision pay documentation.

Although the personnel specialist was familiar with the inmate supervision pay criteria, she did not verify the analyst's eligibility. Instead, the personnel specialist processed the inmate supervision pay, and CDCR paid the analyst.

**Figure 5**  
Timeline of the Analyst's Eligibility for Inmate Supervision Pay



Source: State Controller's Office records and State Auditor's interviews of CDCR staff.

In 2017 personnel staff at the prison completed two internal audits of the inmate supervision pay program that revealed the overpayments. After personnel staff discovered the problem during the first audit, a personnel specialist immediately stopped the inmate supervision pay for the analyst and notified her of the overpayment. The personnel specialist also presented the analyst with payment plan options to repay the overpayments. However, the associate warden told personnel staff to hold off on seeking repayment, so personnel staff never followed up with the analyst to establish a payment plan.

#### **The Associate Warden Chose Not to Seek Repayment as State Law Requires**

After personnel staff discovered the overpayments, the personnel manager informed the associate warden of the audit findings and sought his direction, but the associate warden decided not to pursue collection. The associate warden told investigators that he believed the analyst deserved the inmate supervision pay and did not consider it an overpayment because the analyst actually supervised inmate workers from July 2016 through March 2017. However, the inmate supervision pay criteria do not provide any exceptions to the eligibility requirements. The associate warden took

responsibility for the situation, acknowledging that it was his decision to not seek repayment and stating that he did not recall consulting with other authorities to arrive at that decision.

As of December 2017, CDCR still had not begun to recoup the overpayments from the analyst. The personnel officer informed us that she was still waiting for the associate warden's approval to move forward with the collection process.

### CDCR Continues to Pay Ineligible Employees for Inmate Supervision

Despite our previous recommendations and CDCR's efforts to implement corrective procedures, we found in this investigation that the analyst, her manager, and the associate warden were not aware of CDCR's procedure for its inmate supervision pay program and of CalHR's inmate supervision pay criteria. They claimed to be unaware that the inmate supervision pay procedure and criteria even existed and said they had not received any training related to inmate supervision pay. As a result, they were unfamiliar with the eligible positions, initial approval process, and other requirements for the extra pay. The associate warden was also not aware that CDCR is required to conduct annual audits of its inmate supervision pay program. Although the personnel specialist was familiar with the inmate supervision pay procedure and criteria, she claimed to be unaware that the analyst's position was not eligible for the inmate supervision pay.

Figure 6 shows a timeline of the State Auditor's three previous investigations of CDCR's inmate supervision pay program from 2008 through 2017, in each of which we reported that CDCR had improperly paid one or more employees. Figure 6 also includes this current investigation.

**Figure 6**  
**Timeline of Our Investigations of the Inmate Supervision Pay Program**  
**Showing the Improper Pay We Identified at Nine Prisons**



Source: State Auditor's investigative reports.

In addition, after reviewing the payroll processes at three CDCR prisons, the State Controller's Office published audit findings in 2014 that identified 53 ineligible employees to whom CDCR had inappropriately given inmate supervision pay totaling \$78,315.

### **Recommendations**

To remedy the effects of the improper governmental activity identified by this investigation and to prevent it from recurring, we recommend that CDCR take the following actions:

- Seek repayment from the analyst for the \$2,925 in improper payments.
- Fully implement and continue to follow recommendations from prior investigative reports involving similar inappropriate inmate supervision pay at other CDCR facilities, including the recommendation to train all employees who receive, approve, or issue the inmate supervision pay.
- Provide additional training to the individuals involved in this investigation regarding the eligibility requirements for inmate supervision pay and overpayment procedures.
- Revise the prison's inmate supervision pay approval form to include the date on which the employee received inmate supervision pay training and require signatures on each form from the employee, supervisor, and personnel staff to show that they received the training and are aware of the rules regarding inmate supervision pay.

### **Agency Response**

CDCR reported in March 2018 that it had begun its efforts to implement our recommendations. CDCR indicated that it had established an accounts receivable for the analyst to repay the \$2,925 of improper payments and formally notified her of the repayment process. In addition, CDCR told us that it has continued to implement the recommendations we made during prior investigations, including providing training on the inmate supervision pay program to employees at this prison who receive, approve, or issue inmate supervision pay. CDCR stated that it is revising its procedures for the inmate supervision pay program and will be training its employees on the procedures upon completion. Lastly, CDCR revised its inmate supervision pay approval form at the prison to include training dates and signatures of employees who receive, approve, and issue inmate pay. It stated that it planned to implement a statewide form when it releases its revised procedures for the inmate supervision pay program.

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## CALIFORNIA STATE UNIVERSITY, DOMINGUEZ HILLS: A MANAGER WASTED FUNDS AND USED UNIVERSITY RESOURCES INEFFICIENTLY WHEN HE PURCHASED CAPITAL EQUIPMENT THAT HAS NEVER BEEN INSTALLED

CASE I2017-0195

### Results in Brief

In March 2013, a manager at California State University, Dominguez Hills (Cal State Dominguez Hills) directed a member of his staff to purchase a Nissan-manufactured electric vehicle (EV) quick charger for \$6,840 before the manager had performed the due diligence necessary to ensure that the equipment was compatible with the energy resource plan for the campus. The quick charger has remained unused for five years, its warranty lapsed in 2014, and Nissan is no longer manufacturing replacement parts. As of February 2018, the campus did not have plans to install the quick charger before 2020 or 2021, if at all.

#### About the University

Cal State Dominguez Hills serves primarily the southern part of Los Angeles County and is one of 23 campuses that comprise the CSU system. CSU is committed to sustainable environmental and energy practices.

#### Relevant Criteria

Government Code section 8547.2, subdivision (c), provides that any activity by a state agency or employee that is either economically wasteful or involves inefficiency constitutes an improper governmental activity.

### Background

A CSU policy tasks each campus with developing and maintaining a campuswide integrated strategic energy resource plan, which includes energy projects and an energy management plan (master plan). Executives in the division of administration and finance (finance division) are responsible for executing the master plan and overseeing the energy programs. The master plan at Cal State Dominguez Hills included installing EV charging stations, as well as implementing other rapidly evolving technologies to facilitate sustainable energy. Most commercially available standard EV charging stations can fully charge a vehicle in three to eight hours. While a quick charger can fully charge a vehicle in less than one hour, the quick charger model that Cal State Dominguez Hills purchased is compatible with only three vehicles in the United States: the Nissan Leaf, the Kia Soul EV, and the Mitsubishi i-Miev.

In response to an allegation we received about a manager's wasteful purchase of a quick charger at Cal State Dominguez Hills, we initiated an investigation.

### The Cal State Dominguez Hills Manager Failed to Perform Due Diligence Before Purchasing the Quick Charger

Our investigation found that the manager was inefficient when he failed to perform due diligence before directing a member of his staff to purchase a quick charger, ultimately resulting in a waste of university funds. As the timeline in Figure 7 indicates, the manager learned in February 2013 about an incentive program through which Nissan offered a quick charger at a discount. That same day, the manager directed a member of his staff to purchase the quick charger without first determining whether its installation was feasible and compatible with the campus's energy resource and master plan. The manager's email to his staff member stated, "Let's get one before I change my mind."

The master plan at Cal State Dominguez Hills included a project to install six standard EV charging stations in one of the university's parking lots. After the purchase of the quick charger in March 2013, the manager directed his staff in May 2013 to incorporate the quick charger into the existing EV project. By October 2013, the staff had developed the new specifications for the installation of the six standard EV charging stations and the quick charger into the selected parking lot.

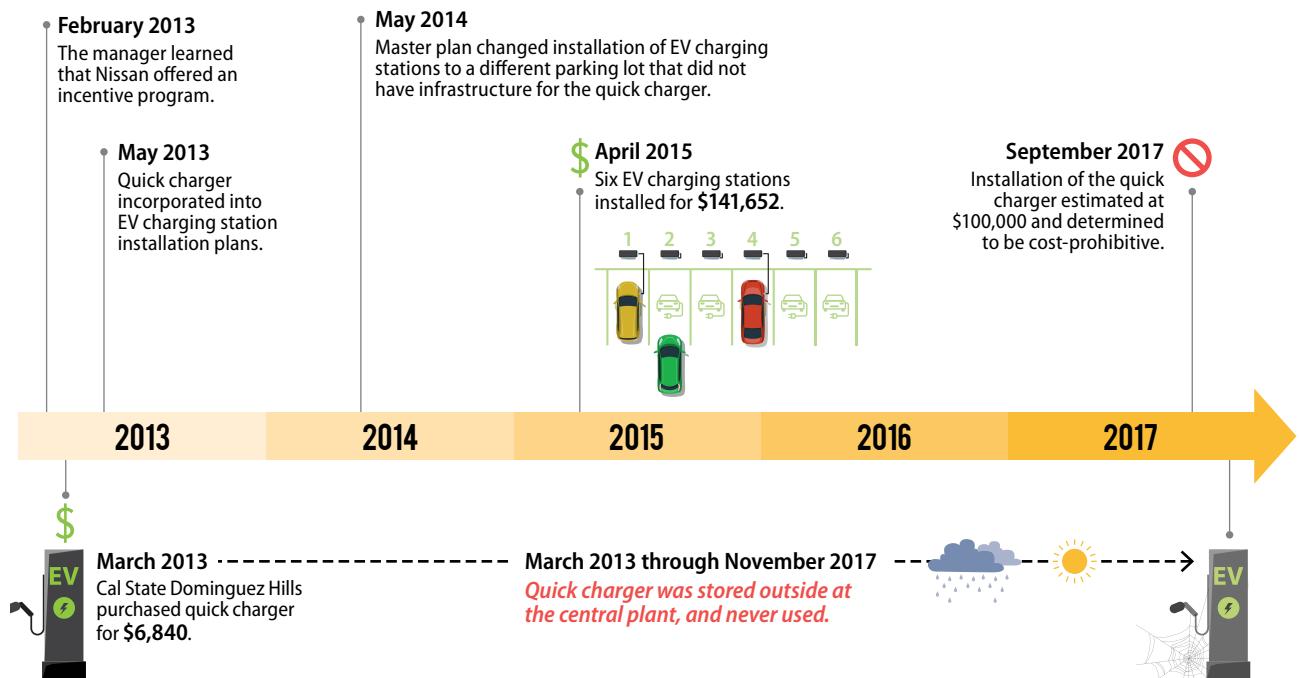
However, a former executive in the finance division made changes to the EV project in May 2014 that moved the installation of the six standard EV charging stations to a different parking lot, which did not have the electrical infrastructure, such as conduits or transformers, to support installation of the quick charger. As a result, the quick charger was excluded from the revised EV project. According to the former executive, he concluded that installing the six standard EV charging stations in the new parking lot was less costly because it was closer to the core of the campus and already connected to power, which had not been the case for the initial parking lot. In April 2015, the university installed the six standard EV chargers at a cost of around \$142,000.

By not ensuring the incorporation into the revised EV project of the capital equipment whose purchase he had directed, the manager failed to perform one of the reasonable duties of his position. Specifically, when the former executive changed the location of the EV project, the manager should have developed an alternative plan either for installation of the quick charger or for its disposition.

In addition to his failure to follow through with seeing that the quick charger was installed or put to good use, the manager allowed it to remain outdoors in an unsecured part of the central plant for nearly five years. The campus moved the quick charger to a secure location only after we initiated our investigation—in

fact, it was one week before our investigator's visit to the campus in November 2017. As of April 2018, the quick charger had not been installed, meaning that expenditure for its purchase was a waste of university funds.

**Figure 7**  
Timeline of the Activity Related to the Quick Charger



Source: State Auditor's review of the quick charger purchase, EV project data from the master plan, and interviews.

Furthermore, the manager did not determine that the installation cost for the quick charger was likely prohibitive—the campus estimates that it could cost \$100,000—until after we inquired about the status of the quick charger. The manager acknowledged that he did not know the installation cost would be that high at the time of purchase. He stated that he looked into getting one because other campuses were starting to install them, it seemed like a good idea at the time, and he could get one at half price. He thought that the cost savings for the purchase of the quick charger could be put into infrastructure cost to support its installation.

According to the finance division's current executive, installation of the quick charger will be coordinated with construction of a new parking structure in 2020 or 2021 unless another opportunity occurs sooner. However, when we spoke to other knowledgeable

university employees, they were skeptical about whether installing the quick charger in the future would be feasible. Specifically, the manager stated that he did not think the university had plans to install the quick charger in the next few years as the university is focusing on solar applications. In addition, the subordinate employee who was tasked originally with purchasing the quick charger stated that the master plan shows Cal State Dominguez Hills is “doing so much on the campus” that he had no idea of a place where they could install the quick charger.

In contrast to the Cal State Dominguez Hills’ manager’s lack of planning and foresight, California State University, Fullerton (Cal State Fullerton) demonstrated due diligence in its May 2014 acquisition and subsequent installation of the same model quick charger. Its quick charger was installed at a significantly lower cost because Cal State Fullerton entered into an incentive program wherein a private energy storage company donated the quick charger and reimbursed Cal State Fullerton up to \$30,000 for installation costs.

### **Recommendations**

To remedy the effects of the improper governmental activity identified by this investigation and to prevent it from recurring, Cal State Dominguez Hills should take the following actions:

- Implement a cost-effective plan to install and use the quick charger in a campus project or develop plans to transfer it to another university or state agency.
- Establish a check-and-balance process regarding procurement decisions to prevent future wasteful purchases.

### **Agency Response**

In April 2018, Cal State Dominguez Hills reported that it took seriously the issue we identified and the recommendations we outlined. However, Cal State Dominguez Hills stated that the report contained several inaccuracies that it believed were important to point out.

First, Cal State Dominguez Hills took issue with our statement that the quick charger model it purchased is compatible only with three vehicles in the United States. Instead, Cal State Dominguez Hills asserted that the quick charger model it purchased is the “world-wide standard” and makes up the majority of all of the quick charger stations in the United States. However, quick chargers in

the United States use one of three standard ports: the CHAdeMO standard, the combined charging system standard, or the Tesla supercharging standard. The quick charger model purchased by Cal State Dominguez Hills uses a CHAdeMO port, with which only the Nissan Leaf, the Kia Soul EV, and the Mitsubishi i-Miev in the United States are compatible, as our report states.

Second, Cal State Dominguez Hills stated that the decision by the manager to purchase the quick charger was consistent with its master plan at the time, and it also stated that when the manager initiated the purchase of the quick charger, he had no way of knowing or anticipating the former executive's decision to change the parking lot location of the six standard EV charging stations. Thus, it asserted that the manager's decision did not demonstrate a lack of due diligence.

However, Cal State Dominguez Hills' response did not mention that the manager failed to develop an alternative plan either for installation of the quick charger or for its disposition after the location for the EV charging stations were changed. In addition, the manager acknowledged to us that he did not know about the high installation cost of the quick charger at the time of the purchase. More importantly, only after we inquired about the status of the quick charger—more than four years after the purchase and three years after the change in plans—did the manager determine that the installation cost for the quick charger was likely a prohibitive \$100,000. Accordingly, we concluded that the manager did not demonstrate due diligence when he purchased the quick charger.

Furthermore, although the report stated the manager allowed the quick charger to remain outdoors in an unsecured part of the central plant for nearly five years, Cal State Dominguez Hills asserted that charging stations are intended to be located outdoors and thus storing it in an outdoor location was not problematic and did not affect its functionality. Cal State Dominguez Hills also stated that our report did not recognize the secure nature of the central plant operation or account for the distance from its central plant to campus parking lots, as the size and bulk of the quick charger renders it difficult to move. It also stated that the quick charger was not in an unsecured location because the quick charger was not disturbed or removed from the campus inappropriately and remains in Cal State Dominguez Hills' inventory.

We recognize that charging stations are intended to be located outdoors and that the quick charger's outdoor location may not have affected its functionality. We also understand that the size and weight of the quick charger may make it difficult to move. Regardless, Cal State Dominguez Hills did not provide evidence to suggest that the quick charger's storage was secure enough to

prevent it from potentially being inappropriately removed. In addition, Cal State Dominguez Hills allowed the quick charger to remain stored outside of its central plant for nearly five years. Only after we initiated our investigation—and one week before our investigator's visit in November 2017—did Cal State Dominguez Hills staff move the quick charger to the secure indoor location where the investigator observed it. If the campus believed the quick charger's previous storage location was appropriate, we are uncertain why it chose to move the quick charger immediately before our visit.

Third, Cal State Dominguez Hills reported that the manager denied stating that the university did not have plans to install the quick charger in the next few years because the university is focusing on solar applications. Our recorded interview with the manager shows that when asked if he had an idea or a projected time frame for when the quick charger might be installed, the manager stated in part that he had talked to the administration about putting in more charging stations and potentially installing the quick charger with those additional charging stations. However, he stated that according to Cal State Dominguez Hills' master plan, the parking lots were "off limits" at that time and Cal State Dominguez Hills was "looking at solar applications and other things." Therefore, the manager's recollection of what he stated during his recorded interview is inaccurate.

Finally, Cal State Dominguez Hills stated that the manager and the subordinate employee whom he asked to purchase the quick charger recently submitted a proposal to the vice president of the finance division for the installation of an additional 50 EV charging stations in one of the parking lots. It stated that this vice president is reviewing and evaluating the proposal, which includes an assessment of cost-effectiveness and potential installation of the quick charger. Regardless, the quick charger remains unused more than five years after its purchase.

## CHAPTER 3

### MISUSE OF STATE PROPERTY

This chapter details some of our investigative work regarding misuse of state property. Misuse of state property is an improper governmental activity that can have significant impact on state government. For example, as a result of weak management by the California Department of Transportation (Caltrans) of a state-owned mobile home park, the tenants of the mobile home park collectively owed the State \$314,977 in overdue rent, late fees, and unpaid utility charges as of December 2015. Caltrans had not billed the tenants for most of these charges because it had not taken the steps necessary to determine how much each tenant owed. Further, it had failed to evict two individuals who illegally occupied mobile homes in the park, and it had neglected to annually review the monthly rental rate within the park. As a result of our investigation, Caltrans implemented all of our recommendations.

In addition to the case that follows, we reviewed 111 cases from July 2017 through June 2018 that involved misuse of state property. We conducted preliminary investigative work on 46 of these cases, and in 15 instances, we obtained sufficient evidence to request additional information from the respective departments, notify the respective departments so they could look into the matters further, or launch investigations of our own, some of which may still be ongoing.

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## CALIFORNIA DEPARTMENT OF FORESTRY AND FIRE PROTECTION: AN ASSISTANT CHIEF MISUSED STATE RESOURCES TO BUILD AN UNAUTHORIZED STRUCTURE

CASE I2017-0912

### Results in Brief

A California Department of Forestry and Fire Protection (CAL FIRE) assistant chief misused state resources when he violated his rental agreement by building an unauthorized structure on state property using staff under his command. In 2016 the assistant chief built a 16-foot-by-20-foot structure with plumbing, electrical, and sewer connections in the backyard of the state residence he rented from CAL FIRE. Although he used personal funds for the materials needed to build the structure, he did not receive written approval from CAL FIRE to build the structure as his rental agreement required or from the Office of the State Fire Marshal (Fire Marshal), which is responsible for inspecting state-owned buildings. Furthermore, the assistant chief misused state employees and caused discredit to CAL FIRE when he had two CAL FIRE staff under his command perform substantive work to build the structure while they were on duty. Finally, the rental agreement CAL FIRE used does not adequately protect the State from liability because the certain provisions within the agreement are ambiguous and insufficient.

### Background

CAL FIRE consists of 21 units throughout the State that are designed to address fire suppression over specific geographic areas. Each unit has an assistant chief who reports to the unit chief and is the second in command at the unit. The unit in this investigation has a compound that consists of administrative offices, a maintenance area for fire trucks and other CAL FIRE equipment, and barracks for firefighters to use while they are on duty. Two state-owned, single-family houses and a mobile home are also located on the compound, and CAL FIRE rents these residences to its employees. The assistant chief who is the subject of this investigation has rented one of the single-family

### About the Department

CAL FIRE is responsible for fire protection and stewardship of more than 31 million acres of California's privately owned wildlands. In addition, CAL FIRE provides emergency services in 36 of the State's 58 counties through contracts with local governments. As part of CAL FIRE, the Fire Marshal supports CAL FIRE's mission to protect life and property through fire prevention programs and enforcement of fire-related laws in state-owned or -operated buildings.

### Relevant Criteria

Government Code section 8314 prohibits state employees from using state resources for personal enjoyment, private gain, or personal advantage.

Government Code section 19572, subdivisions (p) and (t), specify that misuse of state property and other failure of good behavior either during or outside of duty hours that is of such a nature that it causes discredit to the State constitute causes for discipline of an employee.

Health and Safety Code section 13108 and Title 19 of the California Code of Regulations grant the Fire Marshal authority over the design and construction of state-owned buildings and over the enforcement of the applicable building standards and regulations, including requirements for electrical wiring and plumbing. These provisions of law require that construction plans be submitted to the Fire Marshal for review and that structures comply with standards.

homes since 2014. From February through August 2016, the assistant chief built a 16-foot-by-20-foot structure with plumbing, sewer connections, and electricity in the backyard of the home.

In response to an allegation we received that the assistant chief misused state resources, we requested information from CAL FIRE. To respond to our request, CAL FIRE conducted an investigation.

### An Assistant Chief Built an Unauthorized Structure on State Property for Personal Purposes

The assistant chief misused state land when he built an unauthorized structure in the backyard of the home he rented from CAL FIRE. The rental agreement states that the tenant agrees to obtain written consent from the CAL FIRE unit before making any significant improvements or changes to the site. In addition, state law requires building plans for state-owned structures to be submitted to the Fire Marshal for review to ensure compliance with applicable building code requirements. However, the assistant chief did not obtain written approval from his unit chief or designee and did not submit his plans to the Fire Marshal for review before beginning construction in February 2016 on a 16-foot-by-20-foot structure. The assistant chief therefore violated both the rental agreement and state law. Figure 8 shows the interior of the structure in question.

**Figure 8**  
Photographs of the Interior of the Structure



After we made CAL FIRE aware of the misuse of state property, the unit chief instructed the assistant chief to remove the structure or face eviction in November 2017. Complying with the unit chief's order, the assistant chief removed the structure in December 2017.

### **The Assistant Chief Exposed CAL FIRE to Liability**

The assistant chief exposed CAL FIRE to liability by constructing the unauthorized and unpermitted structure on state property. Because he did not obtain a permit through the Fire Marshal's permit review process, CAL FIRE had no assurance that the construction, plumbing, and electrical work complied with applicable building code requirements. In addition to the liability resulting from construction issues, the unit chief reported that he was primarily concerned with the potential liability of the State and CAL FIRE because the assistant chief hosted events in the structure and served alcoholic beverages to dozens of guests. For example, on certain dates in October 2016 and November 2017, the assistant chief invited numerous guests to travel to the residence to experience the décor and to consume alcoholic beverages. The guests then drove off the CAL FIRE compound either in their own vehicles or in a limo bus that their driver parked in front of the residence.

### **CAL FIRE'S Standard Rental Agreement Also Exposes the State to Liability**

The standard rental agreement that CAL FIRE entered into with the assistant chief and with more than 25 other tenants across the State also does not sufficiently protect the State from potential liability claims. Specifically, the rental agreement for CAL FIRE's state-owned housing requires each tenant to obtain written consent from the unit chief before "conducting any major landscaping" or "making any significant improvements or changes" to the property or adjoining area. However, this provision does not sufficiently describe "significant improvement or changes," which leaves the interpretation to each unit chief. When interviewed by CAL FIRE, the assistant chief stated that before he built the structure, he mentioned it to the unit chief and the other assistant chief, and that the final structure he constructed reflected his intentions during those conversations. However, the unit chief and the other assistant chief did not share the assistant chief's understanding of his intentions, and the unit chief reported that he did not give the assistant chief the required approval to build the type of structure that was built. In this instance, all three individuals had different interpretations of the assistant chief's planned structure, and they never discussed or resolved whether the structure constituted a

***The applicable rental agreement clarified that the tenant must not make any alterations to the premises of the rental property without first obtaining written permission from the landlord.***

significant change to the property. Because of the ambiguity in this provision in Cal FIRE's rental agreement, the State is left vulnerable against claims of potential liability against it.

In contrast, we reviewed a general residential rental agreement that offered much greater specificity regarding improvements or alterations. This rental agreement clarified that the tenant must not make *any* alterations to the premises of the rental property without first obtaining written permission from the landlord. If CAL FIRE's rental agreement had included a similar provision, it would have ensured that the assistant chief needed to seek written approval before making any changes to the rental property in which he resided.

Another provision in the CAL FIRE rental agreement aims to limit claims against the State. The provision establishes that neither the State nor CAL FIRE is responsible for losses or damage to the tenant's personal property, equipment, or materials and states that CAL FIRE recommends that the tenant obtain renter's insurance. However, this provision is merely a recommendation rather than a requirement and does not identify a minimum level of insurance coverage. By contrast, the bargaining unit representing firefighters and the State included a provision in the bargaining agreement effective January 2017 that requires all lessees of state-owned housing to secure at their personal expense a broad policy of comprehensive coverage of public liability insurance, insuring the lessees against loss or liability caused by or connected with their occupation or use of the rental properties. It further requires a minimum coverage of \$300,000 for injury and \$500,000 for damage to or destruction of any property. By not including similar provisions in its standard rental agreement, CAL FIRE has not protected the State from potential liability.

The general residential agreement that we analyzed also provided greater specificity with regard to obtaining renter's insurance for the property. In particular, this agreement acknowledges that the landlord does not maintain the insurance to cover personal property damage or loss caused by fire, rain, theft, and other such acts, and the agreement further specifies that the landlord is not responsible for any such occurrences. More importantly, this agreement clarifies that the tenant's failure to maintain an insurance policy waives the tenant's right to seek damages from the landlord in the event of these losses.

Furthermore, the general residential agreement includes a provision stating that a tenant and any guests must not disturb, annoy, endanger, or inconvenience other tenants and neighbors.

In addition, this agreement states that the tenant must not obstruct any public spaces and must ensure that the activities of each tenant and guest do not interfere with the convenience of other residents. Had the standard CAL FIRE rental agreement included this provision, the State would have been more protected against any liability caused by the numerous guests who visited the structure for the assistant chief's private events in 2016 and 2017.

### **The Assistant Chief Misused the Time and Resources of Subordinate Employees Who Felt Obligated to Help Him**

The assistant chief misused subordinate employees to assist him with building the structure. Specifically, two CAL FIRE employees felt obligated to help him build the structure on state time because of his rank. In February 2016, the assistant chief had a heavy fire equipment operator under his command at the time dig holes about one to three feet deep with an auger that the assistant chief rented. The assistant chief also had the employee fill the holes with concrete to serve as part of the structure's foundation. The employee reported that he helped the assistant chief because he was new to state employment and did not know it was wrong. He interpreted the assistant chief's request as "giving me an order to come help him." In addition, the assistant chief used a subordinate battalion chief to help him put sheeting on the roof of the structure. The battalion chief stated that he viewed the work as a request from his boss rather than as a request from a friend. By directing on-duty firefighters under his command to assist him with building an unauthorized structure, the assistant chief misused state resources and exercised poor judgment. Further, his behavior caused discredit to the State.

### **Recommendation**

To address the improper governmental activity we identified in this investigation, CAL FIRE should take the following actions:

- Take appropriate disciplinary action against the assistant chief.
- Modify its standard rental agreement with tenants to limit the State's potential liability by providing more specificity with regard to making improvements or alterations to its rental properties, ensuring that tenants maintain renter's insurance, clarifying that CAL FIRE is not responsible for any personal property damage or loss, and ensuring the tenants and their guests do not interfere with the convenience of other residents of rental properties.

### Agency Response

In June 2018, CAL FIRE reported that it had served the assistant chief with a 30-day unpaid suspension and the unit chief with a letter of warning for not being fully in control of employees who report directly to him. Further, CAL FIRE stated that it agreed with our recommendation to modify its standard rental agreement and requested information from us to assist with its research related to modifying the agreement.

Respectfully submitted,



ELAINE M. HOWLE, CPA  
State Auditor

Date: July 24, 2018

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

# Appendix

## THE CALIFORNIA WHISTLEBLOWER PROTECTION ACT

### The Critical Role of Whistleblowers

Whistleblowers are critical to ensuring government accountability and public safety. Under state law, anyone who reports an improper governmental activity is a whistleblower and is protected from retaliation.<sup>4</sup> An improper governmental activity is any action by a state agency or by a state employee performing official duties that does the following:

- Breaks a state or federal law.
- Is economically wasteful.
- Involves gross misconduct, incompetence, or inefficiency.
- Does not comply with the *State Administrative Manual* or the *State Contracting Manual*.

### Ways That Whistleblowers Can Report Improper Governmental Activities

Reports can be made by calling the toll-free Whistleblower Hotline (hotline) at (800) 952-5665, by mail, or through the State Auditor's website at [www.auditor.ca.gov/contactus/complaint](http://www.auditor.ca.gov/contactus/complaint).

### Investigation of Reports

The State Auditor confidentially investigates reports of improper governmental activity by state agencies and state employees. The State Auditor may conduct an investigation independently or it may elect to have another state agency perform the confidential investigation under its supervision.

<sup>4</sup> The Whistleblower Act can be found in its entirety in Government Code sections 8547 through 8548.5. It is available online at <http://leginfo.legislature.ca.gov>.

### **Actions That May Be Taken When the State Auditor Finds Improper Governmental Activities**

If an investigation establishes that an improper governmental activity has occurred, the State Auditor may take one or more of the following actions:

- Confidentially report the matter to the Attorney General, the Legislature, law enforcement, or any other entity having jurisdiction over the matter.
- Issue a confidential report to the head of the agency involved or to the entity with authority to take action against the state employee involved.
- Issue a public report on the matter, keeping confidential the identities of the individuals involved.

The State Auditor performs no enforcement functions: this responsibility lies with the appropriate state agency, which is required to regularly notify the State Auditor of any action taken, including disciplinary action, until final action has been taken.

### **The Protection of Whistleblowers**

State law protects state employees who blow the whistle on improper governmental activities. The State Auditor will protect a whistleblower's identity to the maximum extent authorized by law. Retaliation by a state employee against a state employee who files a report is unlawful and may result in monetary penalties and imprisonment.

### **Corrective Actions Taken in Response to Investigations**

The chapters of this report describe the corrective actions that state agencies implemented on certain cases for which the State Auditor completed investigations from July 2017 through June 2018. In addition, Table A summarizes all corrective actions that state agencies took in response to investigations from the time that the State Auditor opened the hotline in July 1993 until June 2018. Furthermore, these investigations have resulted in many state agencies modifying or reiterating their policies and procedures to prevent future improper activities.

**Table A**  
**Corrective Actions**  
**July 1993 Through June 2018**

TYPE OF CORRECTIVE ACTION	TOTALS
<i>Convictions</i>	12
<i>Demotions</i>	22
<i>Job terminations</i>	88
<i>Resignations or retirements while under investigation</i>	27*
<i>Pay reductions</i>	58
<i>Reprimands</i>	340
<i>Suspensions without pay</i>	32
<b>Total</b>	<b>579</b>

Source: State Auditor.

\* The State Auditor began tracking resignations and retirements in 2007, so this number includes only those that occurred during investigations since that time.

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