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# Management and Financial Audit of the Department of Public Safety

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A Report to the  
Governor  
and the  
Legislature of  
the State of  
Hawai'i

Report No. 00-05  
February 2000



**THE AUDITOR**  
STATE OF HAWAI'I

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## Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawai'i State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. Financial audits attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.
2. Management audits, which are also referred to as performance audits, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called program audits, when they focus on whether programs are attaining the objectives and results expected of them, and operations audits, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.
3. Sunset evaluations evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.
4. Sunrise analyses are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.
5. Health insurance analyses examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.
6. Analyses of proposed special funds and existing trust and revolving funds determine if proposals to establish these funds are existing funds meet legislative criteria.
7. Procurement compliance audits and other procurement-related monitoring assist the Legislature in overseeing government procurement practices.
8. Fiscal accountability reports analyze expenditures by the state Department of Education in various areas.
9. Special studies respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawai'i's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.



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# OVERVIEW

## *Management and Financial Audit of the Department of Public Safety*

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### Summary

Administering correctional institutions is complex and demanding. The Legislature requested a management and financial audit in the face of facility overcrowding, lack of inmate services, insufficient staffing, and excessive use of overtime.

We found breaches in prison security that seriously jeopardize public safety. For example, the security classification of one-third of our statewide sample was incorrect and resulted in inmates being confined in lower security levels than they should be, and ineligible inmates being released into community furlough programs. Missing facility firearms, keys, and extremely hazardous tools also compromised the well-being of the public, employees, and inmates. Inadequate screening of visitors and deliveries, inoperable security equipment, and few searches for contraband compromise safety.

We also found that inmates were not provided with adequate access to health care services. Initial health and dental examinations and routine physicals were not completed for many inmates. Even when exams were provided they were often late. This was so even after a national accreditation commission reported such deficiencies. In fact, the failure to provide dental examinations increased by 36 percent following the commission's findings.

Moreover, failure to address inmate grievances in a timely manner results in inadequate protection from cruel and unusual punishment and deprives inmates of their rights as protected under federal law and rules.

We also found that the director failed to provide the leadership and guidance needed to efficiently staff facilities and control the department's extraordinary overtime costs. Essential security posts, those posts that must be staffed, are arbitrarily designated by facility wardens and resulted in widespread staffing variations. Flaws in the department's staffing formula identified in our 1992 audit have yet to be addressed and efforts to eliminate abusive leave patterns need improvement. Although the department's sick abuse program initially resulted in overtime decreases, we found overtime costs have since increased every year. Furthermore, not all patterns of potential sick leave abuse are identified and staff are allowed to circumvent the parameters of the sick leave abuse program. For example, during a six-month period one officer called in sick four times before his scheduled days off, three times before or after a weekend, and two times before or after payday without being investigated for potential sick leave abuses.

The department's management of state resources and inmates' funds is also seriously deficient. This has resulted in \$2 million in staff overpayments remaining uncollected, improper inmate pay, and thousands of dollars in state



resources unaccounted for. Furthermore, the success of the department's correctional industries program, an inmate work training program, was compromised when program staff diverted revenue and funding to inmate-affiliated businesses.

We also found the department failed in its fiduciary responsibilities to victims and children of inmates. Although the statutes require the director to enforce victim restitution orders against moneys earned by incarcerated inmates, six of eight facilities failed to garnishee inmates' earnings for restitution. Also new deposits to inmate trust accounts were not garnisheed for those inmates owing child support. The department's fiduciary responsibilities to inmates were also disregarded, resulting in reported inmate account balances being higher than the actual cash available for inmate use.

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## Recommendations and Response

Our report makes a number of recommendations that point to the director's responsibility to ensure public safety through its administration of correctional institutions. We recommended that the director make security controls a top priority. We also recommended that the director improve inmates' access to medical services, comply with the requirements of the federal Civil Rights Act of Incarcerated Individuals, and establish clear guidelines for the sufficient staffing of all correctional institutions. The director should ensure that department staff are properly trained, address problems with possible leave abuses, and ensure the financial integrity of the department's records and assets.

The department responded that our audit provided it with some good information about specific problem areas; however it disagreed with two of our audit findings. The department disputes that security breaches compromise public safety and that the director has not provided adequate leadership to ensure efficient staffing and limit overtime. The department's disputes are without merit; we stand by our audit findings. We used as standards the department's own policies and procedures, the standards of the corrections profession, and accepted principles of management.

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Submitted by

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## Foreword

This report of our management and financial audit of the Department of Public Safety was prepared in response to Section 42 of the General Appropriations Act of 1999 (Act 91, Session Laws Hawaii 1999). We focused on the department's management of its correctional facilities and selected issues of financial accountability.

We wish to express our appreciation for the cooperation and assistance extended to us by the officials and staff of the Department of Public Safety.

Marion M. Higa  
State Auditor

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# Table of Contents

## Chapter 1 Introduction

Background .....	1
Objectives of the Audit.....	6
Scope and Methodology .....	6

## Chapter 2 The Department's Prison System Does Not Ensure Public Safety And Does Not Fulfill Financial Management Requirements

Summary of Findings .....	7
Breaches in Prison Security Jeopardize Public Safety .....	8
Inadequate Inmate Care Places the Department at Risk of Additional Costs .....	16
The Director Has Failed to Provide the Leadership Needed to Efficiently Staff Security Positions and Control Overtime .....	22
Fiscal Management of State Resources and Inmate Funds is Seriously Deficient .....	27
Conclusion .....	34
Recommendations.....	35

## Response of the Affected Agency .....39

## List of Exhibits

Exhibit 1.1	Department of Public Safety Organization Chart .....	2
Exhibit 1.2	Hawaii's Correctional Facilities and Community Correctional Centers .....	3
Exhibit 2.1	Facility Population, Design and Operating Capacities, September 1999 .....	20

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# Chapter 1

## Introduction

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The Department of Public Safety safeguards the public by confining and rehabilitating inmates in secure correctional facilities and enforcing laws to preserve the public peace. However, growing public criticism of facility overcrowding, lack of inmate services, insufficient staffing, and the excessive use of security force led the Legislature to request a management and financial audit of the department. Specifically, the audit request includes the department's planning, management, staffing, expenditures, contracts, and other operational issues. The Legislature requested the audit in Section 42 of the General Appropriations Act of 1999 (Act 91, Session Laws Hawaii 1999).

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## Background

Effective administration of correctional institutions is particularly challenging because correctional facilities are small, self-contained communities that provide a variety of services to individuals charged with or convicted of criminal offenses. Therefore, sound management of correctional institutions is crucial in meeting the department's mission of ensuring public safety and in preparing inmates for reintegration into society.

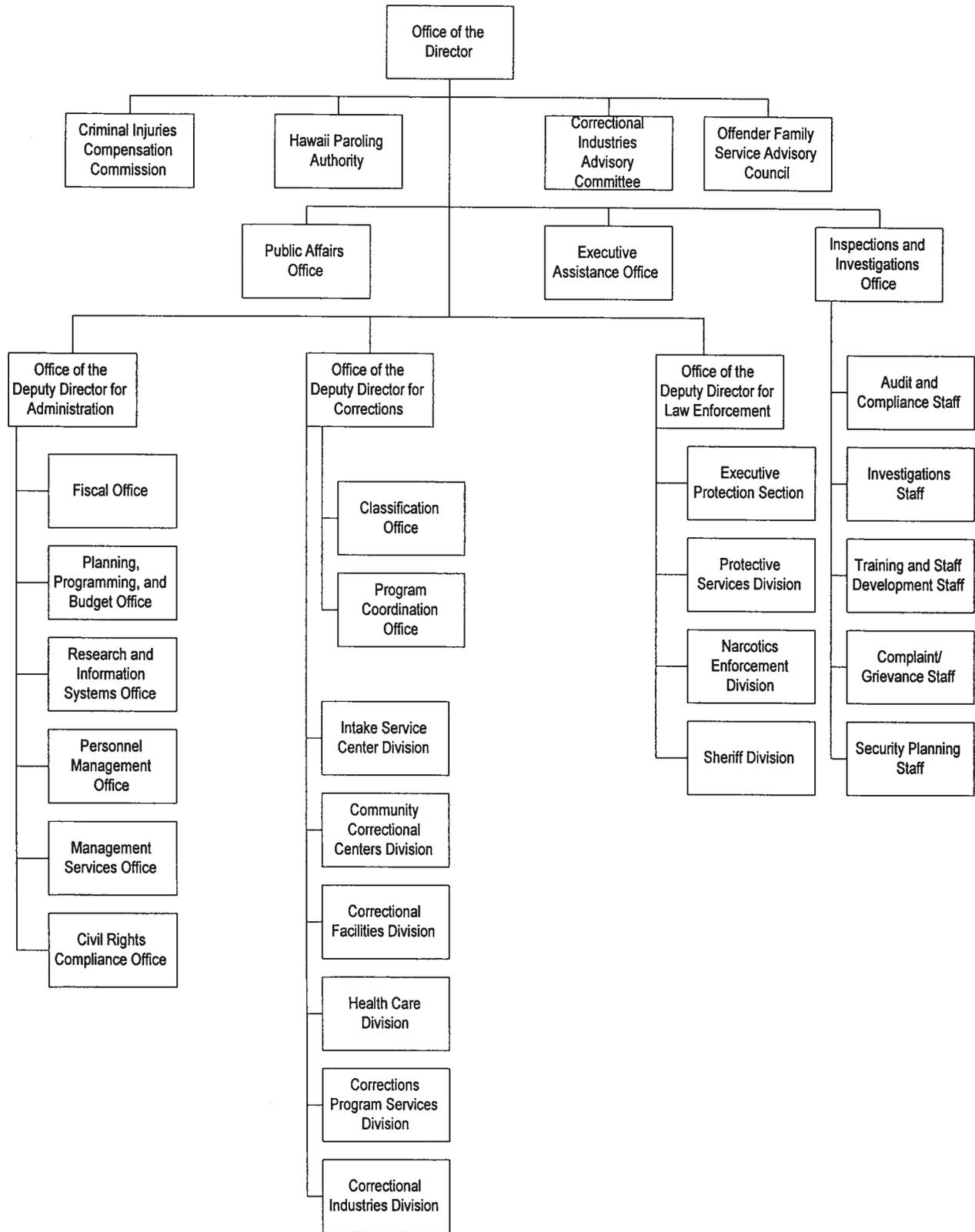
The Legislature recognizes the importance of public safety and commits significant resources to the department. The Legislature appropriated \$141 million to the department for FY1998-99. Approximately \$92 million, or 68 percent, of all FY1998-99 expenditures was attributed to operating the department's correctional institutions. Another \$38 million was spent for other department responsibilities including law enforcement, inspections and investigations, and other administrative functions.

During FY1998-99, over half of the department's 2,439 authorized positions were designated for correctional facilities and community correctional centers. About 80 percent of these institutional positions were security personnel, including adult correctional officers.

## **Organizational structure**

The administration of public safety has historically been fragmented among three entities: the Department of Social Services and Housing, the Judiciary, and the Department of the Attorney General. The social services and housing department operated the correctional facilities, the Judiciary was responsible for sheriffs and security personnel, and the attorney general administered the State's law enforcement office and narcotics division. However, in 1987 the Legislature recognized that the

### Exhibit 1.1 Department of Public Safety Organization Chart



corrections program had grown too large to remain under the Department of Social Services and Housing. The Legislature subsequently transferred correctional responsibilities to a newly created Department of Corrections. The department was renamed the Department of Public Safety when all other public safety functions and employees were consolidated within this department on July 1, 1990. The current organizational structure of the Department of Public Safety is shown in Exhibit 1.1 on page 2 of this chapter.

The department's deputy director for corrections manages the State's three correctional facilities (prisons) and five community correctional centers (jails). Exhibit 1.2 illustrates that Oahu has two correctional facilities (Halawa and Waiawa), and two community correctional centers (Oahu and Women's). Each neighbor island county has one community correctional center. Hawaii County also has one correctional facility, Kulani, which primarily houses inmates eligible for sex offense treatment programs.

### **Exhibit 1.2 Hawaii's Correctional Facilities and Community Correctional Centers**

<b>Island</b>	<b>Facility</b>	<b>Inmate Count*</b>
Oahu	Halawa Correctional Facility	1,192
	Waiawa Correctional Facility	273
	Oahu Community Correctional Center	995
	Women's Community Correctional Center	220
Hawaii	Kulani Correctional Facility	162
	Hawaii Community Correctional Center	223
Maui	Maui Community Correctional Center	327
Kauai	Kauai Community Correctional Center	147

\* Inmate count as of September 1999.

Individuals who are unable to post bail are generally housed in community correctional centers pending trial. In some cases a pre-trial inmate may be housed in a correctional facility. Housing assignments for sentenced inmates are dependent upon such factors as the severity of the inmate's offense, institutional violence, frequency and severity of institutional misconduct, and time remaining until parole eligibility or discharge date. As of September 1999, 1,912 inmates were housed in community correctional centers and an additional 1,627 inmates were housed in correctional facilities, bringing the entire in-state facility count to 3,539. An additional 1,200 inmates were housed in Oklahoma, Tennessee, Minnesota, and Texas.

The department contracts with Corrections Corporation of America and government organizations to house Hawaii inmates in out-of-state facilities to alleviate prison overcrowding. During FY1998-99 the department spent approximately \$18 million to house inmates in these out-of-state facilities.

### ***Inmate services***

The Corrections Program Services Division provides inmates with library access, education, meals, and therapeutic services such as substance and sex abuse treatment programs. The department's rehabilitation efforts include job-training opportunities through facility, community, and correctional industries worklines. In addition to meeting facility and community needs, the worklines provide compensation opportunities for inmates. Their earned wages are deposited into inmate trust funds, the Criminal Injuries Compensation Fund, and the Correctional Industries Revolving Fund. Deposits into the revolving fund are used for inmates' incidental costs during their confinement.

The department reports that the correctional industries program provided inmates with 400 job training opportunities during 1999. During FY1998-99, the program employed 1,057 inmates and generated \$6.1 million in revenues. Correctional Industries inmate workers contributed \$66,057 to the Criminal Injuries Compensation Fund and \$100,000 for their incarceration costs during FY1998-99.

The department's furlough program provides select inmates with opportunities for community experiences in areas of family and social reintegration, education, employment, vocational training, and/or specialized treatment prior to parole. As of June 30, 1999, 308 inmates were participating in furlough programs.

### ***Consent decree***

In 1985, the Oahu and Women's Community Correctional Centers were placed under court jurisdiction as the result of a class action suit initiated by the American Civil Liberties Union (ACLU). Facility overcrowding

and inadequate inmate services spurred the ACLU to seek remedies for inmates; however, the department and plaintiffs waived a hearing and agreed instead to the provisions of the Spear Consent Decree. The consent decree established panels of experts to study prison conditions and develop plans to improve health care, food services, prison environment, corrections staff training, and inmate classification. The Women's Community Correctional Center was released from the consent decree in June 1998. The Oahu Community Correctional Center was released in September 1999.

### ***Previous audit reports***

The Auditor has conducted several audits of the department's security staffing and procurement practices. Report No. 92-27, *A Review of a Formula for Security Staffing at the Department of Public Safety*, recommended that the department prioritize all security posts and work positions. The audit also recommended that the department limit the use of overtime to emergencies or non-coverage of security posts. Together with our consultant James D. Henderson, an authority on correctional security staffing, we reviewed the department's shift relief factor, a formula used for staffing facilities. We concluded that a definitive shift relief factor could not be determined until reliable underlying data became available.

We also conducted a financial audit of the Department of Public Safety, during our 1992 review of security staffing. The financial audit similarly reported on the department's failure to exercise adequate control over the use of leave and overtime, stating that this resulted in excessive overtime costs.

In 1994 we conducted a follow-up audit of the department's security staffing. We found that the department had made steps towards implementing our earlier audit recommendations, but implementation was limited.

Our Report No. 96-16, *Procurement Audit of the Correctional Industries Program*, reported that the program purchased items for agencies without benefit of bids or documented quotes. It then resold the items to other state agencies without using the items to manufacture such goods. This practice allowed state agencies to circumvent the procurement law and resulted in state agencies paying 11 to 37 percent more than they would have had they purchased directly from the vendors.

We recommended that the Legislature amend Section 354D-6, HRS, to prohibit correctional industries from acting essentially as a reseller of another company's products. We also recommended that the director of public safety remove printing services from the list of goods and services that state agencies must purchase from the correctional industries program.

The 1998 Legislature repealed the requirement that state agencies purchase goods and services to the extent possible from the correctional industries program, giving state agencies the option to purchase these goods from other vendors. However, the Legislature did not amend Section 354D-6, HRS, to prohibit the correctional industries from reselling vendors' products that inmates did not use for production.

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## **Objectives of the Audit**

1. Assess whether the Department of Public Safety has implemented sufficient inmate classification and security controls to safeguard the public.
  2. Assess whether the department has effectively managed its resources to ensure fiscal and staffing accountability.
  3. Make recommendations as appropriate.
- 

## **Scope and Methodology**

This audit focused on the department's management of its correctional facilities and its community correctional centers during FY1998-99. We reviewed each of the department's offices only to the extent that they were involved in the management of the department's correctional institutions. Our review of inmate initial classifications and medical screenings was subject to the date of the inmate's admission.

Audit fieldwork included file review of financial transactions and statements, security and other reports, and inmate institutional and medical files; interviews with correctional staff and inmates; observation at all eight facilities; and review of national correctional standards. Observation of visitation screening was conducted during unannounced site visits to all Oahu sites.

Our audit was performed from May 1999 through January 2000 in accordance with generally accepted government auditing standards.

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# Chapter 2

## The Department's Prison System Does Not Ensure Public Safety And Does Not Fulfill Financial Management Requirements

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The management of the prison system impacts the lives of all citizens. Sound management ensures public protection from inmates under the care of the Department of Public Safety. The department's task is to balance inmate rehabilitation and resocialization efforts with the maintenance of public safety. This challenging task requires strong leadership, sound planning, and implementing and adhering to management controls.

Our review of the Department of Public Safety's corrections office raises alarming concerns about the department's failure to ensure both the public and inmate safety. Serious security breaches provide little if any assurance that the department is capable of ensuring public safety. Unsafe and unhealthy facility conditions, coupled with inadequate access to health care, compromise the well-being of inmates and staff. The director has not adequately planned for facility needs as identified in earlier audit reports and by national accrediting organizations. Instead, lax financial management practices allow for fraudulent practices and result in waste. Resources that could be used to improve public safety and inmate care are frittered away.

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### Summary of Findings

1. The Department of Public Safety's failure to properly identify inmate security levels and enforce security controls seriously jeopardizes public safety.
2. The department has failed to adequately ensure the health and safety of its inmates. Specifically, inadequate access to health care, overcrowded facilities, and a non-responsive grievance process indicate that conditions cited in the Spear Consent Decree persist.
3. The director has failed to provide the leadership needed to efficiently staff security positions and to control soaring overtime costs.
4. The department's lax financial management has not safeguarded the State's and inmates' assets from theft. Furthermore, the department has failed in its fiduciary duties to victims and children of inmates.

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## **Breaches in Prison Security Jeopardize Public Safety**

The department failed to ensure public safety by allowing widespread security breaches. Inmate security classifications are incorrect and not timely. As a result, inmates requiring stricter security measures are allowed into the community without supervision. Security is also compromised with prison facilities unable to account for missing weapons, tools, and keys. Of further concern are the department's lax controls to minimize contraband from entering the prison facilities.

### ***Inmate security classifications do not ensure safety***

Public safety is compromised because assignments of inmates' security custody levels are both inaccurate and untimely. Inmates are classified by caseworkers into five custody levels: maximum, close, medium, minimum, and community. Assigning appropriate custody levels is extremely important because it determines inmates' housing assignments and program eligibility. Incorrect and untimely classifications can cause the department to make faulty decisions regarding its facility needs, and can result in inmates being confined and supervised at a level inconsistent with the level of risk they present to themselves, other offenders, department staff, and the community.

### **Security classification assignments are incorrect**

Caseworkers identify inmates' security risks by completing a classification form that weighs various factors, including the severity of the inmate's current offense, prior offense history, remaining time to be served for the minimum sentence, and the inmate's conduct. Each factor is weighted and computed into a final classification score. An inmate's classification score generally determines the inmate's custody level; however, caseworkers can recommend custody levels other than those indicated by the final classification score.

We reviewed 40 inmates' records and found that the department incorrectly classified 13, or one-third, of these inmates. Ten of the thirteen inmates who were incorrectly classified should have been assigned to *higher* security levels, which require stricter confinement and supervision conditions. We found such errors as computation errors, failure to identify and properly weight both inmate misconducts and escape histories, and incorrect identification of the severity of misconducts and prior offenses. These scoring discrepancies were also reported by the department's consultant in 1997. The consultant had informed the department that the classification errors should be dealt with expeditiously if the department's classification system was to operate at its full potential. Although the department's Central Classification Office planned to address the unreliability of inmate classifications, no formal system has been implemented to date.

### **Ineligible inmates participate in furlough**

Inmate access to furlough programs, which allow inmates to enter the community without supervision, is limited to inmates with a “community” classification level. Facility furlough programs rely on caseworkers to accurately classify inmates so that only eligible inmates participate in the program. However, we reviewed the institutional files for 35 furlough participants and found that approximately 60 percent did not meet the requirements for furlough eligibility. Approximately 20 percent of the inmates were not even classified at the community custody level. Furthermore, 35 percent of the inmates were incorrectly classified at the community custody level. Most of these inmates were incorrectly classified because caseworkers used faulty classification instructions. The remaining five percent of the inmates were ineligible for other reasons.

The classification instruction manual incorrectly states that inmates must be within 24 months of parole eligibility or discharge prior to being eligible for community status. This conflicts with department policy that requires inmates to remain at a minimum or higher custody level until 18 months prior to their parole eligibility or discharge date. This discrepancy resulted in caseworkers incorrectly computing inmates at lower custody levels than they were eligible for, and resulted in inmates being released into the community six months earlier than allowed by policy.

### **Inmate security classification reviews are not timely**

Facilities also fail to classify inmates in a timely manner. Department policy requires that pre-trial inmates be classified within 48 hours of admission; however, initial jail classifications were not even documented for 22 of the 40 inmates we reviewed. Furthermore, the initial jail classification of two other inmates was not completed within the 48-hour period. The department also requires that inmates sentenced to prison be classified within 45 days. All inmates in our sample were sentenced to prison; however, there were no records indicating that initial prison classifications had been completed for approximately 20 percent of these inmates. Moreover, about half of the classifications that were completed exceeded the 45-day time period.

Periodic reviews of an inmate's classification are necessary to ensure security. Therefore, the department requires that inmates' classifications be reviewed every six months and when events which may result in classification changes, such as a reduced sentence or inmate misconduct, occur. The department did not review inmate classifications for approximately half of the inmates in our sample within the six-month time period required by department policy. In fact, the security levels of ten inmates were not reviewed at all for anywhere between a year and seven years.

Furthermore, caseworkers did not conduct timely classification reviews for 20 percent of the inmates in our sample who were found guilty of serious misconducts. For example, an inmate at Hawaii Community Correctional Center was found guilty of a serious misconduct five months after the incident. Although this inmate later escaped from furlough during March 1998, the facility had not yet held a misconduct hearing to determine guilt or innocence at the time of our October 1999 site visit. The facility initially revoked the inmate's furlough status; however, it allowed the inmate to return to the furlough program in November 1998 due to delays in the misconduct hearing process. A finding of guilt would have resulted in a change of custody level and the inmate would have been ineligible for furlough. The inmate, a sex offender, was again removed from furlough in April 1999 as the result of an allegedly lewd act in the community.

Thirty-three percent of the misconducts reported at the Hawaii Community Correctional Center during FY1998-99 were outstanding at the time of our visit. The department had not even investigated 40 percent of these misconducts. Approximately 95 percent were categorized as serious misconducts, which includes assaults. Hawaii Community Correctional Center failed to prioritize the review of serious misconducts and convene misconduct hearings. The untimely review of serious misconducts is of special concern because an inmate's classification review is completed *after* a finding of guilt. While guilt is being determined, the inmate's security level should remain unchanged.

### **Inmate classification guidelines need review**

The department revised its classification guidelines during 1997. At that time, the classification instruction manual directed caseworkers to consider inmates for community custody levels six months earlier than the department's procedural manual allowed for. This change occurred at the direction of a former director and current staff speculate it was done to alleviate facility overcrowding. Another former director considered changing the classification instructions to comply with department policy; however, the department's current administration aborted those plans.

Our review of department policy and practices raises serious concern that facility overcrowding, rather than an inmate's security risk, determines the department's inmate classification practices. We believe the department should apply criteria for determining an inmate's security risk independent from space availability. The director informed us that the department is planning to engage the assistance of a consultant to identify what, if any, changes should be made to the current classification system. At a minimum, the director will need to resolve the conflict between the classification instructions and department policy, and ensure that all inmates are classified both timely and correctly.

The department should also consider clarifying classification instructions. For example, the classification officers and one caseworker asserted to us that inmates who refuse drug and sex offender treatment services should be reclassified to a medium custody level. However, this is not required by the current classification instructions. Consequently, not all staff may follow this practice. For example, one caseworker stated that non-participation in programs is not a security issue and should not be factored into an inmate's classification. The department needs to discuss and resolve these issues in order to ensure public safety.

***Firearms and tool controls are disregarded***

Adequate weapon and tool controls are necessary to ensure the safety and well-being of both staff and inmates alike. These controls ensure that all weapons, tools, and equipment are properly secured, distributed, and accounted for. We found that although the department has established procedures to account for its weapons and tools, these procedures are not always followed and are oftentimes disregarded. We found that firearms and tools identified on facility inventories were often missing. Furthermore, tools were not always adequately secured.

**Firearms are unaccounted for**

Department policy requires that each correctional facility establish procedures for the control and accountability of all weapons and security equipment in its custody. All firearms are to be recorded by serial or control number. In addition, control logs must be used to identify all firearms checked out.

We reviewed the department's weapon inventory and found 10 of the 120 firearms we randomly selected could not be accounted for. Six firearms were missing from Halawa, one from Oahu Community Correctional Center, and three from the Women's Community Correctional Center. Concern over alleged lax weapon control was also identified earlier in the 1984 Spear lawsuit. In addition, seven facilities kept their own weapons inventories; six of these facilities' records did not reconcile to the department's official inventory records. Waiawa's weapon inventory lists a total of 27 firearms while the department's inventory for the facility shows only 5 firearms.

**Missing facility tools pose a security risk**

Department policy requires each facility to establish tool and equipment controls to ensure that all tools, knives, and equipment are utilized in a safe and secure manner. The department requires direct supervision of all inmates using tools and accountability and responsibility for the issue, receipt, and disposal of all tools.

The department categorizes all tools in correctional facilities into one of three security classes. Class A tools are extremely hazardous and include such items as knives, blades, screwdrivers, ladders, metal cutting equipment, and other items that may be used in effectuating an escape or causing death or serious injury. Class B tools are considered hazardous and include such items as picks, shovels, and scissors. Class C tools include pens, pencils, calculators, and other items that do not pose a serious safety or security concern. Department policy establishes controls to ensure all Class A and B tools are secured and accounted for.

Tools not in use are to be stored in a secured area, and if applicable, adaptable tools are to be stored on a shadow board. A shadow board has a painted image of each tool that is identical in size and shape to the tool. We visited 45 shop/work areas and found 19 areas did not use shadow boards to secure their adaptable tools. We also observed a crowbar and ladders that were left unsecured at several facilities.

Department policy also requires the department to exercise control over the issuance of tools. Each work area or shop supervisor is responsible for checking out tools to inmates. Inmates and staff must leave a form of identification to account for tools issued to them. Inmates issued Class A tools must be supervised at all times.

Facilities have disregarded these tool controls. Several facilities allowed inmates to sign tools out without proper supervision. In fact, two facilities allowed inmates to distribute tools to other inmates without any supervision. Furthermore, only one facility required inmates to leave any identification when receiving tools. We also observed inmates at Kauai Community Correctional Center and at Halawa, Waiawa, and Kulani Correctional Facilities working with Class A tools without the supervision of an adult correctional officer or work area supervisor.

Lax controls over facility tools raise serious concerns over the facilities' ability to maintain security. We judgmentally selected a sample of 172 tools that pose risks of harm or escape and found that the department could not account for 27 percent of these tools. The Halawa and Waiawa facilities were unable to account for 43 and 82 percent of their tools, respectively. Staff assigned to the correctional industries program were unable to account for approximately half of the tools assigned to their work areas. Although department policy requires each facility to conduct a weekly inventory of all Class A tools, only 24 of the 45 work areas we visited could provide evidence of having conducted weekly inventories.

***Poor key control  
compromises security***

Poor key controls increase the risk of escape and harm to inmates, facility staff, visitors, and the public. Unreliable key inventories and missing facility keys seriously jeopardize the security at each of the

department's facilities. Of further concern, although the Corrections Division administrator and security chiefs informed us that key control is a priority, we found that the department has not dedicated the resources needed to ensure sufficient control over facility keys. Department policy requires security chiefs, locksmiths, or designated staff at each facility to maintain control of all facility keys. However, five facilities do not have locksmiths and three do not have key control officers. In fact, two of the locksmiths are temporarily assigned and reported that they do not have enough time allocated to key control duties since they must also fulfill other responsibilities as adult correctional officers.

### **Key control is hindered by incomplete and inaccurate key inventories**

We reviewed the key inventories for each facility and concluded that seven of the facilities' inventories were unreliable. The key inventories often omitted significant information including keys' identification numbers, number of copies, and distribution. Without this information, facilities are unable to accurately account for all of their keys. In fact, the Oahu Community Correctional Center did not document the number of master keys made nor the distribution of these keys. This lack of record keeping jeopardizes security since these keys allow access to the housing modules and much of the facility. We also found that key inventories at the facilities were inaccurate. For example, Halawa Correctional Facility's key inventory incorrectly identified a key to open the facility's pharmacy. The Women's Community Correctional Center also incorrectly identified the keys needed to provide access to a dorm entrance and a fire exit door.

### **Facility keys are missing**

We judgmentally selected facility master keys and keys providing access to high-risk facility areas to determine whether the facilities could account for these keys. Five facilities were unable to account for keys selected in our sample. For example, the Maui Community Correctional Center could not account for one set of keys to a module that houses inmates with long minimum sentences (21 years or longer), those considered serious escape risks, and inmates requiring higher controls. In another case, Halawa's previous locksmith failed to return the master key to the locksmith office. Although possession of this key provides access to all facility keys, the lock to the locksmith's office had not been changed at the time of our review. Failure to change this lock violates department policy.

We also found that inmate access to facility keys has not been adequately restricted. At the Kulani Correctional Facility a key to a weight room was found in an inmate's locker. Although the key can no

longer be used to access the facility's gym, possession of a security key by an inmate is a serious breach of security. During our site visit to Maui Community Correctional Center another inmate was allowed to hold the keys to the facility's garage area.

**Controls to minimize prison contraband are lax**

The suppression of prison contraband is necessary for sound facility management. Contraband includes illegal and prohibited items such as drugs, weapons, and tattoo machines. We found that controls to minimize contraband in the facilities are lax. Inmates and facility staff report that contraband enters the facility through staff and visitors; however, facilities do not adequately screen visitors nor search facility premises to detect contraband. Security equipment to screen visitors and monitor inmates is inoperable, and deliveries to the facilities are not always searched. Also, inmates suspected of drug abuse are not subjected to urinalysis drug screening in a timely manner. These weak controls compromise the safety and well-being of inmates and staff.

**Visitor screening is inadequate**

According to department policy, visitation is an integral part of the correctional and rehabilitative process. As a result, all correctional facilities in the department are directed to provide the resources and programs necessary to facilitate visits. Visitors to the correctional facilities are required to complete an application form acknowledging the department's rules on contraband and consenting to search before entering a correctional facility. Facility wardens must approve visitor applications.

We observed visitations at the four Oahu facilities and found that not all of the visitors were searched prior to entering the facilities' secured areas. We reviewed visitation records and visitor application files and found that 21 percent of 58 visitors were provided access to secure areas of the facility without proper authorization and approval.

**Security equipment is inoperable**

Several facilities have security equipment in place to aid staff in ensuring that inmates are following rules and regulations, and that contraband is not introduced into the correctional system. These types of equipment include metal detectors, video surveillance cameras, and telephone monitoring equipment. Department policy requires the proper maintenance of these devices to ensure the safe and efficient operation of the facilities.

During our review of the security devices located in the correctional facilities, we found some were inoperable. For example, a metal

detector located at the entrance of Halawa has not worked for over ten years. In addition, Halawa also has a telephone system to monitor the calls placed or received by inmates that was inoperable.

### **Facility deliveries are not adequately screened**

The movement of supplies and vehicles in and out of a facility creates security risks involving escape attempts and the introduction of contraband. Thus, department policy requires that all items carried or transported through the gate and sallyport areas, an enclosure with two gates not to be opened simultaneously, be searched and inspected. Three facilities report that they do not check deliveries entering and exiting the facility. Two of these facilities have sallyport areas that are not being used for their intended purpose.

Enforcement of these controls is especially critical for the Correctional Industries Division given the high volume of inventory and sales entering and exiting the facility. However, the Correctional Industries Division has failed to adequately search deliveries to and from the facility. In fact, although drugs were smuggled into the facility through the program's computer shop approximately five years ago, warehouse personnel and adult correctional officers still do not search deliveries for contraband.

### **Facility searches and inmate drug screenings are not timely**

The department requires frequent unannounced searches of its facilities to deter the flow of contraband and detect any illegal items that may have entered the facilities. Each facility is required to search inmate living areas intermittently—at least every seven days for maximum-security facilities and every ten days for all other facilities. The department also uses canine units for the purpose of detecting narcotics in the facilities.

Our review of search logs and records at the department's eight facilities found that none of the facilities conducted searches of inmate living quarters every ten days. In fact, the Oahu Community Correctional Center could provide reports only for the months of June, July, and September 1999. Moreover, Halawa could provide only one shakedown report for 1998 and a few reports for 1999. By far, the most alarming was the Women's Community Correctional Center that could not provide *any* reports for either 1998 or 1999.

Some of the reports we were able to review indicated that a wide variety of contraband is entering the facilities. For example, drugs, alcohol, and a cellular phone were found in the possession of inmates at the Oahu, Hawaii, Kauai, and Maui Community Correctional Centers and Halawa.

Class A tools such as screwdrivers, shanks (homemade knives), razor blades, and saw blades were also found in the possession of inmates at Kulani, Waiawa, Halawa, and the Oahu and Hawaii Community Correctional Centers.

We also found that the facilities were not conducting adequate follow-up on inmates who were suspected of possessing narcotics by the department's canine unit. While at the Maui Community Correctional Center, we noted that the canine unit had "alerted" facility staff to several inmate housing units indicating that drugs may have been present in the area. Although the facility's canine handler requested that the adult correctional officers screen these inmates for illegal drug use, our review of facility records found that urinalyses had not been conducted for many of these inmates. Furthermore, the facility was unable to account for one of the keys to the urinalysis room at the time of our site visit. This raises concern over the facility's ability to control access to this room and the reliability of urinalyses results.

Of greater concern, the facility's records indicated a canine "alerted" to a vehicle owned by an adult correctional officer assigned to conduct urinalyses of inmates. The department did not even investigate this incident. These security risk occurrences raise questions over the validity of the drug screening results reported by the facility.

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## **Inadequate Inmate Care Places the Department at Risk of Additional Costs**

The department is responsible for providing inmates with a safe, secure, and healthy environment. Failure to provide such an environment not only jeopardizes the health and safety of inmates, but also places the department at risk of incurring additional costs from inadequate health care and overcrowding. The department's dysfunctional grievance process also fails to protect the health and safety of inmates under the department's care. These issues raise serious concerns regarding inmates' civil rights and indicate that the unsafe and unhealthy conditions that resulted in the past consent decree continue to persist. Although federal oversight has been lifted, it may be reinstated.

### ***Access to health care services is inadequate***

Both the Spear Consent Decree and case law from other jurisdictions have upheld inmates' rights to health care. Specifically, the courts have established that the denial of or an unreasonable *delay* in providing health care falls under the concept of cruel and unusual punishment prohibited by the Eighth Amendment of the United States Constitution. The provision of adequate health care services ensures the health and safety of each correctional facility's population. However, the department has not adequately ensured the well-being of Hawaii's

inmates. Instead, initial health screenings, medical and dental examinations, and requested health services are delayed and in many cases never received.

### **The department has not provided inmates with timely health services**

The National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), and department policy require that upon admission to a correctional institution all inmates are to be screened for medical and mental health conditions. Initial screenings allow the department to identify inmates' health services needs, and if necessary, separate these inmates from the general population. Initial health screenings are to assess the physical, mental, and dental condition of each inmate. However, our review of the medical records for 80 inmates found no evidence of screening by either the health care or mental health staff for 47 inmates. Furthermore, the dental records for 60 percent of these 80 inmates also indicated that initial dental screenings were never performed.

A comprehensive initial health assessment and dental exam are required following the inmate's initial health screening. We found no evidence that initial health assessments were ever completed for 20 percent of the inmates in our sample. Provision of the inmate's dental examination was even more problematic, with 35 percent of required dental examinations not completed. Even when these initial health care services are provided, they are often late. For example, approximately 40 percent of the initial health assessments and 30 percent of dental examinations were not provided within required timeframes.

Within the corrections system, preventative health care includes the provision of a routine physical exam. Depending on the inmate's age, these exams are provided either annually or biennially. We found that 80 percent of 66 inmates requiring routine exams did not receive all required examinations. When inmates did receive routine physicals they were often late, in some cases by nearly two years.

National organizations and department policy also require that facilities have a system in place that allows inmates access to health care. We found numerous cases in which the health care units' response times were unreasonable or non-existent. For example, health care units never saw eight inmates who submitted requests for treatment during FY1998-1999. These inmates requested treatment for various conditions from toothaches, swollen gums, and blurry vision, to an irregular heartbeat. At some facilities, inmates submitted repeated requests for the same problem before receiving treatment. One inmate complained of a toothache and submitted eight requests for dental services before a dentist saw him.

Failure to identify and provide needed health services can result in serious harm to inmates, facility staff, and visitors. During 1999, the Oahu Community Correctional Center and Halawa Correctional Facility experienced tuberculosis outbreaks. Tuberculosis is highly contagious and widespread treatment of the disease can be costly. The department can minimize health and financial hardships and such outbreaks by ensuring that all health screenings, initial health assessments, routine physical examinations, and requested health care services are provided in a timely manner.

### **Deficiencies identified by the National Commission on Correctional Health Care have not been adequately addressed**

As a result of its January 1999 site survey, the National Commission on Correctional Health Care found four Hawaii facilities, which were applying for re-accreditation, and two facilities applying for initial accreditation, deficient in a number of standards, including the inadequate provision of health services. The commission also found that staffing levels were insufficient to ensure the adequate provision of these services. The commission noted that many services required staff beyond facility nurses, and it cited the department for lacking a written staffing plan to ensure the adequate provision of services. Based on corrective action plans from the facilities, the commission awarded full accreditation to Kauai Community Correctional Center. Accreditation for the five remaining facilities was awarded; however, the commission will conduct follow-up site surveys in March 2000 to confirm compliance. The follow-up site surveys were initiated due to the gravity and historical nature of the deficiencies identified in the commission's January 1999 site survey.

Our comparison of health services provided prior to and following the commission's site visits indicates that the department has not improved inmates' access to health care. Although the timeliness of initial health assessments has improved, the department still failed to complete initial health assessments for 14 percent of the inmates in our sample. Moreover, the failure to provide dental examinations for inmates actually increased by 36 percent after the commission's site visit. In our sample of inmates needing dental examinations, approximately 62 percent were not seen despite the commission's finding of inadequate dental care.

The ratio of health care staff to each facility's population indicates that health care units are understaffed. We reviewed health care coverage staffing hours provided to us by the health care division administrator. Our review indicates staffing at two of the eight facilities could provide medical coverage to only one-third of these facilities' populations in a one-month period if each patient was seen for approximately 20 minutes.

Similarly, three facilities would only be able to provide dental care to less than half of the population. Therefore, as indicated by our review of the provision of health care services, when demand exceeds availability, services simply are not provided. Since the department's staffing plans do not adequately address actual facility needs, health care coverage will continue to be problematic.

***Overcrowded conditions compromise inmates' health and safety***

Overcrowded correctional facilities lead to unsafe and unhealthy living conditions according to the American Correctional Association. Furthermore, overcrowding contributes to tension among inmates and can increase violent behavior. The department's failure to alleviate overcrowding was also a condition resulting in the Spear Consent Decree. Despite the lifting of this decree, facility overcrowding continues to jeopardize the health and safety of inmates.

**Facilities fail to meet American Correctional Association housing standards**

The American Correctional Association standards for inmate housing require that all cells or sleeping areas allow for a minimum of 35 square feet per inmate. When confinement exceeds 10 hours a day the standards require at least 80 square feet per inmate. However, housing accommodations at Halawa Correctional Facility, Maui Community Correctional Center, and Kauai Community Correctional Center fell far short of these minimum standards. For example, during our October 1999 site visit to Kauai Community Correctional Center, seven inmates were sharing a 160 square foot cell, although the American Correctional Association standards required that these inmates be housed in a cell measuring at least 560 square feet.

**Inmate populations exceed facility design and operating capacities**

Lack of adequate facility space has resulted in the department exceeding both the design and operating capacities of its facilities. The design capacity reflects the population that each facility was designed to hold. The operating capacity considers the optimum facility capacity while remaining within federal guidelines and local fire and safety codes. Therefore, the operating capacity reflects the population the facility can hold for an indefinite period of time without jeopardizing the health and safety of the inmates and staff.

Exhibit 2.1 compares the actual population of each facility to both design and operating capacities. The population counts at Halawa's high and medium security facilities and Maui Community Correctional Center significantly exceed safe operating capacities. The majority of facilities

also exceed their design capacities. Although Exhibit 2.1 indicates a need for medium facility beds such as the Halawa and Maui facilities, the department should address the classification deficiencies we identified earlier prior to planning for future facility space. Failure to address these deficiencies can result in wrong data being used to determine space requirements. Facility design should be based on actual and planned security needs using accurate inmate classifications.

**Exhibit 2.1  
Facility Population, Design and Operating Capacities  
September 1999**

Facility	Actual Population	Design Capacity	Percent Exceeding Design Capacity	Operating Capacity	Percent Exceeding Operating Capacity
Halawa Medium (HMSF)	1,028	496	107%	897	15%
Halawa High (SNF)	164	90	82%	149	10%
Waiawa (WCF)	273	294	(7)%	334	(18)%
Oahu (OCCC)	995	628	58%	949	5%
Women's (WCCC)	220	258	(15)%	258	(15)%
Kulani (KCF)	162	160	1%	160	1%
Hawaii (HCCC)	223	206	8%	243	(8)%
Maui (MCCC)	327	209	56%	260	26%
Kauai (KCCC)	147	140	5%	156	(6)%
<b>Total</b>	<b>3,539</b>	<b>2,481</b>	<b>43%</b>	<b>3,406</b>	<b>4%</b>

***Grievance process is dysfunctional and fails to protect inmates***

An objective and independent grievance system is fundamental to the sound governance of a correctional facility. Federal law protects access to such a grievance system. Recognizing the importance of this federal legislation, the department's grievance process is intended to reduce inmate frustration, improve institutional management, and reduce inmate

litigation. However, lack of timely reviews and investigations of inmate grievances has compromised the integrity of the department's grievance system and has violated inmates' civil rights.

### **The department does not comply with federal civil rights grievance standards**

The Civil Rights of Institutionalized Persons Act, 42 U.S.C., and Title 28 of the Code of Federal Regulations establish minimum standards for the implementation of a grievance system. The federal code requires that all inmate grievances be responded to in writing. The response must include the reason for the decision and a statement entitling the inmate's grievance to further review. We reviewed inmate grievances at each facility and found many grievances were never assigned an initial step of investigation and therefore remain unresolved. The department failed to notify inmates of a written response as required by federal regulation. Furthermore, even when the department provided the inmates with a written response, the response did not include a statement informing the inmate of the right to further review.

The Code of Federal Regulations also prohibits inmates and employees involved in the grievance from resolving the grievance in any capacity to maintain objectivity. On several occasions, the department compromised the objectivity of the grievance process by allowing the staff person the grievance was filed against to resolve the matter. One facility allowed an employee to resolve a complaint regarding an inmate's missing store purchase even though the grievance was filed against this staff person.

Federal regulation also requires that the department provide for an advisory role for employees and inmates in the operation of the grievance system. The department requires that each facility annually solicit staff and inmate input in order to meet this requirement. However, grievance officers and staff at the facilities informed us that this is not done.

### **Response to inmate grievances is not timely**

The Code of Federal Regulations also requires that time limits be established for each stage of the grievance process. Furthermore, all grievances must be discharged within 180 days from initiation to final disposition. Department policy establishes even stricter timeframes for initial review and reviews of an inmate's appeal in a step two or three grievance. Staff must respond to step one and two grievances within 15 days of receipt. Facility staff investigate step one grievances, while facility administrators investigate step two grievances. The division's administrator must respond to step three grievances within 20 days. The

department did not respond to 71 out of 133 grievances within these required timeframes. In one case, the department's response occurred approximately nine months after receiving the grievance. This response also exceeded the maximum response time allowable under federal regulation.

Failure to address grievances in a timely manner results in inadequate inmate protection from cruel and unusual punishment. Furthermore, inmates informed us that they either had no faith in the department's grievance system or feared retaliation from the adult correctional officers and staff.

The director has not allocated sufficient resources to ensure the integrity of the department's grievance system. For example, the department's grievance officer position has been vacant for approximately four years although this position is responsible for ensuring compliance with grievance policies and procedures. Moreover, although department policy requires that each facility have a grievance officer position, only the Oahu facilities have staff dedicated exclusively to tracking and processing inmate grievances. Neighbor island facilities have assigned security staff to serve in the grievance officer positions while retaining other security duties. Staff responsible for tracking grievances reported it is difficult for them to track responses to grievances since they do not have access to the department's grievance database.

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## **The Director Has Failed to Provide the Leadership Needed to Efficiently Staff Security Positions and Control Overtime**

### ***Security post staffing guidelines have not been implemented***

The director has not exercised sufficient leadership to maintain adequate inmate security and control staff use of overtime. Criteria and guidelines for security staffing policies and procedures still need to be developed. Flaws in the department's current staffing formula require the director's attention. These issues have been disregarded by the current administration, despite our earlier recommendations that the department develop a systematic approach to staffing based on clear criteria and careful analysis.

In a well-run correctional system, management is responsible for formulating and adopting comprehensive staffing policies and procedures that determine the need and location of security posts and work positions. Report No. 92-27, *A Review of a Formula for Security Staffing at the Department of Public Safety*, recommended that the department establish basic policies and guidelines for determining such security posts and security work positions. Our 1994 follow-up audit

made similar recommendations, and noted that although the department had made a conscientious effort to address our recommendations, its efforts remained limited.

Seven years after our initial security staffing review, the director has yet to adequately address our recommendations and provide facility staff with the direction and leadership needed to efficiently and effectively staff correctional facilities.

The director has not identified a system-wide security staffing plan to identify the location, purpose, and function of security posts and security work positions. The director and deputy director for corrections informed us that system-wide staffing guidelines have not been developed because each institution's design will dictate different staffing requirements. We disagree. Although facility design may influence staffing, there is still a need for a standardized approach to establishing security posts and work positions. The lack of clear staffing guidelines has resulted in arbitrary staffing decisions and staffing disparities between and within facilities.

### **Wardens arbitrarily designate essential security posts**

The designation of security posts as essential and non-essential directly impacts overtime costs. However, the director has not provided wardens with criteria to be used in designating posts as essential and non-essential. Wardens arbitrarily determine which security posts are essential. Essential security posts must be staffed. Therefore, in the event of staff absences, security staff are pulled from non-essential posts. Wardens decide whether vacant non-essential posts will be filled.

The wide variation among facilities in the percentage of facility posts classified as essential indicates the lack of criteria for determining essential posts. For example, the warden at the Women's Community Correctional Center has designated 64 percent of the facility posts as essential during the second watch while other facilities designate between 30 and 52 percent of their security posts as essential. Furthermore, the Maui Community Correctional Center has designated a program security post to oversee educational classes as essential, while program security posts at the other facilities are non-essential.

We also found disparities within Halawa Correctional Facility's housing modules. Two modules, each housing approximately 260 inmates of similar custody levels, had a different number of essential security posts. One module required only two essential posts, while the second module had three essential posts.

### **Staffing disparities are not adequately justified**

We reviewed each facility's security post and work position plan and identified a range of staffing disparities among facilities that could not solely be explained by the facilities' security designation or design. Facilities housing inmates with similar security custody levels had a wide range of staff to inmate ratios. For example, the staff to inmate ratio at Kauai Community Correctional Center is twice that of Maui Community Correctional Center, although both facilities house pre-trial, minimum, and medium security inmates. Of further concern, at the time of our October 1999 site visit, 50 percent of the Kauai inmates lived in housing units that did not have security posts.

We also reviewed actual security staff to inmate ratios during our facility site visits and found that staffing for maximum security inmates was twice as high at Oahu Community Correctional Center than at Maui Community Correctional Center.

### ***The shift relief factor is flawed***

A shift relief factor is a formula used in the corrections field to determine the security staffing needs of a correctional facility. It is the ratio between the number of work days per year required for a security position and the average days worked by security staff. Our previous staffing reviews found that the data used to determine the department's current shift relief factor (1.65) was unreliable and that more accurate leave data was needed to establish a sound staffing base. The department proposed a new shift relief factor (1.88) that would significantly increase staffing. However, both the current and proposed factors are flawed. The current factor does not include training time for the adult correctional officers, and both the current and proposed factors use questionable and unreliable leave data.

### **Shift relief factor does not allot adequate time for training**

The department's current shift relief factor does not contain time allotted for security staff to receive department-mandated training. Training results in temporary staffing vacancies and should be factored into the department's shift relief factor in order to ensure staffing coverage. Revising the shift relief factor to include training should be a priority given the director's requirement that security staff complete certain types of training including use of force and mental health training. According to training standards set by the American Correctional Association, which department representatives reportedly follow, adult correctional officers should receive a minimum of 40 hours of training per year. The proposed shift relief factor accommodates this standard.

However, our review of the department's training records indicates that staff may not be participating in all required training; therefore, staffing for required training may inflate the department's actual staffing needs. We found disparities between training hours tracked by the department's training and staff development division and individual facilities. The department must ensure that the training records maintained by its training office are reliable since this information is pertinent to the development of a reliable shift relief factor. As we reported in 1992, relatively small changes in the shift relief factor result in significant changes in staffing requirements.

### **Shift relief factor includes potentially abusive leave data**

We also found the department's current and proposed shift relief factors utilize leave data that is questionable and shows potential for abuse. For example, the current shift relief factor assumes that the average security staff will take 14 days of vacation and 12 days of sick leave per year.

The department's proposed shift relief factor increases the average leave from 26 to 62 days, an increase of approximately 2 months. This includes 13.8 days of vacation, 16.5 days of sick leave, and 31.7 days of other types of leave that include unexcused absences, leave without pay, military leave, and worker's compensation. This is extremely high and could be considered an abuse of leave benefits since state employees earn a combined total of 42 vacation and sick days per year. The impression is that the department condones a higher amount of leave for its employees.

### ***Abuses of sick leave and overtime continue***

Our earlier staffing audits reported that the department failed to control soaring overtime costs. We also found patterns of sick leave abuse among adult correctional officers that contributed to the department's excessive overtime costs. Our current review of personnel leave and overtime records indicates that staff continue to abuse sick leave despite the department's effort to discourage such abuse. Our current review included both medical and food service staff and found that overtime costs for these positions also need to be controlled.

### **ACO sick leave is twice the state average**

The department spent approximately \$13.3 million on overtime during FY1998-99, a four percent increase from the previous fiscal year. We reviewed the department's pay records and sign-in sheets and found that 20 percent of the overtime occurrences in our sample were attributed to staff shortages due to sick leave absences.

A 1999 consultant study for the Employees' Retirement System concluded that the average sick days taken by state employees is 10 days annually. However, our review of adult correctional officers' leave records indicates that many officers use approximately twice the amount of sick leave used by the average state employee. Upon reviewing personnel leave records, we found 16 officers took an average of 19 days of sick leave annually. We also found that many officers used their sick leave as it was earned, indicating that sick leave may have been used for purposes other than intended. In one case, an adult correctional officer with 24 years of service had a balance of 2.5 sick leave days although the officer had earned a total of 504 sick leave days over the course of his career.

### **Sick leave abuse program fails to eliminate abusive leave patterns**

The department has implemented a sick leave abuse program that investigates patterns of absences due to sickness in an effort to reduce both overtime and sick leave abuse. While the program helped to reduce overtime costs in its first year of implementation during FY1995-96, overtime costs increased every year thereafter. This trend should lead to questions about the enforcement and effectiveness of the program.

The collective bargaining agreements for food service staff and adult correctional officers allow the department to investigate patterns of sick leave and take progressive disciplinary action as needed. When a pattern of potential sick leave abuse is detected, the employee is placed on a follow-up evaluation for a six-month period. During this period the employee must undergo medical evaluation to verify all absences allegedly due to sickness. The department only recently began to review sick leave patterns for food service staff and has not placed any food service staff on a follow-up evaluation program even though suspected patterns of abuse have been detected.

We also identified adult correctional officers who exhibited patterns of sick leave abuse, as defined in the collective bargaining unit agreements, but who were either not placed on the department's sick leave abuse program or were placed in the program in an untimely manner. Quick detection and corrective action should be taken to minimize overtime costs attributed to sick abuse.

An adult correctional officer stated that he learned to circumvent the sick leave abuse program by staggering sick days and avoiding a pattern of leave abuse. The collective bargaining unit agreements stipulate that patterns of abusive sick leave can include leave before or after holidays, weekends, days off, paydays, or specific days of the week. In order to be considered a pattern the department's personnel office requires that there

be six specific occurrences within a six-month period excluding leave taken before or after holidays. In these latter cases four occurrences are considered a pattern.

Our review of leave records found adult correctional officers who accumulated six or more days of leave. However, officers avoided exhibiting a pattern of abuse by distributing their leave days among several typical leave periods. In one case, an officer called in sick four times before his scheduled days off, three times before or after weekends, and two times before or after paydays without the department investigating whether the officer was abusing his sick leave. The wardens informed us they are aware that staff avoid the sick leave abuse program by distributing their patterns of leave abuse. The collective bargaining unit agreements allow the department to determine an unacceptable pattern on a case-by-case basis. Furthermore, Section 79-8, HRS, authorizes the department to investigate any sick leave absence when an abuse pattern is indicated. Nevertheless, the department did not investigate these leaves of absence.

#### **Medical and food service staff also incur high overtime**

Our review of medical and food service staff's leave and pay records indicates these staff also incur high amounts of overtime. For example, a nurse earned \$37,681 and many food service workers earned over \$10,000 in overtime during FY1998-99. Our review did not identify any patterns of possible sick leave abuse that may have contributed to the high overtime for medical staff; however, we did identify a pattern of possible sick leave abuse for a food service worker. A cook at Oahu Community Correctional Center called in sick ten times before or after his scheduled days off without the facility investigating.

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### **Fiscal Management of State Resources and Inmate Funds is Seriously Deficient**

State law makes the department fiscally responsible for the proper management of state resources, including monetary and physical assets. The department also bears fiduciary responsibility for managing inmate funds and enforcing court ordered payments to victims and children of inmates. We found serious deficiencies in both areas.

#### ***Payments are not adequately scrutinized***

The department has failed to ensure the accuracy of payments made to staff, inmates, and out-of-state facilities housing Hawaii inmates. Poor review of staff attendance and leave records has led to large overpayments and continues to expose the State to unnecessary costs. Payments to inmates who work in the correctional industries program are

also inadequately scrutinized. In addition, the department's cursory review of large payments to out-of-state correctional facilities housing Hawaii inmates increases the risk of paying for services not received.

### **Two million dollars in staff overpayments remain uncollected**

Nearly \$2.4 million in salary overpayments to public safety staff remained uncollected as of July 1999. Inaccurate leave and attendance records contributed to salary overpayments. We noted numerous instances where Form G-1, the official document used to authorize employee absences and validate the type of leave, were not on file to support entries in the leave records. Without an approved G-1 to support payment for absences, an employee may be paid for unauthorized absences. Additionally, we noted discrepancies between daily sign-in sheets and employees' individual time sheets that have resulted in overpayments.

Securing repayment of employee overpayments is delayed because collecting outstanding overpayments is an arduous process that involves identifying the amount overpaid, allowing employees an opportunity to dispute the overpayment through a fair hearing process, and collecting the amount due the State. Prior to commencing a fair hearing, the department must audit every payroll record for those staff identified as being overpaid to determine the accuracy of the amount of overpayment. Staff who claim bankruptcy further hinder collection efforts. The department identified approximately \$176,000 in overpayments as uncollectible as a result of bankruptcy filings. However, the department should not consider these amounts uncollectible until it has referred these situations to the attorney general for collection review. Failure to notify the attorney general's office of bankruptcy notices negates the attorney general's ability to file a proof of claim on behalf of the State for overpayments.

### **Inmates are not properly paid**

The Correctional Industries Division has failed to ensure the accuracy of payments made to inmates. Supervisors are responsible for verifying inmate pay amounts and work hours on workshop payroll summary sheets. These summary sheets are supported by individual inmate timesheets. However, we could not reconcile purchase orders for inmate pay to workshop payroll summaries and individual timesheets because these documents were often missing. For example, an inmate assigned to the correctional industries' sewing shop was paid \$1,083 during March 1999, although there was no timesheet on file to support the amount the program paid the inmate. We also found that over 30 percent of inmate timesheets we reviewed were inaccurate and resulted in both underpayments and overpayments. Inmates assigned to the

administration, sewing, agribusiness, furniture, and computer shop work lines also received pay increases without proper approval from the Correctional Industries administrator and/or pay committee.

**Inadequate review of out-of-state facilities' invoices does not ensure proper payment**

The State spent approximately \$18 million in FY1998-99 for the transportation and operation expenses associated with housing approximately 1,200 inmates in out-of-state correctional facilities. Department policies and good business practices dictate that invoices for these services be verified by a contract monitor for accuracy; however, a department employee reports that these invoices are not thoroughly scrutinized. This is a serious weakness given the high cost of out-of-state facilities and errors detected in past invoices. Also, some facilities report that their custody lists incorrectly identify inmates housed at the facility.

***Thousands of dollars in department assets are unaccounted for***

The department was unable to account for over \$235,000 of the \$1.1 million in property that we tested during our facility site visits. Staff's failure to implement controls, including physical inventories and accurate record keeping of state property, resulted in this discrepancy and increased the risk of theft.

**Department's financial reports are inaccurate**

Section 103D-1206, HRS, requires that an annual property inventory reporting total asset value and identifying items acquired or disposed of during the year be performed. The annual inventory is considered serious, and according to state law, responsible employees may be fined up to \$500 or imprisoned up to six months if the inventory is not completed within the prescribed time. Although the department submitted its annual inventory to the Department of Accounting and General Services, staff failed to verify the information presented in the asset report through a physical inventory. Consequently, the department's reported assets of \$132 million is inaccurate and misrepresents both the department's and State's reported property holdings. This is of serious concern since the department could not account for 21 percent of the assets tested during our review.

**Failure to implement inventory controls increases the risk of theft**

Physical inventory of an agency's property is a control measure used to minimize the risk of theft, loss, and unauthorized disposal of fixed assets. Not implementing an inventory control can increase the likelihood of theft and improper disposal of state property.

Affixing an identification decal to state property also serves as a safekeeping control. However, corrections staff do not follow state administrative rules requiring the tagging of state property. We observed state property that was not properly tagged, including computers, televisions, cameras, sewing machines, ladders, drills, and Sanders. Furthermore, staff report they do not document all property transfers and disposals. For example, staff told us unaccounted tools, including a compressor, router and drill, were disposed of although there were no disposal forms to support the claim.

***Inadequate management of Correctional Industries Program results in financial loss***

The Correctional Industries Division administrator has neglected to ensure sound financial operation of the correctional industries program. Program staff are unable to account for computers and computer components. Moreover, staff and inmates have been allowed to divert program revenues to businesses affiliated with inmates. This is contrary to the program's mission which provides job opportunities and vocational training that best represents the real work world.

**Computer inventories are unaccounted for**

The correctional industries program purchases computer components from vendors to fill computer sales. Inmates solicit quotes from vendors and use this information to prepare customer sales quotes. When customers agree to the sales quote the computer shop supervisor prepares a purchase order request for the cost of the components needed to complete the job order. Purchase order requests are reviewed and approved by the program's administrator. We reviewed the sales quotes, purchase orders, invoices, and delivery slips for 31 computer sales and found discrepancies which raise concerns over the financial management of the correctional industries program.

The computer shop supervisor requested and received authorization from the former program business manager to purchase computer parts not required for job orders. The department could not account for some of these extra parts. In some cases, public schools were given items they had neither ordered nor paid for. It is unclear why these items, including a \$481 digital camera, were given away. Furthermore, Section 345D-7, HRS, requires the administrator to set prices for goods and services as near as practicable to the prevailing market price for similar goods and services. Meanwhile, the computer shop's revenues fell from \$2.4 million during FY1994-95 to \$255,654 during FY1998-99.

Correctional Industries staff pick up computers which need servicing from schools. The item being picked up is documented on a "pickup slip." Our review of delivery slips also identified a high movement of computers to and from one elementary school in comparison with other schools. The frequency of the pickups and deliveries at this school is

questionable. Furthermore, the pickup and delivery records for this school indicate that the program returned more computers than it picked up. The program picked up two computers on February 25, 1997 and returned three computers to the school 17 days later using the same job number.

### **Revenue is diverted to inmate affiliated businesses**

The computer shop supervisor and inmates working in this shop further compromised the success of the correctional industries program by diverting revenue and program funding to inmate affiliated businesses. For example, the supervisor assisted with the preparation of a customer sales quote of approximately \$100,000 in collaboration with LOGICAL Computer Technical Services, a company owned by a former inmate's relative. Although the correctional industries program could have filled the order, the business was diverted to LOGICAL Computer Technical Services. Five months later the supervisor resigned from her position and obtained a position at LOGICAL Computer.

We also identified that the department paid Lions Technology, an inmate's company, approximately \$1,300 for the testing and installation of computers at the Department of Human Services and the Department of Education. We contacted two customers (schools) and one informed us that installation was never done by Lions Technology. Our review of the invoices sent to these schools indicates the schools were never billed for these services. Correctional industries program funding was therefore used to pay an inmate for services never provided.

### ***Victim restitution and child support payments are unpaid***

State law charges the director of public safety with fiduciary responsibility for enforcing court issued restitution and child support orders; however, the department has not fulfilled these responsibilities. Although many inmates are financially capable and legally obligated to make payments, victims and children generally have not received any of the moneys to which they are entitled.

### **Department fails to identify and withhold restitution and child support obligations**

State law assigns responsibility for collecting and disbursing inmates' court ordered restitution and child support payments to the department's director. Section 353-22.6, HRS, requires the director to enforce victim restitution orders against moneys earned by prisoners while incarcerated. The statute prescribes that 10 percent of an inmate's annual earnings be deducted and paid once annually to the victim; however, six of eight facilities failed to garnishee inmate earnings for restitution. Only Halawa Correctional Facility and Waiawa Correctional Facility withheld inmates' earnings for restitution payments.

State law authorizes the director to collect child support from all sources of inmate funds. Up to 30 percent of the monthly deposits or credits to an inmate's trust account must be paid for child support when the total monthly deposits or credits exceed \$15. Facilities that enforced child support orders did not comply with statutory provisions governing payment thresholds and frequency. New deposits to inmate trust accounts in our sample were not garnisheed for those inmates owing child support.

Fiscal staff at three facilities informed us that restitution and child support orders are often not enforced because they are unaware of many inmates' restitution and child support obligations. Although inmates' institutional records contain copies of court orders of restitution amounts, this information was not always recorded by business staff in the facilities' accounting systems. The department's management information system office reported that it provides the Child Support Enforcement Agency (CSEA) with a monthly list of all inmates for the purpose of identifying those inmates who owe child support. However, the department does not receive an updated list from CSEA reporting the child support owed by inmates. This information should be requested and shared with the business staff who are responsible for garnisheeing inmates' accounts. The department needs to address this breakdown in information flow in order to ensure that it fulfills its fiduciary responsibilities to both the victims and children of inmates.

We also found that the restitution orders contained in inmates' institutional files did not always correlate with the reported amounts from the Judiciary. In some cases it appeared that the department's records were inaccurate, and in other cases the Judiciary did not identify inmates owing payment to victims. Inaccurate records are of concern because the Judiciary may not be able to disburse funds to victims even if the department collects it.

### **\$14,000 in restitution collections not paid to victims**

Halawa Correctional Facility and Waiawa Correctional Facility withheld over \$14,000 in restitution from inmate earnings that has not been paid to victims. The two facilities deposit the restitution into a checking account, but neither has identified a conduit for disbursing the moneys to victims. Department officials assert that the facilities do not know the identities or whereabouts of the victims. Furthermore, restitution payments forwarded to the First Circuit Court were returned because the court was unable to locate the victims. Poor coordination between the department and the Judiciary over the identification and disbursement of restitution payments requires resolution.

***Inmate trust accounts are mismanaged***

The department has not fulfilled requirements under Section 353-20, HRS, to deposit moneys and maintain individual ledgers for inmate trust accounts. Inmate ledgers should include inmate earnings from work, donations or receipts from family and friends, and payments for store order purchases and other necessities.

The department has not met its fiduciary responsibility for approximately \$1 million in inmate funds. The failure to adequately reconcile inmate account balances to deposits and bank statements has resulted in significant differences between inmate ledgers and bank statements. The department has also failed to properly allocate inmate earnings between restricted and non-restricted accounts.

**Inaccurate and insufficient monitoring of inmate ledgers results in deficit spending**

The department established policies and procedures to handle the recording and reporting of inmate trust account balances. These procedures were implemented to establish an internal control system that ensures the integrity and accuracy of the accounts.

We found that five of eight facilities had negative inmate trust account balances totaling approximately \$34,000. This balance included approximately \$30,000 for 361 inmates at Halawa Correctional Facility. We were told that some of these negative balances were caused by difficulties with recording multiple inmate requests for withdrawals and the failure to record transactions in a timely manner.

Inadequate monitoring of these accounts places inmate and state moneys at risk. Negative balances result in using one or more inmates' moneys to cover deficiencies in another inmate's account. The State is also at risk if the deficiency is detected after the inmate's release from the prison system. The department must reimburse the deficient checking account balances. In fact, the Oahu Community Correctional Center deposited \$6,328.84 of department funds into the facility's inmate trust checking account in order to eliminate negative inmate account balances. Other facilities report negative balances for many former inmates.

**Inmate earnings are improperly allocated between non-restricted and restricted accounts**

Inmates' earnings are allocated between non-restricted and restricted accounts. The non-restricted account is used for everyday needs, whereas the restricted account is available only for emergency use, or upon either parole or release.

The allocation of earnings between non-restricted and restricted accounts is governed by departmental policy; however, the department did not correctly distribute inmate earnings between these accounts. For example, at the Kauai Community Correctional Center all 11 payroll receipts selected for examination were not properly allocated between non-restricted and restricted funds. In one case, an inmate's net payroll of \$221.29 was not allocated equally between the two accounts. Instead, the entire amount was credited to the non-restricted account, which resulted in more funds being available for current use instead of being saved for use upon release or parole. Without sufficient savings, an inmate's ability to successfully transition to community life may be hindered.

### **Untimely deposits of cash receipts and failure to adequately reconcile bank statements create opportunities for theft and fraud**

The department requires that all cash donations be recorded and deposited within two working days and three business days of receipt, respectively. This policy ensures the safekeeping of cash.

We found that the department did not comply with this policy. We examined 229 cash receipts and found 19 instances where such receipts were not recorded timely. In 51 instances, cash was not deposited timely. One facility did not deposit receipts amounting to \$3,207 until 5 to 20 business days after receipt.

Untimely and inaccurate reconciliation of bank statements to cash receipts creates more opportunities for loss or misuse of cash. One facility did not reconcile bank statements to inmate accounts for almost two years. Another facility failed to resolve a discrepancy when an approximate \$1,000 received and recorded in the cash journal did not agree with the bank statement's deposits for the month. Moreover, checking accounts comprising inmates' moneys for the eight facilities were not successfully reconciled to the ledgers of the inmates' balances. Unaccounted for differences amounted to approximately \$100,000, with one facility reporting an approximate difference of \$41,000. This raises serious concerns since the inmates' ledgers report a higher balance than that reported on the bank statement. Consequently, reported inmates' balances are higher than the actual cash available for their use.

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## **Conclusion**

The Department of Public Safety fails to ensure adequate security over inmates, jeopardizing the public's safety. The department fails to classify inmate security levels correctly, account for weapons and tools, and maintain security equipment. Despite the lifting of the Spear

Consent Decree, the department continues to maintain overcrowded facilities and unsafe and unhealthy conditions—caused partially by inadequate access to health care and a dysfunctional grievance system. In addition, the director has not provided the leadership needed to manage the department's resources properly. Specifically, essential security posts are arbitrarily determined, staffing is disparate and inconsistent among facilities, and overtime costs are high. Fiscal resources have been improperly managed, resulting in lost inventory and moneys. Consequently, the department continues to place the public and state resources at risk.

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## Recommendations

1. We recommend that the director of public safety make security his highest priority by:
  - a. Re-examining the current classification system and, as needed, updating the guidelines used to determine inmate classification levels in order to ensure that classifications are based on security rather than space availability. The director should consider reducing the biennial reclassification of inmates, and require classification reviews only when events in an inmate's history may result in a possible change in custody level. The director should ensure that the department guidelines comply with department policies, and that staff complete the timely and accurate classification of all inmates within department guidelines;
  - b. Requiring all inmate misconducts to be adjudicated in a timely manner as required by the Hawaii Administrative Rules. The wardens of facilities that fail to comply with this standard should be held accountable and progressive disciplinary action taken as needed;
  - c. Filling all tool control and key control officer positions in order to ensure that adequate attention is given to the serious deficiencies in these areas. The director should require staff to immediately update all weapon, tool, and key inventories and account for all items daily;
  - d. Making each warden responsible for ensuring that inmates with access to facility areas where the canine unit "alerted to" are screened for illegal drug use. Wardens should be accountable for ensuring that proper disciplinary procedures are followed and classification reviews are conducted for all inmates testing positive for illegal drug use;

- e. Ensuring that all facilities are adequately staffed and equipment maintained to sufficiently screen inmate visitors and check deliveries. At a minimum, all visitors should be pat-searched for contraband, and metal detector screenings should be consistently performed prior to allowing visitors access to secured facility areas. In addition, all deliveries should be examined for contraband;
  - f. Enforcing the intermittent searches of inmate living areas to detect and deter the flow of contraband; and
  - g. Planning for and resolving inmate populations that exceed facility design and operational capacities.
2. The director should improve inmates' access to medical services by identifying the health care staffing needs of each facility and ensuring that each facility is staffed to comply with department medical service requirements.
  3. The director should ensure compliance with the federal Civil Rights of Institutionalized Persons Act and restore inmate rights in the department's grievance procedures. Specifically, the director should:
    - a. Immediately fill the department's grievance officer position, and other facility grievance positions as needed, to ensure that all inmate grievances are responded to in a timely manner;
    - b. Require that facilities discontinue the practice of allowing partial staff to review and address inmate grievances; and
    - c. Ensure that all facilities have the resources necessary to track grievances.
  4. The director should establish clear guidelines for staffing the department's correctional institutions. The guidelines should identify appropriate staff to inmate ratios for inmates at all custody levels. Once this is done, the department should assess the staffing at each of its correctional institutions to ensure that sufficient staffing is available and that unnecessary or unwarranted positions do not exist.
  5. The training development office should accurately track all adult correctional officer training courses and hours to ensure compliance with training requirements and to provide management with the information needed to revise the current shift relief factor. Once the department is able to accurately identify the average training for

adult corrections officers, this information, together with the state average of sick and vacation leave, should be included in the shift relief factor to identify acceptable staffing levels for facility operations.

6. The department should continue to address problems with possible leave abuses and the resulting overtime costs incurred by facilities. Wardens should improve the timely identification of staff eligible for the sick leave abuse program and implement the program for food service staff.
7. Each warden should ensure that the facilities' asset records are complete and accurate. Any unaccounted for property should be reported to the director for review and investigation as needed.
8. The department's audit and compliance officer should periodically review the financial operations of the Correctional Industries Division to ensure that it fulfills its mission and complies with state law and department policy.
9. The director should ensure that staff, inmates, and out-of-state facilities housing inmates are paid accurately. To improve the accuracy of these payments the director should:
  - a. Require the monthly review of staff leave records;
  - b. Require that inmate pay be withheld if there are no supporting timesheets and that inmate pay be audited by the department auditor, with that auditor ensuring that pay rates are accurate; and
  - c. Require the department's auditor to review the accuracy of the department's custody reports and the accuracy of invoices from out-of-state contractors.
10. The director should comply with Chapter 353, Hawaii Revised Statutes, by enforcing the collection of all restitution and child support orders for inmates under the department's jurisdiction. The director should work with the Chief Justice to ensure that information on all court ordered payments for individuals sentenced to incarceration are routinely shared with the director. The director should also establish procedures for facilities to disburse payments to the Judiciary and Child Support Enforcement Agency as applicable.
11. The director should require that facility staff carry out the proper fiduciary responsibilities over inmate trust accounts. Specifically, staff should be required to:

- a. Make daily deposits and recordation of inmate cash receipts;
- b. Ensure the segregation of cash handling responsibilities;
- c. Properly allocate inmates' pay;
- d. Perform timely monthly reconciliation between inmate ledgers and bank statements; and
- e. Report any discrepancies between inmate ledgers and bank statements to the director with an explanation of the discrepancy.

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## Response of the Affected Agency

### Comments on Agency Response

We transmitted a draft of this report to the Department of Public Safety on January 26, 2000. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department responded that our audit provides it with some good information about specific problem areas; however, the department believes the report also paints an incomplete and unfair picture of corrections.

The department claims that its facilities are secure and that the public is safe, and therefore disagrees with our finding that breaches in security jeopardize public safety. The department reports that "there were no escapes from a secured facility in 1999" and "no incidences of major inmate to inmate or inmate to staff assaults." The department's response downplays the significance of the security breaches we reported, even though it acknowledges problems with firearm, tool, and key controls. The department's statement that its "paper inventory problem in no way jeopardized the safety of our staff or the public," is of concern because security cannot be assured without adequate management controls.

The department also responded that it recognizes the need to improve its classification of inmates. The department reports that it reviewed 192 furlough participants and found all except three were eligible for the program, with the three still being reviewed. It is unclear whether this conclusion is based on the application of department policy or on its actual practice which allows inmates to be released into the community six months earlier. Moreover, given the kinds of errors and anomalies we found when we reviewed inmate files, we stand by our finding.

The department stated that we failed to identify that Halawa Correctional Facility repinned the lock to the locksmith's office when the former locksmith failed to return his key. However, the locksmith made no mention of this when specifically asked what the facility had done to address this security issue.

The department also disagrees with our finding that the director failed to provide the leadership needed to ensure efficient staffing and to control overtime. But the department has not addressed flaws in its current staffing formula and the need to develop system-wide staffing guidelines. The department claims a standardized staffing approach was articulated to the wardens during several meetings. However, the

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department was unable to provide us with any staffing guidelines and every warden informed us such guidelines are non-existent.

The department also stated that the number of essential posts at the Women's Community Correctional Center should be 41 percent rather than 74 percent as indicated in our draft report. We reviewed the work position plan provided to us by the Institutions Division Administrator and corrected a typographical error by changing the percentage from 74 to 64 percent.

The department generally agrees with our findings on inadequate inmate care and the deficient management of state resources and inmates' funds. The department reports it has made significant progress towards improving many serious and long-standing issues and remains committed to correcting them. The issues identified in our report regarding the correctional industries program are currently under criminal and administrative investigation.

Finally, we made some minor changes to our draft report for purposes of accuracy and clarity.

STATE OF HAWAII  
OFFICE OF THE AUDITOR  
465 S. King Street, Room 500  
Honolulu, Hawaii 96813-2917



ATTACHMENT 1

MARION M. HIGA  
State Auditor

(808) 587-0800  
FAX: (808) 587-0830

January 26, 2000

*COPY*

The Honorable Ted Sakai  
Director  
Department of Public Safety  
919 Ala Moana Boulevard  
Honolulu, Hawaii 96814

Dear Mr. Sakai:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Management and Financial Audit of the Department of Public Safety*. We ask that you telephone us by Friday, January 28, 2000, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Wednesday, February 2, 2000.

The Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa  
State Auditor

Enclosures

BENJAMIN J. CAYETANO  
GOVERNOR



STATE OF HAWAII  
**DEPARTMENT OF PUBLIC SAFETY**  
919 Ala Moana Boulevard, 4th Floor  
Honolulu, Hawaii 96814

**TED SAKAI**  
DIRECTOR

**PAULINE N. NAMUO**  
Deputy Director  
Administration

**MARIAN E. TSUJI**  
Deputy Director  
Corrections

**SIDNEY A. HAYAKAWA**  
Deputy Director  
Law Enforcement

February 3, 2000

Ms. Marion Higa  
State Legislative Auditor  
465 South King Street, Suite 500  
Honolulu, Hawaii 96813

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OFF. OF THE AUDITOR  
STATE OF HAWAII

Dear Ms. Higa,

Thank you for the opportunity to respond to your audit report. We have reviewed your findings, and in general, your report has provided us with some good information about specific problem areas throughout our department. We are deeply concerned, however, about the way in which you have presented your findings. In many instances, they paint an incomplete and unfair picture of what really happens in Corrections operations. Your statement that "Breaches in Prison Security Jeopardize Public Safety" is false. At no time during your audit review period was public safety compromised or jeopardized. This statement is an example of an unsubstantiated conclusion, using unnecessarily inflammatory language, drawn from unsupported assumptions and the lack of understanding of Corrections operations. This kind of reporting is really counter-productive to our department because it 1) removes the focus from specific problems that need to be resolved and 2) paints an unfair, incomplete, inaccurate, and distorted picture of our department.

**Finding #1: Breaches in Prison Security Jeopardize Public Safety**

We disagree with this finding. The public is safe. This finding is based on a set of faulty assumptions or wrong information. First of all, there were no escapes from a secured facility in 1999. Secondly, we have had no incidences of major inmate to inmate or inmate to staff assaults in 1999. We understand that we need to strengthen the administration of our security program. To this end, we recently hired a security coordinator who came to us from one of the largest correctional systems in the nation, and who has begun the process of assessing and improving our security procedures. However, we have not compromised the safety and security of our inmates, of the staff, and of the public.

**Firearms Control:**

We were alarmed when your staff reported to us that 10 firearms could not be accounted for. As a result, we immediately conducted a complete inventory of our weapons and have accounted for all except two. One weapon, assigned to Halawa has been missing since 1970. The other weapon, assigned to WCCC, has been missing for almost ten years. Unfortunately, inventory records were not corrected. We do have an administrative problem with weapons inventory and we have immediately corrected this problem by updating our inventory listings. Our department failed to properly record the disposal or transfer of weapons, some of which occurred years, perhaps decades ago; but this paper inventory problem in no way jeopardized the safety of our staff or the public.

The audit report points to the 1984 Spear lawsuit, which found that the department was lax in its weapon control. Weapons inventory control is a long-standing problem in our department, which your audit has helped us to identify and correct. But the department's 1984 problem with weapons management and the paper inventory problem that we recently corrected is really an unfair comparison.

**Tool Control:**

The same paper inventory problem exists with our tool control. The department will be reevaluating our classification of tools because our policy describing the use of Class A and B tools was written with the medium and high security facilities in mind. For example, we need to reassess the classification of a ladder as a Class A tool at a minimum security facility such as Waiawa or Kulani, where there are no perimeter fences to begin with. Again, public safety is not compromised, however, because at the higher security facilities such as Halawa, no inmate is allowed to leave the work area without a complete body search and without passing through a metal detector.

**Key Control:**

We also acknowledge that we have problems with key control. However the audit team draws conclusions that are not based on facts. First, the audit report states that the Maui Community Correctional Center could not account for a set of keys to a module that houses inmates with long minimum sentences. The report fails to say, however, that the set of missing keys does not open an inmate cell door or any exit doors to Module C. Instead, these keys open the food hatch and storage area. All security keys are accounted for at MCCC. As a result of the audit, however, MCCC has revised its key control to reflect a more accountable method of verifying possession of keys.

The audit report also states that Halawa's previous locksmith did not return keys to his office and because Halawa has not changed its locks, the department violated its own policy. However, the audit report failed to mention that the lock for the locksmith's office was repinned. Because the lock was

repinned, the original key to the locksmith's office no longer works. Repinning is less costly than changing the lock but achieves the same result.

**Classification:**

The audit team reached the conclusion that problems with inmate classification also jeopardizes public safety. This is another example of a faulty finding based on a set of weak allegations. The audit report points to computation errors, failure to identify and properly weigh inmate misconducts and escape histories, ineligible inmates participating in furlough, untimely classification reviews, and inconsistencies between the policy and the practice.

Regarding computation errors, your report does not provide information about the entire classification system. The central classification office reviews all classification scores prior to any transfer of an inmate, any decrease in an inmate's custody, and any exception cases. This review includes a recomputation if errors are found. The department established this process to ensure the safety of the public. We recognize that there will be human errors, and as a result, we double check our work to protect the public.

Furthermore, the audit report cites that our 1997 classification consultant also found scoring discrepancies. The auditors failed to report, however, the discrepancies were minor, to wit: 1) the consultant found scoring errors in only one case; 2) for escape histories, the consultant found absolutely no errors in scoring. 3) For misconducts, the consultant found that an informal misconduct was erroneously included in one inmate's classification score, which actually created higher score than he deserved.

Because the department does not have access to the auditor team's work papers, we cannot confirm their findings regarding furlough ineligibility, however, we have conducted our own survey of furlough participation and found that 189 of 192 inmates on furlough are appropriately placed. Three cases are still being reviewed.

The audit team found that the classification policy, which allows furlough when an inmate is 18 months to parole eligibility, is inconsistent with current practices, which awards community custody at 24 months. However, the auditors failed to report that a memo was issued in 1992 allowing inmates to participate in the furlough program with 24 months left to parole eligibility or discharge. In 1998, this change in policy was reviewed by a previous director—a former prosecutor—and was left unchanged. In short, the discrepancy between the policy and the actual practice is a technicality that does not result in a lessening of public safety.

The audit report then cited an example involving an inmate on work furlough from the Hawaii Community Correctional Center (HCCC). This inmate, according to the auditors, was found guilty of a serious misconduct five months after an incident. Meanwhile, the inmate remained on work furlough. The audit

team implies that our untimely processing of misconducts placed the public at risk.

The auditor team further alleges that had the inmate been found guilty of escape immediately, his custody level would have increased and he would have been ineligible for furlough. The facts do not support these allegations. The inmate did not escape. He returned late from work. The Prosecutor's Office did not charge him with an escape. In fact, he was not charged with any crime. Because contract violations such as this do not warrant termination of furlough status, the inmate's furlough status was reinstated.

The department recognizes that it has to make improvements in its classification process and procedures. Through our strategic planning process, we formed a task force in November 1999 to look specifically at how we can make necessary changes. However, the system, as it currently operates, does not jeopardize public safety.

### **Finding #2: Inadequate Inmate Care Places the Department at Risk of Additional Costs**

#### **Access to Health Care**

The department couldn't agree more with the audit team's findings that we must identify our health care staffing needs to improve access to health care. We just recently hired a health care administrator who is dealing with many long standing issues to be resolved. As the audit report points out, access to dental and mental health services is limited due to the lack of badly needed staff and resources.

In the past ten years, our inmate population has more than doubled. There is a significantly higher incidence of mental illness, contagious diseases, and other serious health problems among the inmate population. However, there has been only a minimal increase in our health care resources. In fact, Halawa, where the population is more than twice its design capacity, has struggled with the same staffing level for the past ten years.

#### **Overcrowding**

The department has been actively and strenuously working towards developing a new prison facility to resolve our overcrowding crisis, yet no mention of these efforts was made in the audit report. Instead, the auditor states that "the department's failure to alleviate overcrowding was also a condition resulting in the Spear Consent Decree. Despite the lifting of this decree, facility overcrowding continues to jeopardize health and safety of inmates."

Halawa Correctional Facility is the only medium security prison in the State, and even with 1,200 Hawaii inmates housed in mainland facilities, Halawa is still overcrowded by well over double its design capacity. Overcrowding places a costly and potentially disastrous strain on the facility's physical infrastructure;

reduces opportunities for treatment; and renders treatment and reintegration programs ineffective.

We also need to mention that in the past five years, we have expanded the Hawaii, Maui, Kauai, Oahu, and Women's Community Correctional Centers, and the Waiawa Correctional Facility. We also have designed an additional expansion to Oahu Community Correctional Center. However, because of the growth in the inmate population—something beyond our control—we remain overcrowded.

**Finding #3: The Director Has Failed to Provide the Leadership Needed to Efficiently Staff Security Positions and Control Overtime**

**Security Staffing**

This finding is wrong. It is based on incorrect assumptions, statements, and conclusions. For example:

- 1) The audit report states: "The director and deputy director for corrections informed us that system-wide staffing guidelines have not been developed because each institution's design will dictate different staffing requirements."

In actuality, the director and deputy director were asked about whether they have established inmate to staff ratios for facilities. They told the auditors that staffing plans must take into account other factors such as facility design, program availability, and type of inmate in addition to inmate-to-staff ratios. The audit report statement is a mis-representation of what was said by the director and deputy director.

- 2) The audit report states: "Although facility design may influence staffing, there is still a need for standardized approach to establishing security posts and work positions."

A standardized approach to establishing security posts and work positions was developed and was clearly articulated to the wardens at several meetings. The director also formed a task force composed of a division administrator and two senior wardens. This task force visited every facility and reviewed each facility's work position plan prior to finalization.

- 3) The audit report states: "However, the director has not provided wardens with criteria to be used in designating posts as essential and non-essential."

The bargaining unit 10 contract defines essential and program posts. In addition, the director has instructed the wardens to use the first watch staffing complement as a guide to designating essential and non-essential posts.

- 4) The audit report states: "The wide variation among facilities in the percentage of facility posts classified as essential indicates the lack of criteria for determining essential posts."

This statement is erroneous and indicates a lack of understanding about the staffing and scheduling processes of eight unique facilities with different physical designs, program requirements, and inmate types. A thorough review and understanding of the department's work position plans reveals just the opposite. When comparing the staffing patterns for all eight facilities, there are far more common elements than there are differences. Evidently, the audit team chose to focus on the few variations, all of which can be explained, had we been asked.

For example, we can explain why MCCC has designated its education program post as essential, while the same post at other facilities are non-essential. This difference is caused by the designs of the facilities. MCCC's education program post oversees the law library in addition to educational classes. Inmates have a constitutional right to access to legal materials. At MCCC, the education/library complex is relatively isolated. It cannot be covered by other posts, including rover posts. In other facilities, however, the law library can be covered by other posts, and therefore, can be kept vacant even if the education post is not filled.

The auditor's report also questions essential post designations at Halawa, stating that two modules housing inmates with similar custody levels had different numbers of essential security posts. This is accurate, but does not indicate an inconsistency. Halawa has four housing modules. Each module has three security posts, however, every other module designates all three security posts as essential. The other two modules only designate two as essential. If lockdown conditions prevail, that extra security post—a supervisor—is shared between the other two modules.

The audit report also cites apparent "staffing disparities that could not solely be explained by the facilities' security designation or design." The audit report notes the "wide range of staff to inmate ratios" in facilities housing inmates with similar custody levels. As an example, the report cites the difference between the Kauai Community Correctional Center (KCCC) and the Maui Community Correctional Center (MCCC). The reason for the disparity is readily apparent to any corrections professional. KCCC has three distinct housing units. Two of these units have central stations, which must be covered at all times. The third unit houses a unique program, which has been widely praised in the local media and which has won a national award.

MCCC, on the other hand, has seven distinct housing units, all with control stations that must be covered at all times. In addition, because of its sprawling nature, it has a central control station, which is completely separate—this also must be covered at all times. These fixed posts dictate a higher staffing level.

Finally, the audit team's calculations are simply wrong. The report states that 74% of the facility posts at the Women's Community Correctional Center (WCCC) are designated as essential during second watch, while other facilities designate between 30 and 52 percent. This is completely incorrect. WCCC's second watch essential post percentage is 41%, which falls right in line with the other facilities.

**Sick Leave and Overtime abuses:**

The audit report questions the success of the patterns of sick leave program established by the department to address sick leave abuse. In addition, the audit report focuses on the problems of the program without mentioning that as a result of the program, our department has terminated 8 employees and has disciplined 52 others. Moreover, the examples used are misleading. The contract clearly states that absences substantiated by a physician's statement cannot be used to establish a pattern. We are aware that many adult corrections officers utilize sick leave at a high rate. However, these individuals produce physician's statements, thus avoiding the program.

With respect to our problems with overtime, the auditors were informed that the department has implemented a management accountability system as of October 1, 1999, that requires division and facility administrators to submit monthly data reports for review by a panel appointed by the director. Each division administrator and facility warden is required to periodically appear before the panel to review the monthly reports, identify problem areas, and discuss corrective measures. Phase one of this management accountability system focuses on the causes of overtime and for the first time in the history of the department, we have hard data that will help us to identify trends in overtime use and abuse, and therefore, concentrate our efforts in the appropriate areas.

**Finding #4: Fiscal Management of State Resources and Inmate Funds Is Seriously Deficient**

**Salary Overpayments:**

We fully acknowledge that we have a long standing overpayment problem. As pointed out in the audit report, the process of collecting repayments from employees is long and arduous. The new bargaining unit contracts require that incidents of overpayment be reviewed by the union via the grievance process. For all cases, the process requires us to audit all leave records before we can schedule hearings to determine repayment requirements and agreements. Because employee records came to our department unaudited from the Department of Human Services in 1988, we are faced with having to audit old records for employees who have been working for the system for many years, with very limited staff. To address this problem, the department has asked for outside assistance to help us to audit our records.

Despite these challenges, our department has made several major improvements.

- Prior to July 1999, the employee repayment schedule allowed employees to pay \$100 maximum per paycheck. We have raised that repayment ceiling to up to 20% of the employee's gross salary based on the amount that they owe the department.
- We have reduced our new instances of overpayments despite the fact that the state payroll system has not changed, even with the payroll lag. Since August 1999, there have been only 15 instances of overpayments totaling \$6,524.
- We have reduced the net overpayment amount from \$2.4 million to 2.2 million at the end of the 1999 calendar year.
- We have secured repayment agreements from about 251 employees for a total of about \$1 million.
- We have completed the audits of 77 employee records, totaling \$316,851, and forwarded these records to the unions for repayment negotiations.

Finally, the department has asked to be the pilot site for the state's new KRONOS computerized time and attendance payroll system. We have been awarded the opportunity to be the pilot site, and have been planning implementation of the system since September 1999. We are confident that this system will dramatically improve our payroll process, thereby reducing our overtime instances.

#### Assets Management, Victim Restitution and Child Support Payments, and Inmate Trust Accounts

The department has recently completed installation of our Corrections Management Information System, which will assist us in managing our fiscal functions. For example, the CMIS has an inmate trust accounting component that will standardize the process and assist us in correcting deficit balances. We acknowledge that we have had a long standing inmate trust accounting problem and our fiscal office is working on an overall corrective action plan.

The issues involving our Correctional Industries program are currently under administrative and criminal investigation. With the assistance of your office in providing us with further information, we can take action on all valid allegations cited in your report.

At the audit exit conference held between your audit team's leaders and my department's management staff on January 14, 2000, your staff began the meeting by explaining that the charge of your office is not to look at the positive aspects and accomplishments of your auditees, but rather, to focus on problems. Though we understand that this may be true, we, who work on a day-to-day

basis in Corrections can't help but struggle with this notion because so many of our achievements respond directly to the problems to which you point.

Our department knows that we have deficiencies; some of which are long standing and may take months to resolve. We have been tackling as many issues as possible, with the resources that we have—we simply can't solve all of our problems immediately and simultaneously. We have already made significant progress towards improving many serious and long standing issues that have plagued our department for years, and we don't plan to rest until we have corrected each one.

It is my understanding that our response to your audit findings may be published as an appendix to the final public report. With this in mind, it is unfortunate that given the large scope of this audit and the seriousness of the findings, we were not able to conduct a thorough analysis of your findings, to submit a more detailed response within your deadline of six working days. Although we may not be able to address every issue in this written response, be assured that we have already begun and will continue to investigate each point that you have made. We will be releasing a more detailed response to this report when our investigations and analyses are complete.

Very truly yours,



TED SAKAI  
Director