Office of Law Enforcement Support

Semiannual Report

July 1, 2021–December 31, 2021

Independent review and assessment of law enforcement and employee misconduct at the California developmental centers and Stabilization, Training, Assistance and Reintegration facilities

Promoting a safe, secure and therapeutic environment

This report is prepared and distributed per California Welfare and Institutions Code Section 4023.8 et seq.

Contents

Introduction

I am pleased to present the twelfth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health & Human Services Agency. This report details OLES's oversight and monitoring of the Department of Developmental Services (DDS) from July 1 through December 31, 2021.

In this report, the OLES provides details on 87 reported incidents and the results of completed investigations and monitored cases. In response to deficiencies OLES identified while monitoring cases, the DDS agreed to communicate and involve OLES in the pre-disciplinary processes and stated they will endeavor to include percipient witnesses from criminal investigations in its administrative investigations. The DDS also developed additional training for staff on the OLES reporting guidelines. In addition, per OLES's recommendation, DDS resumed use of an early intervention system to monitor incidents for selected performance indicators and proactively identify potential performance problems with law enforcement staff.

During this reporting period, OLES expanded our reporting guidelines to include the intake of use of force by law enforcement and further delineated drug-related incidents previously reported under the significant interest-other incident type category.

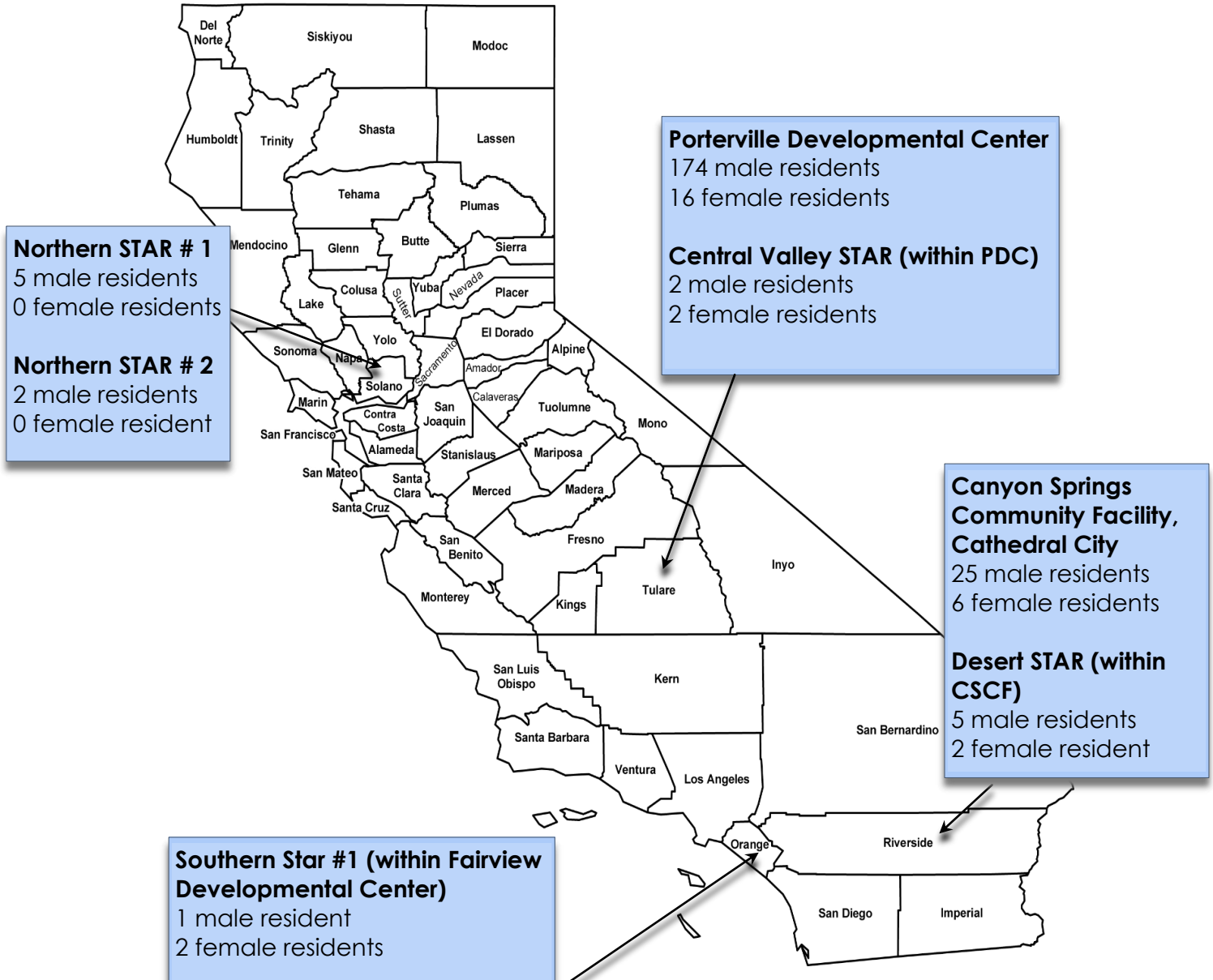
As OLES begins its seventh year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DDS.

We are grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DDS management and personnel. We welcome comments and questions. Please visit the OLES website at https://www.oles.ca.gov/.

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the DDS facilities below. Population numbers as of December 31, 2021, were provided by the department. Residents in DDS receiving acute crisis services are listed in Stabilization, Training, Assistance and Reintegration (STAR) homes.



Northern STAR # 1
5 male residents
0 female residents

Northern STAR # 2
2 male residents
0 female resident

Porterville Developmental Center
174 male residents
16 female residents

Central Valley STAR (within PDC)
2 male residents
2 female residents

Canyon Springs Community Facility, Cathedral City
25 male residents
6 female residents

Desert STAR (within CSCF)
5 male residents
2 female resident

Southern Star #1 (within Fairview Developmental Center)
1 male resident
2 female residents

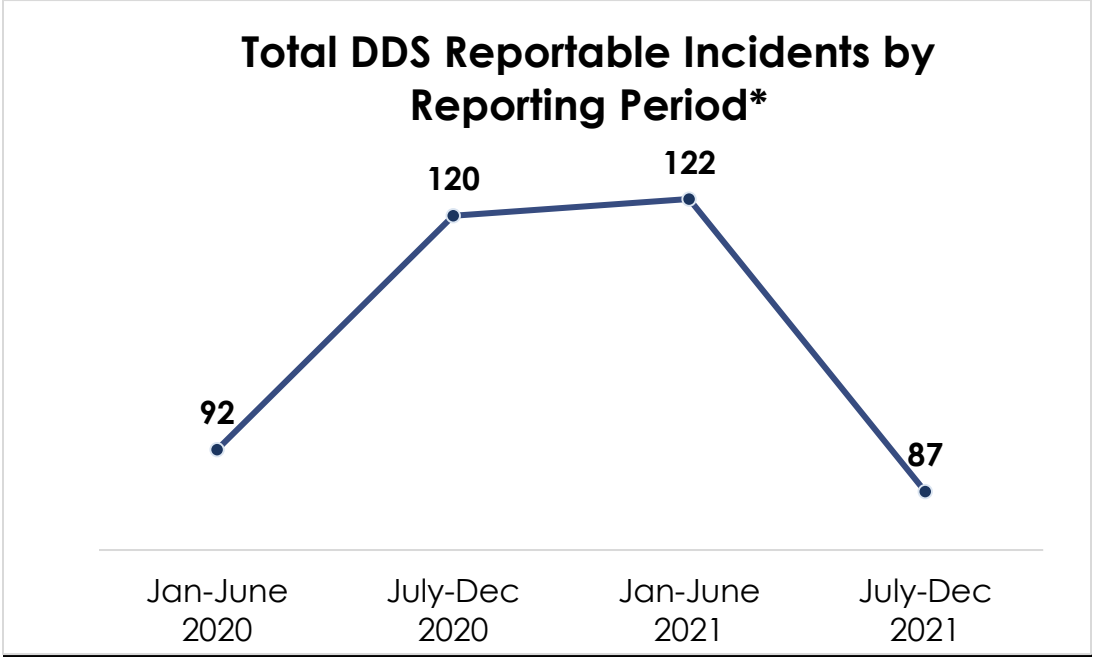
Southern Star #2 (within Fairview Developmental Center)
0 male residents
5 female residents

DDS Facility Population Chart

Facility	Number of Male Residents	Number of Female Residents	Total
Canyon Springs	25	6	31
Porterville	174	16	190
Central Valley STAR	2	2	4
Desert STAR	5	2	7
Northern STAR #1	5	0	5
Northern STAR #2	2	0	2
Southern STAR #1	1	2	3
Southern STAR #2	0	5	5
Total	214	33	247

Executive Summary

During the reporting period of July 1, 2021, through December 31, 2021, the Office of Law Enforcement Support (OLES) received and processed 87 reportable incidents[1] at the Department of Developmental Services (DDS). Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents, resident deaths and other occurrences, per Welfare and Institutions Code, sections 4023, 4023.6 and 4427.5. This is a decrease of 35 incident reports compared to the prior reporting period, which had 122 incident reports. The DDS reported significantly fewer allegations of abuse and sexual assault in this reporting period. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



* Historical numbers are unadjusted and are provided as they were previously published.

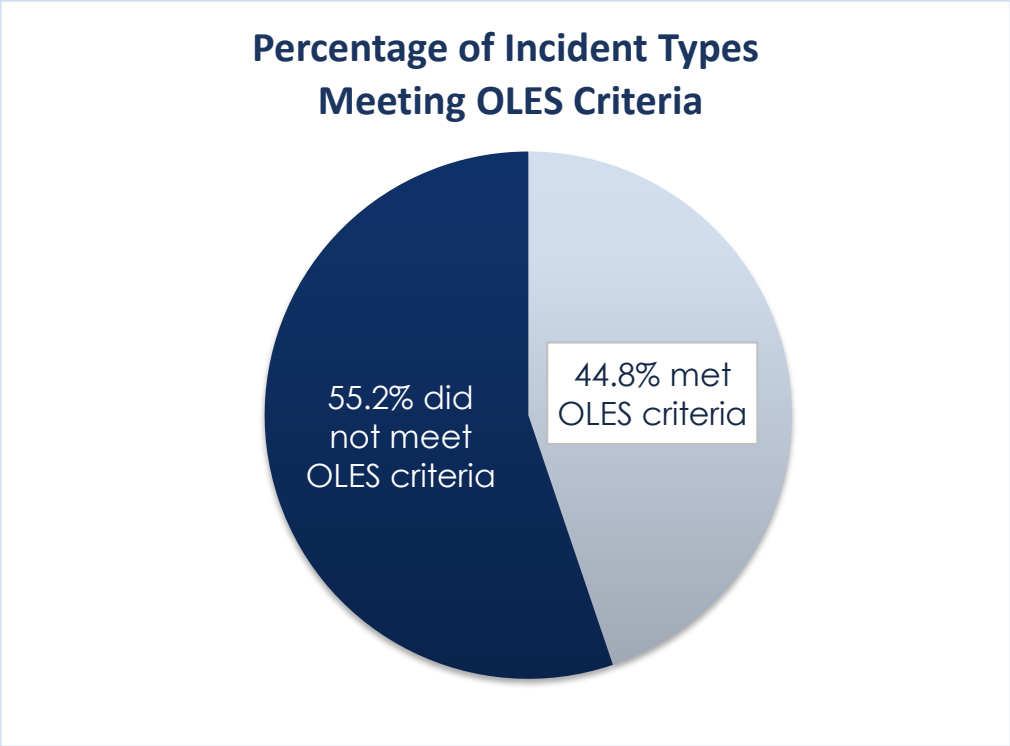
Incident Types Meeting OLES Criteria

The DDS reports to OLES any incidents and associated reportable incident types[2] listed

[1] Reportable incidents are pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix D) and existing agreements between OLES and the department.

[2] The OLES defines an incident as an event in which allegations or occurrences meeting the OLES criteria may arise from or have taken place. Allegations or occurrences from incidents such as allegations of sexual assault or physical abuse, or an occurrence of a broken bone are referred to as incident types.

in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. An incident type "meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 87 reported incidents, the OLES identified nine incidents with two or more incident types. The DDS reported a total of 96 incident types during this reporting period. Forty-three, or 44.8 percent of the 96 incident types reported by DDS met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported were abuse, sexual assault and misconduct. Allegations of abuse represented the largest number of alleged incident types reported by DDS during this reporting period. The OLES received 37 reports of alleged abuse, which accounted for 38.5 percent of all reported incident types reported by DDS. The DDS reported 10 allegations of sexual assault, making sexual assault the second most frequently reported incident type from DDS. The DDS reported nine allegations of misconduct, which is an increase of one incident type when compared to the prior reporting period.

Resident Deaths

There were no resident deaths reported to OLES in this reporting period.

Resident Arrests

There were no resident arrests reported to OLES in this reporting period.

Results of Completed OLES Investigations on DDS Law Enforcement

Per statute[3], an OLES investigation is initiated after OLES is notified of an allegation that a DDS law enforcement officer of any rank committed serious administrative or criminal misconduct. As of December 31, 2021, DDS had 80 sworn staff members.

Appendix A of this report provides information on the four OLES investigations that were completed during this reporting period. These investigations involved allegations against three sworn staff members and allegedly occurred in 2021. The OLES submitted three completed administrative investigations to the chief of the DDS Office of Protective Services for disposition and monitored the disposition process. In the criminal case, OLES found sufficient evidence for a probable cause referral to the district attorney's office.

Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the department and the discipline process for employees involved in misconduct. These completed monitored cases included allegations against psychiatric technicians, senior psychiatric technicians, officers and custodial staff.

In Appendix B and C of this report, OLES provides information on seven monitored pre-disciplinary administrative cases and four monitored criminal cases that, by December 31, 2021, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. Three pre-disciplinary administrative cases had sustained allegations. During this reporting period, DDS did not refer any criminal investigations to a prosecuting agency.

Of the 11 pre-disciplinary phase cases provided in Appendix B and C, four cases were rated as procedurally insufficient only. One pre-disciplinary case was rated both procedurally and substantively insufficient. The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in two administrative cases, which are provided in Appendix C. The OLES rated both disciplinary phase administrative cases procedurally and substantively sufficient.

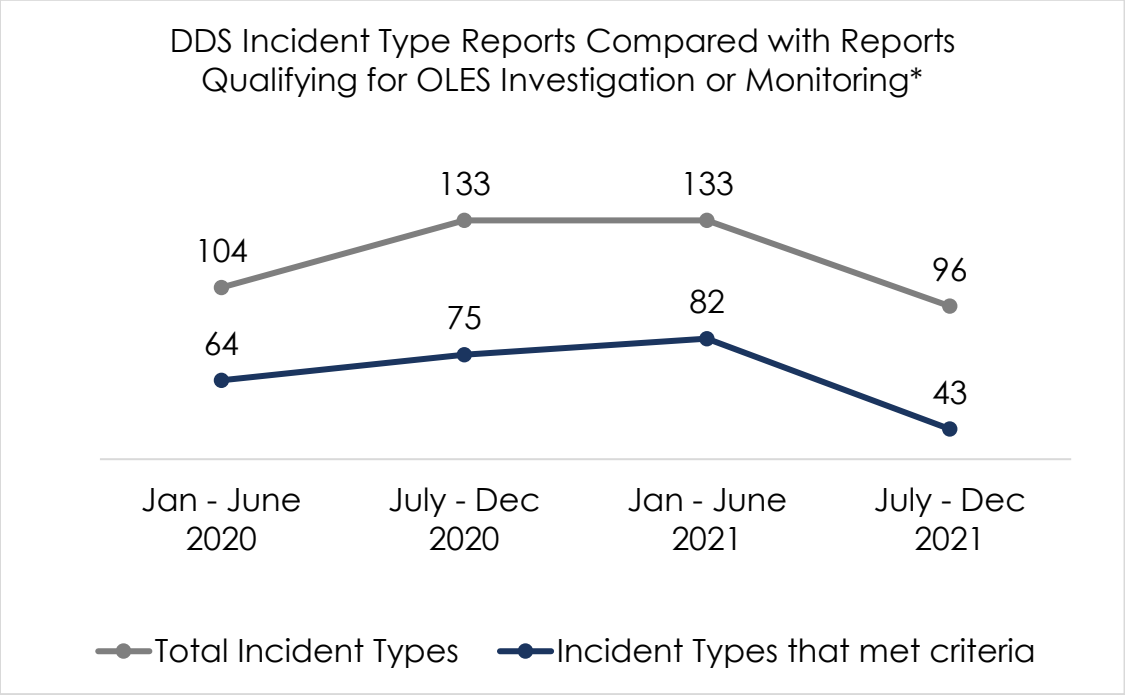
[3] Welfare and Institutions Code Section 4023, 4023.6, 4427.5. (See Appendix D).

Incidents and Incident Types

Every OLES case is initiated by a report of an incident or allegation. The OLES receives reports 24 hours a day, seven days a week. During this reporting period, the majority of incident reports came from the facilities.

Decrease in Reported Incidents and Incident Types

The number of DDS incidents reported to OLES from July 1 through December 31, 2021, decreased 28.7 percent, from 122 during the prior reporting period to 87 in this reporting period. From the 87 reported incidents, the OLES identified 96 incident types, as nine of the incidents featured two or more incident types. Forty-three of the 96 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic departmental issue.



* Numbers are unadjusted and are provided as they were previously published.

Most Frequent Incident Types Reported this Period

Of the 96 reported incident types from DDS, 56 incident types or 58.3 percent of all reported incident types fell into the following three categories: abuse, sexual assault and misconduct. These three incident type categories accounted for 33 incident types or 76.7 percent of all DDS reportable incident types that met the criteria for OLES to investigate, monitor or research for potential systemic departmental issues.

Alleged abuse was the most frequent DDS incident type reported in this reporting period. The 37 abuse allegations accounted for 38.5 percent of all DDS incident types reported. Twenty-three abuse allegations met OLES criteria for investigation or

monitoring. Alleged sexual assault represented the second highest category for the number of incident types reported, with 10 reports. Four alleged sexual assault incident types met criteria for investigation or monitoring. The total number of misconduct incident types rose from eight incident types to nine. Six of the nine misconduct incident types met criteria for investigation.

Most Frequent Incident Types July 1 through December 31, 2021

Incident Type Categories	Prior Period Incident Types January 1 through June 30, 2021	Current Period Incident Types July 1 through December 31, 2021	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	66	37	-43.9%	23
Sexual Assault	21	10	-52.4%	4
Misconduct	8	9	+12.5%	6

Incident Types by Reporting Period

The following table compares the total count of reported incident types during this reporting period to the total count from the two prior reporting periods.

Incident Type Categories	Prior Period July 1- December 31, 2020 (Reported)*	Prior Period July 1 – December 31, 2020 (Meets Criteria)*	Prior Period January 1- June 30, 2021 (Reported) *	Prior Period January 1- June 30, 2021 (Meets Criteria) *	Current Period July 1- December 31, 2021 (Reported)	Current Period July 1- December 31, 2021 (Meets Criteria)
Abuse	51	44	66	51	37	23
Broken Bone (Known Origin)	4	1	7	0	4	0
Broken Bone (Unknown Origin)	4	3	2	2	4	4
Burn	9	1	2	0	4	0
Death	1	0	1	1	0	0
Genital Injury (Known Origin)	0	0	0	0	2	1
Genital Injury (Unknown Origin)	2	1	1	0	2	2
Head/Neck	8	0	7	1	3	0

Incident Type Categories	Prior Period July 1- December 31, 2020 (Reported)*	Prior Period July 1 – December 31, 2020 (Meets Criteria)*	Prior Period January 1- June 30, 2021 (Reported) *	Prior Period January 1- June 30, 2021 (Meets Criteria) *	Current Period July 1- December 31, 2021 (Reported)	Current Period July 1- December 31, 2021 (Meets Criteria)
Injury						
Misconduct	2	2	8	8	9	6
Neglect	12	11	3	3	5	3
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
OPS Use of Force	-	-	-	-	4	0
Pregnancy	0	0	0	0	0	0
Resident on Resident Assault/GBI	3	0	4	0	0	0
Sexual Assault	18	10	21	14	10	4
Sexual Assault-OJ**	3	0	0	0	3	0
Significant Interest-Attack on Staff***	4	0	4	2	6	0
Significant Interest-Attempted Suicide	0	0	0	0	0	0
Significant Interest-AWOL	6	0	0	0	2	0
Significant Interest-Child Pornography	0	0	0	0	0	0
Significant Interest-Drugs****	-	-	-	-	0	0
Significant Interest-Other*****	4	0	4	0	0	0
Significant Interest-Overfamiliarity	2	2	1	0	1	0

Incident Type Categories	Prior Period July 1- December 31, 2020 (Reported)*	Prior Period July 1 – December 31, 2020 (Meets Criteria)*	Prior Period January 1- June 30, 2021 (Reported) *	Prior Period January 1- June 30, 2021 (Meets Criteria) *	Current Period July 1- December 31, 2021 (Reported)	Current Period July 1- December 31, 2021 (Meets Criteria)
Significant Interest- Resident Arrest	0	0	2	0	0	0
Significant Interest-Riot	0	0	0	0	0	0
Total	133	75	133	82	96	43

*Numbers in this column are unadjusted and provided as they were previously published.
**These incidents occurred outside the jurisdiction of DDS.
***The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department reported to OLES and therefore does not reflect all attacks on staff that may have occurred.
****Beginning in the July 1, 2021, through December 31, 2021, reporting period, the OLES distinguished drug-related allegations and crimes by patients or staff as a separate incident type. These incidents include verified drug offenses by patients and allegations of drug trafficking or smuggling against patients or staff.
*****Any other incident of significant interest, e.g., a stolen vehicle being pursued on departmental grounds.

Incident Types Reported from Developmental Centers or Canyon Springs Community Facility

Eighty-one of the 96 reported incident types came from a developmental center or the Canyon Springs Community Facility (CSCF). The incident types reported by Fairview Developmental Center (FDC) and Sonoma Developmental Center (SDC) did not involve residents. As shown in the *Incident Types by Reporting Period* table, the developmental centers and CSCF did not report any incident types from the following incident type categories: death, non-resident on resident assault/GBI, pregnancy, resident on resident assault/GBI, significant interest-attempted suicide, significant interest-child pornography, significant interest-drugs, significant interest-other, significant interest-resident arrest and significant interest-riot.

The following table lists the number of reported incident types by facility for categories that had a least one reported incident type.

Incident Type Category	Canyon Springs	Fairview	Porterville	Sonoma	Total
Abuse	12	0	22	0	34
Broken Bone (Known Origin)	0	0	3	0	3
Broken Bone (Unknown Origin)	0	0	4	0	4
Burn	0	0	4	0	4
Genital Injury (Known Origin)	0	0	2	0	2
Genital Injury (Unknown Origin)	0	0	2	0	2
Head/Neck Injury	0	0	2	0	2
Misconduct	2	3	3	1	9
Neglect	1	0	3	0	4
OPS Use of Force	0	0	4	0	4
Sexual Assault	4	0	6	0	10
Significant Interest-Attack on Staff*	1	0	1	0	2
Significant Interest - Overfamiliarity	0	0	1	0	1
Total	20	3	57	1	81

*The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department has reported to OLES and therefore does not reflect all attacks on staff that may have occurred.

Incident Types Reported from STAR Homes

Fifteen of the 96 incident types reported by DDS came from Stabilization, Training, Assistance and Reintegration (STAR) homes. The state-operated STAR homes provide person-centered support and crisis stabilization to residents, so that they can successfully transition to a more appropriate, less restrictive community living setting. Incident types reported from STAR homes are listed in the table below. Northern STAR #2 did not report any incidents in this reporting period.

Incident Type Category	Central Valley STAR	Desert STAR	Northern STAR #1	Southern STAR #1	Southern STAR #2	Total
Abuse	1	1	0	1	0	3
Broken Bone (Known Origin)	1	0	0	0	0	1
Head/Neck	0	0	0	1	0	1
Neglect	0	0	1	0	0	1
Sexual Assault-OJ*	0	0	2	0	1	3
Significant Interest-Attack on Staff**	2	0	2	0	0	4

Incident Type Category	Central Valley STAR	Desert STAR	Northern STAR #1	Southern STAR #1	Southern STAR #2	Total
Significant Interest-Over-Familiarity	0	0	2	0	0	2
Total	4	1	7	2	1	15

*These incidents occurred outside the jurisdiction of DDS.
**The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department reported to OLES and therefore does not reflect all attacks on staff that may have occurred.

Distribution of DDS Incident Types

As of December 31, 2021, the DDS population decreased by 18 residents since the last report, with 247 residents. With 247 residents department-wide, this equates to 0.39 incident types per resident. As shown in the table below, among the developmental centers and CSCF, CSCF had the highest ratio of reported incident types to total resident population.

DDS Developmental Center Population and Total Incident Types

Facility	Number of Residents*	Total Incident Types	Ratio of Incident Types to Population
Canyon Springs	31	20	0.645
Fairview	0	3	-
Porterville	190	57	0.300
Sonoma	0	1	-
Totals	221	81	0.367

* The department provided population numbers as of December 31, 2021.

Reports from STAR homes were reported in the same frequency as the prior reporting period. The average length of stay for a resident in a STAR home during the reporting period was 12 months. In the previous report, DDS reported 22 residents resided in STAR homes on June 30, 2021. During the reporting period, 13 new residents were admitted to the STAR homes. On June 30, 2021, there were 22 residents in STAR homes.

The following table lists the ratio of incident types to the cumulative total of residents who resided in a STAR home during the reporting period. Northern STAR #1 and Central Valley STAR had the highest ratio of incident types to total population.

DDS STAR Home Population and Total Incident Types

Facility	Number of Residents on June 30, 2021*	Number of Residents Admitted from July 1 through December 31, 2021**	Total Resident Count	Total Incident Types	Ratio of Incident Types to Total Population Count
Central Valley STAR	3	3	6	4	0.667
Desert STAR	10	3	13	1	0.077
Northern STAR #1	4	2	6	7	1.167
Northern STAR #2	0	2	2	0	0
Southern STAR #1	2	2	4	2	0.500
Southern STAR #2	3	1	4	1	0.250
Total	22	13	35	15	0.429

* Numbers in this column are unadjusted and provided as they were previously published.

**The department provided population numbers as of December 31, 2021.

Sexual Assault Allegations

Following the abuse incident type, sexual assault was the second most frequently reported incident type from July 1 through December 31, 2021. The 10 alleged sexual assault incident types in this reporting period accounted for 10.4 percent of all reported incident types from DDS. Four sexual assault incident types met OLES criteria for investigation, monitoring or research into systemic department issues. The DDS reported three incident types under the sexual assault-OJ category. The sexual assault-OJ incident type category includes allegations that implicated family, friends, or others in incidents that occurred when residents were not in a DDS facility.

Of these 10 sexual assault incident types, six were reported by Porterville Developmental Center (PDC) and four were reported by CSCF. Six allegations of sexual assault involved a resident assaulting another resident. Three allegations involved non-law enforcement staff on a resident. The remaining allegation involved a law enforcement staff on a resident.

All DDS reports of alleged sexual assaults received by OLES during the reporting period are shown in the following table.

DDS - Sexual Assault Incidents Reported July 1 through December 31, 2021

Facility	Resident on Resident	Non-Law Enforcement Staff on Resident	Law Enforcement Staff on Resident	OJ*	Total
Canyon Springs	4	0	0	0	4
Northern STAR #1	0	0	0	2	2
Porterville	2	3	1	0	6
Southern STAR #2	0	0	0	1	1
Totals	6	3	1	3	13

*Sexual Assault-OJ is a resident report of an alleged sexual assault that occurred before the resident was in the care of the DDS or outside the jurisdiction of the facility.

Reports of Residents Absent without Leave

The DDS reported two significant interest-absent without leave (AWOL) incident types involving non-forensic residents from Northern STAR #1 during this reporting period. During an outdoor walk, a resident walked away from staff onto a local roadway and threw rocks at staff. The resident voluntarily returned to the facility with staff and did not sustain any injuries requiring more than first aid. In the second incident, a resident ran from his residence and onto a roadway. The resident returned to the facility a few minutes later after several verbal prompts from staff and did not sustain any injuries from the incident.

Notification of Incident Types

Different incident types require different kinds of notification to OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq., and agreements between OLES and the department, certain serious incident types are required to be reported to OLES within two hours of their discovery. Notification of these "Priority One" incident types was deemed to be satisfied by a telephone call to the OLES hotline in the two-hour period and the receipt of a detailed report within 24 hours of the time and date of discovery of the reportable incident. "Priority Two" threshold incidents require notification within 24 hours of the time and date of discovery. Priority One and Two threshold incident types are shown in the tables below.

Priority One Notifications – Two Hour Notification

Incident	Description
ADW	An assault with a deadly weapon (ADW) against a resident by a non-resident.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a resident.
Broken Bone (U)	A broken bone of a resident when the cause of the break is undetermined and was not witnessed by staff.
Deadly force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a resident, including a resident that is officially declared brain dead by a physician or other authorized medical professional noting the date and time, or a death that occurs up to 30 days from resident discharge from the DDS facility.
Genital Injury (U)	An injury to the genitals of a resident when the cause of injury is undetermined and was not witnessed by staff.
Physical Abuse	Any report of physical abuse of a resident implicating staff.
Sexual Assault	Any allegation of sexual assault of a resident.

Priority Two Notifications – 24 Hour Notification

Incident	Description
Broken Bone (K)	A broken bone of a resident when the cause of the break is known or witnessed by staff.
Burn	Any burns of a resident. This does not include sunburns or mouth burns caused by consuming hot food or liquid unless blistering occurs.
Genital Injury (K)	An injury to the genitals of a resident when the cause of injury is known or witnessed by staff.
Head/Neck Injury	Any injury to the head or neck of a resident requiring treatment beyond first-aid that is not caused by staff or law enforcement. Or any tooth injuries, including but not limited to, a chipped, cracked, broken, loosened or displaced tooth that resulted

Incident	Description
	from a forceful impact, regardless of treatment. Injuries that are beyond treatment of first aid include physical trauma resulting in an altered level of consciousness or loss of consciousness or the use of skin adhesive, staples or sutures.
Neglect	Any staff action or inaction that resulted in, or reasonably could have resulted in a resident death, or injury requiring treatment beyond first-aid.
OPS Use of Force	Any Office of Protective Services staff member within DDS that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject, regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by the subject to the officer or officers.
Resident Arrest	Any arrest of a resident.
Peace Officer Misconduct	Any allegations of peace officer misconduct, whether on or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties. Allegations against a peace officer that include a priority one incident type must be reported in accordance with the priority one reporting requirements.
Pregnancy	A resident pregnancy.
Significant Interest	Any incident of significant interest to the public, including, but not limited to: AWOL, suicide attempt (requiring treatment beyond first-aid), commission of serious crimes by resident(s) or staff, drug trafficking or smuggling, child pornography, riot (as defined for OLES reporting purposes), over-familiarity between staff and residents or any incident which may potentially draw media attention.

Timeliness of Notifications

During this reporting period, DDS timely reporting of incident types to OLES was 96.6 percent. When calculating timeliness, OLES excluded seven incident types that involved a resident attack on staff or was a use of force incident reported prior to the inclusion of the use of force incident type in the OLES reporting guidelines. Of the 89 incident types evaluated for timeliness, 86 were reported timely and three incident types were not. Two of the untimely incident types were unreported and discovered by OLES when reviewing the DDS daily logs or incident reports.

With the exception of three incident types from PDC, all incident types reported by DDS were timely. Northern STAR #2 did not report any incidents.

The following table provides the percentage of timely notifications to OLES for each facility.

Rank	DDS Facility	Number of Incident Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Canyon Springs	19	19	100%
1	Central Valley STAR	2	2	100%
1	Desert STAR	1	1	100%
1	Fairview	3	3	100%
1	Northern STAR #1	5	5	100%
1	Sonoma	1	1	100%
1	Southern STAR #1	2	2	100%
1	Southern STAR #2	1	1	100%
2	Porterville	55	52	94.5%
	Total	89	86	96.6%

Intake

All incidents received by OLES during the six-month reporting period are reviewed at a daily Intake meeting by a panel of assigned OLES staff members. Based on statutory requirements, the panel determines whether allegations against law enforcement officers warrant an internal affairs investigation by OLES. If the allegations are against other DDS staff members and not law enforcement personnel, the panel determines whether the allegations warrant OLES monitoring of any departmental investigation. A flowchart of all the possible OLES outcomes from Intake is shown in Appendix E. To ensure OLES is independently assessing whether an allegation meets its criteria, OLES requires the departments to broadly report misconduct allegations.

For incidents that initially do not appear to fit the criteria[4] for OLES involvement, the OLES categorizes the incident under the "Pending Review" category and conducts an extra step to ensure the incident is properly categorized. When allegations are unclear and additional information is needed to finalize an initial intake decision, OLES may review video files or digital recordings of a particular hallway, day room, or staff area where a resident was located. Once OLES obtains and evaluates the additional materials or information, the decision to initially deem an incident as not meeting OLES criteria is reviewed again and may be reversed.

For the July 1 through December 31, 2021, reporting period, 46 of the total 94 cases opened for DDS incidents that occurred within DDS' jurisdiction or 48.9 percent were assigned a pending review. The OLES opened cases for two incidents that may have occurred while the resident was not housed within a DDS facility and assigned those cases a pending review. The OLES opened five administrative investigations and one criminal investigation. The OLES opened 34 monitored criminal cases and six monitored administrative cases.

The table on the following page provides the case assignments for all incidents received by OLES during the reporting period.

[4] Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix D).

Cases Opened in July 1 through December 31, 2021

OLES Case Assignments	July 1 – December 31, 2021	Percentage of Opened Cases
Pending Review	46	48.9%
Monitored, Criminal	34	36.2%
Monitored, Administrative	6	6.4%
OLES Investigations, Administrative	5	5.3%
OLES Investigations, Criminal	1	1.2%
Outside Jurisdiction*	2	2.1%
Totals	94	100%

*Outside Jurisdiction includes incidents that may have occurred while the resident was not housed within a DDS facility.

Completed Investigations and Monitored Cases

The OLES has several statutory responsibilities under the California Welfare and Institutions Code Section 4023 et seq. (see Appendix D). These include:

- Investigate allegations of serious misconduct by DDS law enforcement personnel. These investigations can involve criminal or administrative wrongdoing, or both.
- Monitor investigations conducted by DDS law enforcement into serious misconduct allegations against non-law enforcement staff at the departments. These investigations can involve criminal or administrative wrongdoing, or both.
- Review and assess the quality, timeliness and completion of investigations conducted by the departmental police personnel.
- Monitor the employee discipline process in cases involving staff at DDS.
- Review and assess the appropriateness of disciplinary actions resulting from a case involving an investigation and report the degree to which OLES and the hiring authority agree on the disciplinary actions, including settlements.
- Monitor that the agreed-upon disciplinary actions are imposed and not inappropriately modified. Note that this can include monitoring adverse actions against employees all the way through Skelly hearings, State Personnel Board proceedings and lawsuits.

OLES Investigations

During this reporting period, OLES completed three administrative investigations and one criminal investigation involving DDS law enforcement. If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, OLES submits the investigation to the appropriate prosecuting agency. In this reporting period, the OLES referred one criminal investigation to the district attorney's office.

All completed OLES investigations into administrative wrongdoing or misconduct are forwarded to facility management for review. In this reporting period, three administrative cases were referred to management for possible discipline of state employees. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted.

The following table shows the results of the four completed OLES investigations in this reporting period. These investigations are summarized in Appendix A.

Results of Completed OLES Investigations

Type of Investigation	Total completed July 1- December 31, 2021	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	3	N/A	3	N/A
Criminal	1	1	N/A	0
Total	4	1	3	0

OLES Monitored Cases

In this report, OLES provides information on 11 completed monitored cases. There were no monitored criminal cases referred to a prosecuting agency. There were seven monitored pre-disciplinary administrative cases. Three of the seven monitored administrative cases had sustained allegations. Results of OLES monitored cases are provided in the table below.

Results of Monitored Cases

Type of Case/Result	Total
Criminal/Referred to Prosecuting Agency	0
Criminal/Not Referred	4
Total Criminal	4
Administrative/With Sustained Allegations	3
Administrative/Without Sustained Allegations	4
Total Administrative	7
Grand Total	11

The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in two administrative cases, which are provided in Appendix C. The OLES rated both disciplinary cases procedurally and substantively sufficient.

Pre-Disciplinary Phase Cases

Of the 11 DDS pre-disciplinary phase cases in Appendix B and C, OLES rated four cases procedurally insufficient only and one case both procedurally and substantively insufficient. The following table provides the type of case and the corresponding number of cases rated procedurally or substantively insufficient.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	0	0
Criminal/Not Referred	1	0

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Administrative/With Sustained Allegations	2	1
Administrative/Without Sustained Allegations	2	0
Total	5	1

Significant procedural deficiencies found in insufficient cases and their potential consequences include, but are not limited to the following:

Procedural Deficiencies found in Insufficient Cases

Procedural Deficiency	Potential Consequence
Failure to notify OLES of incident within required timeframe	This prevents OLES from properly processing and classifying or assigning the case. Many reporting requirements are required by statute.
Failure to consult with OLES regarding sufficiency of investigation and investigative findings in a timely manner	The consult should take place within 45 days. This may prevent the case from being processed in a timely manner.

Corrective action plans for deficiencies in pre-disciplinary phase cases are provided in Appendix B and C.

DDS Use of Blue Team/IA Pro

In March 2015, the OLES provided the Legislature with a report that described the challenges faced by law enforcement at DDS along with recommendations to address these challenges. One of the recommendations was for DDS to use an early intervention (EI) system to monitor incidents for selected performance indicators such as use of force and patient complaints. The intent was for the department to use data to proactively identify potential performance problems with law enforcement staff. The DDS selected the IAPro/Blue Team software for its EI system. BlueTeam is the interface of IAPro that allows officers and supervisors to input and manage incidents such as use of force, field-level discipline, complaints and vehicle accidents. The software also allows these incidents to be routed through the chain-of-command with review and approval at each step.

In the OLES semiannual report covering the period of January 1, 2016, through June 30, 2016, OLES recommended DDS review monthly reports from the system to ensure employees with the identified behavior or activities received prompt management attention. The OLES also recommended using the employee trends pinpointed in the system to review whether training was adequate or needed to be updated or supplemented. During the semiannual reporting period of July 1 through December 31, 2016, DDS reported PDC conducted a pilot to test the Blue Team/IA Pro early intervention system. The DDS agreed to track eight incident-types: Use of Force, Patient Complaints, Citizens Complaints, Citizens Complaints-Other, Vehicle Accidents, Administrative Investigation, Censurable Incident Report and Merit Salary Advance Denial.

Due to having only four qualifying incidents at the end of the pilot, DDS determined that the IA Pro portion of the early intervention system could be used alone at DDS headquarters rather than having each facility use Blue Team. When a qualifying incident occurs, DDS headquarters would enter the information into IAPro and the DDS chief of law enforcement would work with the law enforcement command staff at the facilities to review the incidents. As reported in the semiannual report covering January 1, through June 30, 2017, after review and input by OLES, DDS issued its policy and activated the early intervention system in June 2017.

Without consultation or notice to OLES, DDS stopped using the Blue Team/IA Pro database prior to the current OPS Chief's tenure. In December 2021, after OLES confirmed the department's failure in data collection, DDS promptly agreed to resume use of the early intervention system to monitor incidents for selected performance indicators and proactively identify potential performance problems with law enforcement staff. The DDS is retroactively entering data into the system.

The OLES will work collaboratively with the department to ensure DDS resumes use of the database and continue to monitor the department's implementation.

DDS Tracking of Law Enforcement Compliance with Training Requirements

Compliance with POST Training Mandates

The DDS OPS is a California Peace Officer Standards and Training (POST) participating agency and is audited by POST every training cycle to ensure that law enforcement personnel complete Perishable Skills Training (PST) and Continuing Professional Training (CPT). The current POST two-year training cycle ends December 31, 2022.

At the end of the third quarter in September 2021, the DDS reported 41 percent of the 82 total sworn staff completed the necessary PST and 43 percent completed CPT.

At the end of the fourth quarter in December 2021, the DDS reported eight percent of the 80 total sworn staff completed the necessary PST and 58 percent completed CPT. The decrease in the fourth quarter for completed PST training is due to an update in POST PST hour requirements, which required staff to complete an additional four hours of use of force training, including staff that had already completed their PST for the 2021/2022 POST cycle.

Tracking Methods

The DDS continues to track training compliance with training mandates using the Knowledge Management System within Lexipol, POST, spreadsheets and rosters. The DDS is exploring software options to more efficiently track training.

Additional Mandated Data

The OLES is required by statute to publish data in its semiannual report about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where residents are the perpetrators. All the mandated data for this reporting period came directly from DDS and are presented in the following tables.

Adverse Actions against Employees

Facility	Administrative investigations completed*	Adverse action taken**	No adverse action taken***	Resigned/retired pending adverse action****
Canyon Springs and Desert STAR	3	1	2	0
Northern STAR 1 and 2	4	4	0	0
Porterville and Central Valley STAR	5	5	0	0
Southern STAR 1 and 2	1	1	0	0
Total	13	11	2	0

* Administrative investigations completed includes all formal investigations and direct actions that resulted in or could have resulted in an adverse action. These numbers do not include background investigations, Equal Employment Opportunity investigations or progressive discipline of minor misconduct that did not result in an adverse action against an employee.

** Adverse action taken refers to a Notice of Adverse Action being served to an employee after a formal or informal investigation (Direct Action) was completed. Direct adverse action taken refers to a Notice of Adverse Action being served to an employee without the completion of a formal investigation. These numbers include rejecting employees during their probation periods.

*** No adverse action taken refers to cases in which formal administrative investigations were completed and it was determined that no adverse action was warranted or taken against the employees.

**** Resigned or retired pending adverse action refers to employees who resigned or retired prior to being served with an adverse action. Note that DDS reports these as completed investigations.

Criminal Cases against Employees

DDS Facilities	Total Cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Canyon Springs and Desert STAR	2	0	2	0
Northern STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR	1	0	1	0
Southern STAR 1 and 2	0	0	0	0
Total	3	0	3	0

* Employee criminal cases include criminal investigations of any employee. Numbers are for investigations which were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

** Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to an outside prosecuting entity.

*** Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by a prosecuting agency.

**** Cases rejected by prosecuting agencies are criminal cases that were submitted to a prosecuting agency and rejected for prosecution by that agency.

Resident Criminal Cases

DDS Facilities	Total Cases*	Referred to prosecuting agencies**	Not Referred***	Rejected by prosecuting agencies****
Canyon Springs and Desert STAR	2	0	2	0
Northern STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR	81	43	33	5
Southern STAR 1 and 2	0	0	0	0
Total	83	43	35	5

* Resident criminal cases include criminal investigations involving residents. Numbers are for investigations that were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

** Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to outside prosecuting entities.

*** Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by prosecuting agencies.

**** Cases rejected by prosecuting agencies are criminal cases that were submitted to prosecuting agencies and rejected for prosecution.

Reports of Employee Misconduct to Licensing Boards

Reports of employee misconduct to California licensing boards include any reports of misconduct made against a state employee.

DDS Facilities	Public Health
Canyon Springs and Desert STAR	1
Northern STAR 1 and 2	0
Porterville and Central Valley STAR	21
Southern STAR 1 and 2	0
Total	22

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of July 1 through December 31, 2021.

Case Detail	Description
Incident Date	02/08/2021
OLES Case Number	2021-00176-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On February 8, 2021, an officer allegedly verbally threatened a department employee.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	02/19/2021
OLES Case Number	2021-00217-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On February 19, 2021, a sergeant improperly used The California Law Enforcement Telecommunications System (CLETS) for non-official purposes.
Disposition	The OLES conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office.

Case Detail	Description
Incident Date	02/19/2021
OLES Case Number	2021-00217-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On February 19, 2021, a sergeant improperly used The California Law Enforcement Telecommunications System (CLETS) for non-official purposes.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	01/01/2021
OLES Case Number	2021-00314-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between January 1, 2021, and January 31, 2021, an off duty investigator allegedly inappropriately touched a minor.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and criminal cases that, by December 31, 2021, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. The OLES monitored each departmental investigation for both procedural and substantive sufficiency.

- Procedural sufficiency includes the notifications to OLES, consultations with OLES and investigation activities for timeliness, among other things.
- Substantive sufficiency includes the quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

Criminal-Not Referred

Case Detail	Description
Incident Date	05/08/2021
OLES Case Number	2021-00567-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 8, 2021, a psychiatric technician allegedly hit a resident in the stomach.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The hiring authority failed to timely notify OLES of the incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the incident on May 8, 2021, at 1150 hours. The template was due 24 hours after the date of discovery; however, they did not send the template until May 11, 2021.
Department Corrective Action Plan	OPS leadership developed additional training for the Canyon Springs officers to improve their timeliness of Priority 1 and Priority 2 telephone and template notifications.

Case Detail	Description
Incident Date	05/11/2021
OLES Case Number	2021-00592-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 11, 2021, a resident alleged that a psychiatric technician had previously him on the top of his head on an unknown date.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/05/2021
OLES Case Number	2021-00706-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 5, 2021, a senior psychiatric technician allegedly hit a resident on his leg while attempting to restrain the resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/14/2021
OLES Case Number	2021-00860-1C
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 14, 2021, a psychiatric technician allegedly battered a resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Administrative-With Sustained Allegations

Case Detail	Description
Incident Date	09/17/2020
OLES Case Number	2020-01007-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	Between September 17, 2020, and September 18, 2020, a custodian allegedly failed to notify the department about his exposure to COVID-19 and his symptoms prior to entering the developmental center.
Disposition	The hiring authority sustained the allegations and determined corrective action and training was appropriate disposition. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services did not timely report the alleged incident to the OLES.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on September 28, 2020 at 1443 hours, but did not notify the OLES until October 1, 2020, at 0958 hours, over 43 hours later.

Department Corrective Action Plan	As a result of the error, the OPS Special Investigations Lieutenant has since met with the Investigator and all Investigators to discuss the deficiency and the proper procedure with Priority 1 and Priority 2 OLES Notifications. The Operations Lieutenant will continue to monitor all allegations reported to OPS, to ensure all OLES Notifications are made on time.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	10/09/2020
OLES Case Number	2020-01032-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 9, 2020, a former resident alleged a psychiatric technician had repeatedly struck him on an undetermined date.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. A draft copy of the investigative report was not forwarded to the OLES. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. A draft copy of the investigative report was not forwarded to OLES. 2. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?

	No. The hiring authority did not consult with OLES regarding the sufficiency of the investigation and the investigative findings.
Department Corrective Action Plan	The Hiring Authority will communicate with and involve OLES in the pre-disciplinary processes.

Case Detail	Description
Incident Date	02/08/2021
OLES Case Number	2021-00176-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 8, 2021, an officer allegedly verbally threatened a department employee.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/01/2021
OLES Case Number	2021-00314-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between January 1, 2021, and January 31, 2021, an off duty investigator allegedly inappropriately touched a minor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/09/2021
OLES Case Number	2021-00426-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Unfounded 2. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 9, 2021, two psychiatric technicians allegedly dragged a resident down a hallway.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. A draft copy of the investigative report was not forwarded to the OLES. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. A draft copy of the investigative report was not forwarded to the OLES. 2. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with OLES regarding the sufficiency of the investigation and the investigative findings.
Department Corrective Action Plan	The Commander, Lieutenant, and Sergeant will continue to review cases to comply with OLES's legal and Department policy requirements. The Hiring Authority will communicate with and involve OLES in the pre-disciplinary processes.

Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases

On the following pages are cases that, in this reporting period, OLES monitored in both their pre-disciplinary phase as well as the discipline phase. Each phase was rated separately.

Investigations and other activities conducted by the departments during the pre-disciplinary phase are rated for procedural and substantive sufficiency.

- Procedural sufficiency includes the notifications to OLES, consultations with OLES and investigation activities for timeliness, among other things.
- Substantive sufficiency includes the quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

The disciplinary phase is rated for procedural and substantive sufficiency.

- Procedural sufficiency includes, among other things, whether OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion.
- Substantive sufficiency includes the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

Procedurally and Substantively Insufficient in the Pre-Disciplinary Phase

Case Detail	Description
Incident Date	09/03/2020
OLES Case Number	2020-00913-2A
Case Type	Monitored
Incident Types	1. Burns 2. Neglect
Allegations	1. Dishonesty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On September 3, 2020, a psychiatric technician assistant allegedly failed to protect the health and safety of a resident when he walked the resident outside in 110 degree temperatures and had the client stand barefoot on a metal step for several minutes while the psychiatric technician attempted to unlock a door. The temperature of the metal steps was measured as 140 degrees. The resident suffered

	severe burns to his feet. It is further alleged the psychiatric technician assistant was dishonest during his investigative interviews.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The department served the psychiatric technician assistant with the notice of dismissal. The OLES concurred. However, the psychiatric technician assistant resigned before the disciplinary action took effect. A letter indicating the psychiatric technician assistant resigned pending disciplinary action was placed in his official personnel file.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. Prior to the opening of the administrative case, the department completed a thorough criminal investigation. Relevant evidence obtained in the criminal case was excluded from the administrative report. Specifically, the department did not include the statements of two percipient staff witnesses. The first witness stated in the criminal investigation that when he arrived on scene, the resident was wearing socks. The subject psychiatric technician assistant ultimately admitted that he walked the barefoot resident back and forth to the outside shower on the hot pavement prior to putting socks on the resident. The fact that the first witness said he saw the resident with socks on is direct evidence that the subject psychiatric technician assistant was attempting to hide the resident's burned feet. The second witness stated in the criminal investigation that prior to her arrival on scene she had a phone conversation wherein the subject psychiatric technician assistant told her that the resident had a cut on his right foot. Upon viewing the resident's feet, the second psychiatric technician immediately saw that the resident's feet were painfully burned; not cut. The second witness was a critical witness to the subject psychiatric technician assistant's dishonest and misleading statements and to his efforts to cover up the burns and his own misconduct. Furthermore, the administrative report did not contain two prior inconsistent statements voluntarily given by the subject psychiatric technician assistant at the onset of the criminal investigation. Instead, the report contained interviews of the two investigators recalling what the subject psychiatric technician assistant had told them seven months prior. The best evidence would have been the actual subject interviews. These omissions had the potential to affect the

	appropriate outcome of the case. The hiring authority must be able to consider all of the evidence adduced in an investigation in order to make an appropriate and just decision regarding the findings and penalty. Although the subject psychiatric technician assistant resigned, if he had not and instead appealed the case to the State Personnel Board, the omissions would prevent the department from presenting all relevant evidence at hearing, thereby risking an adverse decision resulting in the return of the subject psychiatric technician assistant to the facility.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. Relevant interviews from the criminal report were excluded from the draft administrative report. 2. Was the final investigative report thorough and appropriately drafted? No. Relevant interviews from the criminal report were excluded from the final administrative report.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	Training was conducted regarding this incident. OPS investigators will endeavor to include percipient witnesses from a criminal investigation in its administrative investigations.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	01/02/2020
OLES Case Number	2020-00013-2A
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin) 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty

Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained 7. Not Sustained
Penalty	**Initial:** Suspension **Final:** Suspension
Incident Summary	On January 2, 2020, a psychiatric technician allegedly failed to properly assess and provide medical attention to an injured resident, failed to document the incident and failed to update medical staff regarding the resident's injuries. A second psychiatric technician allegedly mocked and laughed at the resident. A third psychiatric technician allegedly failed to supervise residents.
Disposition	The hiring authority sustained the allegations against the first and second psychiatric technicians and determined a two month suspension and a salary reduction of 5 percent for 12 months, respectively, were the appropriate penalties. The hiring authority determined there was insufficient evidence to sustain the allegation against the third psychiatric technician. The OLES concurred with the hiring authority's determinations. Both psychiatric technicians filed appeals with the State Personnel Board. Prior to the prehearing settlement conference, the department entered into a settlement agreement with the second psychiatric technician whereby the department agreed to lower the salary reduction to 5 percent for six months. At the prehearing settlement conference, the department entered into a settlement agreement with the first psychiatric technician, whereby the department agreed to lower the suspension to 25 days. The OLES concurred with the settlements.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix D: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

(a) The Office of Law Enforcement Support within the California Health and Human Services Agency shall investigate both of the following:
(1) Any incident at a developmental center or state hospital that involves developmental center or state hospital law enforcement personnel and that meets the criteria in Section 4023 or 4427.5, or alleges serious misconduct by law enforcement personnel.
(2) Any incident at a developmental center or state hospital that the Chief of the Office of Law Enforcement Support, the Secretary of the California Health and Human Services Agency, or the Undersecretary of the California Health and Human Services Agency directs the office to investigate.

(b) All incidents that meet the criteria of Section 4023 or 4427.5 shall be reported immediately to the Chief of the Office of Law Enforcement Support by the Chief of the facility's Office of Protective Services.

(c) (1) Before adopting policies and procedures related to fulfilling the requirements of this section related to the Developmental Centers Division of the State Department of Developmental Services, the Office of Law Enforcement Support shall consult with the executive director of the protection and advocacy agency established by Section 4901, or his or her designee; the Executive Director of the Association of Regional Center Agencies, or his or her designee; and other advocates, including persons with developmental disabilities and their family members, on the unique characteristics of the persons residing in the developmental centers and the training needs of the staff who will be assigned to this unit.
(2) Before adopting policies and procedures related to fulfilling the requirements of this section related to the State Department of State Hospitals, the Office of Law Enforcement Support shall consult with the executive director of the protection and advocacy agency established by Section 4901, or his or her designee, and other advocates, including persons with mental health disabilities, former state hospital residents, and their family members.

4023.7.

(a) The Office of Law Enforcement Support shall be responsible for contemporaneous oversight of investigations that (1) are conducted by the State Department of State Hospitals and involve an incident that meets the criteria of Section 4023, and (2) are conducted by the State Department of Developmental Services and involve an incident that meets the criteria of Section 4427.5.

(b) Upon completion of a review, the Office of Law Enforcement Support shall prepare a written incident report, which shall be held as confidential.

4023.8.

(a) (1) Commencing October 1, 2016, the Office of Law Enforcement Support shall issue regular reports, no less than semiannually, to the Governor, the appropriate policy and budget committees of the Legislature, and the Joint Legislative Budget Committee, summarizing the investigations it conducted pursuant to Section 4023.6 and its oversight of investigations pursuant to Section 4023.7. Reports encompassing data from January through June, inclusive, shall be made on October 1 of each year, and reports encompassing data from July to December, inclusive, shall be made on March 1 of each year.

(2) The reports required by paragraph (1) shall include, but not be limited to, all of the following:

(A) The number, type, and disposition of investigations of incidents.

(B) A synopsis of each investigation reviewed by the Office of Law Enforcement Support.

(C) An assessment of the quality of each investigation, the appropriateness of any disciplinary actions, the Office of Law Enforcement Support's recommendations regarding the disposition in the case and the level of disciplinary action, and the degree to which the agency's authorities agreed with the Office of Law Enforcement Support's recommendations regarding disposition and level of discipline.

(D) The report of any settlement and whether the Office of Law Enforcement Support concurred with the settlement.

(E) The extent to which any disciplinary action was modified after imposition.

(F) Timeliness of investigations and completion of investigation reports.

(G) The number of reports made to an individual's licensing board, including, but not limited to, the Medical Board of California, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, or the California State Board of Pharmacy, in cases involving serious or criminal misconduct by the individual.

(H) The number of investigations referred for criminal prosecution and employee disciplinary action and the outcomes of those cases.

(I) The adequacy of the State Department of State Hospitals' and the Developmental Centers Division of the State Department of Developmental Services' systems for tracking patterns and monitoring investigation outcomes and employee compliance with training requirements.

(3) The reports required by paragraph (1) shall be in a form that does not identify the agency employees involved in the alleged misconduct.

(4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise made available to the public upon their release to the Governor

and the Legislature.

(b) The protection and advocacy agency established by Section 4901 shall have access to the reports issued pursuant to paragraph (1) of subdivision (a) and all supporting materials except personnel records.

California Welfare and Institutions Code 4427.5

4427.5.

(a) (1) A developmental center shall immediately report the following incidents involving a resident to the local law enforcement agency having jurisdiction over the city or county in which the developmental center is located, regardless of whether the Office of Protective Services has investigated the facts and circumstances relating to the incident:

(A) A death.

(B) A sexual assault, as defined in Section 15610.63.

(C) An assault with a deadly weapon, as described in Section 245 of the Penal Code, by a nonresident of the developmental center.

(D) An assault with force likely to produce great bodily injury, as described in Section 245 of the Penal Code.

(E) An injury to the genitals when the cause of the injury is undetermined.

(F) A broken bone, when the cause of the break is undetermined.

(2) If the incident is reported to the law enforcement agency by telephone, a written report of the incident shall also be submitted to the agency, within two working days.

(3) The reporting requirements of this subdivision are in addition to, and do not substitute for, the reporting requirements of mandated reporters, and any other reporting and investigative duties of the developmental center and the department as required by law.

(4) Nothing in this subdivision shall be interpreted to prevent the developmental center from reporting any other criminal act constituting a danger to the health or safety of the residents of the developmental center to the local law enforcement agency.

(b) (1) The department shall report to the agency described in subdivision (i) of Section 4900 any of the following incidents involving a resident of a developmental center:

(A) Any unexpected or suspicious death, regardless of whether the cause is immediately known.

(B) Any allegation of sexual assault, as defined in Section 15610.63, in which the alleged perpetrator is a developmental center or department employee or contractor.

(C) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in Section 15610.63, in which a staff member is implicated.

(2) A report pursuant to this subdivision shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 4023

4023

(a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of Section 4900 the following incidents involving a resident of a state mental hospital:
  (1) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
  (2) Any allegation of sexual assault, as defined in Section 15610.63, in which the alleged perpetrator is an employee or contractor of a state mental hospital or of the Department of Corrections and Rehabilitation.
  (3) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in Section 15610.63, in which a staff member is implicated.

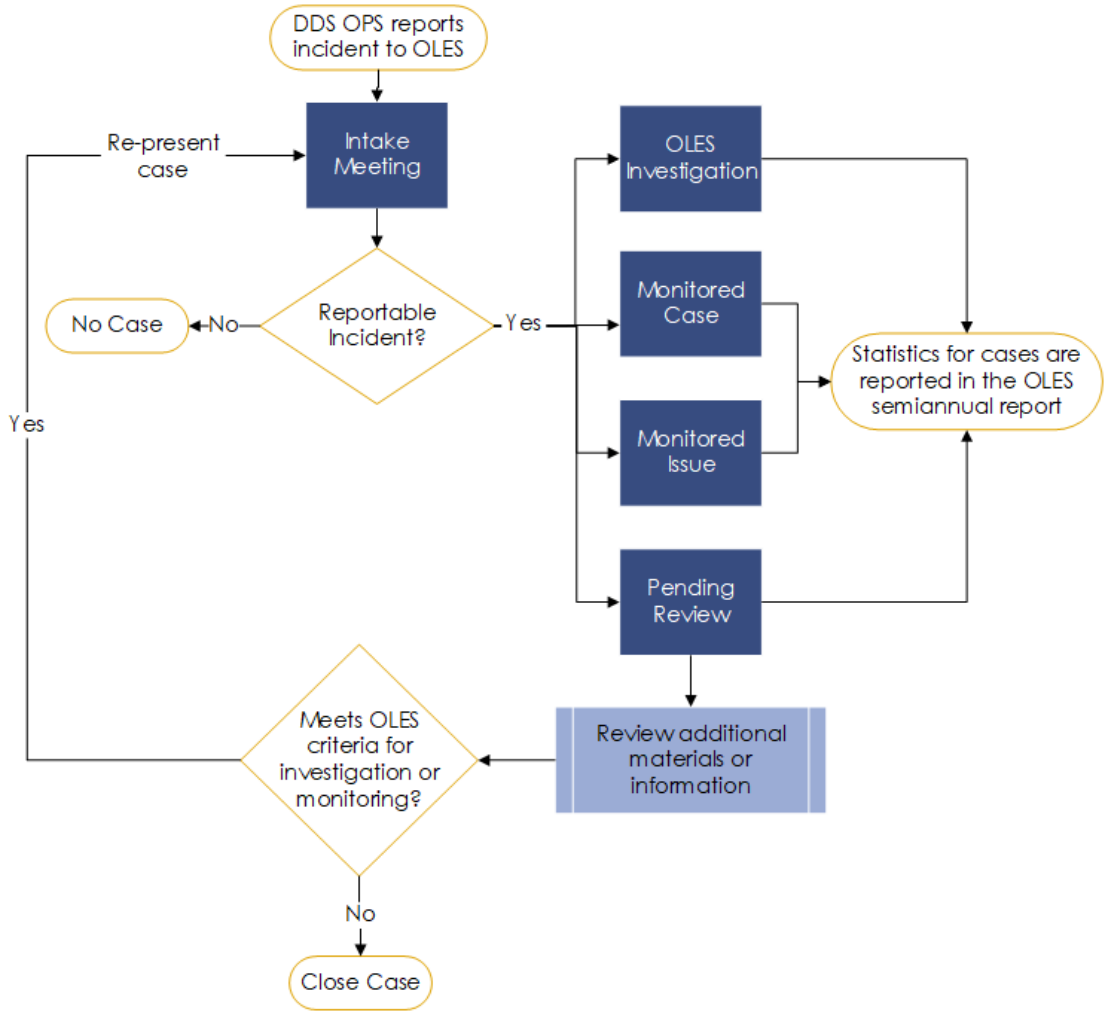
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 15610.63 (Physical Abuse)

Section 15610.63, states, in pertinent part: "Physical abuse" means any of the following:

(a) Assault, as defined in Section 240 of the Penal Code.
(b) Battery, as defined in Section 242 of the Penal Code.
(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.
(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
(e) Sexual assault, that means any of the following:
  (1) Sexual battery, as defined in Section 243.4 of the Penal Code.
  (2) Rape, as defined in Section 261 of the Penal Code.
  (3) Rape in concert, as described in Section 264.1 of the Penal Code.
  (4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code.
  (6) Sodomy, as defined in Section 286 of the Penal Code.
  (7) Oral copulation, as defined in Section 288a of the Penal Code.
  (8) Sexual penetration, as defined in Section 289 of the Penal Code.
  (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.
(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
  (1) For punishment.
  (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
  (3) For any purpose not authorized by the physician and surgeon.

Appendix E: OLES Intake Flow Chart



Outline Description

1. OLES receives a notification of an incident and discusses the incident during an intake meeting
2. The disposition of the incident may be assigned to any of the following:
    a. No Case
    b. Pending Review
        i. If the disposition is "Pending Review", the case is reviewed for additional information and is re-presented at an intake meeting if the additional information meets OLES criteria. From there, the case may be investigated, monitored or become a monitored issue.
    c. OLES Investigation Case
    d. Monitored Case
    e. Monitored Issue

Appendix F: Guidelines for OLES Processes

If an incident becomes an OLES internal affairs investigation involving serious allegations of misconduct by DDS law enforcement officers, it is assigned to an OLES investigator. Once the investigation is complete, OLES begins monitoring the disciplinary phase. This is handled by a monitoring attorney (AIM) at OLES.

If, instead, an incident is investigated by DDS but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DDS investigator and the department attorney, if one is designated[5], throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

1. Department notifies OLES of an incident that meets OLES reporting criteria.
2. The OLES reviews the incident and makes a case determination.
3. If the case is monitored by OLES, the OLES AIM meets with the OPS administrative investigator and identifies critical junctures.
4. DDS law enforcement completes investigation and submits final report.

Critical Junctures

1. Site visit
2. Initial case conference
    a. Develop investigation plan
    b. Determine statute of limitations
3. Critical witness interviews
4. Draft investigation report

It is recommended that within 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority must consult with the AIM attorney on the discipline decision, including 1) the allegations for which the employee should be exonerated, the allegations for which the evidence is insufficient and the allegations should not be sustained, or the allegations

[5] The best practice is to have an employment law attorney from the department involved from the outset to guide investigators, assist with interviews and gathering of evidence, and to give advice and counsel to the facility management (also known as the hiring authority) where the employee who is the subject of the incident works.

that should be sustained; and 2) the appropriate discipline for sustained allegations, if any. If the AIM believes the hiring authority's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.

45 Days

1. The AIM attends the disposition conference, discusses and analyzes the case with the appropriate department representative.
2. Additional investigation may be required.
3. The AIM meets with executive director at the facility to finalize disciplinary determinations.
4. The process for resolving disagreements may be enacted.

Once a final determination is reached regarding the appropriate allegations and discipline in a case, it is recommended that a Notice of Adverse Action (NOAA) be finalized and served upon the employee within 60 days.

60 Days

1. The department's human resources unit completes the NOAA and provides it to AIM for review.
2. The approved NOAA is provided to the executive director for service to the employee.

State employees subject to discipline have a due process right to have the matter reviewed in a Skelly hearing by an uninvolved supervisor who, in turn, makes a recommendation to the hiring authority, that is, whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee[6]. It is recommended that the Skelly due process meeting be completed within 30 days.

30 Days

1. The Skelly process is conducted by an uninvolved supervisor with the AIM present.
2. The AIM is notified of the proposed final action, including any pre-settlement discussions or appeals. The AIM monitors the process.

State employees who receive discipline have a right to challenge the decision by filing an appeal with the State Personnel Board (SPB), which is an independent state agency. The OLES continues monitoring through this appeal process. During an appeal, a case can be concluded by settlement (a mutual agreement between the department(s) and the employee), a unilateral action by one party withdrawing the appeal or disciplinary action, or an SPB decision after a contested hearing. In cases where the SPB decision is subsequently appealed to a Superior Court, OLES continues to monitor the case until final resolution.

[6] Skelly v. State Personnel Board, 15 Cal. 3d 194 (1975)

Conclusion

1. The department attorney notifies AIM of any SPB hearing dates. The AIM monitors all hearings.
2. The department attorney notifies and consults with AIM prior to any settlements or changes to disciplinary action.
3. The AIM notes the quality of prosecution and final disposition.