Office of Law Enforcement Support

Semiannual Report

July 1, 2022–December 31, 2022

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 fourteenth 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, 2022.

In this report, the OLES provides details on 83 reported incidents and the results of completed investigations and monitored cases.

The OLES rated some monitored cases as insufficient by the department during this reporting period. Of the 22 pre-disciplinary phase cases, the OLES rated 12 cases insufficient. Significant deficiencies found in insufficient cases include, but are not limited to, failure to consult with the OLES monitor and delayed or incomplete investigations. Corrective action plans for deficiencies were provided by the department and are included in this report.

DDS accomplished a near perfect record for timely reporting of mandated incidents, achieving 97.9 percent.

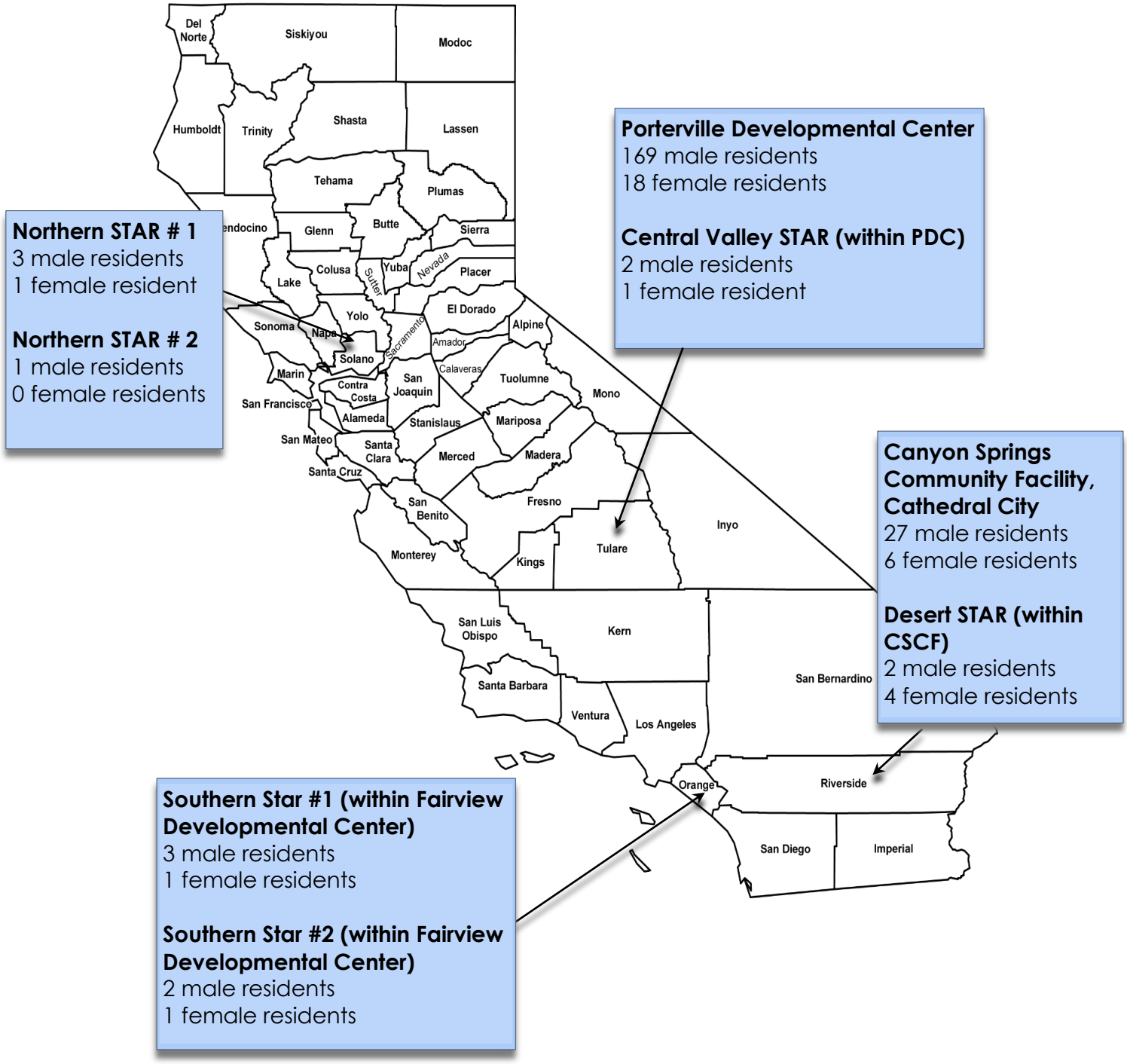
As OLES is in its eighth year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DDS.

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 reflect the total residents served as of December 31, 2022, and 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
3 male residents
1 female resident

Northern STAR # 2
1 male residents
0 female residents

Porterville Developmental Center
169 male residents
18 female residents

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

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

Desert STAR (within CSCF)
2 male residents
4 female residents

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

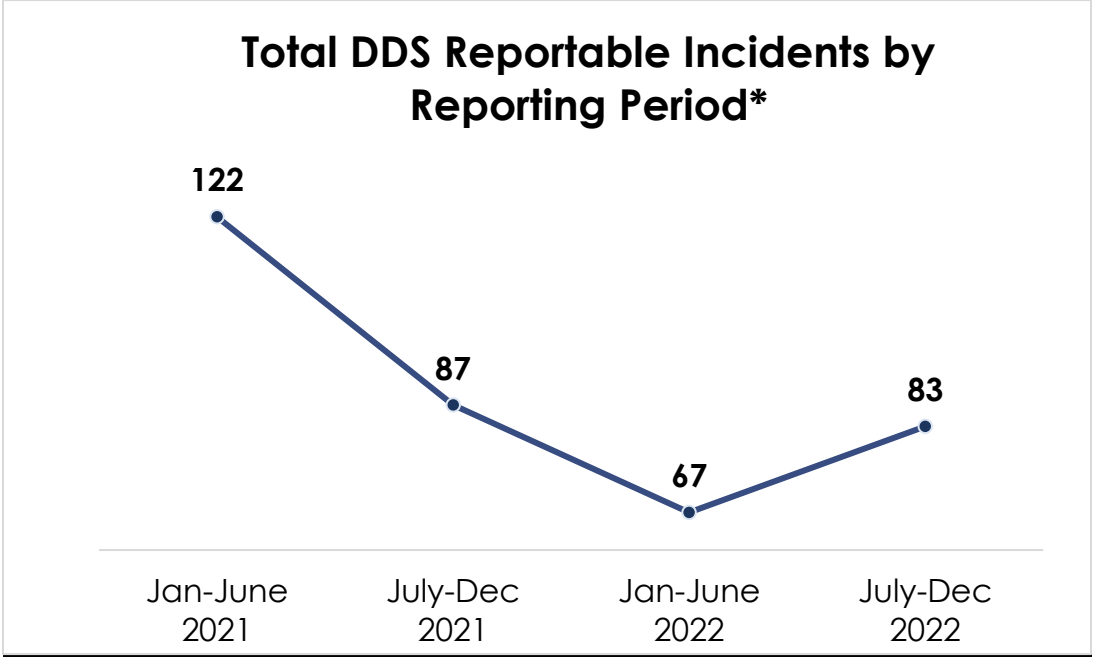
Southern Star #2 (within Fairview Developmental Center)
2 male residents
1 female residents

Total Residents Served by Facility

Facility	Number of Male Residents	Number of Female Residents	Total
Canyon Springs	27	6	33
Porterville	169	18	187
Central Valley STAR	2	1	3
Desert STAR	2	4	6
Northern STAR #1	3	1	4
Northern STAR #2	1	0	1
Southern STAR #1	3	1	4
Southern STAR #2	2	1	3
Total	209	32	241

Executive Summary

During the reporting period of July 1, 2022, through December 31, 2022, the Office of Law Enforcement Support (OLES) received and processed 83 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 an increase of 24 incident reports compared to the prior reporting period, which had 67 incident reports. The DDS reported significantly fewer allegations of abuse 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.

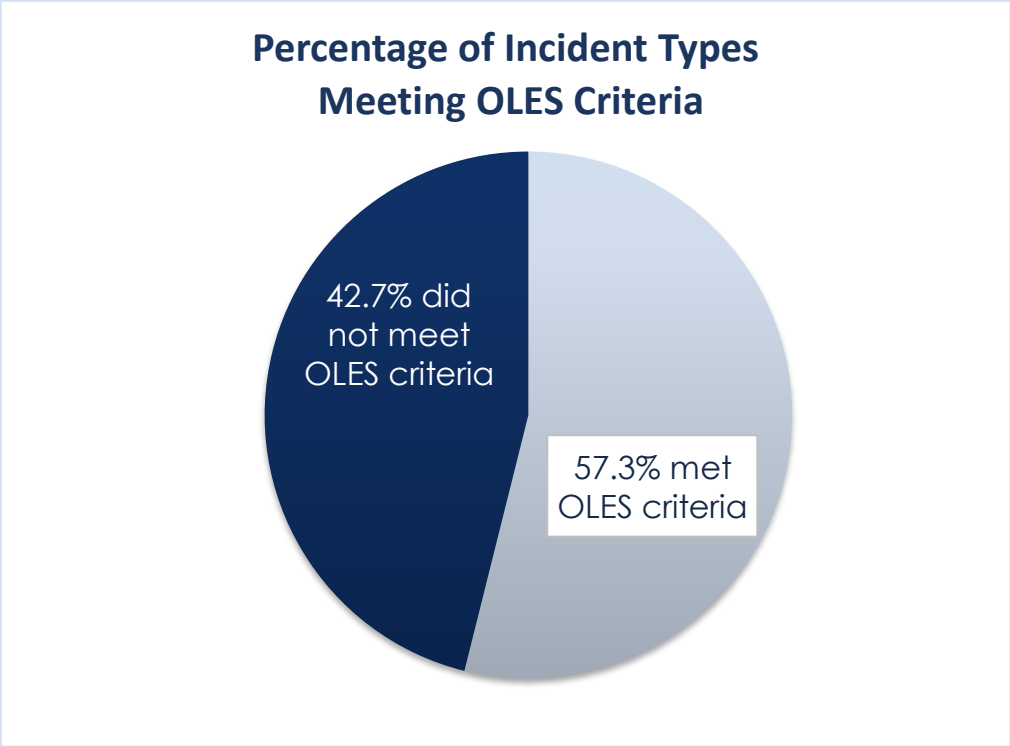
Incident Types Meeting OLES Criteria

The DDS reports to OLES any incidents and associated reportable incident types[2] listed in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. An incident type

[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.

"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 83 reported incidents, the OLES identified six incidents with two or more incident types. The DDS reported a total of 89 incident types during this reporting period. Fifty-one, or 57.3 percent of the 89 incident types reported by DDS met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported were abuse, sexual assault, burns and neglect. Allegations of abuse represented the largest number of alleged incident types reported by DDS during this reporting period. The OLES received 29 reports of alleged abuse, which accounted for 32.6 percent of all reported incident types reported by DDS. The DDS reported 11 allegations of sexual assault and eight reports of resident burns. Allegations of abuse and sexual assault, continue to be the most frequently reported incident types.

Resident Deaths

The DDS did not report any resident deaths during this reporting period.

Resident Arrests

The OLES works collaboratively with DDS to ensure residents receive the best possible treatment and care at the local jurisdiction holding facility. The OLES also reviews each circumstance to safeguard resident rights and make certain there is strict compliance to the laws of arrest. The purpose of OLES oversight of resident arrests is twofold:

- To ensure continuity of resident treatment and care through an agreement or an understanding between the state facility and the local jurisdiction holding facility.
- To determine the circumstances of the arrest, and if there is no arrest warrant filed by a district attorney, that the arrest meets or exceeds the best practices standard for probable cause arrest.

During this reporting period, DDS reported one resident arrest. The arrest was for violations of the following statutes.

Statute	Description
Penal Code section 451.5(A)	arson
Penal Code section 594(B)(1)	vandalism

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, 2022, DDS had 68 sworn staff members.

Appendix A of this report provides information on three administrative and one criminal investigation that OLES completed during this reporting period. 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 one 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.

In Appendix B and C of this report, OLES provides information on eight monitored pre-disciplinary administrative cases and one monitored criminal cases that, by December 31, 2022, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. Eight pre-disciplinary administrative case had sustained allegations. During this reporting period, DDS had one criminal investigation referred to a prosecuting agency.

Of the 22 pre-disciplinary phase cases provided in Appendix B and C, the OLES rated 12 cases insufficient. The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in seven administrative cases, which is provided in Appendix C. The OLES rated the disciplinary phase administrative case sufficient.

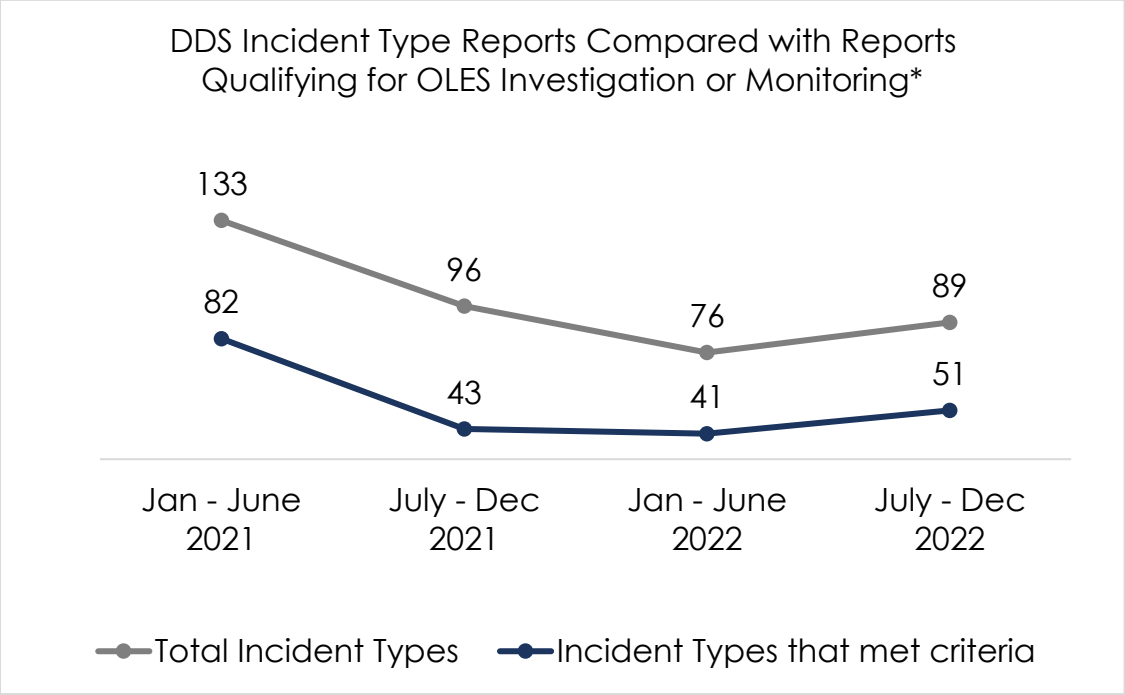
[3] Welfare and Institutions Code Section 4023, 4023.6, 4427.5. (See Appendix D).

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.

Increase in Reported Incidents and Incident Types

The number of DDS incidents reported to OLES from July 1 through December 31, 2022, increased 24 percent, from 67 during the prior reporting period to 83 in this reporting period. From the 83 reported incidents, the OLES identified 89 incident types, as six of the incidents featured two or more incident types. Fifty-one of the 83 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 89 reported incident types from DDS, 55 incident types or 61.8 percent of all reported incident types fell into the following four categories: abuse, sexual assault, burns and neglect. These four incident type categories accounted for 37 incident types or 72.5 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 29 abuse allegations accounted for 32.6 percent of all DDS incident types reported. Twenty-six abuse allegations met OLES criteria for investigation or monitoring.

Sexual assault represented the second highest category for the number of incident types reported, with 11 reports.

Reports of burns increased by 100 percent. Allegations of neglect increased by 75 percent.

Most Frequent Incident Types July 1 through December 31, 2022

Incident Type Categories	Prior Period Incident Types July 1 through December 31, 2021	Current Period Incident Types	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	37	29	-21.6%	26
Sexual Assault	10	11	+10.0%	2
Burn	4	8	+100.0%	2
Neglect	4	7	+75.0%	7

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, 2021 (Reported)*	Prior Period July 1- December 31, 2021 (Meets Criteria)*	Prior Period January 1- June 30, 2022 (Reported)*	Prior Period January 1- June 31, 2022 (Meets Criteria)*	Current Period July 1- December 31, 2022 (Reported)	Current Period July 1- December 31, 2022 (Meets Criteria)
Abuse	37	23	22	16	29	26
Broken Bone (Known Origin)	4	0	1	0	3	0
Broken Bone (Unknown Origin)	4	4	4	4	1	1
Burn	4	0	4	0	8	2
Death	0	0	1	0	0	0
Genital Injury (Known Origin)	2	1	1	0	5	0
Genital Injury (Unknown Origin)	2	2	4	3	3	3
Head/Neck Injury	3	0	3	0	3	0

Incident Type Categories	Prior Period July 1- December 31, 2021 (Reported)*	Prior Period July 1- December 31, 2021 (Meets Criteria)*	Prior Period January 1- June 30, 2022 (Reported)*	Prior Period January 1- June 31, 2022 (Meets Criteria)*	Current Period July 1- December 31, 2022 (Reported)	Current Period July 1- December 31, 2022 (Meets Criteria)
Misconduct	9	6	8	8	5	5
Neglect	5	3	4	3	7	7
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
OPS Use of Force	4	0	0	0	2	0
Pregnancy	0	0	0	0	0	0
Resident on Resident Assault/GBI	0	0	1	0	1	0
Sexual Assault	10	4	8	5	11	2
Sexual Assault-OJ**	3	0	0	0	1	0
Significant Interest-Attack on Staff***	6	0	9	0	0	0
Significant Interest-Attempted Suicide	0	0	0	0	0	0
Significant Interest-AWOL	2	0	1	0	4	2
Significant Interest-Child Pornography	0	0	0	0	0	0
Significant Interest-Drugs******	0	0	0	0	0	0
Significant Interest-Other*******	0	0	1	0	2	0
Significant Interest-Overfamiliarity	1	0	2	2	3	3
Significant Interest-Resident Arrest	0	0	2	0	1	0

Incident Type Categories	Prior Period July 1- December 31, 2021 (Reported)*	Prior Period July 1- December 31, 2021 (Meets Criteria)*	Prior Period January 1- June 30, 2022 (Reported)*	Prior Period January 1- June 31, 2022 (Meets Criteria)*	Current Period July 1- December 31, 2022 (Reported)	Current Period July 1- December 31, 2022 (Meets Criteria)
Significant Interest-Riot	0	0	0	0	0	0
Total	96	43	76	41	89	51

*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 residents or staff as a separate incident type. These incidents include verified drug offenses by resident and allegations of drug trafficking or smuggling against residents or staff.
*****Any other incident of significant interest, e.g., an arson on departmental grounds, and alleged off-site misconduct.

Distribution of DDS Incident Types

The following table compares the total number of residents served by facility to the total number of incident types reported during the reporting period.

Population and Total Incident Types

Facility	Number of Residents Served*	Total Incident Types
Canyon Springs	33	11
Fairview	0	0
Porterville	187	68
Sonoma	0	0
Central Valley STAR	3	0
Desert STAR	6	2
Northern STAR #1	4	3
Northern STAR #2	1	3
Southern STAR #1	4	0
Southern STAR #2	3	1

* The DDS provided population numbers as of December 31, 2022.

Sexual Assault Allegations

The 11 alleged sexual assault incident types in this reporting period accounted for 12.4 percent of all reported incident types from DDS. Two sexual assault incident types met OLES criteria for investigation, monitoring or research into systemic department issues. The DDS reported one incident under the sexual assault-outside jurisdiction (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.

Eight allegations of sexual assault involved a resident assaulting another resident. Three allegations involved non-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.

Sexual Assault Allegations Reported July 1 through December 31, 2022

Allegation Type	Total
Resident on Resident	8
Law Enforcement Staff on Resident	0
Non-Law Enforcement Staff on Resident	3
Unknown Person on Resident	0
OJ*	1
Total	12

*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.

Resident Deaths

The DDS did not report any resident deaths during this reporting period.

Reports of Head or Neck Injuries

The DDS reported three head or neck injuries during this reporting period. These head or neck injuries were the result of two falls and a resident-on-resident altercation.

Reports of Residents Absent without Leave

The DDS reported four significant interest-absent without leave (AWOL) incident types. Two residents left their facilities without authorization but were later returned to safety. Two other residents made attempts to leave their facilities without authorization but were unsuccessful.

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.

On April 28, 2022, OLES changed reporting requirements for sexual assault allegations. Sexual assault allegations against staff, law enforcement or unidentified person(s) remained a priority one notification. Resident on resident sexual assault allegations and allegations of sexual assault that occurred before the resident was in the care of DDS became a priority 2 notification. Priority One and Two incident types are listed 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.
Priority 1 Sexual Assault	Any allegation of sexual assault of a resident against staff, law enforcement personnel or unidentified person(s).

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

Incident	Description
	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 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.
Priority 2 Sexual Assault	Any allegation of sexual assault between two residents. Any allegation of sexual assault that occurred before the resident was in the care of the department (Outside Jurisdiction).
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

The DDS missed one timely report and achieved 97.9 percent in timely incident type reports. The prior reporting period had 92.3 percent timely reports.

Timeliness by Incident Type
The following table provides the percentage of timely notifications by incident type.

Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Abuse	29	0	29	100%
Broken Bone (Known Origin)	3	0	3	100%
Broken Bone (Unknown Origin)	1	0	1	100%
Burn	8	0	8	100%
Death	0	0	0	-
Genital Injury (Known Origin)	5	0	5	100%
Genital Injury (Unknown Origin)	3	1	3	66.7%
Head/Neck	3	0	3	100%
Misconduct	5	0	5	100%
Neglect	7	0	7	100%
Priority 1: Sexual Assault	3	0	3	100%
Priority 2: Sexual Assault	9	0	9	100%
Resident on Resident Assault/GBI	1	0	1	100%
Significant Interest – AWOL	4	0	4	100%
Significant Interest – Other	2	0	2	100%
Significant Interest – Over-Familiarity	3	0	3	100%
Significant Interest – Resident Arrest	1	0	1	100%
Use of Force	2	0	2	100%
Total	89	1	89	98.9%

The following table compares the percentage of timely notifications by facility. With the exception of Canyon Springs, all facilities timely reported incidents.

DDS Facility	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Canyon Springs	11	1	11	90.9%

DDS Facility	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Fairview	0	0	0	-
Porterville	68	0	68	100%
Sonoma	0	0	0	-
Central Valley STAR	0	0	0	-
Desert STAR	2	0	2	100%
Northern STAR #1	3	0	3	100%
Northern STAR #2	3	0	3	100%
Southern STAR #1	0	0	0	-
Southern STAR #2	1	0	1	100%
DDS HQ	1	0	1	100%
Total	89	1	89	98.9%

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, 2022, reporting period, 41 of the total 96 cases opened for DDS incidents that occurred within DDS's jurisdiction or 42.7 percent were assigned a pending review. The OLES opened 4 administrative investigations and one criminal investigation. The OLES opened 42 monitored criminal cases and 7 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 from July 1 through December 31, 2022

OLES Case Assignments	July 1 – December 31, 2022	Percentage of Opened Cases
Pending Review	41	42.7%
Monitored, Criminal	42	43.8%
Monitored, Administrative	7	7.3%
OLES Investigations, Administrative	4	4.2%
OLES Investigations, Criminal	1	1.0%
Outside Jurisdiction*	1	1.0%
Totals	96	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 the criminal investigation to the district attorney's office.

Three OLES investigations into administrative wrongdoing or misconduct were forwarded to facility management for review and 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, 2022	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	3	N/A	3	0
Criminal	1	1	N/A	0
Total	4	1	3	0

OLES Monitored Cases

In this report, OLES provides information on 22 completed monitored cases. The DDS referred one monitored criminal case to the district attorney's office. There were 13 monitored administrative cases. Eight of the 13 monitored administrative cases had sustained allegations. In one of the sustained cases, training was provided. The remaining seven resulted in disciplinary action. 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	1
Criminal/Not Referred	8
Total Criminal	9
Administrative/With Sustained Allegations	8
Administrative/Without Sustained Allegations	5
Total Administrative	13
Grand Total	22

The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceeding in seven administrative cases, which are provided in Appendix C. The OLES rated four disciplinary cases insufficient. Of the 22 pre-disciplinary phase cases in Appendix B and C, OLES rated 12 cases insufficient. Significant deficiencies found in insufficient cases include, but are not limited to, failure to consult with the OLES monitor and delayed or incomplete investigations. Corrective action plans for deficiencies are provided in Appendices 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 resident 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. Blue Team 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, Resident 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 completed retroactively entering data on May 25, 2022, and reported inputting 11 new entries during the reporting period.

On February 14, 2023, OLES requested that DDS provide an updated report capturing all entries into Blue Team/IA Pro to determine whether DDS had continued utilizing the program after retroactively entering data on May 25, 2022. The OLES reviewed the DDS report and determined that since May 25, 2022, there were five new entries, of which

two were not reportable incidents. There were no entries in the Use of Force category, despite DDS having notified OLES of two incidents of reportable use of force during the same reporting period. The OLES will continue to monitor the department's usage of Blue Team/IA Pro.

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 ended December 31, 2022.

At the end of the third quarter in September 2022, the DDS reported 67 percent of the 73 total sworn staff completed the necessary PST and 97 percent completed CPT.

At the end of the last quarter in December 2022, the DDS reported 88 percent of the 70 total sworn staff completed the necessary PST and 97 percent completed CPT.

Six staff were on extended leave, with no expected return to duty date in 2022 and did not complete the required training.

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 reported that the DDS OPS Training Committee meets regularly to discuss training compliance and training operations.

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	0	3	0
Northern STAR 1 and 2	1	1	0	0
Porterville and Central Valley STAR	10	10	0	0
Southern STAR 1 and 2	0	0	0	0
Fairview	1	1	0	0
Total	15	12	3	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	8	0	5	0
Northern STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR	4	2	2	2
Southern STAR 1 and 2	0	0	0	0
Fairview	0	0	0	0
Total	12	2	7	2

* 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	0	0	0	0
Northern STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR	34	33	1	7
Southern STAR 1 and 2	0	0	0	0
Fairview	0	0	0	0
Total	34	33	1	7

* 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	0
Northern STAR 1 and 2	0
Porterville and Central Valley STAR	14
Southern STAR 1 and 2	0
Fairview	0
Total	14

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, 2022. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

To protect the anonymity of law enforcement personnel, OLES refers to an officer, sergeant or investigator as an "officer." The rank of lieutenant or above is referred to as "law enforcement supervisor."

Case Details	Description
OLES Case Number	2022-00118-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly falsely reported that a resident had recanted his allegations of abuse by staff members.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Details	Description
OLES Case Number	2022-00141-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly ordered other officers not to handcuff a violent resident who had assaulted and injured a staff member. The responding officer allegedly did not handcuff the aforementioned resident.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Details	Description
OLES Case Number	2022-00486-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer was allegedly dishonest during an investigative interview.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Details	Description
OLES Case Number	2022-00734-2C
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly improperly stored a firearm in a state vehicle and possessed a firearm in a secure treatment area. The officer also allegedly entered a private office in order to unlawfully retrieve the firearm.
Disposition	The Office of Law Enforcement Support conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by December 31, 2022, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

The OLES rated each case as sufficient or insufficient after assessing the department's performance in conducting the internal investigation. A sufficient case indicates the department complied with policies and procedures governing the pre-disciplinary process. For each case that OLES rated insufficient, OLES identified the deficiencies in the investigative assessment of the case table and listed the department's corrective

action plan submitted to OLES.

Case Details	Description
OLES Case Number	2020-01115-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Incident Summary	A staff member allegedly shut a door on a resident's hand which fractured the resident's hand.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The hiring authority did not inform OLES of the findings and penalty conference; therefore, OLES was unable to attend. Additionally, the incident was discovered on November 2, 2020; however, the investigation report was not completed until May 9, 2021, 188 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The hiring authority did not inform OLES of the findings and penalty conference; therefore, OLES was unable to attend. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The incident was discovered on November 2, 2020; however, the investigation report was not completed until May 9, 2021, 188 days later.
Department Corrective Action Plan	The OPS Headquarters (HQ) Investigations Unit reviewed investigative timeframe requirements to ensure they maintained compliance. The OPS conferred with the Hiring Authority to remind them of the requirements to have the OLES included in the findings and penalty conference.

Case Details	Description
OLES Case Number	2021-00929-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed and forced a resident against a wall. A second psychiatric technician allegedly engaged in an overly familiar relationship with 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. The OLES concurred.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigator did not notify the OLES of the victim interview.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator did not notify the OLES of the victim's interview, thereby preventing OLES from providing real-time monitoring.
Department Corrective Action Plan	The Investigator was counseled and provided training on the need to coordinate with the OLES Attorney-Monitor to provide real-time monitoring.

Case Details	Description
OLES Case Number	2022-00118-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Incident Summary	An officer allegedly falsely reported that a resident had recanted his allegations of abuse by staff members.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
OLES Case Number	2022-00141-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Incident Summary	An officer allegedly ordered other officers not to handcuff a violent resident who had assaulted and injured a staff member. A second officer allegedly failed to handcuff the aforementioned resident.
Disposition	The hiring authority determined the allegation was unfounded. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
OLES Case Number	2022-00270-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a resident in the chest, causing pain.
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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services did not cooperate with OLES. The investigator did not notify OLES prior to interviewing the resident. The investigation was completed without consultation with OLES. The investigative report was finalized and the case closed without consultation with OLES.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The investigator did not have any contact with OLES and completed the investigation and report without consultation. 2. 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 before the report was finalized and the investigation closed. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator interviewed the complaining resident without notice to OLES. The investigation was completed, the investigative report finalized, and the case was

	closed, all without consultation with OLES.
Department Corrective Action Plan	The OPS counseled the investigator regarding the procedures and necessity of complying with the OLES report requirements.

Case Details	Description
OLES Case Number	2022-00310-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A resident was diagnosed with an open lesion on his right buttock.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
OLES Case Number	2022-00439-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Incident Summary	Staff member allegedly did not adequately monitor two minor residents who engaged in sexual activity.
Disposition	Contrary to policy and procedure, the Office of Protective Services did not submit the case to the hiring authority for review. Instead, the investigator determined that the allegations were "inconclusive."
Investigative	**Case Rating:** Insufficient

Assessment	The department did not comply with policies and procedures governing the investigative process. The department did not timely notify OLES regarding the incident. The investigator interviewed two witnesses without notice to OLES. The investigator did not question a percipient witness about that witness' relevant prior inconsistent statements. The investigator did not provide OLES with a draft or final report. The final report was poorly organized and difficult to follow. It contained extraneous and inappropriate materials including the investigator's opinions, speculation and irrelevant emails. The investigator made inappropriate findings contrary to department policy. The investigator's superiors approved the report and closed the case without consultation with OLES. The report was not forwarded to the hiring authority for review and findings determinations.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The investigator interviewed two witnesses without notification to OLES and prior to an initial consultation with OLES. 2. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not question a percipient witness about that witness's prior inconsistent statements. 3. 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 The report was finalized and approved without notification to OLES. 4. Was the final investigative report thorough and appropriately drafted? • No The final investigative report, which OLES reviewed well after it was finalized, was poorly organized making it difficult to understand, contained findings on "allegations" that were not actual allegations in the case, contained extraneous and confusing information regarding the interplay between the criminal and administrative cases, contained the investigator's personal opinions and speculation, contained emails between OLES and the investigator that were irrelevant to an administrative

	investigation and contained findings that were inconsistent with department policy. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator rejected OLES's recommendation not to interview a percipient witness for a second time necessitating a higher level of review. The investigator rejected OLES's recommendation to conduct a second interview of a second percipient witness to confront that witness with their prior inconsistent statements. The investigator finalized the report without consultation with OLES. The investigator's chain of command approved the report without consultation with OLES. 6. Was the investigation thorough and appropriately conducted? • No The Investigative Plan was not comprehensive, did not adequately scope the investigation, and failed to address the allegation of neglect of duty. The reporting witness was not confronted with his numerous inconsistent statements. 7. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No Contrary to DDS policy, the case was not submitted to the hiring authority for their determination on the sufficiency of the investigation and investigative findings.
Department Corrective Action Plan	The OPS reminded the Investigator of the requirements for consulting with OLES Attorney Monitors, the need to provide draft reports, and the consequences for failing to comply. The OPS further counseled the Investigator regarding the need to consider the OLES Attorney Monitors' suggestions. When OPS Headquarters was made aware of the case insufficiencies, Headquarters personnel worked with the Investigator to reorganize the report, then resubmit the case to the OLES.

Case Details	Description
OLES Case Number	2022-00466-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a resident on the face and thigh.
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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services did not provide OLES with requested audio copy of the interviews conducted by the responding officer, did not provide OLES with notice that the draft report was ready for OLES review, and did not respond to OLES's feedback on the sufficiency of the investigative report. Additionally, the investigation did not address the documented bruising on the resident's thighs.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? • No The investigator who conducted the interview of the resident did not inquire about the documented bruises on the resident's thighs. The resident had previously told the responding officer that the psychiatric technician had hit him on the thighs, resulting in bruising. 2. 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 The Office of Protective Services did not notify OLES that a draft report was ready for review. However, OLES reviewed the investigator's report on June 28, 2022, and provided feedback on report insufficiencies. The Office of Protective Services did not respond to the feedback. 3. Was the draft investigative report provided to OLES for

	review thorough and appropriately drafted? • No The interview of the resident did not address the resident's allegation that he had been hit on the thighs, resulting in documented bruising. 4. Was the final investigative report thorough and appropriately drafted? • No The interview of the resident did not address the resident's allegation that he had been hit on the thighs, resulting in documented bruising. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The Office of Protective Services did not provide OLES with requested audio of the interviews conducted by the responding officer, did not provide OLES with notice that the draft report was ready for OLES review, and did not respond to OLES's feedback on the sufficiency of the investigative report. 6. Was the investigation thorough and appropriately conducted? • No The investigation did not address the documented bruising on the resident's thighs.
Department Corrective Action Plan	The OPS counseled the investigator regarding the procedures and necessity of complying with the OLES report requirements. OPS will provide ongoing training with Officers, Investigators, and Supervisors regarding required OLES consultation and communication and ensure the reports include all necessary content. OPS will conduct separate training for the Investigators to ensure they understand the OLES consultation requirements, the reasons for them, and the consequences for failing to follow these requirements.

Case Details	Description
OLES Case Number	2022-00486-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Incident Summary	An officer was allegedly dishonest during an investigative interview.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
OLES Case Number	2022-00632-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pulled a resident's hair and dragged the resident by her feet.
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 a lack of evidence.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The responding officer's report lacked detail concerning the allegations. The investigator did not confer with OLES prior to initiating his investigation. The investigator did not notify OLES of a conversation with the officer. Neither the draft or final investigative report were thorough or appropriate. The investigator failed to interview any

	percipient witnesses.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The responding officer's investigation and report was not sufficiently detailed and did not adequately address the allegations. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The investigator did not confer with OLES concerning an investigative plan. 3. Were all of the interviews thorough and appropriately conducted? • No The investigator did not interview any percipient witnesses. 4. Was the final investigative report thorough and appropriately drafted? • No The final investigative report was neither thorough nor appropriate in that it only comprised a summary of a conversation the investigator had with the officer. No investigation was undertaken. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator did not consult with OLES about his intention not to interview any witnesses prior to completing his report. The investigator did not inform OLES of his conversation with the officer thereby preventing OLES from monitoring. 6. Was the investigation thorough and appropriately conducted? • No The investigator did not actually conduct an investigation at all; he merely had a conversation with the initial responding officer and did not interview any percipient witnesses.
Department Corrective Action Plan	The OPS has been working with the investigator to improve the quality of their reports and counseled the investigator regarding the procedures and necessity of complying with the OLES report requirements. OPS will take extra steps to ensure the initial report by the responding officer is sufficiently detailed and ensure all percipient witnesses are interviewed. OPS will conduct separate training for the Investigators to ensure they understand the OLES consultation requirements, the

	reasons for them, and the consequences for failing to follow these requirements.

Case Details	Description
OLES Case Number	2022-00680-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly sexually assaulted 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. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
OLES Case Number	2022-00729-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a resident several times on the face, causing scratches and bruising.
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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. Both the

	draft and final report contained immaterial information. OPS did not respond to OLES' recommendations concerning identified deficiencies in the investigative report and likewise made no changes to the draft report to ensure the final report was thorough and appropriately drafted.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The draft investigative report contained immaterial information. 2. Was the final investigative report thorough and appropriately drafted? • No The final investigative report contained immaterial information. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? • No OPS did not respond to OLES' recommendations concerning identified deficiencies in the investigative report and likewise made no changes to the report to ensure it was thorough and appropriately drafted.
Department Corrective Action Plan	The OPS has been working with the investigator to improve the quality of their reports. OPS will provide ongoing training regarding OLES reporting procedures, including follow-up consultation and communication with the assigned monitor.

Case Details	Description
OLES Case Number	2022-00770-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly pushed a resident to the ground. A psychiatric technician assistant allegedly witnessed the incident and failed to intervene and report the alleged abuse.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause

	determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The department did not consult with the OLES monitor during the investigation and did not provide a copy of the draft investigative report for review prior to forwarding it to the district attorney's office.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The department did not consult with the OLES upon case initiation and prior to finalizing the investigative plan. 2. 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 The department did not provide a copy of the draft investigative report to the OLES prior to forwarding it to the district attorney's office.
Department Corrective Action Plan	The facility management generated a tracking form that verifies the reports are sent to OLES before sending the reports to the District Attorney's Office. This form is signed by the OLES monitor upon receipt of the report. A new OPS Lieutenant was assigned to the Investigative Unit, who will ensure clear communication with OLES during the investigation process. The OPS Lieutenant will ensure the report tracking forms are signed, verifying both parties receive the reports.

Case Details	Description
OLES Case Number	2022-00907-1A
Case Type	Monitored
Incident Types	1. Burn 2. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Incident Summary	A psychiatric technician allegedly allowed a resident to

	touch a hot pan and burn herself.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and ordered training on maintaining proper supervision of residents. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Details	Description
OLES Case Number	2022-01428-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin) 2. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A resident inserted a foreign object in his urethra while on a one-to-one observation with a pre-licensed psychiatric technician. The resident was examined by a health services specialist who erroneously determined there was no foreign object inside the resident's urethra, thereby preventing the resident from obtaining appropriate medical care. Four days later, the resident received an x-ray that showed the presence of the foreign object. The resident was transported to an outside medical facility where he underwent surgery.
Disposition	The case was not referred to the district attorney's office based on the Office of Protective Services' determination that there was a lack of probable cause. The OLES did not concur with this determination because it was based on an insufficient investigation. The Office of Protective Services did not open an administrative investigation despite being ordered to by their commanding supervisor. The OLES did not concur with that determination because the investigative efforts were incomplete and there were outstanding questions that needed to be addressed. The OLES sought supervisory review; however, several layers of the Office of Protective Services personnel failed to respond to OLES and closed their case despite the incomplete investigation.

Investigative Assessment	**Case Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The notification to OLES was insufficient because it did not include the potential neglect of the health services specialist for allegedly failing to adequately examine the resident. The initial responding officer did not ask basic investigative questions. Furthermore. the officer did not provide the pre-licensed psychiatric technician with the legally required Beheler admonition prior to questioning. The second responding officer received information that the pre-licensed psychiatric technician made a conflicting statement to a colleague; however, the officer did not include the content of the statement in his report. The probable cause determination was made without consultation with OLES and was based on an incomplete investigation. Although the draft report was provided to OLES, OPS did not respond to OLES's feedback and concerns. OLES sent an email regarding substantive concerns with the investigation to two investigators, one sergeant, one lieutenant and two commanders and received no response. The investigator assigned to conduct the criminal investigation conducted no interviews and gathered no potential evidence. The investigation left many questions unanswered about the incident. Also, the investigator did not address the potential neglect of the health services specialist in allegedly conducting an incomplete medical evaluation of the resident.
Pre-Disciplinary Assessment	1. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES? • No The notification did not include the health services specialist as a suspect for allegedly failing to adequately examine the resident resulting in a four day delay in the resident receiving medical care. 2. Did the department adequately respond to the incident? • No The initial responding officer did not ask the resident basic questions such as when the incident took place, where the incident occurred and whether there were witnesses to the incident. Further, the officer did not provide the pre-licensed psychiatric technician with the

	legally required Beheler admonition prior to questioning the pre-licensed psychiatric technician. 3. Was the incident properly documented? • No The second responding officer indicated in his report that he received information that the pre-licensed psychiatric technician allegedly made a statement that conflicted with his original statement to the first responding officer. The second officer did not indicate what the conflicting statement was. 4. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The OPS did not confer with OLES upon case initiation or prior to finalizing an investigative plan. It is undetermined whether an investigative plan was created. 5. Did the department appropriately determine the deadline for taking disciplinary action (statute of limitation date)? • No It is undetermined if the department appropriately determined the deadline for taking disciplinary action because OPS did not consult with OLES. 6. Did OPS adequately consult with OLES and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? • No Despite clear direction from a commander to open an administrative investigation along with OLES's recommendation to open an administrative investigation, OPS failed to do so. 7. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not conduct any interviews or gather any potential evidence. 8. Were all of the interviews thorough and appropriately conducted? • No The investigator did not conduct any interviews. 9. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The draft investigative report was neither thorough nor appropriately drafted. The investigator did not conduct any interview or gather any potential evidence. 10. Was the final investigative report thorough and

	appropriately drafted? • No The final investigative report was neither thorough nor appropriately drafted. No changes were made to the draft report. 11. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution? • No OPS did not appropriately determine whether there was probable cause to believe a crime was committed. The probable cause determination was based on an incomplete investigation. 12. Did OPS cooperate with and provide continued real-time consultation with OLES? • No OPS did not cooperate with or provide real-time consultation with OLES. The investigation was completed without any consultation with OLES. Although the draft report was provided to OLES, OPS did not respond to OLES's feedback and concerns. Further, OLES sent an email regarding substantive concerns with the investigation to two investigators, one sergeant, one lieutenant and two commanders and received no response. 13. Was the investigation thorough and appropriately conducted? • No The investigator did not conduct any interviews or gather any potential evidence. The investigation left unanswered many questions about the incident. Furthermore, the investigator did not address the potential neglect of the health services specialist in allegedly conducting an incomplete medical evaluation of the resident.
Department Corrective Action Plan	The OPS has been working with the investigator to improve the quality of their reports and counseled the investigator regarding the procedures and necessity of complying with the OLES report requirements.

Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases

On the following pages are cases that, in this reporting period, OLES monitored both their pre-disciplinary phase as well as the discipline phase. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period. Each phase was rated separately.

Investigations and other activities conducted by the departments during the pre-disciplinary phase are rated for sufficiency based on consultations with OLES and investigation activities for timeliness, quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

The disciplinary phase is rated for sufficiency based on timely consultation with OLES during the disciplinary process, and whether the entire disciplinary process was conducted in a timely fashion, 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.

Case Details	Description
OLES Case Number	2020-00974-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	A senior psychiatric technician, three psychiatric technicians, a psychiatric technician assistant and a psychiatric technician student allegedly left a resident alone in a room while in full bed restraints. Two of the psychiatric technicians also allegedly falsified records regarding the observation of the resident.
Disposition	The hiring authority sustained the allegations against the senior psychiatric technician and two psychiatric technicians, but found insufficient evidence to sustain the

	allegations against the remaining staff. The hiring authority determined dismissal was the appropriate penalty for the two psychiatric technicians, and presented the senior psychiatric technician with a letter of expectation and additional training. The OLES concurred with the hiring authority's determination. The two psychiatric technicians filed appeals with the State Personnel Board and, prior to the evidentiary hearing, the department entered into a settlement agreement with the psychiatric technicians, wherein they agreed to resign in lieu of dismissal. The OLES concurred.
Investigative Assessment	**Case Rating:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process because the investigation took over 18 months to complete.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The incident occurred on September 20, 2020. The first draft of the investigative report was not provided to OLES for review until September 9, 2021, nearly one year later. In October 2021, the hiring authority requested additional investigation, and the second draft report was not provided to OLES until March 25, 2022. Thus, the investigation took over 18 months to complete.
Disciplinary Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The facility management generated a tracking form that verifies the reports are sent to OLES before sending the reports to the District Attorney's Office. This form is signed by the OLES monitor upon receipt of the report.

Case Details	Description
OLES Case Number	2021-00429-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 2. 3. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A senior psychiatric technician, two psychiatric technicians and a psychiatric technician assistant allegedly pushed a resident to the ground, struck him with protective pads and threw a bucket of water on the patient's head. The senior psychiatric technician also allegedly used an improper restraint technique. The senior psychiatric technician and the psychiatric technician assistant allegedly failed to properly report the incident. The two psychiatric technicians allegedly failed to properly supervise the resident.
Disposition	The hiring authority sustained allegations against the senior psychiatric technician for failing to report the use of a restraint technique, and imposed a 5 percent salary reduction for three months. The OLES concurred. The senior psychiatric technician filed an appeal with the State Personnel Board, but later withdrew his appeal. The hiring authority also sustained allegations against the two psychiatric technicians for failing to properly supervise the resident, and imposed a 5 percent salary reduction for six months against one of the psychiatric technicians. The OLES concurred. That psychiatric technician filed an appeal with the State Personnel Board. The department and the psychiatric technician entered into an agreement, wherein the department agreed to modify the penalty to a letter of reprimand, and pay one month of backpay. In return, the psychiatric technician agreed to withdraw his appeal, and waive any other backpay.

	The OLES concurred because the psychiatric technician no longer worked for the department, and some amount of the original salary reduction will remain forfeited. The other psychiatric technician resigned before any action could be taken. The hiring authority sustained an allegation against the psychiatric technician assistant for failing to report the incident; however, the psychiatric technician assistant resigned before any action could be taken. No other allegations were sustained. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed in a timely manner. The hiring authority did not timely consult regarding the investigation and investigative findings, and did not timely serve the disciplinary action.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The OLES completed its review of the final investigative report on November 1, 2021; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings until March 14, 2022, 133 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The Office of Protective Services discovered the incident on April 10, 2021; however, the investigation was not completed until October 8, 2021, 181 days later.
Disciplinary Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The disciplinary action was not served in a timely manner.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The hiring authority decided to take action against the senior psychiatric technician and one of the psychiatric technicians on March 14, 2022; however, the disciplinary actions were not served until May 26, 2022, and May 27, 2022, 73 and 74 days later.

Department Corrective Action Plan	The OPS Headquarters (HQ) Investigations Unit reviewed investigative timeframe requirements to ensure they maintained compliance. The OPS conferred with the Hiring Authority to remind them of the requirements to have the OLES included in the findings and penalty conference.

Case Details	Description
OLES Case Number	2021-00499-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	A nurse allegedly failed to administer medication to a resident. After failing to timely administer the medication, the nurse allegedly disposed of the medication in a collection container. The nurse also allegedly documented that she administered the medication to the patient when she had not.
Disposition	The hiring authority sustained the allegations against the nurse and determined a letter of reprimand was the appropriate penalty. The OLES concurred. The nurse did not file an appeal with the State Personnel Board.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed in a timely manner. The hiring authority did not timely consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The OLES completed its review of the investigative report on January 28, 2022; however, the consultation regarding the sufficiency of the investigation and the

	investigative findings was not scheduled until April 14, 2022, 76 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The incident was discovered on April 23, 2021; however, the investigative report was not provided to the OLES for review until December 15, 2021, 236 days later.
Disciplinary Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The disciplinary action was not served until September 8, 2022, 133 days later after the hiring authority made findings and penalty determinations,
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No On April 28, 2022, the hiring authority decided to take disciplinary action against the nurse; however, the disciplinary action was not served until September 8, 2022, 133 days later.
Department Corrective Action Plan	The facility management generated a tracking form that verifies the reports are sent to OLES. This form is signed by the OLES monitor upon receipt of the report. A new OPS Lieutenant was assigned to the Investigative Unit, who will ensure clear communication with OLES during the investigation process. The OPS Lieutenant will ensure the report tracking forms are signed, verifying both parties receive the reports. Moving forward, the OPS Lieutenant will ensure if a particular case exceeds the allotted time frame, the OPS Lieutenant will keep OLES apprised of the reasons for the extra time necessary to complete the case.

Case Details	Description
OLES Case Number	2021-00759-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Other failure of good behavior
Findings	1. Sustained 2. Not Sustained

Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	An officer allegedly surreptitiously recorded a conversation with supervisors. The officer was allegedly dishonest to a supervisor regarding the alleged recording.
Disposition	The hiring authority sustained the allegation that the officer was dishonest when he claimed he surreptitiously recorded a conversation. The hiring authority found insufficient evidence to sustain the allegation that the officer recorded the conversation. The hiring authority determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Following a pre-hearing settlement conference, the department entered into a settlement agreement with the officer wherein the officer agreed to withdraw his appeal and resign in lieu of dismissal. In exchange, the department agreed to provide one month of back pay to the officer. The OLES concurred with the settlement as it achieved the ultimate goal of separating the officer from employment with the department.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
OLES Case Number	2021-01311-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	An officer allegedly mishandled evidence from a criminal case.

Disposition	The hiring authority sustained the allegation and determined a letter of reprimand was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer filed an appeal with the State Personnel Board but subsequently withdrew it.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The OLES was not provided with a copy of the draft disciplinary action before it was served.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? • No The OLES was not provided with a copy of the draft disciplinary action.
Department Corrective Action Plan	The employee responsible for completing the employee action was provided training/instruction to provide the OLES a copy before service.

Case Details	Description
OLES Case Number	2021-01466-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	Two officers allegedly disseminated an evidentiary photograph without authorization.
Disposition	The hiring authority sustained the allegation against the first officer. The first officer was already pending dismissal for an unrelated case so the misconduct from this case was included with that disciplinary action. The second officer resigned before the investigation was concluded. A letter indicating the second officer resigned under unfavorable circumstances was placed in his official

	personnel file. The first officer filed an appeal with the State Personnel Board. Following a pre-hearing settlement conference, the department entered into a settlement agreement with the first officer wherein the officer agreed to withdraw his appeal and resign in lieu of dismissal. In exchange, the department agreed to provide one month of back pay to the officer. The OLES concurred with the settlement as it achieved the ultimate goal of separating the officer from employment with the department.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
OLES Case Number	2022-00404-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	An on-duty senior psychiatric technician allegedly engaged in inappropriate sexual activity with an on-duty psychiatric technician while the psychiatric technician was assigned to enhanced observation of a resident. The senior psychiatric technician and the psychiatric technician were allegedly dishonest during their investigative interviews.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty for both employees. The OLES concurred with the hiring authority's determination. The senior psychiatric technician resigned

	during the investigation; therefore, disciplinary action was not imposed. The psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Insufficient The department did not comply with the policies and procedures governing the disciplinary process. The department attorney did not provide OLES with a copy of the draft disciplinary action and consult with OLES.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? • No The OLES was not provided with a copy of the draft disciplinary action.
Department Corrective Action Plan	The OPS conferred with the DDS Legal Department to remind them of the requirements to have the OLES included in the findings and penalty conference. The OPS will continue to work with the DDS Legal Department to remind them of the requirements to share the draft disciplinary actions and consult with the OLES Attorney Monitor.

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.

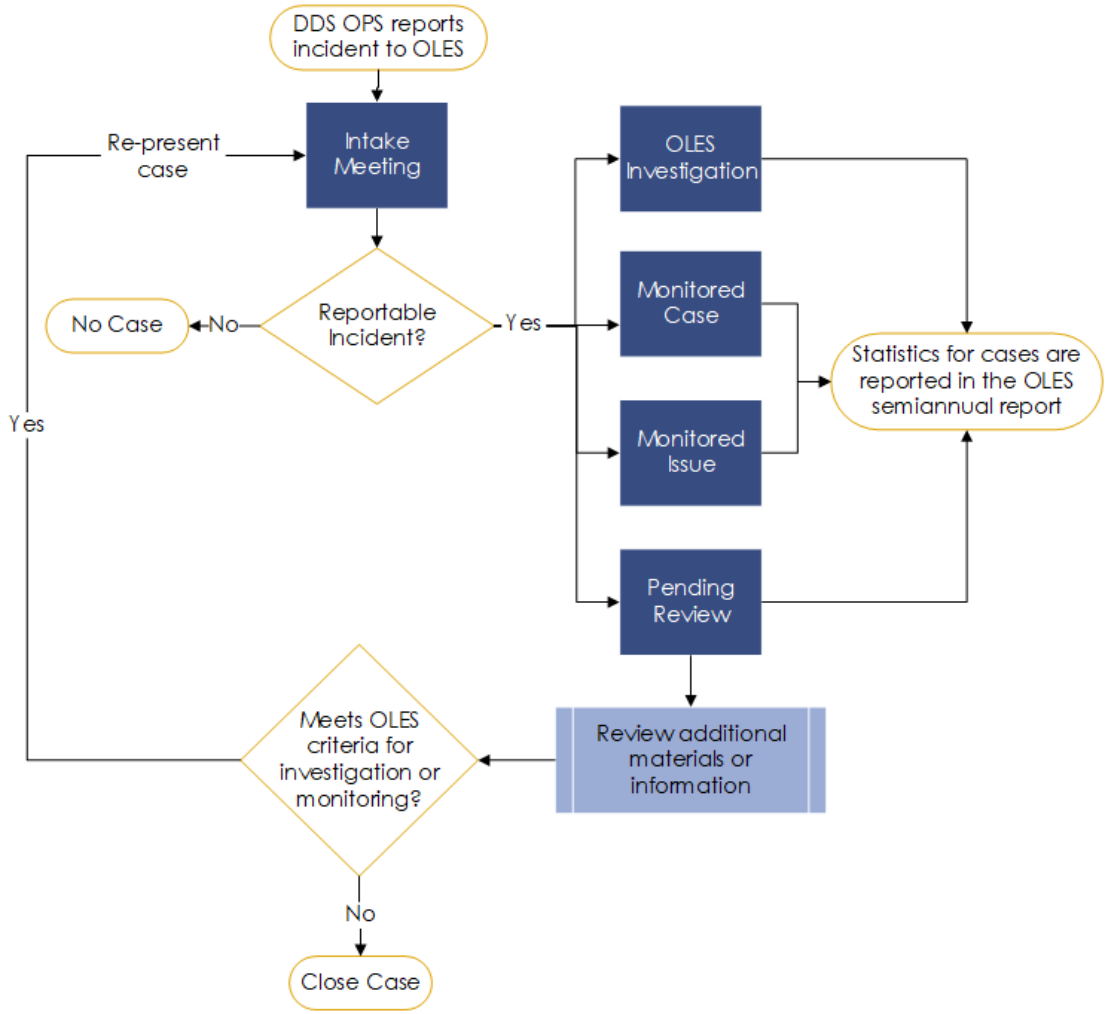
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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.
