



Office of Law Enforcement Support

Semiannual Report

January 1, 2026 - June 30, 2026

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.

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Introduction

I am pleased to present the semiannual report (SAR) 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 January 1 through June 30, 2026.

In this report, OLES provides details on 57 reported incidents and the results of completed investigations and monitored cases.

OLES continued to monitor DDS' usage of Blue Team/IAPro, the legislative mandated early intervention system used to monitor incidents for selected performance indicators such as use of force and resident complaints. DDS indicated that training has now been provided to all staff responsible for entering data into Blue Team/IA Pro. OLES will continue to monitor the department's consistent and proper usage of Blue Team/IAPro.

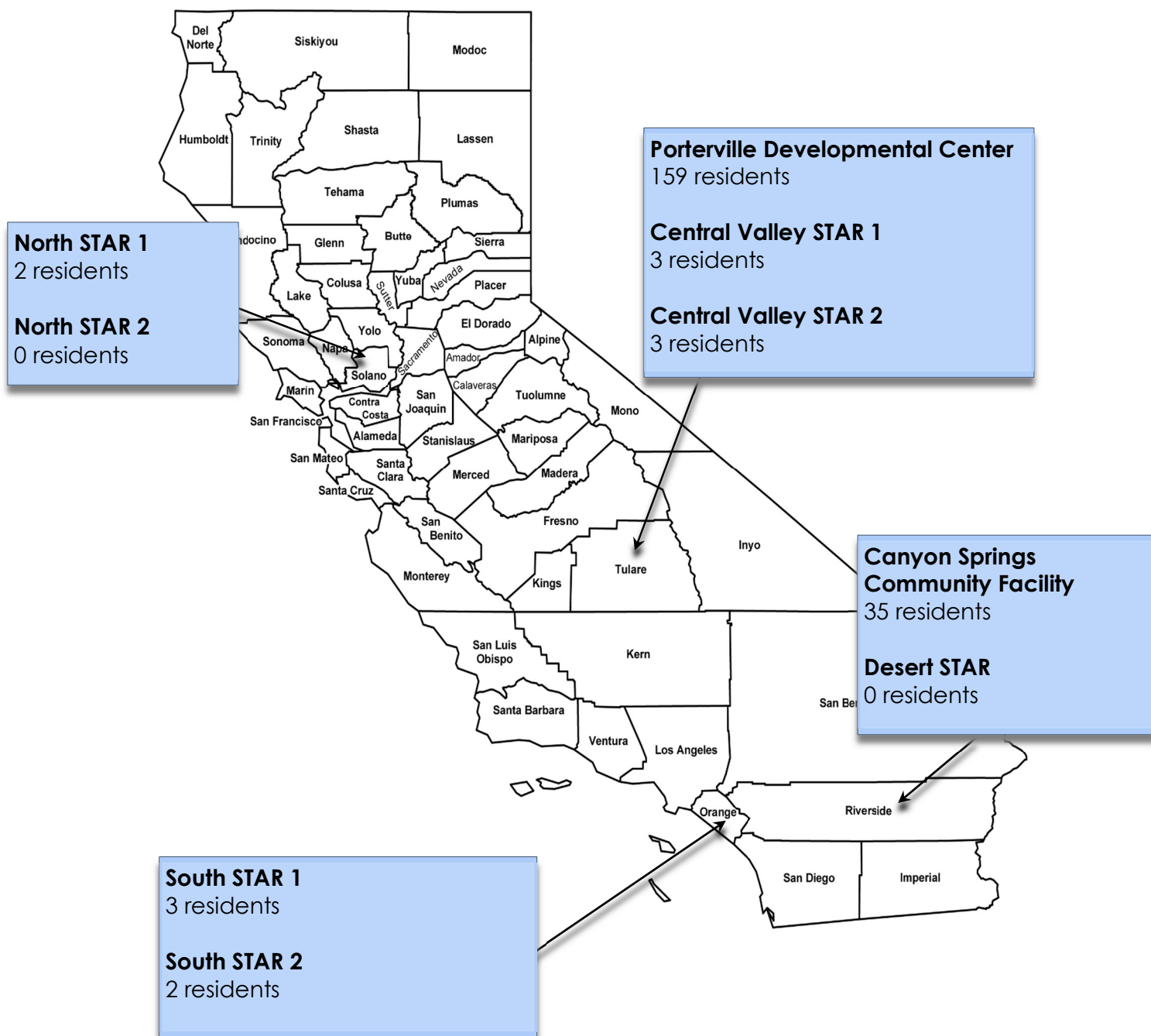
DDS timely reported 99.6 percent of mandated incidents for the period of January 1 through June 30, 2026.

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/>.

Christine Allen
Director
Office of Law Enforcement Support

Facilities

OLEs provides oversight and conducts investigations for the DDS facilities below. Population numbers reflect the total residents served as of January 1 through June 30, 2026, and were provided by the department. Residents in DDS receiving acute crisis services are listed in Stabilization, Training, Assistance and Reintegration (STAR) homes.

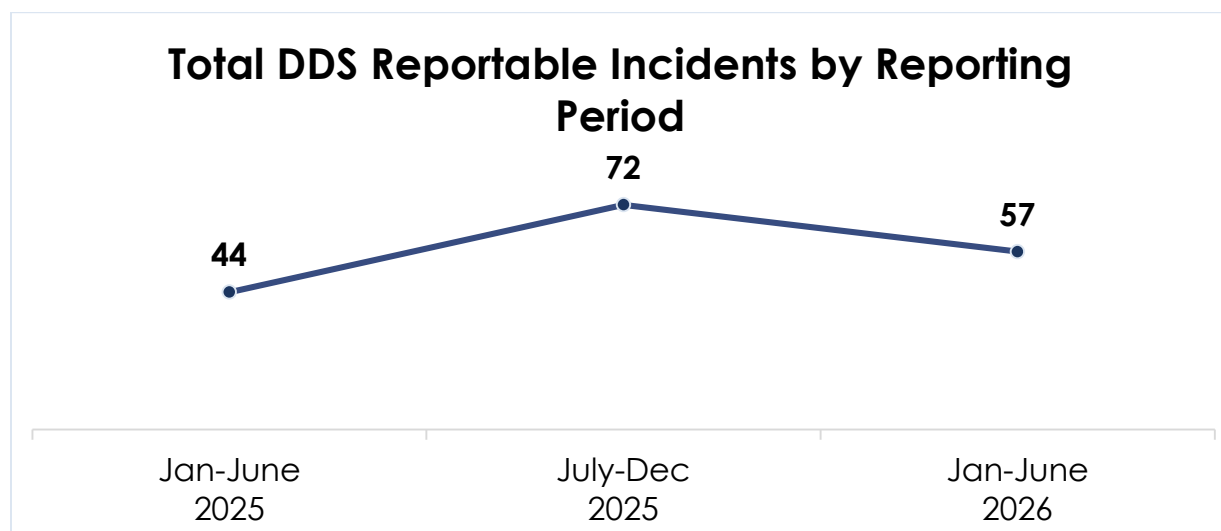


Total Residents Served by Facility

Facility	Total
Canyon Springs	35
Central Valley STAR 1	3
Central Valley STAR 2	3
Desert STAR	0
North STAR 1	2
North STAR 2	0
Porterville	159
South STAR 1	3
South STAR 2	2
Total	207

Executive Summary

During the reporting period of January 1 through June 30, 2026, OLES received and processed 57 reportable incidents¹ at DDS facilities. Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents, and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is a decrease of 15 incident reports compared to the prior reporting period, which had 72 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior two reporting periods.



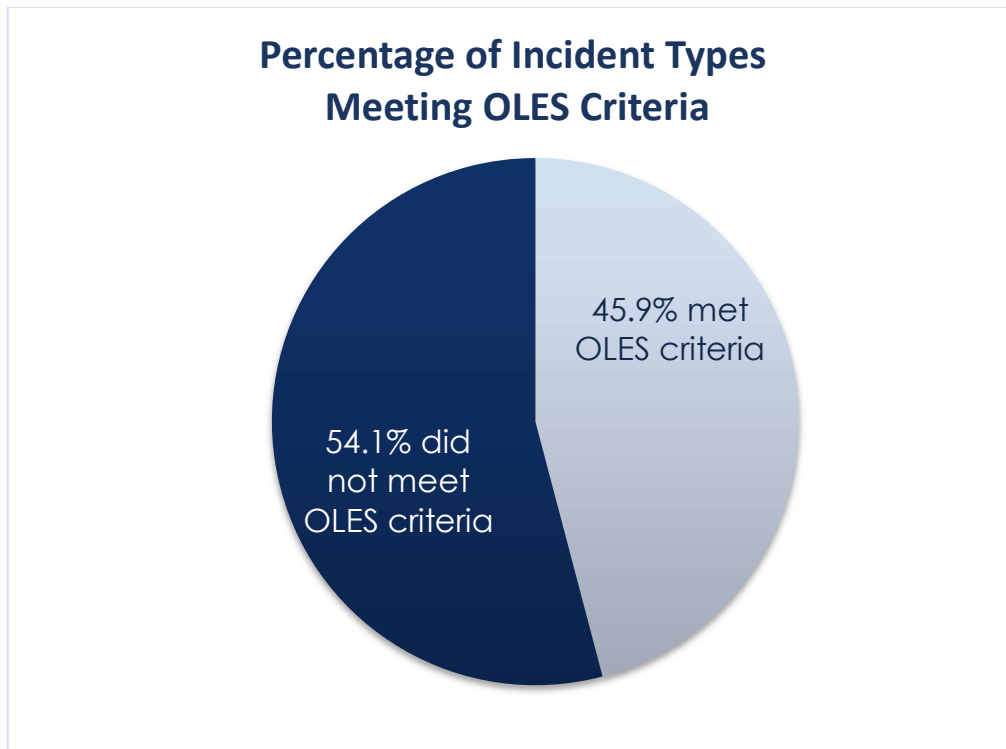
Numbers are unadjusted and are provided as they were previously published.

Incident Types Meeting OLES Criteria

DDS reports to OLES any incidents and associated reportable incident types² listed in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. An incident type meeting criteria is an occurrence that OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 57 reported incidents, OLES identified three incidents with two or more incident types. DDS reported a total of 61 incident types during this reporting period. Twenty-eight, or 45.9 percent, of the 61 incident types reported by DDS met OLES criteria.

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 OLES defines an incident as an event in which allegations or occurrences meeting 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.



Most Frequent Incident Types

The most frequent incident types reported were abuse, use of force by law enforcement, and sexual assault. Allegations of abuse represented the largest number of alleged incident types reported by DDS during this reporting period. OLES received 19 reports of alleged abuse, which accounted for 31.2 percent of all reported incident types reported by DDS. DDS reported eight allegations of use of force by law enforcement and seven incidents of sexual assault.

Resident Deaths

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

Resident Arrests

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

- 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.

DDS reported three resident arrests during this reporting period.

Results of Completed OLES Investigations on DDS Law Enforcement

Per statute,³ an OLES investigation is initiated after OLES is notified of an allegation that a DDS law enforcement officer of any rank committed serious administrative or criminal misconduct. As of June 30, 2026, DDS had 66 sworn staff members. During this period, OLES completed one investigation involving DDS sworn personnel.

Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the department and the discipline process for employees involved in misconduct. In Appendices B and C of this report, OLES provides information on eight monitored administrative cases and 15 monitored criminal cases that by June 30, 2026, had sustained or not sustained allegations or a decision whether to refer the case to the district attorney's office. These monitored cases included allegations against psychiatric technicians, psychiatric technician assistants, officers, registered nurses, unit supervisors and several other types of staff members.

Two pre-disciplinary administrative cases had sustained allegations. None of the 15 criminal investigations were referred to prosecuting agencies.

OLES monitored 23 pre-disciplinary cases; 21 of the pre-disciplinary phase cases are listed in Appendix B and two are listed in Appendix C. OLES rated two of the 23 pre-disciplinary phase cases insufficient. Deficiencies found in insufficient cases include, but are not limited to incomplete or missing interviews, failure to cooperate with OLES, hiring authority failing to make timely findings on completed investigations, and delayed investigations.

OLES monitored the disciplinary actions, Skelly hearings, settlements and State Personnel Board proceedings in two administrative cases listed in Appendix C. Both of the disciplinary phase cases were rated sufficient.

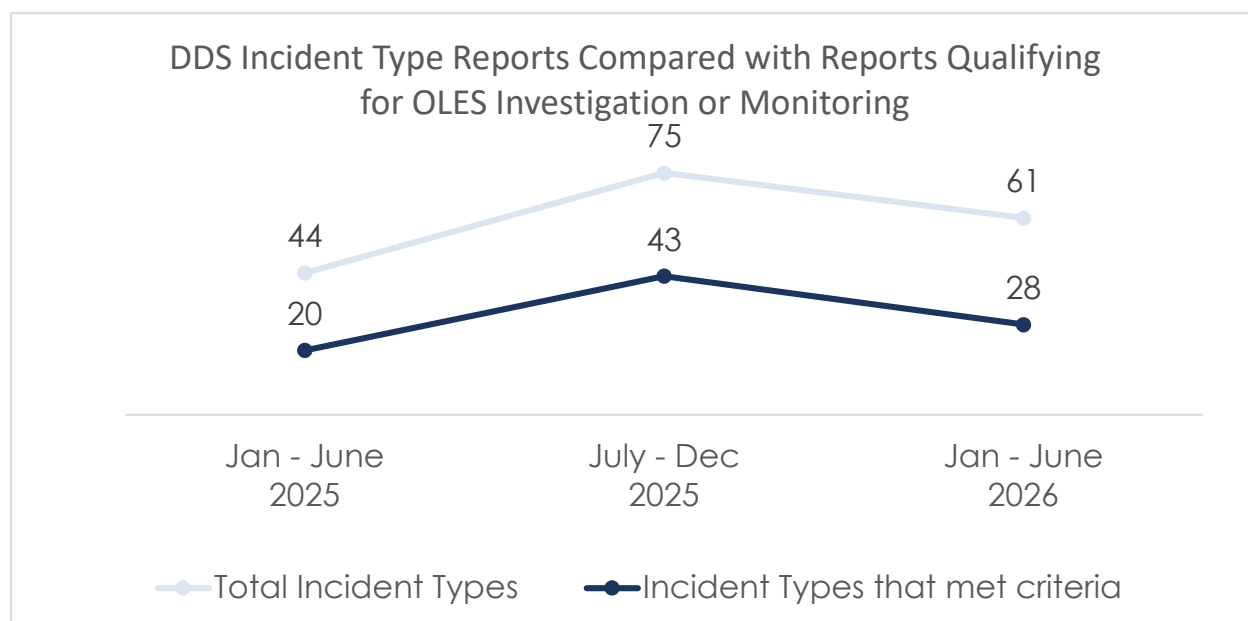
³ Welfare and Institutions Code sections 4023, 4023.6, and 4427.5 (see Appendix D).

Incidents and Incident Types

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

Increase in Reported Incidents and Incident Types

The number of DDS incidents reported to OLES from January 1 through June 30, 2026, decreased, from 72 during the prior reporting period to 57 in this reporting period. From the 72 reported incidents, OLES identified 61 incident types, as three of the incidents featured two or more incident types. Twenty-eight of the 61 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 61 reported incident types from DDS, 55.7 percent of all reported incident types fell into the following three categories: abuse, use of force by law enforcement and sexual assault. These three incident type categories accounted for 34 incident types or 75 percent of all DDS reportable incident types that met the criteria for OLES to investigate or monitor.

Alleged abuse was the most frequent DDS incident type reported in this reporting period. The 19 abuse allegations accounted for 31.2 percent of all DDS incident types reported. All 19 abuse allegations met OLES criteria for investigation or monitoring. Use of force by law enforcement and sexual assaults represented the second and third highest categories for the number of incident types reported, with eight and seven reports each.

Most Frequent Incident Types January 1 through June 30, 2026

Incident Type Categories	Prior Period Incident Types June 1 through December 31, 2025	Current Period Incident Types January 1 through June 30, 2026	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	33	19	-42.4%	19
PSB Use of Force	4	8	+100%	0
Sexual Assault	11	7	-36.4%	2

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 January 1- June 30, 2025 (Reported)	Prior Period January 1- June 30, 2025 (Meets Criteria)	Prior Period July 1- December 31, 2025 (Reported)	Prior Period July 1- December 31, 2025 (Meets Criteria)	Current Period January 1- December 31, 2026 (Reported)	Current Period January 1- December 31, 2026 (Meets Criteria)
Abuse	18	14	33	30	19	19
AWOL	2	0	0	0	0	0
Broken Bone (Known Origin)	2	0	3	0	4	1
Broken Bone (Unknown Origin)	2	0	6	0	5	0
Burn	3	0	3	0	2	0
Child Sexual Abuse Material	0	0	0	0	0	0
Death	1	1	0	0	0	0
Drugs ¹	0	0	1	0	0	0
Genital Injury (Known Origin)	2	0	2	1	1	0
Genital Injury (Unknown Origin)	0	0	2	0	0	0
Head/Neck Injury	1	0	2	0	4	0
Misconduct ²	4	4	0	0	4	4
Neglect	0	0	4	2	2	1
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
Over- Familiarity	1	1	3	2	0	0
Pregnancy	0	0	0	0	0	0
PSB Use of Force	0	0	4	0	8	0
Resident Arrest	1	0	0	0	3	0

Incident Type Categories	Prior Period January 1- June 30, 2025 (Reported)	Prior Period January 1- June 30, 2025 (Meets Criteria)	Prior Period July 1- December 31, 2025 (Reported)	Prior Period July 1- December 31, 2025 (Meets Criteria)	Current Period January 1- December 31, 2026 (Reported)	Current Period January 1- December 31, 2026 (Meets Criteria)
Resident-on-Resident Assault/GBI	1	0	0	0	1	1
Riot	0	0	0	0	0	0
Sexual Assault	4	0	11	7	7	2
Significant Interest ³	1	0	1	1	0	0
Suicide (Attempted)	0	0	0	0	1	0
Total	44	20	75	43	61	28

¹ Beginning in the July 1, 2021, through June 30, 2023, reporting periods, OLES distinguished drug-related allegations and crimes by residents or staff as a separate incident type. These incidents include verified drug offenses by residents and allegations of drug trafficking or smuggling against residents or staff.

² The misconduct statistics were allegations which did not involve residents.

³ Significant Interest is an incident that may draw media attention.

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	35	7
Central Valley STAR 1	3	2
Central Valley STAR 2	3	2
Desert STAR	0	0
North STAR 1	2	2
North STAR 2	0	0
Porterville	159	48
South STAR 1	3	0
South STAR 2	2	0
Totals	207	61

The DDS provided population numbers as of June 30, 2026.

Sexual Assault Allegations

The seven alleged sexual assault facility incident types in this reporting period accounted for 11.5 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.

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

Sexual Assault Allegations Reported January 1 through June 30, 2026

Allegation Type	Total
Resident-on-Resident	5
Law Enforcement Staff-on-Resident	0
Non-Law Enforcement Staff-on-Resident	2
Unknown Person-on-Resident	0
Total	7

Reports of Resident Deaths

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

Reports of Head or Neck Injuries

The DDS reported four head or neck injuries during this reporting period. Two of the incidents were the result of self-injurious behavior, the remaining two were dental failures.

Reports of Residents Absent without Leave

The DDS did not report any incidents of absence without leave (AWOL) during this reporting period.

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 1 incident types was deemed to be satisfied by a telephone call to 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 2 threshold incidents require notification within 24 hours of the time and date of discovery. Priority 1 and 2 threshold incident types are shown in the tables below.

Priority 1 Notification Descriptions

Incident	Description
Abuse - Physical	Any report of physical abuse of a resident implicating staff.
Assault with a Deadly Weapon by a Non-Patient	Any assault with a deadly weapon (ADW) against a patient by a non-patient. A non-patient is any person who is not a patient in the DSH facility. This can be a staff member, hospital police officer, visitor, custodian or contracted employee.
Broken Bone (Unknown Origin)	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 (Unknown Origin)	An injury to the genitals of a resident when the cause of injury is undetermined and was not witnessed by staff.
Sexual Assault: Priority1	Any allegation of sexual assault of a resident against staff or unidentified person(s).

Priority 2 Notification Descriptions

Incident	Description
Absent Without Leave (AWOL)	A resident is AWOL when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in police intervention to recover the resident.
Assault with GBI	A patient on patient assault with force likely to produce great bodily injury (GBI), including but not limited to, loss of consciousness, concussion, bone fracture, protracted loss of impairment of function of any bodily member or organ; a wound requiring suture or serious disfigurement.
Attempted Patient Suicide	Requires treatment beyond first aid.
Broken Bone (Known Origin)	A broken bone of a resident when the cause of the break is known or witnessed by staff.
Burn	Any burns of a resident. This does not include sunburns or mouth burns caused by consuming hot food or liquid unless blistering occurs.
Child Sexual Abuse Material	Discovered in any facility.
Drugs	Includes allegations of use, trafficking or smuggling by patients, staff or visitors. When reporting recovered drugs or patient use, a field presumptive positive or lab positive test is required.
Genital Injury (Known Origin)	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 patient requiring treatment beyond first aid that is not caused by staff or law enforcement, regardless of whether the patient refuses treatment. This includes physical trauma resulting in an altered level of consciousness (ALOC) or loss of consciousness (LOC). Any tooth injury, including but not limited to, chipped, cracked, broken, loosened or displaced teeth that resulted from a forceful impact, regardless of treatment. Treatment beyond first aid includes the use of skin adhesive such as DERMABOND®, 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.
PSB Use of Force	Any Protective Services Branch (PSB) 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.
Over-Familiarity	Conduct between a staff member and patient that extends

Incident	Description
	beyond authorized treatment or is contrary to the treatment plan and treatment success of the patient.
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.
Pregnancy	A resident pregnancy.
Resident Arrest	Any resident arrest by warrant or probable cause.
Riot	For the purposes of reporting to OLES, a riot disrupts normal operations; has the potential of expansion and requires a response outside normal resources.
Sexual Assault: Priority 2	Any allegation of sexual assault between two patients.
Significant Interest	An incident of significant interest to the public, including but not limited to commission of serious crimes by patient(s) or staff, or any incident which may potentially draw media attention.

Timeliness of Notifications

The DDS achieved a 93.6 percent overall rating in timeliness of notifications. The prior reporting period had 100 percent in timely reports.

The following table compares the percentage of timely notifications by facility.

DDS Facility	Total Reported Incident Types	Number of Timely Notifications	Number of Untimely Notifications	Percentage of Timely Notifications
Canyon Springs	7	7	0	100.0%
Central Valley STAR 1	2	2	0	100%
Central Valley STAR 2	2	2	0	100%
Desert STAR	0	0	0	N/A
North STAR 1	2	2	0	100%
North STAR 2	0	0	0	N/A
Porterville	48	47	1	97.9%
South STAR 1	0	0	0	N/A
South STAR 2	0	0	0	N/A
Total	61	60	1	99.6%

Intake

All incidents received by OLES during the six-month reporting period are reviewed at a daily intake meeting by a panel of assigned OLES staff members. Based on statutory requirements, the panel determines whether allegations against law enforcement officers warrant an internal affairs investigation by OLES. If the allegations are against other DDS staff members and not law enforcement personnel, the panel determines whether the allegations warrant OLES monitoring of any departmental investigation. A flowchart of all the possible OLES outcomes from Intake is shown in Appendix E. To ensure OLES is independently assessing whether an allegation meets its criteria, OLES requires the departments to broadly report misconduct allegations. For incidents that initially do not appear to fit the criteria⁴ for OLES involvement, 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 January 1 through June 30, 2026, reporting period, 32 of the total 57 cases opened for DDS incidents that occurred within DDS's jurisdiction or 56.1 percent were assigned a pending review. OLES opened 21 monitored criminal cases and 1 monitored administrative case.

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

Cases Opened from January 1 through June 30, 2026

OLES Case Assignments	January 1 – June 30, 2026	Percentage of Opened Cases
Pending Review	32	56.1%
Monitored, Criminal	21	36.8%
Monitored, Administrative	1	1.8%
OLES Investigations, Administrative	3	5.3%
OLES Investigations, Criminal	0	0
Totals	57	100.0%

⁴ Welfare and Institutions Code section 4023.6 et. seq. (see Appendix D).

Completed Investigations and Monitored Cases

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 one investigation involving DDS law enforcement misconduct. The investigation was administrative and forwarded to facility management for review. 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.

OLES Monitored Cases

In this report, OLES provides information on 23 completed monitored cases. Fifteen investigations were criminal, and eight investigations were administrative. The DDS did not refer any of the monitored criminal cases to a district attorney's office. There were sustained allegations in two of the administrative cases. Results of OLES monitored cases are provided in the table below.

Results of Monitored Cases

Type of Case/Result	Total
Criminal/Referred to Prosecuting Agency	0
Criminal/Not Referred	15
Total Criminal	15
Administrative/With Sustained Allegations	2
Administrative/Without Sustained Allegations	6
Total Administrative	8
Grand Total	23

Pre-Disciplinary Phase Cases

Of the 21 pre-disciplinary phase cases provided in Appendix B, OLES rated two of the 21 cases insufficient. Corrective Action Plans were provided by the department and are published in Appendix B.

Disciplinary Phase Cases

There were two disciplinary phase cases this reporting period. Each of those cases were rated sufficient.

DDS Use of Blue Team/IAPro

In March 2015, 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 system (EIS) 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 Blue Team/IAPro software for its EIS. Blue Team/IAPro is an interface 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.

During the semiannual reporting period of July 1 through December 31, 2016, DDS reported PDC conducted a pilot to test the Blue Team/IAPro 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 IAPro portion of the EIS could be used alone at DDS headquarters rather than having each facility use Blue Team. 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 EIS in June 2017.

After learning in December 2021 that DDS had stopped using the system, discussions led to its reinstatement, with retroactive data entry completed. DDS reported that training was provided to all staff responsible for entering data into Blue Team/IA Pro, ensuring their familiarity with the system and enabling them to utilize it effectively.

During this SAR period, OLES requested data from DDS regarding the use-of-force incidents entered in the Blue Team/IAPro system between July 1, through December 31, 2025. DDS reported that four use-of-force incidents were entered. OLES will continue monitoring the department's use of Blue Team/IAPro.

DDS Tracking of Law Enforcement Compliance with Training Requirements

Compliance with POST Training Mandates

The Department of Developmental Services (DDS) Protective Services Branch (PSB) 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 Continuing Professional Training (CPT) and Perishable Skills Training (PST) per 11 CCR §1005. The current POST two-year training cycle started January 1, 2025, and ends December 31, 2026.

CPT is intended to maintain, update, expand, and/or enhance an individual's knowledge and/or skills. Of the 24-hour CPT requirement, a minimum of 18 hours consist of Perishable Skills training (Arrest and Control, Driver Training/Awareness, Firearms, Use of Force, and Communications). Perishable Skills training is required for all peace officers below the middle management position.

Between January 1 and June 30, 2026, the third quarter of the POST training cycle, the DDS reported ninety-five percent of the 46 applicable sworn staff completed the necessary PST and ninety-nine percent completed the quarterly CPT requirements. One officer did not complete the required CPT training due to being on leave.

Training Mandates and Records

The DDS has established a dedicated Training Unit to ensure efficiency, standardization, and regulatory compliance across the entire department. The unit's primary objectives are to strengthen accuracy and consistency in quarterly reporting, training oversight, and operational functions. The Training Unit successfully established a fully in-house training program for PST, in alignment with the DDS OPS 2026-2027 Strategic Plan. All aspects of training are conducted internally, with the exception of firearms instruction, which is delivered by an outside, licensed provider. The unit consistently monitors training progress, ensures compliance, and assesses operational requirements to maintain high standards and support ongoing effectiveness.

Addressing Deficiencies in Training Compliance

The Department continues to audit daily training bulletins, policy, and policy updates to be reviewed and acknowledged by all PSB personnel via the Knowledge Management System within Lexipol.

During the quarterly review of training compliance, deficiencies are highlighted and brought to the attention of the supervising officers and plans are made to reach compliance within the next quarter.

Additional Mandated Data

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 ¹	Adverse action taken ²	No adverse action taken ³	Resigned/retired pending adverse action ⁴
Canyon Springs and Desert STAR	1	1	0	0
North STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR 1 and 2	24	21	3	0
South STAR 1 and 2	0	0	0	0
Total	25	22	3	0

¹ Administrative investigations completed includes all 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.

² Adverse action taken refers to a notice of adverse action being served to an employee after an 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 an investigation. These numbers may include rejecting employees during their probation periods.

³ No adverse action taken refers to cases in which an administrative investigation was completed, and it was determined that no adverse action was warranted or taken against the employees.

⁴ 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 ¹	Referred to prosecuting agencies ²	Not referred ³	Rejected by prosecuting agencies ⁴
Canyon Springs and Desert STAR	5	0	5	0
North STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR 1 and 2	0	0	0	0
South STAR 1 and 2	0	0	0	0
Total	5	0	5	0

¹ 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.

² Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to an outside prosecuting agency.

³ 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.

⁴ Cases rejected by prosecuting agencies are criminal cases that were submitted to a prosecuting agency and rejected for prosecution by that agency. This column includes rejected cases that were referred from prior reporting periods. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

Resident Criminal Cases

DDS Facilities	Total Cases ¹	Referred to prosecuting agencies ²	Not Referred ³	Rejected by prosecuting agencies ⁴
Canyon Springs and Desert STAR	0	0	0	0
North STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR 1 and 2	12	9	0	3
South STAR 1 and 2	0	0	0	0
Total	12	9	0	3

¹ 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.

² Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to outside prosecuting agencies.

³ 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.

⁴ Cases rejected by prosecuting agencies are criminal cases that were submitted to prosecuting agencies and rejected for prosecution. This column includes rejected cases that were referred from prior reporting periods. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

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
North STAR 1 and 2	0
Porterville and Central Valley STAR 1 and 2	7
South STAR 1 and 2	0
Total	7

Appendix A: Completed OLES Investigations

Case Details	Description
Incident Date	06/04/2025
OLES Case Number	2025-00689-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement supervisor allegedly made inappropriate comments and engaged in unwanted physical contact with multiple female employees.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Appendix B: Pre-Disciplinary Cases Monitored by OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2026, 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.

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
Incident Date	02/04/2024
OLEs Case Number	2024-00215-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly physically assaulted a resident. A registry psychiatric technician allegedly witnessed the abuse and failed to report the abuse.
Disposition	The psychiatric technician retired during the investigation and a "resignation under unfavorable circumstances" letter was placed in his Official Personnel File. The registry psychiatric technician also resigned during the investigation but because registry employees do not have Official Personnel Files, no "resignation under unfavorable circumstances" letter was issued.

Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	02/10/2025
OLES Case Number	2025-00168-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Referred
Incident Summary	A resident died from a pulmonary embolism caused by deep leg thrombosis. The death was not expected.
Disposition	The Protective Services Branch completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/24/2025
OLES Case Number	2025-00767-2A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty

	9. Inexcusable neglect of duty 10. Inexcusable neglect of duty 11. Inexcusable neglect of duty 12. Inexcusable neglect of duty 13. Inexcusable neglect of duty 14. Inexcusable neglect of duty 15. Inexcusable neglect of duty 16. Inexcusable neglect of duty 17. Inexcusable neglect of duty 18. Inexcusable neglect of duty 19. Inexcusable neglect of duty 20. Inexcusable neglect of duty 21. Inexcusable neglect of duty 22. Inexcusable neglect of duty 23. Inexcusable neglect of duty 24. Inexcusable neglect of duty 25. Inexcusable neglect of duty 26. Inexcusable neglect of duty 27. Inexcusable neglect of duty 28. Inexcusable neglect of duty 29. Inexcusable neglect of duty 30. Inexcusable neglect of duty 31. Inexcusable neglect of duty 32. Inexcusable neglect of duty 33. Inexcusable neglect of duty 34. Inexcusable neglect of duty 35. Inexcusable neglect of duty 36. Inexcusable neglect of duty 37. Inexcusable neglect of duty 38. Inexcusable neglect of duty 39. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Unfounded 3. Unfounded 4. Unfounded 5. Not Sustained 6. Unfounded 7. Unfounded 8. Unfounded 9. Not Sustained 10. Unfounded 11. Unfounded

	12. Unfounded 13. Not Sustained 14. Unfounded 15. Unfounded 16. Not Sustained 17. Unfounded 18. Unfounded 19. Unfounded 20. Not Sustained 21. Unfounded 22. Unfounded 23. Unfounded 24. Not Sustained 25. Unfounded 26. Unfounded 27. Unfounded 28. Not Sustained 29. Unfounded 30. Unfounded 31. Unfounded 32. Not Sustained 33. Unfounded 34. Unfounded 35. Unfounded 36. Not Sustained 37. Unfounded 38. Unfounded 39. Unfounded
Penalty	Initial: Training Final: Training
Incident Summary	A senior psychiatric technician, and three psychiatric technicians allegedly failed to intervene and report a psychiatric technician assistant for an inappropriate overly familiar relationship with a resident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations; however, ordered training for the senior psychiatric technician and the three psychiatric technicians. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with policies and

	procedures governing the investigative process. The hiring authority did not timely consult with the OLES regarding 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 hiring authority did not timely consult with the OLES regarding investigative findings. The OLES review of the investigative report was completed on October 14, 2025; however, the hiring authority did not conduct the findings conference until December 18, 2025, 65 days later.
Department Corrective Action Plan	The Executive Director or designee will maintain ongoing coordination with OLES regarding investigative findings, case status, and potential disciplinary or administrative actions, particularly in cases involving multiple subjects or unresolved investigations. In the identified case, coordination will continue because multiple subjects were involved, and the primary subject retired before the investigation was completed. PDC Executive Management has implemented a case-management and tracking system to notify Performance Management when findings conferences with OLES are required, and ensure cases remain actively monitored through final disposition. Any delays or barriers will be promptly communicated to OLES, along with the reason, the anticipated resolution timeframe, and the corrective action plan. Executive Management and Performance Management will provide continued oversight to ensure findings conferences, required communications, final decisions, and supporting documentation are completed in a timely and consistent manner.

Case Details	Description
Incident Date	07/14/2025
OLES Case Number	2025-00841-2A
Case Type	Monitored
Incident Types	1. Over-Familiarity

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly sexually assaulted a resident on multiple occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/17/2025
OLES Case Number	2025-00995-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A registry psychiatric technician allegedly restrained a resident by laying on the resident with her face on the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/26/2025
OLES Case Number	2025-01027-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Discourteous treatment 2. Discourteous treatment 3. Discourteous treatment
Findings	1. Unfounded 2. Unfounded 3. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly tickled a resident and made fun of the resident for urinating in bed. A second psychiatric technician allegedly mocked the resident for not being allowed to go home. A third psychiatric technician allegedly made derogatory remarks about the resident's religion and race.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/10/2025
OLES Case Number	2025-01235-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A psychiatric technician allegedly pushed 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 Protective Services Branch did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator did not provide the suspect psychiatric technician with the required legal admonitions before taking a statement.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? • No The investigator failed to provide the proper admonition to the psychiatric technician prior to obtaining potentially incriminating statement.
Department Corrective Action Plan	The assigned investigator was immediately contacted by the Supervising Special Investigator (SSI-1) upon the matter being brought to the management's attention. The investigator was counseled and provided remedial training regarding the appropriate admonishment required during criminal and administrative investigations. Additionally, the SSI-1 responsible for the Special Investigations Unit (SIU) developed and implemented a training and development plan for all members of the unit, including the investigator who failed to provide the appropriate admonishment. The training reinforced the PSB's policies, procedures, and expectations concerning the applicable rules and requirements governing criminal and administrative admonishments. The assigned investigator acknowledged and demonstrated an understanding of the applicable policies, procedures, and expectations. The SIU SSI-1 will continue to provide ongoing mentorship, guidance, and training regarding the proper administrative and criminal admonishments, development of investigative case plans, monitoring of

	interviews, coordination with assigned OLES representatives, and preparation of investigative reports. These measures will be utilized to ensure investigators consistently adhere to applicable policies, procedures, and expectations regarding admonishments of this nature and to ensure they are appropriately administered and documented.
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Case Details	Description
Incident Date	10/23/2025
OLES Case Number	2025-01300-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly sexually abused a resident on an unknown date.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/30/2025
OLES Case Number	2025-01344-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act

	4. Criminal Act 5. Criminal Act 6. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred 6. Not Referred
Incident Summary	An unidentified staff allegedly engaged in sexual activity with a resident. Additionally, a psychiatric technician assistant allegedly engaged in sexual activity with the same 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. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/14/2025
OLES Case Number	2025-01436-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly kicked 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 department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/14/2025
OLES Case Number	2025-01436-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly kicked a resident. A psychiatric technician assistant allegedly witnessed the kicking and was dishonest about the kicking during the investigative inquiry.
Disposition	The hiring authority determined the evidence was inconclusive and did not sustain the allegation against the senior psychiatric technician; however, the hiring authority believed corrective action was needed and issued additional training in situational awareness and client abuse prevention. The OLES concurred with the hiring authority's determination. The hiring authority determined the evidence was inconclusive and did not sustain the allegation against the psychiatric technician assistant; however, the hiring authority believed corrective action was needed and issued additional training in situational awareness and client abuse prevention. The OLES concurred with the hiring authority's determination.

Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	12/07/2025
OLES Case Number	2025-01522-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly placed a resident in a chokehold, pushed the resident down, and shoved the resident's face into a bed.
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. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/13/2025
OLES Case Number	2025-01560-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant and a psychiatric

	technician allegedly struck a resident and pulled her hair when the resident attempted to leave the facility.
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	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/12/2025
OLES Case Number	2025-01561-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pushed a client to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/23/2025
OLES Case Number	2025-01607-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly pushed a resident's legs to her ribs, struck her with a fist, and pushed the resident against a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/22/2025
OLES Case Number	2025-01608-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a resident's knees up to her chest.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/03/2026
OLES Case Number	2026-00017-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a resident during a wall containment.
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.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/20/2026
OLES Case Number	2026-00070-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly kicked a resident's leg six times while the resident was on enhanced observation. In a prior incident, the psychiatric technician allegedly choked the resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Protective Services Bureau did not open an administrative investigation. OLES concurred.

Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	01/25/2026
OLES Case Number	2026-00119-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Two psychiatric technician assistants allegedly tried to take away food that was being eaten by a resident. The two psychiatric technician assistants then allegedly prevented the resident from leaving, used blocking pads to bring the resident to the ground, and kept the resident on the ground for a short period of time.
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. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/02/2026
OLES Case Number	2026-00727-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly entered a resident's bedroom and kissed the resident on the neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Protective Services Branch did not open an administrative investigation. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

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
Incident Date	08/05/2023
OLES Case Number	2024-01370-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	An officer allegedly engaged in off duty employment without authorization. The officer also allegedly was overly familiar with an outside jail inmate. The officer was allegedly dishonest during

	the investigation.
Disposition	The hiring authority sustained the allegations and 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. During the pre-hearing settlement conference, the department entered into a settlement agreement wherein the officer agreed to resign in lieu of termination. The OLES concurred with the settlement as it achieved the goal of separating the officer from state service.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	06/04/2025
OLES Case Number	2025-00689-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	An officer allegedly made inappropriate comments to staff and engaged in unwanted physical touching. It is also alleged the officer made false statements in the course of an administrative investigation.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. The officer filed an appeal with the State Personnel Board. Prior to the evidentiary hearing, the department entered into a

	settlement agreement with the officer, wherein he agreed to resign in lieu of dismissal. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix D: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

- (a) The Office of Law Enforcement Support within the California Health and Human Services Agency shall investigate both of the following:
 - (1) Any incident at a developmental center or state hospital that involves developmental center or state hospital law enforcement personnel and that meets the criteria in section 4023 or 4427.5 or alleges serious misconduct by law enforcement personnel.
 - (2) Any incident at a developmental center or state hospital that the Chief of the Office of Law Enforcement Support, the Secretary of the California Health and Human Services Agency, or the Undersecretary of the California Health and Human Services Agency directs the office to investigate.
- (b) All incidents that meet the criteria of section 4023 or 4427.5 shall be reported immediately to the Chief of the Office of Law Enforcement Support by the Chief of the facility's Protective Services Branch.
- (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 Protective Services Branch 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

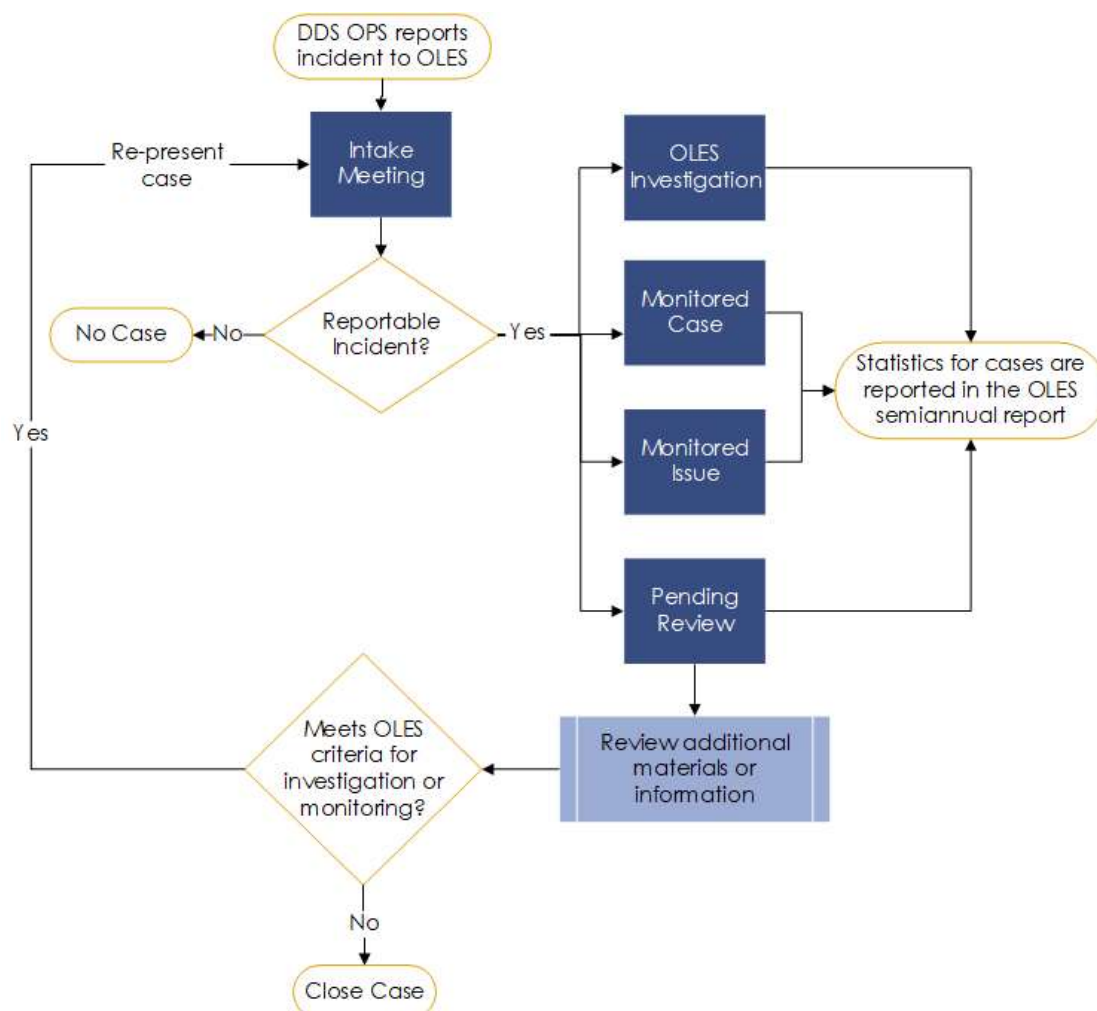
- (a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of section 4900 the following incidents involving a resident of a state mental hospital:
 - (1) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
 - (2) Any allegation 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. OLES reviews the incident and makes a case determination.
3. If the case is monitored by OLES, the OLES AIM meets with the PSB 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, 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. 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.