Office of Law Enforcement Support

Semiannual Report

January 1, 2020–June 30, 2020

Independent review and assessment of law enforcement and employee misconduct at the California developmental centers

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

As the coronavirus disease 2019 (COVID-19) pandemic spread, we saw devastating effects on the economy, healthcare systems and communities. As is the case with many disasters, vulnerable populations can be disproportionately affected by COVID-19. Among those vulnerable populations include the residents housed in the California developmental centers and Stabilization, Training, Assistance, and Reintegration (STAR) homes operated by the Department of Developmental Services (DDS).

In response to COVID-19, DDS took special measures to protect the health, safety and welfare of residents and employees while ensuring continuity of care. These measures include, but are not limited to screenings for staff, increased cleaning and sanitizing in facilities, increasing inventory of personal protective equipment and other emergency supplies, limiting visits and training for both staff and residents on COVID-19.

During these unprecedented times, providing safe, high-quality resident care and services is essential to ensuring positive resident outcomes. The Office of Law Enforcement Support (OLES) recognizes the individual actions of DDS staff, law enforcement and management who play a vital role in protecting residents from COVID-19. As we navigate through these challenging times, it is critical that we continue to respond with compassion, commitment and urgency. The OLES is grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DDS management and personnel.

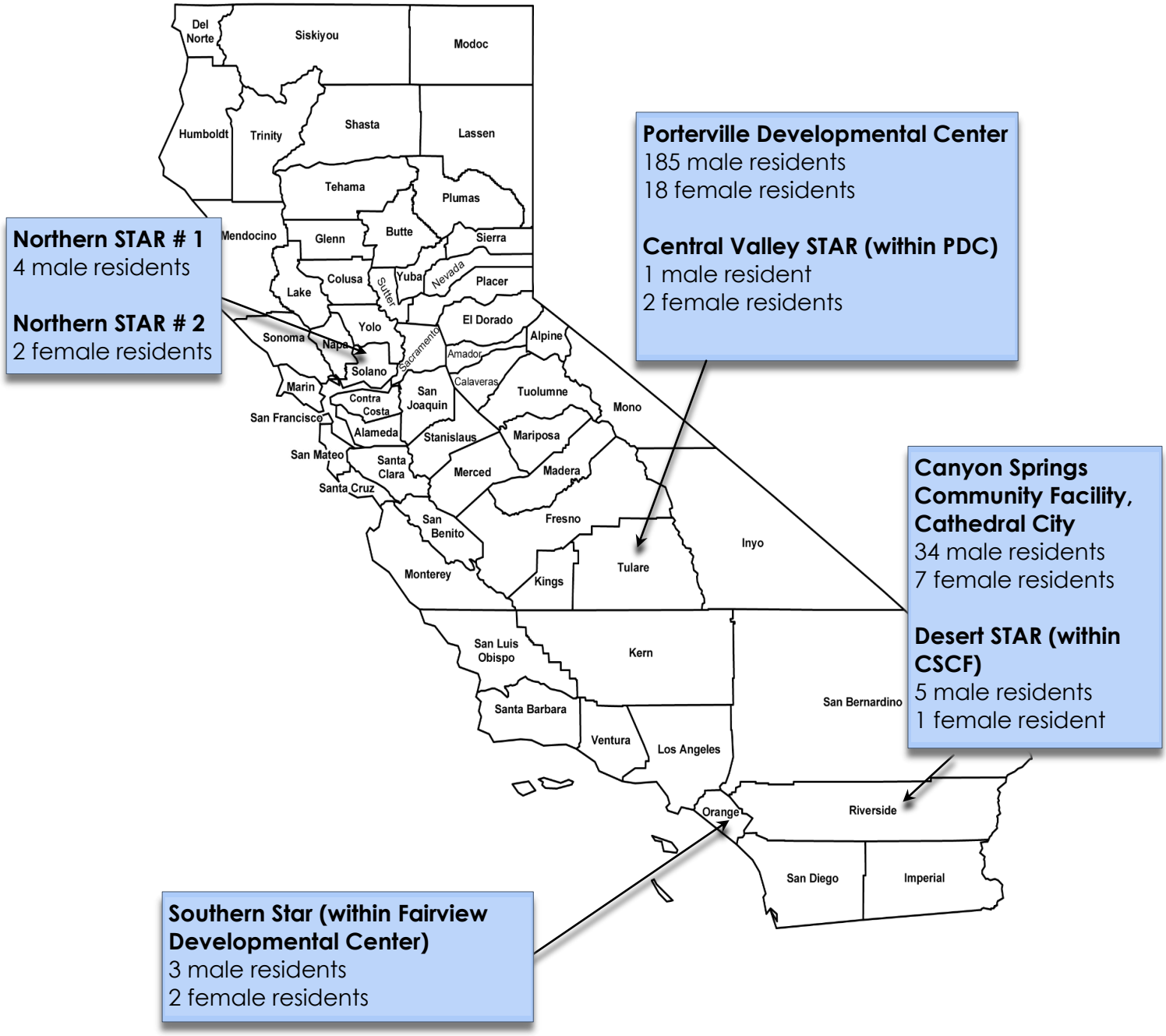
I am pleased to present the ninth semiannual report by the OLES in the California Health and Human Services Agency. Beginning with this report, the OLES will publish separate reports for the DDS and Department of State Hospitals. This report details OLES' oversight and monitoring of the DDS from January 1 through June 30, 2020.

We welcome comments and questions. Please visit the OLES website at https://www.oles.ca.gov/.

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the DDS facilities below. Population numbers as of June 30, 2020, 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
4 male residents

Northern STAR # 2
2 female residents

Porterville Developmental Center
185 male residents
18 female residents

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

Canyon Springs Community Facility, Cathedral City
34 male residents
7 female residents

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

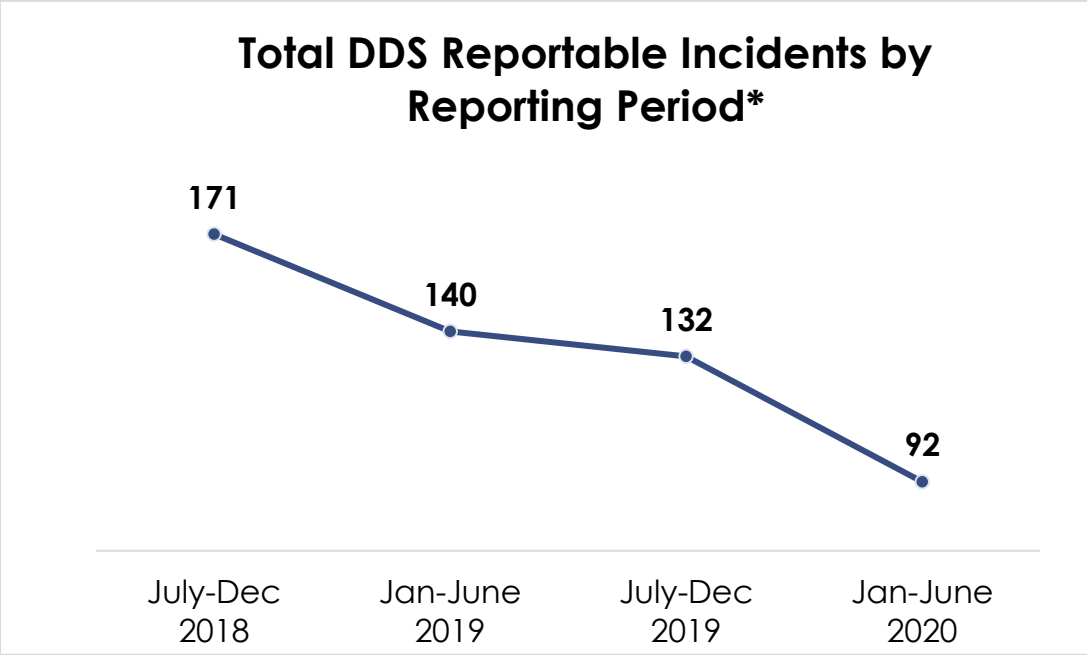
Southern Star (within Fairview Developmental Center)
3 male residents
2 female residents

DDS Facility Population Chart

Facility	Number of Male Residents	Number of Female Residents	Total
Canyon Springs	34	7	41
Porterville	185	18	203
Central Valley STAR	1	2	3
Desert STAR	5	1	6
Northern STAR #1	4	0	4
Northern STAR #2	0	2	2
Southern STAR	3	2	5
Total	232	32	264

Executive Summary

During the reporting period of January 1, 2020, through June 30, 2020, the Office of Law Enforcement Support (OLES) received and processed 92 reportable incidents[1] at the Department of Developmental Services (DDS). Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents, resident deaths and other occurrences, per Welfare and Institutions Code, sections 4023, 4023.6 and 4427.5. This is a decrease of 40 incident reports compared to the prior reporting period which had 132 incident reports. 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

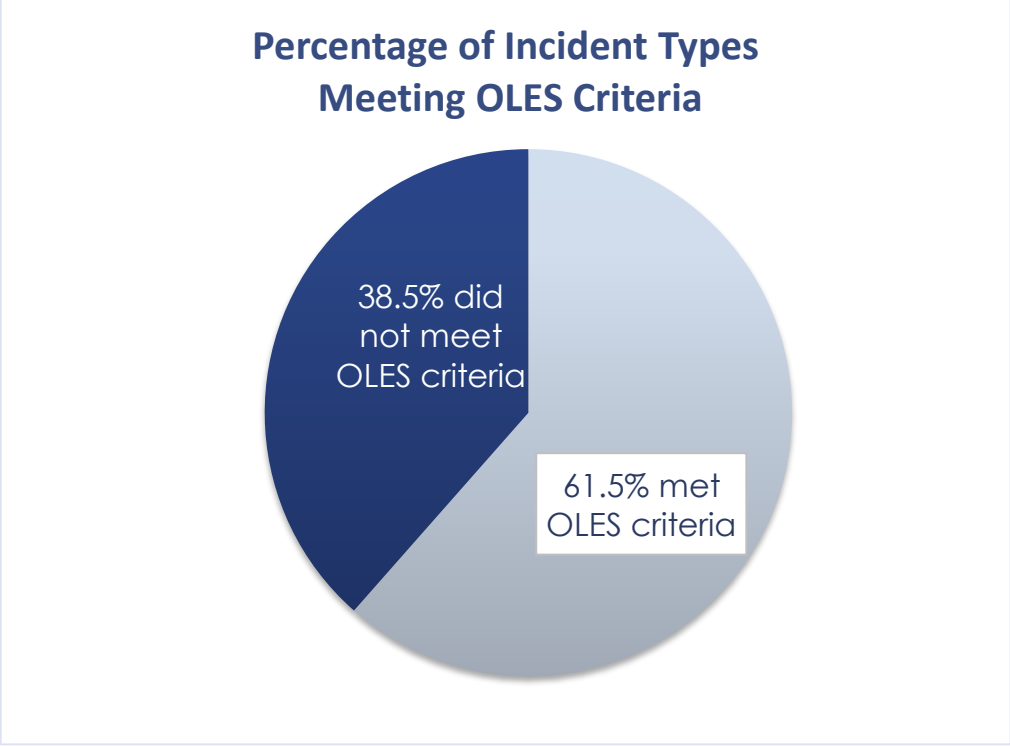
The DDS reports to OLES any incidents and associated reportable incident types[2] listed in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. During this reporting period, the OLES amended its reporting guidelines to allow

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

[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.

for more accurate and relevant data collection. The OLES differentiated incidents of broken bone and genital injury in which the cause is undetermined. The broken bone and genital injury incident types are separated into incident types of known origin and incident types of unknown origin. In addition, OLES further analyzed allegations against peace officers for reportable incident types within each incident. For example, an allegation of abuse by a peace officer is reported under the abuse incident type and also the misconduct incident type. The OLES also introduced the significant interest-over-familiarity incident type, an incident type used for conduct between a staff member and a resident that extends beyond authorized treatment or is contrary to the treatment plan and treatment success of the resident. Collecting data and ensuring quality, quantitative and qualitative data are critical to OLES' effective oversight and monitoring. This more specific data enables OLES to better identify trends and outliers, make comparisons and extract insights that can improve resident outcomes.

An incident type "meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 92 reported incidents, the OLES identified 11 incidents with two or more incident types. The DDS reported a total of 104 incident types during this reporting period. Sixty-four, or 61.5% of the 104 incident types reported by DDS met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported were abuse, sexual assault, misconduct and head or neck injuries. Allegations of abuse represented the single largest number of alleged incident types reported by DDS during this reporting period. The OLES received 56 reports of alleged abuse, which accounted for 53.8% of all reported incident types reported by DDS. The DDS reported 12 allegations of sexual assault, making sexual assault the second most frequently reported incident type from DDS. Allegations of misconduct rose 233.3% from three reported incident types in the prior reporting period to 10 reported in this reporting period. Following misconduct, incidents of head or neck injuries were the fourth most frequent incident type with seven reported incident types under the head or neck injury category. Reports of the head or neck injury incident type declined 30% from 10 incident types to seven.

Resident Deaths

There were no resident deaths reported to OLES in 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 and/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 resident was arrested for committing a violation of Penal Code section 243(d), a battery with serious bodily injury.

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 criminal misconduct or serious administrative misconduct during certain threshold incidents. As of June 30, 2020, DDS had 92 sworn staff members.

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

Appendix A of this report provides information on the three OLES investigations that were completed during this reporting period. These investigations involved allegations against three sworn staff members. Two investigations involved an incident that allegedly occurred in 2020 and one investigation involved an alleged incident from 2019. The OLES submitted two completed administrative investigations to the chief of the DDS Office of Protective Services for disposition and monitored the disposition process. The OLES conducted an inquiry into one criminal allegation and determined there was insufficient evidence that a crime was committed. The case was closed without referral to a district attorney's office. A summary of the review and decision was provided to the department.

Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the department and the discipline process for employees involved in misconduct. These completed monitored cases included allegations against 24 psychiatric technicians, three psychiatric technician assistants, three senior psychiatric technicians, two officers and one resident. One psychiatric technician was the subject in three allegations; in all those cases, the investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office.

In Appendix B of this report, OLES provides information on eight monitored administrative cases and 16 monitored criminal cases that, by June 30, 2020, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. Five pre-disciplinary administrative cases had sustained allegations and two criminal investigations resulted in referrals to prosecuting agencies.

The OLES monitored 24 pre-disciplinary phase cases, which are provided in Appendix B. Ten of the 24 pre-disciplinary phase cases were rated as procedurally insufficient only. One case was rated both procedurally and substantively insufficient. The DDS failed to complete investigations within the 120-day required timeframe in 10 cases out of the 11 cases rated as procedurally insufficient.

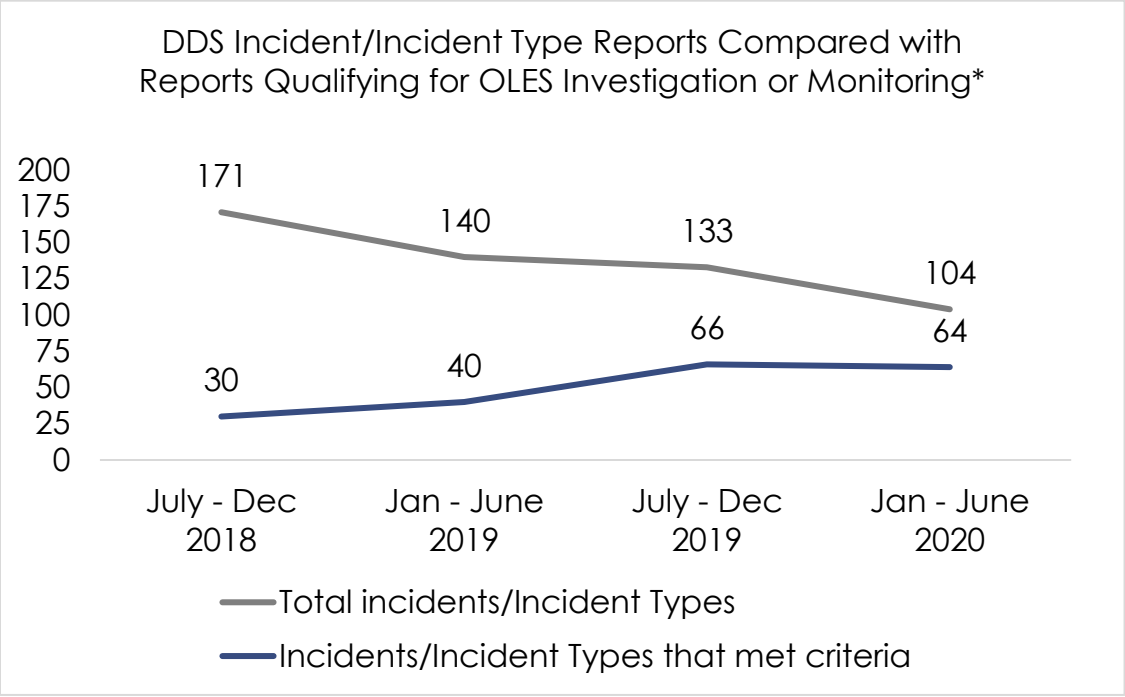
The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in one administrative case, which is provided in Appendix C. The OLES rated this case both procedurally and substantively sufficient.

Incidents and Incident Types

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

Decrease in Reported Incidents and Incident Types

The number of DDS incidents reported to OLES from January 1 through June 30, 2020, decreased 30.3 percent, from 132 during the prior reporting period to 92 in this reporting period. From the 92 reported incidents, the OLES identified 104 incident types, as 11 of the incidents featured two or more incident types. Sixty-four of the 104 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic departmental issue. When compared to the prior reporting period, both the number of reported incident types and incident types meeting OLES criteria decreased in this reporting period.



* Numbers are unadjusted and are provided as they were previously published. Beginning in the July through December 31, 2019, reporting period, the OLES switched from reporting incidents to reporting incident types.

Most Frequent Incident Types Reported this Period

Of the 104 reported incident types from DDS, 85 incident types or 81.7 percent of

all reported incident types fell into the following four categories: abuse, sexual assault, misconduct and head or neck injury. These four incident type categories accounted for 56 incident types or 87.5 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 56 abuse allegations accounted for 53.8 percent of all DDS incident types reported. Forty-three of the abuse allegations met OLES criteria for investigation or monitoring. Alleged sexual assault represented the second highest category for the number of incident types reported, with 12 reports. Three alleged sexual assault incident types met criteria for investigation or monitoring. The total number of misconduct allegations significantly rose when compared to the total reported in the prior reporting period. Three of the 10 incident types under the misconduct category involved allegations of abuse against a peace officer. The remaining seven incident types were allegations of peace officer misconduct that did not involve residents. Nine of the 10 reported allegations of misconduct met OLES criteria. Despite fewer reports of head or neck injuries in this reporting period, head or neck injuries were the fourth most frequently reported incident type. One head or neck injury incident type met OLES criteria.

Most Frequent Incident Types January 1 through June 30, 2020

Incident Type Categories	Prior Period Incidents Types July 1, 2019, through December 31, 2019	Current Period Incident Types January 1 2020, through June 30, 2020	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	81	56	-30.9%	43
Sexual Assault	14	12	-14.3%	3
Misconduct	3	10	+233.3%	9
Head/Neck	10	7	-30%	1

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/Incident Type Categories	Prior Period January 1- June 30, 2019 (Reported)*	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Prior Period July 1- Dec 31, 2019 (Reported)*	Prior Period July 1- Dec 31, 2019 (Meets Criteria)*	Current Period January 1- June 30, 2020 (Reported)	Current Period January 1 - June 30, 2020 (Meets Criteria)
Abuse	94	33	81	51	56	43
Broken Bone	8	0	9	1	-	-
Broken Bone (Known Origin)	-	-	-	-	4	2
Broken Bone (Unknown Origin)	-	-	-	-	1	1
Burn	1	0	1	0	3	0
Death	2	0	2	0	0	0
Genital Injury	1	0	1	1	-	-
Genital Injury (Known Origin)	-	-	-	-	0	0
Genital Injury (Unknown Origin)	-	-	-	-	1	1
Head/Neck Injury	5	0	10	0	7	1
Misconduct**	4	3	3	2	10	9
Neglect	6	4	5	5	4	4
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
Pregnancy	0	0	0	0	0	0
Resident on Resident Assault/GBI	5	0	1	0	1	0
Sexual Assault	11	0	14	6	12	3
Sexual Assault-OJ***	0	0	0	0	1	0
Significant Interest-Attack on Staff******	0	0	3	0	0	0

Incident/Incident Type Categories	Prior Period January 1- June 30, 2019 (Reported)*	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Prior Period July 1- Dec 31, 2019 (Reported)*	Prior Period July 1- Dec 31, 2019 (Meets Criteria)*	Current Period January 1- June 30, 2020 (Reported)	Current Period January 1 - June 30, 2020 (Meets Criteria)
Significant Interest- Attempted Suicide	0	0	0	0	0	0
Significant Interest-AWOL	1	0	3	0	1	0
Significant Interest-Child Pornography	0	0	0	0	0	0
Significant Interest- Other***	1	0	0	0	2	0
Significant Interest- Overfamiliarity	-	-	-	-	0	0
Significant Interest- Resident Arrest	1	0	0	0	1	0
Significant Interest-Riot	0	0	0	0	0	0
Totals	140	40	133	66	104	64

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

**Beginning in the January 1, 2020, through June 30, 2020, reporting period, the OLES identified applicable incident types within each incident involving peace officer misconduct. For example, an allegation of abuse by a peace officer is recorded as one incident type for abuse and one incident type for misconduct.

***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.

*****Any other incident of significant interest, e.g., a staff member performing the Heimlich maneuver to save a resident that was choking on food or officers confiscating prohibited items from a contracted staff member at the vehicle search sally port.

Incident Types Reported from Developmental Centers or Canyon Springs Community Facility

Ninety-eight of the 104 reported incident types came from a developmental center or the Canyon Springs Community Facility (CSCF). Incident types reported by Fairview Developmental Center (FDC) involving residents were reported prior to the facility's closure. One incident type reported by FDC and the misconduct incident type listed under Sonoma Developmental Center (SDC) did not involve residents. As shown in the *Incident Types by Reporting Period* table on the previous two pages, the developmental centers and CSCF did not report any incident types from the following incident type categories: death, genital injury (known), non-resident on resident assault/GBI, pregnancy, significant interest-attack on staff, significant interest-attempted suicide, significant interest-child pornography, significant interest-overfamiliarity and significant interest-riot. The following table lists the number of reported incident types by facility for categories that had a least one reported incident type.

Incident Type Category	Canyon Springs	Fairview	Porterville	Sonoma	Total
Abuse	19	3	29	0	51
Broken Bone (Known Origin)	1	0	3	0	4
Broken Bone (Unknown Origin)	0	0	1	0	1
Burn	0	0	3	0	3
Genital Injury (Unknown Origin)	0	0	1	0	1
Head/Neck Injury	1	2	3	0	6
Misconduct*	2	1	6	1	10
Neglect	0	0	4	0	4
Resident on Resident Assault/GBI	1	0	0	0	1
Sexual Assault	5	1	6	0	12
Sexual Assault-OJ**	1	0	0	0	1
Significant Interest-AWOL	0	0	1	0	1
Significant Interest-Other****	0	0	2	0	2
Significant Interest-Resident Arrest	1	0	0	0	1
Total	31	7	59	1	98

*Beginning in the January 1, 2020, through June 30, 2020, reporting period, the OLES identified applicable incident types within each incident involving peace officer misconduct. For example, an allegation of abuse by a peace officer is

recorded as one incident type for abuse and one incident type for misconduct.
**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 has reported to OLES and therefore does not reflect all attacks on staff that may have occurred.
****Any other incident of significant interest, e.g., a staff member performing the Heimlich maneuver to save a resident that was choking on food or officers confiscating prohibited items from a contracted staff member at the vehicle search sally port..

Incident Types Reported from STAR homes

Six of the 104 incident types reported by DDS came from Stabilization, Training, Assistance and Reintegration (STAR) homes. Incident types reported from STAR homes include abuse and head or neck injuries. The OLES did not receive any incident reports from Northern STAR #2 or Central Valley STAR in this reporting period.

Incident Type Category	Desert STAR	Northern STAR #1	Southern STAR	Total
Abuse	1	2	2	5
Head/Neck Injury	0	1	0	1
Total	1	3	2	6

Distribution of DDS Incident Types

As of June 30, 2020, the DDS population dropped from 270 residents to 264 residents. With 264 residents department-wide, this equates to 0.39 incident types per resident. By June 30, 2020, all residents transitioned out of the Fairview Developmental Center and the general treatment area of Porterville Developmental Center (PDC). The PDC had a population size of 203 residents in the secured treatment program which was 76.9% of the reported DDS facility population.

As shown in the table below, among the developmental centers and CSCF, CSCF had the highest ratio of reported incident types to total resident population. Ten of the 31 incident types reported by CSCF derived from allegations of one resident.

DDS Developmental Center Population and Total Incident Types

Facility	Number of Residents*	Total Incident Types	Ratio of Incident Types to Population
Canyon Springs	41	31	0.756

Facility	Number of Residents*	Total Incident Types	Ratio of Incident Types to Population
Fairview	0	7	-
Porterville	203	59	0.291
Sonoma	0	1	-
Totals	244	98	0.401

* The department provided population numbers as of June 30, 2020.

Reports from STAR homes increased as more residents were admitted. On June 30, 2020, there were 20 residents in STAR homes. As shown in the table below, Northern Star #1 reported three incident types in this reporting period, which was the highest number of reported incident types amongst the STAR homes. Northern STAR #1 had the highest ratio of incident types to total population on June 30, 2020, which was 0.750.

DDS STAR Home Population and Total Incident Types

Facility	Number of Residents*	Total Incident Types	Ratio of Incident Types to Population
Central Valley STAR	3	0	0
Desert STAR	6	1	0.167
Northern STAR #1	4	3	0.750
Northern STAR #2	2	0	0
Southern STAR	5	2	0.400
Total	20	6	0.300

* The department provided population numbers as of June 30, 2020.

Sexual Assault Allegations

Following the abuse incident type, sexual assault was the second most frequently reported incident type from January 1 through June 30, 2020. The 12 alleged sexual assault incident types in this reporting period accounted for 11.5% of all reported incident types from DDS. Three of the sexual assault incident types met OLES criteria for investigation, monitoring or research into systemic department issues. There was one reported incident type under the sexual assault-OJ category, which did not meet OLES criteria. The sexual assault-OJ incident type category includes allegations that implicated family, friends, or others in incidents that occurred when residents were not in a DDS facility.

Of these 12 sexual assault incident types, five were reported by CSCF, six by PDC and one by FDC. Six allegations of sexual assault involved a resident assaulting other residents(s). The remaining six 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.

DDS - Sexual Assault Incidents Reported January 1 through June 30, 2020

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

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

Reports of Residents Absent without Leave

In this reporting period, PDC reported one incident type under the significant interest-absent without leave (AWOL) category. A resident left his unit without permission and was located on grounds between other units. An officer escorted the resident back to his unit without incident.

Notification of Incident Types

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

Priority One Notifications – Two Hour Notification

Incident	Description
ADW	An assault with a deadly weapon (ADW) against a resident by a non-resident.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a resident.
Broken Bone (U)	A broken bone of a resident when the cause of the break is undetermined.
Deadly force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a resident.
Genital Injury (U)	An injury to the genitals of a resident when the cause of injury is undetermined.
Physical Abuse	Any report of physical abuse of a resident implicating staff.
Sexual Assault	Any allegation of sexual assault of a resident.

Priority Two Notifications – 24 Hour Notification

Incident	Description
Broken Bone (K)	A broken bone of a resident when the cause of the break is known by staff.
Burn	Any burns of a resident. This does not include sunburns or mouth burns caused by consuming hot food or liquid unless blistering occurs.
Genital Injury (K)	An injury to the genitals of a resident when the cause of injury is known 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

Incident	Description
	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.
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.
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.
Pregnancy	A resident pregnancy.
Significant Interest	Any incident of significant interest to the public, including, but not limited to: AWOL, suicide attempt (requiring treatment beyond first-aid), commission of serious crimes by resident(s) or staff, 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

In this reporting period, DDS timely reporting of incidents to OLES statewide decreased from 97 percent to 96.7 percent when compared to the prior reporting period. All incidents reported from FDC, SDC and STAR homes were timely. One of the three untimely incidents was unreported and discovered by OLES when reviewing the DDS facility daily incident logs.

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

Rank	DDS Facility	Number of Incident Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Desert STAR	1	1	100%
1	Fairview	7	7	100%
1	Northern STAR #1	2	2	100%
1	Southern STAR	2	2	100%
1	Sonoma	1	1	100%
2	Porterville	52	51	98.1%
3	Canyon Springs	27	25	92.6%
	Total	92	89	96.7%

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 January 1 through June 30, 2020, reporting period, 39 of the total 101 cases opened for DDS incidents that occurred within DDS' jurisdiction or 38.6 percent were assigned a pending review. The OLES opened a case for an incident that may have occurred while the resident was not housed within a DDS facility and assigned the case a pending review. The OLES opened six administrative investigations and one criminal investigation. The OLES opened 45 monitored criminal cases and nine monitored administrative cases.

The table on the following page provides the case assignments for all incidents received by OLES during the reporting period. Please note that the table on the following page separates out the outside jurisdiction case from the Pending Review cases.

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

Cases Opened in January 1 through June 30, 2020

OLES Case Assignments	January 1 – June 30, 2020	Percentage of Opened Cases
Pending Review	39	38.6
Monitored, Criminal	45	44.6
Monitored, Administrative	9	8.9
OLES Investigations, Administrative	6	5.9
OLES Investigations, Criminal	1	1%
Outside Jurisdiction*	1	1%
Totals	101	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 investigations. Two investigations were administrative cases and one was criminal.

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, OLES did not refer any criminal investigations to a prosecuting agency. All completed OLES investigations into administrative wrongdoing or misconduct are forwarded to facility management for review. In this reporting period, two administrative cases were referred to management for possible discipline of state employees. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted. The following table shows the results of the three completed OLES investigations in this reporting period. These investigations are summarized in Appendix A.

Results of Completed OLES Investigations

Type of Investigation	Total completed January 1- June 30, 2020	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	2	N/A	2	0
Criminal	1	0	N/A	1
Total	3	0	2	1

The OLES provided the department with a summary of the review and decision of all administrative and criminal investigations in which the OLES determined there was insufficient evidence that the allegations were true.

OLES Monitored Cases

In this report, OLES provides information on 25 completed monitored cases. By the end of the reporting period, 16 monitored criminal cases had either been referred or not referred to a prosecuting agency. Two out of 16 criminal cases were referred to a prosecuting agency.

There were nine completed monitored administrative cases. Eight monitored administrative cases had allegations that were sustained or not sustained during this reporting period. One of the monitored administrative cases had sustained allegations that OLES reported on in the prior reporting period. 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	2
Criminal/Not Referred	14
Total Criminal	16
Administrative/With Sustained Allegations	5
Administrative- With Sustained Allegations Reported in the Prior Reporting Period	1
Administrative/Without Sustained Allegations	3
Total Administrative	9
Grand Total	25

The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in one administrative case, which is provided in Appendix C. The OLES rated the administrative case as procedurally and substantively sufficient.

Pre-Disciplinary Phase Cases

Of the 24 DDS pre-disciplinary phase cases in Appendix B, the OLES rated 10 cases procedurally insufficient and one case both procedurally insufficient and substantively insufficient. The DDS' failure to complete investigations within the 120-day required timeframe was the most frequent procedural deficiency observed in pre-disciplinary phase cases. Of the 11 cases, 10 were procedurally insufficient due to delayed investigations, three from PDC and seven from CSCF. The untimely investigations ranged from 149 days to 401 days, with a median of 217.5 days. The following table provides the type of case and the corresponding number of cases rated procedurally or substantively insufficient.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	0	0
Criminal/Not Referred	9	1
Administrative/With Sustained Allegations	2	0
Administrative/Without Sustained Allegations	0	0
Total	11	1

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

Procedural and Substantive Deficiencies found in Insufficient Cases

Procedural Deficiency	Potential Consequence
Failure to complete investigations within 120 days	As investigations age, memories may fade, witnesses may become unavailable, residents may be discharged or transferred.
Failure to identify and interview witnesses	This increases the likelihood of missing or erroneous information.
Level of care staff did not report incident in a timely manner	This delays department's initial response and delays notification to OLES.
Failure to provide required legal admonition prior to taking a statement	This may compromise the integrity of the statement and render a statement inadmissible in court. In some cases, it may violate union contracts or the Public Safety Officer Bill of Rights.

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

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	5	3	2	0
Fairview	2	0	2	0
Porterville	12	12	0	0
Totals	19	15	4	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	15	0	15	0
Fairview	2	0	2	0
Porterville	1	0	1	0
Totals	18	0	18	0

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

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

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

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

Resident Criminal Cases

DDS Facilities	Total Cases*	Referred to prosecuting agencies**	Not Referred***	Rejected by prosecuting agencies****
Canyon Springs	4	0	4	0
Fairview	0	0	0	0
Porterville	22	20	2	11
Totals	26	20	6	11

* 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	Registered Nursing	Vocational Nursing/Psych Tech	Medical Board	Pharmacy	Public Health
Canyon Springs	0	0	0	0	8
Fairview	0	0	0	0	0
Porterville	0	0	0	0	20
Totals	0	0	0	0	28

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2020.

Case Detail	Description
Incident Date	11/29/2019
OLES Case Number	2019-01325-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On November 29, 2019, an officer allegedly was under the influence of alcohol while on duty.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	02/19/2020
OLES Case Number	2020-00174-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	On February 19, 2020, an officer allegedly spat on and threatened a resident with a baton.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	01/25/2020
OLES Case Number	2020-00204-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On January 25, 2020, an officer allegedly offered a second officer a bribe in exchange for false testimony at an upcoming State Personnel Board hearing. The officer also allegedly accessed a third officer's email account without authorization.

Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2020, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. The OLES monitored each departmental investigations for both procedural and substantive sufficiency.

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

Criminal-Referred to Prosecuting Agency

Case Detail	Description
Incident Date	01/02/2020
OLES Case Number	2020-00013-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin) 2. Neglect
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On January 2, 2020, three psychiatric technicians allegedly failed to provide medical attention to a resident who injured his head during an incident with another resident.
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	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/05/2020
OLES Case Number	2020-00018-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On January 5, 2020, a psychiatric technician allegedly fell asleep while assigned to provide constant observation of a resident.
Disposition	The investigation established 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	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Criminal-Not Referred

Case Detail	Description
Incident Date	12/08/2018
OLES Case Number	2018-01326-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 8, 2018, a resident alleged he was sodomized by another resident against his will.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The

	investigator failed to provide OLES with a copy of the draft investigative report. The investigation was not completed until 401 days from the date of discovery. While some delay was attributable to the need for forensic DNA testing of the evidence, the investigator failed to submit all evidence for testing in a timely manner, thereby causing a substantial delay.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The investigator failed to provide OLES with a copy of the draft investigative report before it was forwarded to the hiring authority. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to provide OLES with a draft report and failed to provide OLES with forensic reports in a timely manner. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on December 10, 2018; however, the investigation was not completed until January 15, 2020, 401 days later. While some delay was attributable to the need for forensic testing of the evidence, the investigator did not timely submit all evidence for testing, thereby causing a substantial delay.
Department Corrective Action Plan	In the future, the CSCF will ensure the OLES monitor is provided a copy of the draft report for review by OLES. The evidence processing procedures have been changed to ensure evidence is managed properly. Additionally, the Investigator has been directed to ensure the OLES monitor is updated with the progress of the investigation and to provide the monitor with a draft when completed. Investigations shall be completed within 60 days unless an extension is approved by OPS headquarters and OLES notification has been made as

	to the reasons for the delay.

Case Detail	Description
Incident Date	03/06/2019
OLES Case Number	2019-00343-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 6, 2019, a psychiatric technician allegedly used profanity and threatened to assault a resident before placing his arm around the resident's neck and pushing the resident on a bed.
Disposition	The investigation failed to establish 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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to prepare for all aspects of the investigation, including obtaining all relevant documents prior to questioning witnesses and failing to develop witness questions. The investigator failed to ask the reporting party, who was a percipient witness, any questions about the allegations of physical abuse. The investigator's failure to conduct a thorough and complete interview necessitated a subsequent interview with the witness. The investigation was not completed until 356 days from the date of discovery. The investigation was not completed until nine days before the deadline to take criminal action.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator failed to adequately prepare for the reporting party's interview. The investigator failed to obtain all relevant documents prior to the interview and failed to prepare questions for the witness.

	2. Were all of the interviews thorough and appropriately conducted? No. The interview of the reporting party was neither thorough nor appropriately conducted. The investigator failed to ask the witness questions regarding the allegation of physical abuse thereby necessitating a second interview. Furthermore, because the investigator did not obtain relevant documents before the interview, he did not thoroughly question the witness. 3. Was the investigation or subject-only interview completed at least 90 days before the deadline to take disciplinary action or the deadline for a prosecuting agency to file charges? No. The incident allegedly occurred on March 6, 2019; however, the investigation was not completed until February 25, 2020, 356 days later. The statute of limitations for a misdemeanor charge would have expired on March 5, 2020, nine days before the investigation was completed. 4. Was the investigation thorough and appropriately conducted? No. The investigator failed to adequately prepare for the investigation, failed to thoroughly interview the reporting party, and failed to complete the investigation in a timely manner. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 4, 2019; however, the investigation was not completed until February 25, 2020, 356 days later.
Department Corrective Action Plan	This Investigator is no longer with the department and specific corrective action cannot be addressed with them. The commander will ensure the new Investigator will receive proper training in all aspects of

	investigations to ensure thoroughness and accuracy. Investigations shall be completed within 60 days unless approved by OPS headquarters and OLES notification has been made as to the reasons for the delay.

Case Detail	Description
Incident Date	04/25/2019
OLES Case Number	2019-00416-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 25, 2019, a psychiatric technician allegedly took a resident to buy marijuana and smoked marijuana with the resident during an off-grounds outing.
Disposition	The investigation failed to establish 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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 260 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 25, 2019; however, the investigation was not completed until January 10, 2020, 260 days later.
Department Corrective Action Plan	The new Investigator shall be required to submit investigations within 60 days for review. If the investigation is not approved within 90 days, then the Investigator/command must seek approval from OPS HQ and notify the OLES monitor of the reason to the delay.

Case Detail	Description
Incident Date	07/14/2019
OLES Case Number	2019-00717-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 14, 2019, a psychiatric technician allegedly grabbed a resident's breast and buttocks. A second psychiatric technician allegedly regularly grabs the resident's buttocks, and other staff members regularly grab the resident's breast and buttocks. On July 20, 2019, an unidentified suspect allegedly raped the resident.
Disposition	The investigation failed to establish 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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 192 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 21, 2019; however, the investigation was not completed until January 28, 2020, 192 days later.
Department Corrective Action Plan	New investigative procedures were put into effect at the end of January 2020, including weekly and monthly SIU meetings to review cases and procedures, as well as plan for successful case completion.

Case Detail	Description
Incident Date	08/25/2019
OLES Case Number	2019-00868-1C
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 25, 2019, four psychiatric technicians and one psychiatric technician assistant allegedly placed a resident in five point restraints for approximately five hours.
Disposition	The investigation failed to establish 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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator initially failed to conduct a thorough interview of the resident. The investigation was not completed until 225 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator did not adequately prepare for the resident's interview because initially, the investigator did not ask the resident a single question after she gave a narrative of what occurred. 2. Were all of the interviews thorough and appropriately conducted? No. After asking the resident to provide a narrative of what occurred, the investigator did not ask any follow up questions until prompted to do so. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on August 26, 2019; however, the investigation was not completed until April 6, 2020, 225 days later.
Department Corrective Action	The new Investigator shall be required to submit investigations within 60 days for review and to conduct

Plan	a thorough investigation including collecting all relevant evidence, performing proper interviews, and submitting the report in a timely manner. If the investigation is not approved within 90 days, then the Investigator/command must seek approval from OPS HQ and notify the OLES monitor of the reason to the delay.

Case Detail	Description
Incident Date	09/07/2019
OLES Case Number	2019-00948-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 7, 2019, two psychiatric technicians allegedly pulled on and struck a resident's arms.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Special Investigations did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. Level of care staff failed to timely notify the Office of Protective Services of the allegation. The investigation was not completed until 210 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. Level of care staff discovered the incident on September 9, 2019, at 0800; however, did not notify the Office of Protective Services until 1316, approximately five hours later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The incident was discovered on September 9, 2019; however, the investigation was not completed until April 6, 2020, 210 days later.
Department Corrective Action Plan	The Investigator is no longer with the Department; however, the new Commander discussed several issues with the new Investigator about proper investigation techniques, timeliness, collection of evidence, and OLES relationship as it relates to keeping the Attorney Monitor apprised of the case progress and submitting a draft copy for review. The Commander will meet with the Facility Director, to help facilitate training for level of care staff regarding timely notification to OPS.

Case Detail	Description
Incident Date	09/24/2019
OLES Case Number	2019-01044-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 24, 2019, a psychiatric technician allegedly used profanity and pulled a resident out of bed by her wrist, causing a bruise.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Investigative Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator initially failed to fully question the resident about all aspects of the allegations. The investigative report included incorrect and irrelevant information. The investigation was not completed until 195 days from the date of discovery.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? No. During the interview of the client, she alleged that

	during the incident she had been sexually assaulted. The investigator initially refused to question the client about this because it was not part of the original allegation. After OLES recommended the investigator fully question the client on all aspects of her allegation, the investigator asked further questions. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report included incorrect information in an effort to justify the investigator's failure to initially question the client about her sexual assault allegation. The draft report included incorrect dates regarding the incident. 3. Was the final investigative report thorough and appropriately drafted? No. The final report included the incorrect information regarding the investigator's justification for failing to initially question the resident about the sexual assault allegation. Not only was this information factually incorrect, the information is not relevant and should not be included in an investigative report. 4. Was the investigation thorough and appropriately conducted? No. The investigator did not conduct an organized or thorough investigation. Primarily, the interviews lacked focus and were not appropriately detailed. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on September 25, 2019; however, the investigation was not completed until April 6, 2020, 195 days later.
Department Corrective Action Plan	The Investigator is no longer with the Department; however, the Commander discussed several issues with the new Investigator about proper investigation techniques, providing correct information in

	investigative reports, timeliness, collection of evidence, and OLES relationship as it relates to keeping the Attorney Monitor apprised of the case progress and submitting a draft copy for review.

Case Detail	Description
Incident Date	11/02/2019
OLES Case Number	2019-01216-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 2, 2019, a senior psychiatric technician allegedly grabbed and sexually assaulted a resident.
Disposition	The investigation failed to establish 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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/19/2019
OLES Case Number	2019-01266-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 19, 2019, a psychiatric technician allegedly pushed a resident to the floor.
Disposition	The investigation failed to establish 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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient

	The department failed to comply with policies and procedures governing the investigative process. Two staff members failed to timely report the incident. The responding officer failed to identify and interview the percipient witnesses. The investigator inappropriately questioned two witnesses about potential administrative violations during the course of the criminal investigation and failed to provide the two witnesses with the required legal admonition before eliciting incriminating statements from the two witnesses. The Office of Protective Services did not provide OLES with a draft investigative report. The investigation was not completed until 149 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. Two employees failed to timely report the incident. 2. Did the department adequately respond to the incident? No. The responding officer failed to identify and interview the percipient witnesses to the alleged incident. 3. Were all of the interviews thorough and appropriately conducted? No. The investigator improperly questioned two witnesses about their violation of administrative policy during the course of a criminal investigation and without providing the two witnesses with the legally required admonition. The investigator followed this course of action even though, prior to the interviews, he was instructed not to do so by his supervisor. 4. 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 OLES did not receive a draft investigative report. 5. Was the investigation thorough and appropriately conducted? No. The responding officer did not conduct a thorough investigation because he failed to identify and interview percipient witnesses to the incident. The investigator conducted administrative interviews during the course of a criminal investigation and failed to provide two witnesses with the legally required admonition before taking their statements. 6. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 19, 2019; however, the investigation was not completed until April 15, 2020, 149 days later.
Department Corrective Action Plan	The Commander has initiated additional training for patrol officers as it relates to conducting proper investigations. The additional training had to be postponed due to COVID -19 pandemic, the training will be re-scheduled at the next available opportunity. The Investigator is no longer with the Department; however, the Commander discussed several issues with the new Investigator about proper investigation techniques, timeliness, principles of case bifurcation, and OLES relationship as it relates to keeping the Attorney Monitor apprised of the case progress and submitting a draft copy for review.

Case Detail	Description
Incident Date	11/01/2019
OLES Case Number	2020-00112-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 1, 2019, a psychiatric technician assistant allegedly battered a resident during a wall containment procedure. On January 9, 2020, two

	psychiatric technicians allegedly threatened to arrange an assault of the resident by another resident.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The department did not open an administrative investigation. The OLES did not concur with the department's decision to not open an administrative investigation because issues arose concerning the behavior of staff working on the unit during the criminal investigation that should have been investigated in an administrative investigation.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	02/09/2020
OLES Case Number	2020-00137-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 9, 2020, a psychiatric technician assistant allegedly slapped a resident.
Disposition	The investigation failed to establish 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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The department did not timely notify the OLES of the incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident?

	No. The Office of Protective Services learned of the incident on February 9, 2020, at 0705 hours, but did not notify the OLES until February 10, 2020, at 0707 hours, over 26 hours later.
Department Corrective Action Plan	The Watch Commander has since been further trained on this issue. The OPS Commander insured the Operations Lieutenant met and discussed the proper procedure with the Watch Commander in relation to Priority One and Priority Two OLES Notifications. The Operations Lieutenant will continue to monitor all allegations reported to OPS, to insure all OLES Notifications are made in a timely manner.

Case Detail	Description
Incident Date	02/24/2020
OLES Case Number	2020-00225-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 24, 2020, a psychiatric technician and psychiatric technician assistant allegedly admitted to staff at a community home that the way to control a resident was to "prone him on the floor and spread his legs until he felt pain," which is not an authorized control technique.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/07/2020
OLES Case Number	2020-00350-1C
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 7, 2020, a psychiatric technician allegedly yelled at a resident, used profanities and threatened to slap the resident.
Disposition	The investigation failed to establish 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	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/20/2020
OLES Case Number	2020-00403-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 20, 2020, a resident alleged that another resident had previously been assaulted, on an undetermined date, by a psychiatric technician.
Disposition	The investigation failed to establish 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 also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Administrative-With Sustained Allegations

Case Detail	Description
Incident Date	06/26/2018
OLES Case Number	2018-01203-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** No Penalty Imposed
Incident Summary	On June 26, 2018, a psychiatric technician allegedly kicked and struck a resistive resident. The psychiatric technician was also allegedly dishonest and uncooperative during the investigation. Two other psychiatric technicians were allegedly uncooperative during the investigation.
Disposition	The hiring authority sustained the allegations against the first psychiatric technician, and determined dismissal was the appropriate penalty. The OLES concurred. However, the first psychiatric technician had resigned before completion of the investigation; therefore, no disciplinary action was taken. A letter indicating the first psychiatric technician resigned under adverse circumstances was placed in his official personnel file. The hiring authority also sustained allegations against the other two psychiatric technicians, and ordered training for both of them. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The administrative investigation was opened on November 8, 2018; however, the investigation took 305 days to complete. The department did not timely respond to the OLES' inquiries regarding the status of the case disposition. The Office of Protective Services delayed 109 days before providing the final supplement of the investigative report to the OLES for review.

Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. Although the investigator completed the supplemental investigation on February 25, 2020, the Office of Protective Services did not forward a draft of the revised investigative report to OLES until June 12, 2020, 109 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The department opened an administrative investigation on November 8, 2018; however, the investigation was not completed until 305 days later.
Department Corrective Action Plan	New investigative procedures were put into effect at the end of January 2020, including weekly and monthly SIU meetings to review cases and procedures, as well as plan for successful case completion. These meetings will encourage improved communication between OPS, OLES & DDS Legal.

Case Detail	Description
Incident Date	03/14/2018
OLES Case Number	2019-00399-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 3. Dishonesty 4. Inexcusable neglect of duty 5. Willful disobedience
Findings	1. Sustained 2. Unfounded 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Dismissal **Final:** Disciplinary Phase Pending
Incident Summary	On March 14, 2018, a psychiatric technician allegedly struck a resident on the face, causing visible injury. The psychiatric technician allegedly completed inaccurate notes about the resident's injury, and was also allegedly

	dishonest during the investigation. A second psychiatric technician allegedly failed to accurately report the resident's injury, and allegedly failed to ensure the resident had been medically assessed. The second psychiatric technician was also allegedly dishonest during the investigation. A third psychiatric technician allegedly failed to notice the injury.
Disposition	The hiring authority sustained allegations against two of the psychiatric technicians and determined dismissal was the appropriate penalty. The OLES concurred. No allegations were sustained against the third psychiatric technician. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. An investigator was assigned to conduct the administrative investigation on July 3, 2019; however, the investigative report was not completed until December 16, 2019, 167 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. An investigator was assigned to conduct the administrative investigation on July 3, 2019; however, the investigative report was not completed until December 16, 2019, 167 days later.
Department Corrective Action Plan	The Investigator has now been trained in report deadlines and timeliness. New investigative procedures were put into effect at the end of January 2020, including weekly and monthly SIU meetings to review cases and procedures, as well as plan for successful case completion. SIU to stay current on trainings and new procedures.

Case Detail	Description
Incident Date	06/07/2019
OLES Case Number	2019-00551-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Dishonesty 2. Other

	3. Other failure of good behavior 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Dismissal **Final:** Disciplinary Phase Pending
Incident Summary	On June 7, 2019, a psychiatric technician allegedly kicked a chair on which a resident was sitting, then kicked the resident. A food service worker allegedly failed to report he witnessed the alleged abuse. On April 10, 2020, the psychiatric technician was allegedly dishonest during his investigative interview.
Disposition	The hiring authority sustained the allegations that the psychiatric technician had an inappropriate interaction with the resident and that he was dishonest during his investigative interview, and determined dismissal was the appropriate penalty. The hiring authority found insufficient evidence that the psychiatric technician physically abused the resident. The hiring authority sustained the allegation that the food service worked failed to report that he witnessed the psychiatric technician's inappropriate contact with the resident, and determined a letter of reprimand was the appropriate penalty. The OLES concurred with the findings.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/22/2019
OLES Case Number	2019-01174-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Abuse
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment
Findings	1. Not Sustained 2. Sustained

Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On October 22, 2019, a psychiatric technician allegedly admitted to previously wrestling with a resident, forcing the resident to take cold showers, and spraying the resident with an ice filled water gun.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation of abuse; however, the hiring authority sustained an allegation that the psychiatric technician had engaged in unprofessional conduct, which warranted a letter of instruction. However, the psychiatric technician no longer worked at the hospital; therefore, the letter of instruction was not served on the employee. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	12/10/2019
OLES Case Number	2019-01357-1A
Case Type	Monitored
Incident Types	1. Neglect 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Disciplinary Phase Pending
Incident Summary	On December 10, 2019, three psychiatric technicians allegedly failed to follow policy before, during, and after a facility-wide lockdown. The first psychiatric technician allegedly failed to obtain the observation forms for the residents he was supervising, failed to properly process the observation forms when he left the area, and was dishonest during his investigative

	interview. The second psychiatric technician allegedly left two residents outside unattended. A third psychiatric technician allegedly failed to supervise a resident after the lockdown was lifted.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against all three psychiatric technicians. The OLES concurred with the hiring authority's determination. The hiring authority served the first psychiatric technician with a letter of reprimand. The second and third psychiatric technicians were issued letters of instruction. The OLES concurred with the hiring authority's penalty assessments.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	11/07/2019
OLES Case Number	2019-01260-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 7, 2019, a psychiatric technician allegedly struck a resident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/29/2019
OLES Case Number	2019-01325-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Drunkenness on duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 29, 2019, an officer allegedly was under the influence of alcohol while on duty.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/25/2020
OLES Case Number	2020-00204-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	On January 25, 2020, an officer allegedly offered a second officer a bribe in exchange for false testimony at an upcoming State Personnel Board hearing. The officer also allegedly accessed a third officer's email account without authorization.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. However, the hiring authority determined the third officer allowed the first officer to look at her emails and provided counseling and training to both officers on the department's email usage policy. The OLES concurred with the hiring

	authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Appendix C: Discipline Phase Case

When an administrative investigation, either by the department or by OLES, is completed, an investigation report with facts about the allegations is sent to the hiring authority. The discipline phase commences as the hiring authority decides whether to sustain any allegations against the employee. This decision is based upon the evidence presented. If there is a preponderance of evidence showing the allegations are factual, the hiring authority can sustain the allegations. If one or more allegations are sustained, the hiring authority must impose appropriate discipline.

The OLES assesses every discipline phase case for both procedural and substantive sufficiency:

- Procedural sufficiency includes, among other things, whether OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion. Both departments have implemented policies that incorporate OLES' recommendation to serve a disciplinary action within 60 days after a decision is made to impose discipline.

- Substantive sufficiency includes the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

Procedurally and Substantively Sufficient Case

Case Detail	Description
Incident Date	12/06/2018
OLES Case Number	2018-01320-1A
Case Type	Monitored
Incident Types	1. Abuse
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. Dishonesty 8. Dishonesty
Findings	1. Sustained

	2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Not Sustained 7. Sustained 8. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	On December 6, 2018, a psychiatric technician allegedly struck and pushed a resident, causing the resident to fall. A second psychiatric technician and a psychiatric technician assistant allegedly failed to report the incident and provide medical assistance to the resident. A food service worker also allegedly witnessed the incident and failed to report the misconduct. On March 14, 2019, and March 18, 2019, respectively, the psychiatric technician assistant and the psychiatric technician were allegedly dishonest during their investigative interviews.
Disposition	The hiring authority found sufficient evidence to sustain the allegations against both psychiatric technicians and the psychiatric technician assistant. The first psychiatric technician retired before the investigation was completed. Therefore, no disciplinary action could be taken, and a letter indicating he retired under adverse circumstances was placed in his official personnel file. The hiring authority determined dismissal was the appropriate penalty for the second psychiatric technician and the psychiatric technician assistant. The hiring authority found insufficient evidence to sustain the allegation against the food service worker, but did impose corrective action regarding the importance of reporting incidents of abuse or neglect of residents. The OLES concurred with the hiring authority's determinations. The psychiatric technician assistant retired before the effective date of his disciplinary action. A letter indicating the psychiatric technician retired pending disciplinary action was placed in his official personnel file. The second psychiatric technician filed an appeal with the State Personnel Board. Prior to the pre-hearing settlement conference, the psychiatric technician resigned in lieu of termination. The OLES

	concurred with the settlement agreement.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix D: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

(a) The Office of Law Enforcement Support shall be responsible for contemporaneous oversight of investigations that (1) are conducted by

the State Department of State Hospitals and involve an incident that meets the criteria of Section 4023, and (2) are conducted by the State Department of Developmental Services and involve an incident that meets the criteria of Section 4427.5.

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

California Welfare and Institutions Code 4427.5

4427.5.

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

(A) A death.

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

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

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

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

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

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

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

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

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

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

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

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

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

California Welfare and Institutions Code 4023

4023

(a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of Section 4900 the following incidents involving a resident of a state mental hospital:

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

(2) Any allegation of sexual assault, as defined in Section 15610.63, in which the alleged perpetrator is an employee or contractor of a state mental hospital or of the Department of Corrections and Rehabilitation.

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

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

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

(a) Assault, as defined in Section 240 of the Penal Code.

(b) Battery, as defined in Section 242 of the Penal Code.

(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.

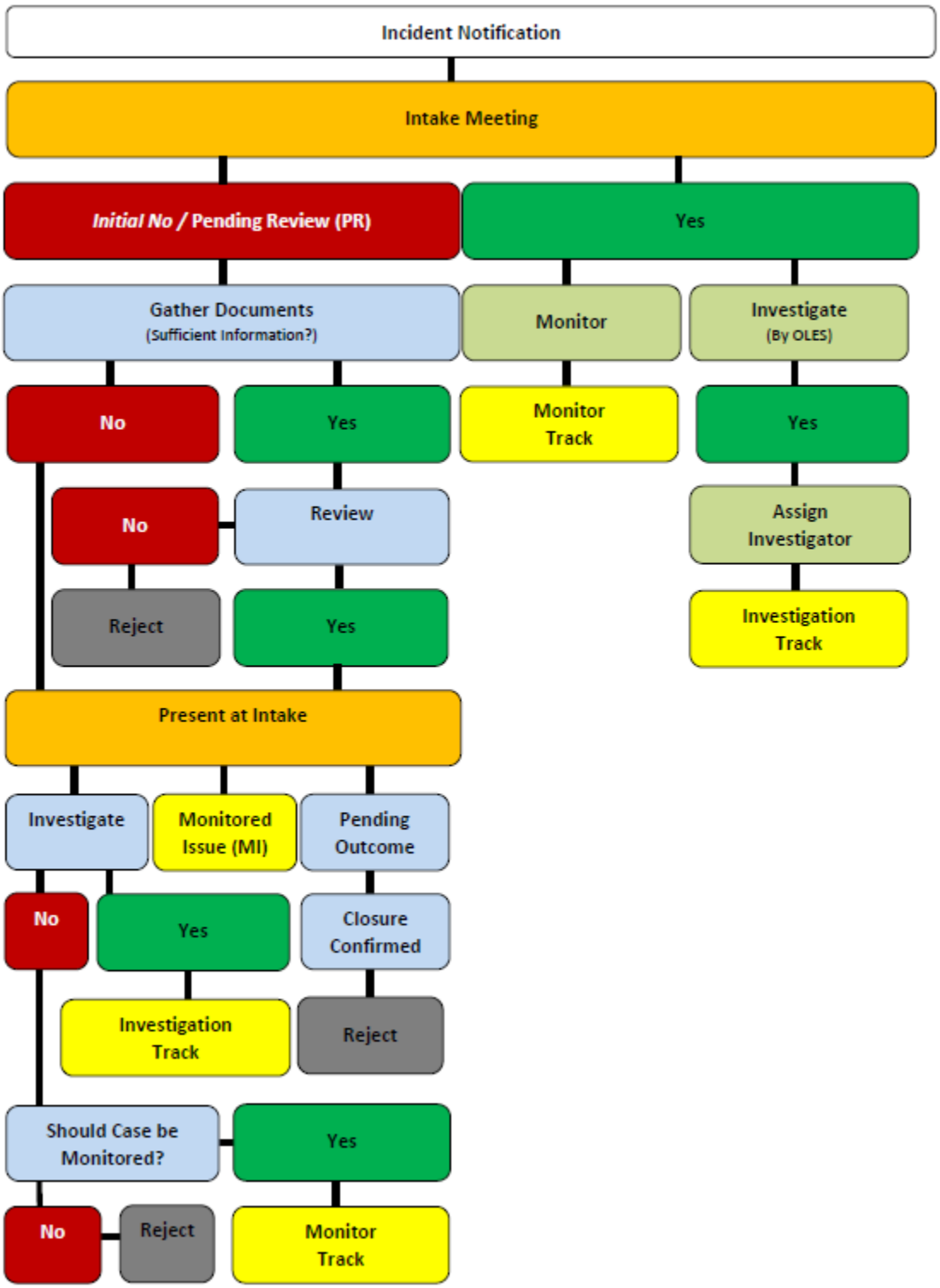
(d) Unreasonable physical constraint, or prolonged or continual deprivation of

food or water.

(e) Sexual assault, that means any of the following:
(1) Sexual battery, as defined in Section 243.4 of the Penal Code.
(2) Rape, as defined in Section 261 of the Penal Code.
(3) Rape in concert, as described in Section 264.1 of the Penal Code.
(4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code.
(6) Sodomy, as defined in Section 286 of the Penal Code.
(7) Oral copulation, as defined in Section 288a of the Penal Code.
(8) Sexual penetration, as defined in Section 289 of the Penal Code.
(9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.

(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
(1) For punishment.
(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
(3) For any purpose not authorized by the physician and surgeon.

Appendix E: OLES Intake Flow Chart



Outline Description

1. OLES receives a notification of an incident and discusses the incident during an intake meeting
2. The disposition of the incident case may be assigned to any of the following:
    a. Initial No/Pending Review
    b. OLES Monitored Case
    c. OLES Investigation Case
3. If the disposition is "Initial No/Pending Review", the case is reviewed for sufficient information and is represented at an intake meeting. From there, the case may be investigated, become a monitored issue, be monitored, be investigated or be rejected.

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
    a. Primary subject(s) recorded
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

[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.

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 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

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

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.

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.