Office of Law Enforcement Support

Semiannual Report

July 1, 2020–December 31, 2020

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

Promoting a safe, secure and therapeutic environment

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

Contents

Introduction

I am pleased to present the tenth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency. This report details OLES's oversight and monitoring of the Department of Developmental Services (DDS) from July 1 through December 31, 2020.

In this report, the OLES provides details on 120 reported incidents and the results of completed investigations and monitored cases. In response to procedural and substantive insufficiencies OLES identified while monitoring cases, the DDS implemented a tracking log for investigations and instructed supervisory staff to more actively work with investigators to address barriers to investigations. The DDS also developed additional training for officers to improve investigative and report writing skills. For disciplinary actions, the department committed to increased consultation with OLES prior to serving actions and ensuring timeliness of Notice of Adverse Action (NOAA) service.

In the previous semiannual report, the OLES highlighted key preventative measures DDS took in response to COVID-19. In the prior reporting period of January 1, 2020, through June 30, 2020, DDS reported one resident tested positive for COVID-19. As of December 2020, DDS reported 26 individuals from Canyon Springs Community Facility and 33 individuals form Porterville Developmental Center who tested positive for COVID-19. The DDS continues to screen individuals, ensure personal protective equipment is worn, quarantine COVID-19 positive individuals and provide education on COVID-19. The DDS plans to offer vaccinations for all individuals and staff who provide consent.

During this pandemic, the care and services provided to residents by DDS staff, law enforcement and management continues to be a priority. As OLES enters its sixth year of oversight and monitoring, we remain committed to continuous quality improvement and instilling accountability at DDS.

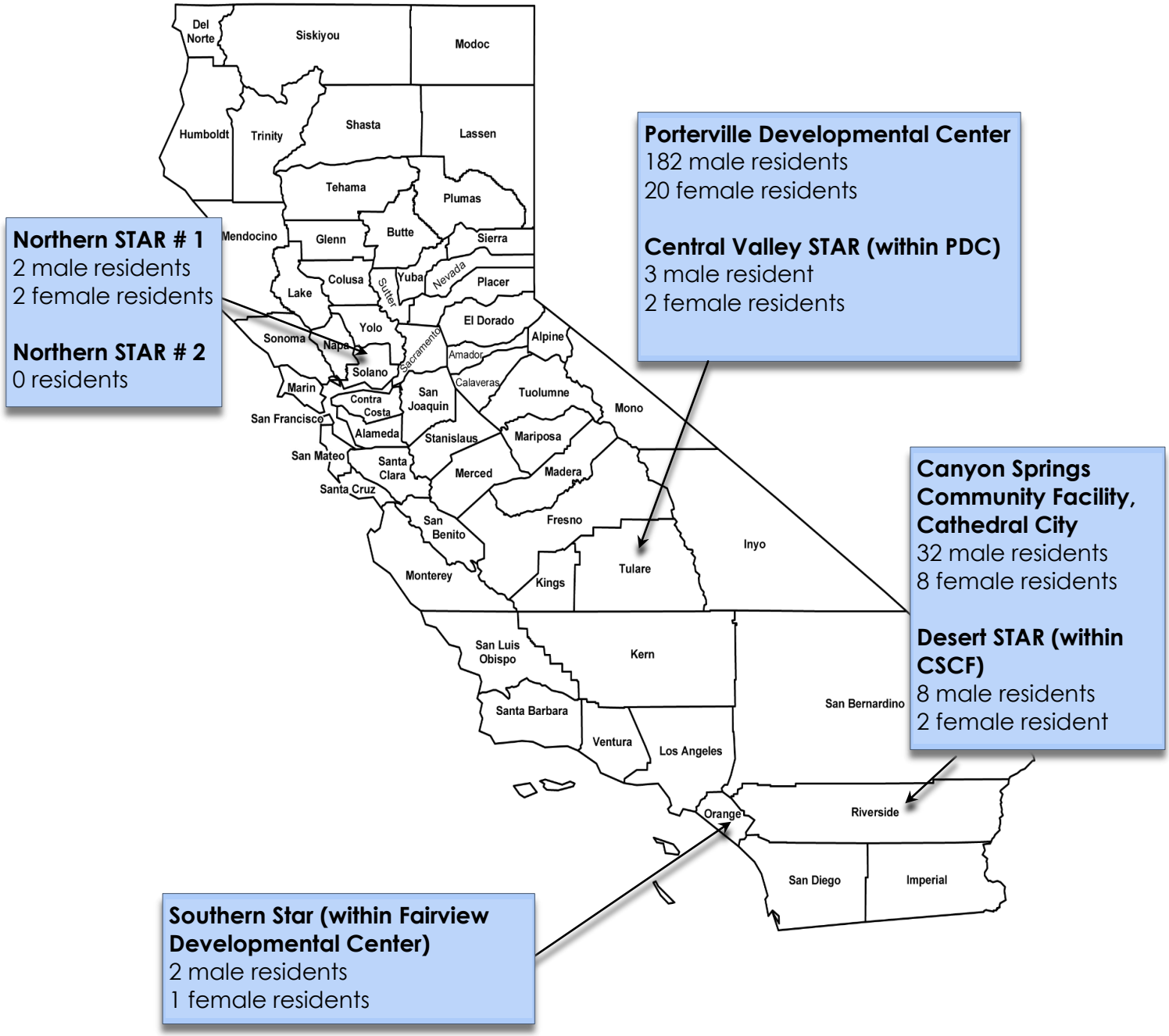
We are grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DDS management and personnel.

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

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the DDS facilities below. Population numbers as of December 31, 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
2 male residents
2 female residents

Northern STAR # 2
0 residents

Porterville Developmental Center
182 male residents
20 female residents

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

Canyon Springs Community Facility, Cathedral City
32 male residents
8 female residents

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

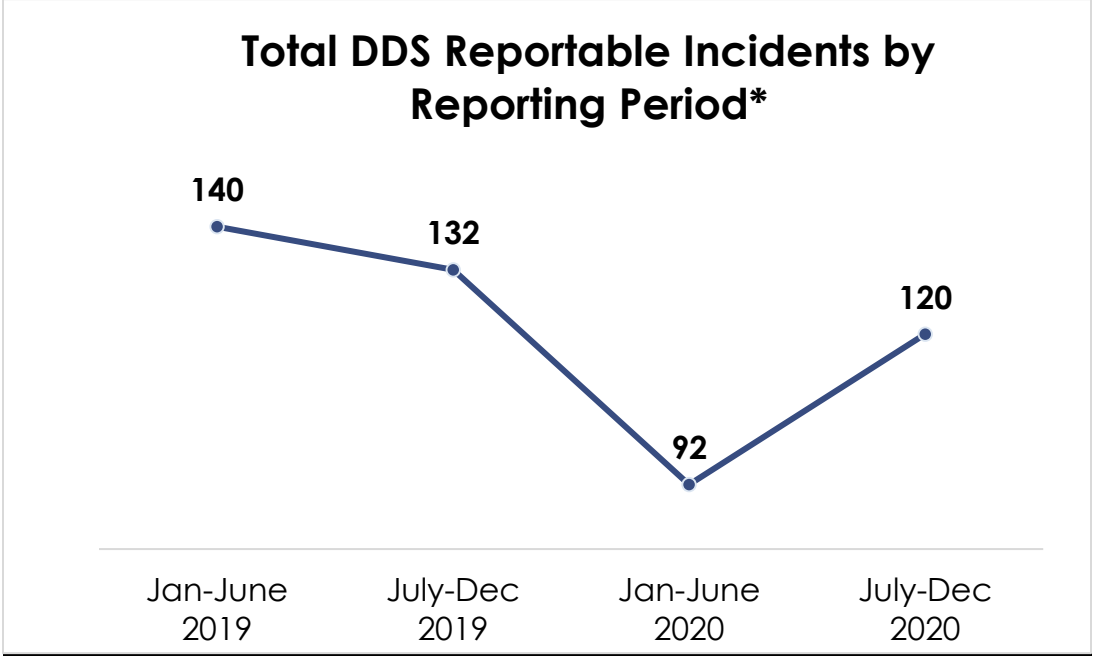
Southern Star (within Fairview Developmental Center)
2 male residents
1 female residents

DDS Facility Population Chart

Facility	Number of Male Residents	Number of Female Residents	Total
Canyon Springs	32	8	40
Porterville	182	20	202
Central Valley STAR	3	2	5
Desert STAR	8	2	10
Northern STAR #1	2	2	4
Northern STAR #2	0	0	0
Southern STAR	2	1	3
Total	232	32	264

Executive Summary

During the reporting period of July 1, 2020, through December 31, 2020, the Office of Law Enforcement Support (OLES) received and processed 120 reportable incidents[1] at the Department of Developmental Services (DDS). Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents, resident deaths and other occurrences, per Welfare and Institutions Code, sections 4023, 4023.6 and 4427.5. This is an increase of 28 incident reports compared to the prior reporting period which had 92 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.

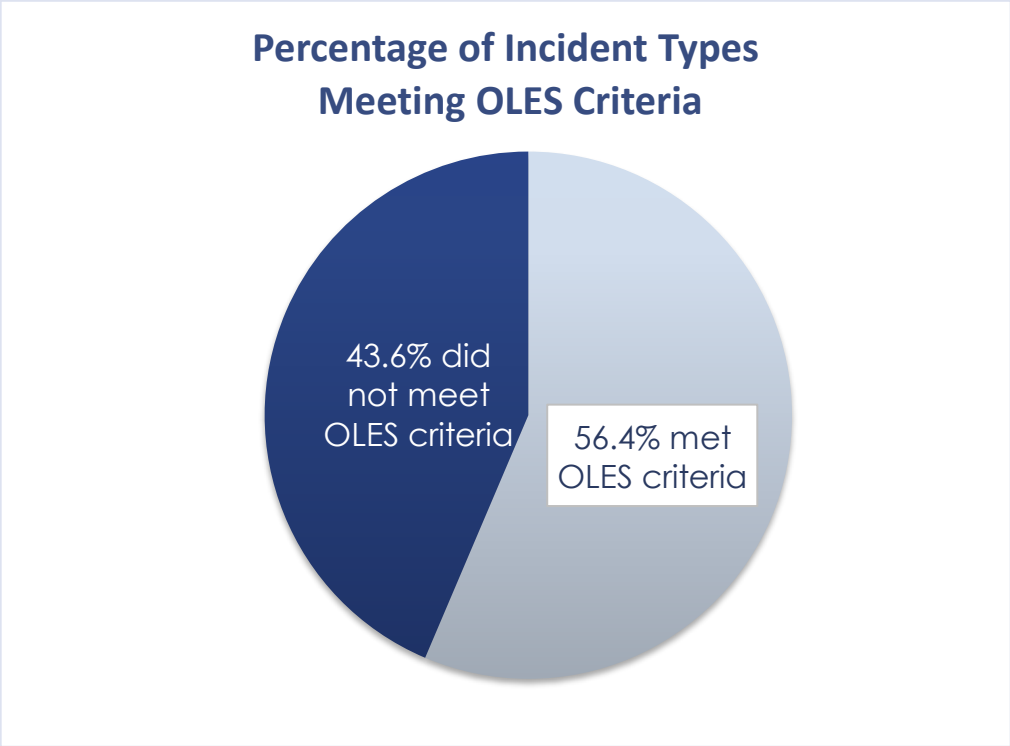
Incident Types Meeting OLES Criteria

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. An incident type "meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for

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

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

investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 120 reported incidents, the OLES identified 11 incidents with two or more incident types. The DDS reported a total of 133 incident types during this reporting period. Seventy-five, or 56.4 percent of the 133 incident types reported by DDS met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported were abuse, sexual assault, neglect, burn 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 51 reports of alleged abuse, which accounted for 38.3% of all reported incident types reported by DDS. The DDS reported 18 allegations of sexual assault, making sexual assault the second most frequently reported incident type from DDS. The DDS reported twelve allegations of neglect, which is a 200 percent increase from the number reported in the prior reporting period. Incidents of resident burns also rose 200 percent, from three reported incident types in the prior reporting period to nine reported in this reporting period. Following neglect and burns, incidents of head or neck injuries were the fifth most frequent incident type with eight reported incident types. Reports of the head or neck injury incident type increased 14.3 percent from seven incident types to eight.

Resident Deaths

The DDS reported one resident death in this reporting period. The death was expected due to the resident's existing medical conditions.

Resident Arrests

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

Results of Completed OLES Investigations on DDS Law Enforcement

Per statute[3], an OLES investigation is initiated after OLES is notified of an allegation that a DDS law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents. As of December 31, 2020, DDS had 77 sworn staff members.

Appendix A of this report provides information on the four OLES investigations that were completed during this reporting period. These investigations involved allegations against four sworn staff members. All four investigations involved an incident that allegedly occurred in 2020. The OLES submitted three completed administrative investigations to the chief of the DDS Office of Protective Services for disposition and monitored the disposition process.

Results of Completed OLES Monitored Cases

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

In Appendix B and D of this report, OLES provides information on nine monitored pre-disciplinary administrative cases and 15 monitored criminal cases that, by December 31, 2020, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. Three pre-disciplinary administrative cases had sustained allegations and no criminal investigations were referred to a prosecuting agency.

Of the 24 pre-disciplinary phase cases provided in Appendix B and D, 10 cases were rated as procedurally insufficient only. One case was rated both procedurally and substantively insufficient. The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in eight administrative cases, which are provided in Appendix C and D. The OLES rated three disciplinary phase administrative cases procedurally insufficient.

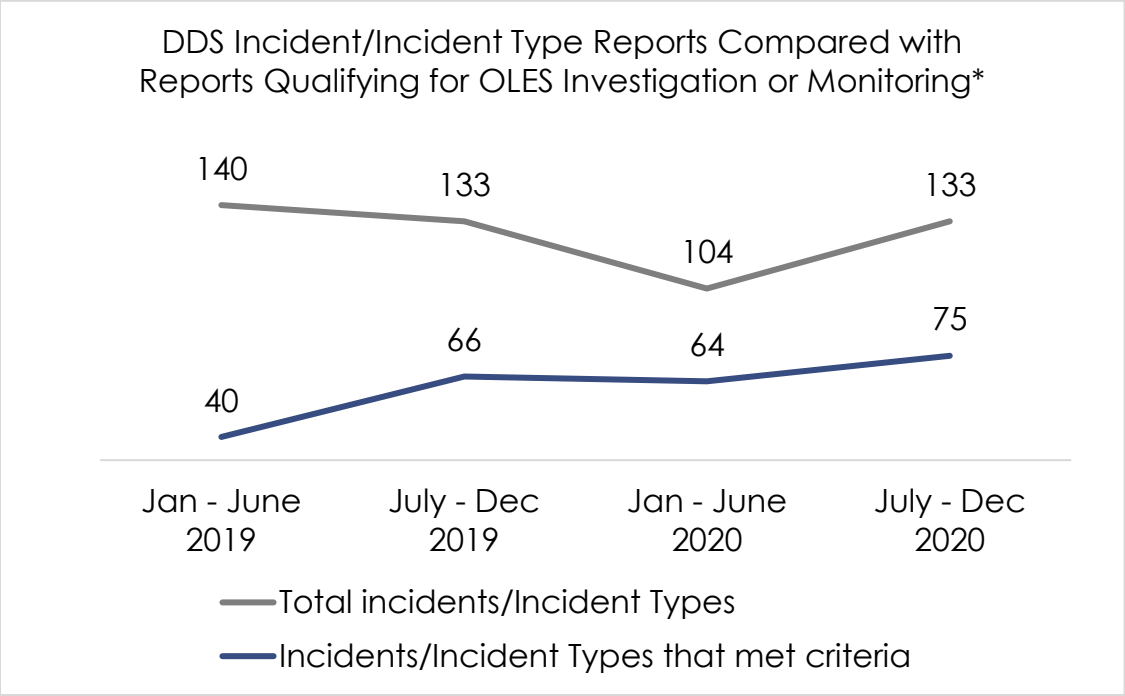
[3] Welfare and Institutions Code Section 4023, 4023.6, 4427.5. (See Appendix E).

Incidents and Incident Types

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

Increase in Reported Incidents and Incident Types

The number of DDS incidents reported to OLES from July 1 through December 31, 2020, increased 30.4 percent, from 92 during the prior reporting period to 120 in this reporting period. From the 120 reported incidents, the OLES identified 133 incident types, as 11 of the incidents featured two or more incident types. Seventy-five of the 133 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 increased 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 133 reported incident types from DDS, 98 incident types or 73.7 percent of all reported incident types fell into the following five categories: abuse, sexual assault, neglect, burn and head or neck injury. These five incident type categories accounted for 66 incident types or 88 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 51 abuse allegations accounted for 38.3 percent of all DDS incident types reported. Forty-four 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 18 reports. Ten alleged sexual assault incident types met criteria for investigation or monitoring. The total number of neglect incident types rose from four incident types to 12, representing a 200 percent increase. Reports of the burn incident type also rose by 200 percent, from three reported incident types to nine. Seven out of the nine burn incident types involved the use of a cigarette. Head or neck injuries were the fifth most frequently reported incident type with eight incident types; none of the head or neck incident types met OLES criteria.

Most Frequent Incident Types July 1 through December 31, 2020

Incident Type Categories	Prior Period Incidents Types January 1 2020, through June 30, 2020	Current Period Incident Types July 1 through December 31, 2020	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	56	51	-8.9%	44
Sexual Assault	12	18	+50%	10
Neglect	4	12	+200%	11
Burn	3	9	+200%	1
Head/Neck	7	8	+14.3%	0

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 July 1- Dec 31, 2019 (Reported)*	Prior Period July 1- Dec 31, 2019 (Meets Criteria)*	Prior Period January 1- June 30, 2020 (Reported)*	Prior Period January 1 - June 30, 2020 (Meets Criteria)*	Current Period July 1- December 31, 2020 (Reported)	Current Period July 1 – December 31, 2020 (Meets Criteria)
Abuse	81	51	56	43	51	44
Broken Bone	9	1	-	-	-	-
Broken Bone (Known Origin)	-	-	4	2	4	1
Broken Bone (Unknown Origin)	-	-	1	1	4	3
Burn	1	0	3	0	9	1

Incident/Incident Type Categories	Prior Period July 1- Dec 31, 2019 (Reported)*	Prior Period July 1- Dec 31, 2019 (Meets Criteria)*	Prior Period January 1- June 30, 2020 (Reported)*	Prior Period January 1 - June 30, 2020 (Meets Criteria)*	Current Period July 1- December 31, 2020 (Reported)	Current Period July 1 – December 31, 2020 (Meets Criteria)
Death	2	0	0	0	1	0
Genital Injury	1	1	-	-	-	-
Genital Injury (Known Origin)	-	-	0	0	0	0
Genital Injury (Unknown Origin)	-	-	1	1	2	1
Head/Neck Injury	10	0	7	1	8	0
Misconduct**	3	2	10	9	2	2
Neglect	5	5	4	4	12	11
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
Pregnancy	0	0	0	0	0	0
Resident on Resident Assault/GBI	1	0	1	0	3	0
Sexual Assault	14	6	12	3	18	10
Sexual Assault-OJ***	0	0	1	0	3	0
Significant Interest-Attack on Staff******	3	0	0	0	4	0
Significant Interest-Attempted Suicide	0	0	0	0	0	0
Significant Interest-AWOL	3	0	1	0	6	0
Significant Interest-Child Pornography	0	0	0	0	0	0
Significant Interest-Other*******	0	0	2	0	4	0
Significant Interest-Overfamiliarity	-	-	0	0	2	2

Incident/Incident Type Categories	Prior Period July 1- Dec 31, 2019 (Reported)*	Prior Period July 1- Dec 31, 2019 (Meets Criteria)*	Prior Period January 1- June 30, 2020 (Reported)*	Prior Period January 1 - June 30, 2020 (Meets Criteria)*	Current Period July 1- December 31, 2020 (Reported)	Current Period July 1 – December 31, 2020 (Meets Criteria)
Significant Interest- Resident Arrest	0	0	1	0	0	0
Significant Interest-Riot	0	0	0	0	0	0
Totals	133	66	104	64	133	75

*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 tram or vehicle accident or residents being evacuated due to a wildland fire.

Incident Types Reported from Developmental Centers or Canyon Springs Community Facility

One hundred and seventeen of the 133 reported incident types came from a developmental center or the Canyon Springs Community Facility (CSCF). The incident type reported by Fairview Developmental Center (FDC) involved a former resident. The two incident types reported by the Sonoma Developmental Center (SDC) did not involve residents. As shown in the *Incident Types by Reporting Period* table, the developmental centers and CSCF did not report any incident types from the following incident type categories: genital injury (known), non-resident on resident assault/GBI, pregnancy, significant interest-attempted suicide, significant interest-child pornography 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	0	28	0	47
Broken Bone (Known Origin)	2	0	2	0	4
Broken Bone (Unknown Origin)	0	0	3	0	3
Burn	4	0	5	0	9

Incident Type Category	Canyon Springs	Fairview	Porterville	Sonoma	Total
Death	0	0	1	0	1
Genital Injury (Unknown Origin)	0	0	2	0	2
Head/Neck Injury	4	0	4	0	8
Misconduct*	0	0	1	1	2
Neglect	1	0	8	0	9
Resident on Resident Assault/GBI	1	0	2	0	3
Sexual Assault	7	1	10	0	18
Sexual Assault-OJ**	1	0	2	0	3
Significant Interest-Attack on Staff***	3	0	0	0	3
Significant Interest-AWOL	0	0	1	0	1
Significant Interest-Other******	0	0	1	1	2
Significant Interest- Over-Familiarity	0	0	2	0	2
Total	42	1	72	2	117

*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 tram or vehicle accident or residents being evacuated due to a wildland fire.

Incident Types Reported from STAR homes

Sixteen of the 133 incident types reported by DDS came from Stabilization, Training, Assistance and Reintegration (STAR) homes. The state-operated STAR homes provide person-centered support and crisis stabilization to residents, so that they can successfully transition to a more appropriate, less restrictive community living setting. Incident types reported from STAR homes are listed in the table below.

Incident Type Category	Central Valley STAR	Desert STAR	Northern STAR #1	Northern STAR #2	Southern STAR	Total
Abuse	0	1	2	0	1	4
Broken Bone (Unknown Origin)	0	0	1	0	0	1
Neglect	2	0	1	0	0	3
Significant	1	0	0	0	0	1

Incident Type Category	Central Valley STAR	Desert STAR	Northern STAR #1	Northern STAR #2	Southern STAR	Total
Interest-Attack on Staff						
Significant Interest-AWOL	3	0	2	0	0	5
Significant Interest-Other	0	0	1	1	0	2
Total	6	1	7	1	1	16

Distribution of DDS Incident Types

As of December 31, 2020, the DDS population remained at 264 residents. With 264 residents department-wide, this equates to 0.50 incident types per resident. As shown in the table below, among the developmental centers and CSCF, CSCF had the highest ratio of reported incident types to total resident population.

DDS Developmental Center Population and Total Incident Types

Facility	Number of Residents*	Total Incident Types	Ratio of Incident Types to Population
Canyon Springs	40	42	1.05
Fairview	0	1	-
Porterville	202	72	0.356
Sonoma	0	2	-
Totals	242	117	0.483

* The department provided population numbers as of December 31, 2020.

Reports from STAR homes increased as new residents were admitted. The average length of stay for a resident in a STAR home during the reporting period was 12 months. In the previous report, DDS reported 20 residents resided in STAR homes on June 30, 2020. During the reporting period, 12 new residents were admitted to the STAR homes. On December 31, 2020, there were 22 residents in STAR homes.

The following table lists the ratio of incident types to the cumulative total of residents who resided in a STAR home during the reporting period. Central Valley STAR and Northern Star #1 had the highest ratios of incident types to total population. Desert STAR had the lowest ratio at 0.077 incident types per resident.

DDS STAR Home Population and Total Incident Types

Facility	Number of Residents on June 30, 2020*	Number of Residents Admitted from July 1 through December 2020**	Total Resident Count	Total Incident Types	Ratio of Incident Types to Total Population Count
Central Valley STAR	3	2	5	6	1.200
Desert STAR	6	7	13	1	0.077
Northern STAR #1	4	2	6	7	1.167
Northern STAR #2	2	0	2	1	0.500
Southern STAR	5	1	6	1	0.167
Total	20	12	32	16	0.500

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

**The department provided population numbers as of December 31, 2020.

Sexual Assault Allegations

Following the abuse incident type, sexual assault was the second most frequently reported incident type from July 1 through December 31, 2020. The 18 alleged sexual assault incident types in this reporting period accounted for 13.5% of all reported incident types from DDS. Ten of the sexual assault incident types met OLES criteria for investigation, monitoring or research into systemic department issues. There were three reported incident types 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 18 sexual assault incident types, seven were reported by CSCF, 10 by Porterville Developmental Center (PDC) and one by FDC. Five allegations of sexual assault involved a resident assaulting another resident. Ten allegations involved non-law enforcement staff on a resident. The remaining three allegations involved an unknown person on a resident. All DDS reports of alleged sexual assaults received by OLES during the reporting period are shown in the following table.

DDS - Sexual Assault Incidents Reported July 1 through December 31, 2020

Facility	Resident on Resident	Non-Law Enforcement Staff on Resident	Unknown Person on Resident	OJ *	Total
Canyon Springs	2	4	1	1	8
Fairview	1	0	0	0	1
Porterville	2	6	2	2	12
Totals	5	10	3	3	21

*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, DDS reported six significant interest-absent without leave (AWOL) incident types. The PDC reported one incident type under the significant interest- AWOL category; Central Valley STAR reported three incident types and Northern STAR #1 reported two.

At PDC, a resident crawled under a fence at the West side of the courtyard and was later found hiding behind Unit 15. The resident did not leave the secure treatment area and did not require treatment beyond first aid.

At Central Valley STAR, a juvenile resident jumped over a courtyard fence and ran approximately 100 yards before officers captured the resident and returned him to his unit. The resident sustained superficial abrasions which were treated with first aid. A week later, the same resident ran from staff and superficially cut himself with a piece of broken glass before officers captured him and returned him to his unit. A week after the incident described above, the same resident jumped over the unit courtyard fence and ran northbound towards the Administration Building. Officers captured the resident near the front entrance of the facility and escorted him back to his unit. The resident did not sustain any injuries from the incident.

At Northern STAR #1, a resident ran away from the home without being detected by on-duty nocturnal staff. The facility administrator discovered the resident attempting to get into a van. The resident was returned to the facility and did not sustain any injuries. Another resident attempted to run away from staff while walking outside the facility. Staff escorted the resident back to the facility. The resident did not sustain any injuries from the incident.

Notification of Incident Types

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

Priority One Notifications – Two Hour Notification

Incident	Description
ADW	An assault with a deadly weapon (ADW) against a resident by a non-resident.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a resident.
Broken Bone (U)	A broken bone of a resident when the cause of the break is undetermined.
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 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.

Incident	Description
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, the OLES evaluated the timeliness of incident types rather than incidents. In the prior reporting period, DDS timely reporting of incidents was 96.7 percent. During this reporting period, DDS timely reporting of incident types to OLES was 90.9 percent. The OLES excluded one significant interest-attack on staff incident type from Central Valley STAR from the total count when calculating timeliness. Of the 132 incident types evaluated for timeliness, 120 were reported timely and 12 incident types were not.

All incidents reported from FDC, SDC and STAR homes were timely. Two of the 12 untimely incidents were 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	Central Valley STAR	5	5	100%
1	Desert STAR	1	1	100%
1	Fairview	1	1	100%
1	Northern STAR #1	7	7	100%
1	Northern STAR #2	1	1	100%
1	Sonoma	2	2	100%
1	Southern STAR	1	1	100%
2	Canyon Springs	42	38	90.5%
3	Porterville	72	64	88.9%
	Total	132	120	90.9&

Intake

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

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

For the July 1 through December 31, 2020, reporting period, 49 of the total 123 cases opened for DDS incidents that occurred within DDS' jurisdiction or 39.8 percent were assigned a pending review. The OLES opened two administrative investigations. The OLES opened 60 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. 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 E).

Cases Opened in July 1 through December 31, 2020

OLES Case Assignments	July 1 – December 31, 2020	Percentage of Opened Cases
Pending Review	49	39.8%
Monitored, Criminal	60	48.8%
Monitored, Administrative	9	7.3%
OLES Investigations, Administrative	2	1.6%
OLES Investigations, Criminal	0	-
Outside Jurisdiction*	3	2.4%
Totals	123	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 E). 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 four administrative investigations involving DDS law enforcement. All completed OLES investigations into administrative wrongdoing or misconduct are forwarded to facility management for review. In this reporting period, three administrative cases were referred to management for possible discipline of state employees. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted.

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

Results of Completed OLES Investigations

Type of Investigation	Total completed July 1- December 31, 2020	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	4	N/A	3	1
Criminal	0	0	N/A	0
Total	4	0	3	1

The OLES provided the department with a summary of the review and decision of the administrative investigation in which the OLES determined there was insufficient evidence that the allegation(s) were true.

OLES Monitored Cases

In this report, OLES provides information on 30 completed monitored cases. By the end of the reporting period, none of the 15 monitored criminal cases were referred to a prosecuting agency. There were nine completed, monitored pre-disciplinary administrative cases. Nine of the fifteen monitored administrative cases had allegations that were sustained or not sustained during this reporting period. Six of the fifteen 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	0
Criminal/Not Referred	15
Total Criminal	15
Administrative/With Sustained Allegations	3
Administrative- With Sustained Allegations Reported in the Prior Reporting Period	6
Administrative/Without Sustained Allegations	6
Total Administrative	15
Grand Total	30

The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in eight administrative case, which is provided in Appendix C and D. Of the eight disciplinary cases, three were rated as procedurally insufficient.

Pre-Disciplinary Phase Cases

Of the 24 DDS pre-disciplinary phase cases in Appendix B and D, the OLES rated 10 cases procedurally insufficient and one case both procedurally insufficient and substantively insufficient. The primary procedural deficiency was the department's inadequate initial response to incidents. Specifically, the failure of the responding officer to conduct thorough and detailed interviews. 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	8	1
Administrative/With Sustained Allegations	0	0
Administrative/Without Sustained Allegations	3	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 notify OLES of resident and subject interviews	This prevents OLES from providing real-time monitoring of the investigation.
Failure to notify OLES of incident within required timeframe	This prevents OLES from properly processing and classifying or assigning the case. Many reporting requirements are required by statute.
Failure to identify and interview witnesses	This increases the likelihood of missing or erroneous information.
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.
Failure to conduct thorough and detailed interviews	This may necessitate a second interview and prevent officers from fully investigating the full scope of the allegation(s).

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

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	3	2	1	0
Porterville	6	5	1	0
Sonoma	2	1	0	1
Totals	11	8	2	1

* 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	4	0	4	0
Porterville	1	0	1	0
Totals	5	0	5	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	1	1	0	1
Porterville	28	17	9	12
Totals	29	18	9	13

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

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

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

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

Reports of Employee Misconduct to Licensing Boards

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

DDS Facilities	Public Health
Canyon Springs	1
Fairview	1
Porterville	14
Totals	16

Appendix A: Completed OLES Investigations

The following tables provide information on four investigations completed by OLES in the reporting period of July 1 through December 31, 2020.

Case Detail	Description
Incident Date	03/17/2020
OLES Case Number	2020-00402-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On March 17, 2020, an officer allegedly omitted or gave false information while testifying at a State Personnel Board hearing.
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	05/21/2020
OLES Case Number	2020-00538-1A
Case Type	Investigative
Incident Type	1. Misconduct 2. Misconduct
Incident Summary	On May 21, 2020, an anonymous letter was forwarded to the OLES alleging that a senior member of the Office of Protective Services had threatened and mistreated a subordinate.
Disposition	The Office of Law Enforcement Support conducted an investigation 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	06/14/2020
OLES Case Number	2020-00613-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On June 14, 2020, an officer allegedly violated the department's no pursuit policy and failed to arrest or cite a driver, which he had stopped, for unsafe driving violations.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	06/16/2020
OLES Case Number	2020-00627-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On June 16, 2020, an officer was arrested by an outside law enforcement agency for the possession and transportation of narcotics.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on seven monitored administrative cases and 15 monitored criminal cases that, by December 31, 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 investigation for both procedural and substantive sufficiency.

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

Criminal-Not Referred

Case Detail	Description
Incident Date	06/06/2020
OLES Case Number	2020-00590-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 6, 2020, three psychiatric technicians allegedly held a resident on her bed, causing significant bruising to her arms. The psychiatric technicians also allegedly held a pillow against the resident's face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/15/2020
OLES Case Number	2020-00621-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 15, 2020, a psychiatric technician allegedly struck a

	resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open and administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/18/2020
OLES Case Number	2020-00631-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 18, 2020, two psychiatric technicians allegedly pushed and struck a resident while she was showering.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/18/2020
OLES Case Number	2020-00633-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 18, 2020, a senior psychiatric technician allegedly placed a pillow over a resident's head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative	**Procedural Rating:** Insufficient

Assessment	**Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The department failed to notify OLES of the allegation, failed to consult during the investigation, and closed the case without OLES input or review. The initial responding officer failed to conduct a thorough investigation and only conducted a cursory interview of the victim, and failed to obtain evidence or interview the senior psychiatric technician. The subsequent investigator failed to provide the legally required admonition prior to obtaining a statement from the senior psychiatric technician and included opinion and conjecture in his final report. The Office of Protective Services failed to notify OLES that the investigative report was complete or that the case had been closed.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority failed to report the incident to OLES. 2. Was the hiring authority's response to the incident appropriate? No. The responding officer failed to conduct a thorough interview of the victim resident and failed to interview the suspect senior psychiatric technician. The officer likewise failed to identify potential witnesses and conduct interviews. The initial responding officer did not adequately prepare for the investigation. 3. Was the incident properly documented? No. The responding officer's report was lacking in significant detail. 4. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The Office of Protective Services was notified that OLES was monitoring the investigation on June 29, 2020; however, did not confer with OLES throughout the remainder of the investigation which was ongoing until July 27, 2020. 5. Were all of the interviews thorough and appropriately conducted?

	No. The interview conducted by the initial responding officer was neither thorough nor appropriately conducted. The subsequent investigator failed to provide the subject senior psychiatric technician with the legally required admonition prior to the subject's interview. 6. Was the final investigative report thorough and appropriately drafted? No. The final investigative report contained opinion and conjecture. 7. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The department did not provide any consultation with OLES throughout the investigation.
Department Corrective Action Plan	The Commander instituted a new tracking log for OLES monitored cases. Officers were directed to review the requirements for reporting cases to OLES. Additionally, the investigator has been directed to ensure the OLES Monitor is updated with the progress of the investigation (including interviews) and to provide the Monitor with a draft when completed. The Investigator was also directed to ensure all proper admonitions are given. The new OLES log will ensure the OLES monitor is notified when the case is considered closed and the investigator shall consult with the monitor prior to doing so. The Commander, Sergeant, and Investigator developed additional training for the Canyon Springs officers to assist in improving their investigative and report writing skills. Topics include, interview and interrogation, report writing, evidence collection, and laws related to their duties with OPS. The Riverside District Attorney's Office has partnered with OPS to provide instruction on report writing and Penal Code Section 368. The training has been postponed until further notice due to COVID restrictions at the facility.

Case Detail	Description
Incident Date	06/28/2020
OLES Case Number	2020-00687-1C
Case Type	Monitored
Incident Types	1. Sexual Assault

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 28, 2020, two persons allegedly inappropriately touched a resident by rubbing their knuckles down his back and between his buttocks.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/03/2020
OLES Case Number	2020-00713-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 3, 2020, a psychiatric technician allegedly wrapped his legs around a resident's neck and rubbed his genitals on the resident's neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/14/2020
OLES Case Number	2020-00726-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 14, 2020, one senior psychiatric technician, three psychiatric technicians, and one recreational therapist allegedly struck a resident with a cord and with restraint-free

	crisis management pads.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/14/2020
OLES Case Number	2020-00729-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 14, 2020, a supervising cook allegedly slapped a resident's hand.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The draft investigative report did not include a statement from the supervising cook about whether he physically abused the resident.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report did not include a statement from the supervising cook about whether he physically abused the resident.
Department Corrective Action Plan	The report was reviewed by the monitor prior to the OPS review process and was incomplete. However, the supervisor directed the officer to continue with his investigation and to interview the supervising cook and to complete his investigation in a timely manner.

Case Detail	Description
Incident Date	07/19/2020
OLES Case Number	2020-00737-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 19, 2020, a psychiatric technician allegedly pushed, poked, and slapped a resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to provide the psychiatric technician with the legally required admonition before taking her statement.
Pre-Disciplinary Assessment	1. Was the investigation thorough and appropriately conducted? No. The investigator failed to provide the psychiatric technician with the legally required admonition before taking her statement.
Department Corrective Action Plan	The Commander and Sergeant will continue to review cases to ensure they comply with legal and department policy requirements.

Case Detail	Description
Incident Date	08/19/2020
OLES Case Number	2020-00869-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 19, 2020, a senior psychiatric technician allegedly struck a resident on the shoulder and ribs.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

	The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/04/2020
OLES Case Number	2020-00917-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 4, 2020, a psychiatric technician allegedly struck and pushed a resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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 draft investigative report did not include an interview with a percipient witness who overheard the resident admit he had been dishonest when he made the abuse allegation.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report did not include an interview with a percipient witness who overheard the resident admit that he was dishonest in making the allegation.
Department Corrective Action Plan	The officer was directed to interview the witness and complete his investigation.

Case Detail	Description
Incident Date	09/21/2020
OLES Case Number	2020-00972-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 21, 2020, a psychiatric technician allegedly hit a resident in the mouth. When the resident attempted to report the matter to the police, the psychiatric technician allegedly pushed the resident in the back.
Disposition	The case was not referred to the district attorney's office due

	to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative case due to a 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 responding officer failed to interview the resident at the outset of the investigation and therefore, did not obtain an understanding of the full scope of the investigation. As a result, the officer did not initially ask the psychiatric technician all relevant questions pertaining to all allegations, thereby necessitating a second interview of the psychiatric technician.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not interview the victim resident at the outset of the investigation. As a result, he did not have a full understanding of the scope of the allegations when he interviewed the psychiatric technician and therefore failed to ask all relevant questions. As a result, the psychiatric technician had to be interviewed a second time. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The interview of the psychiatric technician was not thorough. The report lacked sufficient detail and failed to provide a clear description of the incident. As a result, a second interview had to be conducted.
Department Corrective Action Plan	As a matter of practice, it is always more effective to interview the victim first when investigating any crime. This was addressed with the officer who was directed to conduct a second interview and obtain all necessary information for the investigation. The Commander, Sergeant, and investigator developed additional training for the Canyon Springs officers. Topics include, interview and interrogation, report writing, evidence collection, and laws related to their duties with OPS. The Riverside District Attorney's office has partnered with OPS to also provide instruction on report writing and analysis of Penal Code Section 368. The training has been postponed until further notice due to COVID restrictions at the facility.

Case Detail	Description
Incident Date	09/20/2020
OLES Case Number	2020-00977-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 20, 2020, a psychiatric technician allegedly pushed a resident, causing the resident to fall and break his wrist.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The responding officer failed to conduct thorough and detailed interviews thereby necessitating a second interview of the resident. The draft report did not adequately reflect the information gathered during the course of the investigation.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer failed to conduct thorough and detailed interviews thereby necessitating a second interview of the resident. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The officer's report lacked sufficient detail and did not include all of the relevant information he obtained during the interviews.
Department Corrective Action Plan	The officer was directed by the Sergeant to conduct further follow-up and to provide a detailed statement from the alleged victim. The officer conducted all necessary interviews and completed the report for review and a draft was then submitted to the OLES monitor for review. The Commander, Sergeant, and Investigator developed additional training for the Canyon Springs officers to assist in improving their investigative skills. Topics include, interview and interrogation, report writing, evidence collection, and

	laws related to their duties with OPS. The Riverside District Attorney's office has partnered with OPS to also provide instruction on report writing and Penal Code Section 368. The training has been postponed until further notice due to COVID restrictions at the facility.

Case Detail	Description
Incident Date	09/27/2020
OLES Case Number	2020-00996-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 27, 2020, a psychiatric technician allegedly verbally abused three residents and hit a fourth resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not properly conducted. The investigatory interviews were not thorough and as a result, the psychiatric technician had to be interviewed for a second time. Basic questions were not addressed and there was little follow up to the answers provided by the witnesses. The investigative report was neither concise nor well-written and reflected the deficiencies in the investigation.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer failed to conduct thorough interviews, necessitating a second interview of the psychiatric technician. The witness and resident interviews lacked fundamental detail. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report was neither thorough nor adequate and contained incomplete interviews. 3. Was the final investigative report thorough and appropriately drafted?

	No. The final report was not well written, and left some fundamental questions unanswered. 4. Was the investigation thorough and appropriately conducted? No. The interviews lacked sufficient detail.
Department Corrective Action Plan	The Commander, Sergeant, and Investigator developed additional training for the Canyon Springs officers to assist in improving their investigative and report writing skills. Topics include, interview and interrogation, report writing, and laws related to their duties with OPS. The Riverside District Attorney's office has partnered with OPS to also provide instruction on report writing and Penal Code Section 368. The training has been postponed until further notice due to COVID restrictions at the facility.

Case Detail	Description
Incident Date	09/27/2020
OLES Case Number	2020-00997-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 27, 2020, a psychiatric technician allegedly slapped a resident in the face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The responding officer failed to properly scope the investigation and therefore didn't fully investigate all potential crimes. The officer did not identify or interview all potential percipient witnesses on scene. The draft and final reports were not thorough and the officer failed to provide OLES with timely notification of the psychiatric technician's interview, thereby preventing monitoring.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer failed to identify all of the

	potential crimes and therefore conducted an incomplete investigation. The officer failed to identify and interview all the potential witnesses. The officer failed to adequately prepare for witness interviews and ask fundamental and detailed questions. The interviews were short and cursory. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report failed to include an interview with the psychiatric technician and other relevant witness interviews. 3. Was the final investigative report thorough and appropriately drafted? No. The final report did not include interviews of relevant percipient witnesses. 4. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The officer failed to timely notify OLES of the psychiatric technician's interview.
Department Corrective Action Plan	The officer was directed by the Sergeant to conduct additional interviews and to focus his investigation on certain identified allegations as there was another officer already investigating aspects of the allegations made to him that he was unaware of. Once the officer completed his assigned tasks, a draft report was sent to the monitor for review. The approved report addressed all matters relevant to the criminal allegation of abuse the officer was investigating. OPS will try and provide the Monitor with as much time as possible to ensure OLES participation. The Commander, Sergeant, and Investigator developed additional training for the Canyon Springs officers to assist in improving their investigative and report writing skills. Topics include, interview and interrogation, report writing, and laws related to their duties with OPS. The Riverside District Attorney's office has partnered with OPS to also provide instruction on report writing and Penal Code Section 368. The training has been postponed until further notice due to COVID restrictions at the facility.

Administrative-With Sustained Allegations

Case Detail	Description
Incident Date	12/01/2019
OLES Case Number	2020-00439-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	Between December 2019 and January 2020, a lieutenant allegedly submitted a referral to the district attorney's office without authorization.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. 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.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	03/18/2020
OLES Case Number	2020-00279-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 18, 2020, a senior psychiatric technician allegedly kicked and knocked down 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:** Insufficient **Substantive Rating:** Sufficient The hiring authority failed to comply with the department's policies and procedures governing the pre-disciplinary process. The date of discovery was March 19, 2020; however, the investigation was not complete until August 20, 2020, 154 days later.

Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The date of discovery was March 19, 2020; however, the investigation was not complete until August 20, 2020, 154 days later.
Department Corrective Action Plan	The Commander will participate in weekly Investigator case update meetings. The Lieutenant will also assure Investigators are on track with expected completion dates. The Lieutenant will utilize a tracking log to monitor the length of a case and meet with the Investigators weekly to identify any barriers in advance.

Case Detail	Description
Incident Date	03/17/2020
OLES Case Number	2020-00402-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 17, 2020, an officer allegedly gave false testimony at a State Personnel Board hearing.
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	03/01/2020
OLES Case Number	2020-00403-2A
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	Between March 1, 2020, and March 31, 2020, a psychiatric technician allegedly kicked and stepped on 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	05/07/2020
OLES Case Number	2020-00470-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Head/Neck
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On May 7, 2020, a senior 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:** Insufficient **Substantive Rating:** Sufficient The hiring authority failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on May 8, 2020; however, the investigation was not completed until September 28, 2020, 143 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on May 8, 2020; however, the investigation was not completed until September 28, 2020, 143 days later.
Department Corrective Action Plan	The Commander will participate in weekly Investigator meetings. The Lieutenant will also assure Investigators are on track with expected completion dates. The Lieutenant will utilize a tracking log to monitor the length of a case and meet with the investigators weekly to identify any barriers in advance.

Case Detail	Description
Incident Date	05/15/2020
OLES Case Number	2020-00514-1A
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 May 15, 2020, a psychiatric technician allegedly assaulted a restrained resident. Other staff members allegedly failed to report the incident in a timely manner.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services failed to notify OLES of the resident and subject interviews thereby preventing OLES from real-time monitoring of the investigation. Further, the Office of Protective Services failed to provide OLES with a draft of the investigative report and closed the investigation without consulting with OLES.
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 department did not provide OLES with a draft copy of the investigative report before the investigation was closed. 2. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The OLES was not notified of either the resident or subject staff interviews.
Department Corrective Action Plan	The investigator has been directed to ensure the OLES Monitor is updated with the progress of the investigation (including when interviews are conducted). Additionally, the investigator was directed to provide the Monitor with a draft when completed as directed by a supervisor. After OLES review, the supervisor has been directed to consult with the Monitor for case closure.

Case Detail	Description
Incident Date	06/06/2020
OLES Case Number	2020-00590-2A

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 June 6, 2020, three psychiatric technicians allegedly held a resident on her bed, causing significant bruising to her arms. The psychiatric technicians also allegedly held a pillow against the resident's face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. 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.

Appendix C: Discipline Phase Case

Appendix C provides information on six discipline phase cases. 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 Insufficient Cases

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:** Resigned In Lieu of Dismissal
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. Both psychiatric technicians filed appeals with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into settlement agreements with both psychiatric technicians. The first psychiatric technician resigned in lieu of dismissal. The OLES concurred with the settlement as this ensured the first psychiatric technician no longer worked for the department. The department reduced the penalty against the second psychiatric technician from a dismissal to a three-month suspension, and the second psychiatric technician agreed to withdraw her appeal. The OLES concurred because the resulting penalty was still significant enough to deter future misconduct.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority made disciplinary determinations on February 20, 2020; however, the two disciplinary actions were not served until June 30, 2020, and July 1, 2020; 132 and 133 days later, respectively.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority made disciplinary determinations on February 20, 2020; however, the two disciplinary actions were not served until June 30, 2020, and July 1, 2020; 132 and 133 days later, respectively.
Department Corrective Action Plan	The Administrative Services Director and Commander will closely scrutinize the timeliness of requested reports/documents and ensure policies and procedure are being adhered to for timeliness of NOAA service.

Case Detail	Description
Incident Date	05/04/2019
OLES Case Number	2019-00449-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Willful disobedience
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On May 4, 2019, a psychiatric technician allegedly left a resident in a secured outdoor courtyard unattended overnight, falsified legal documents and was dishonest during his investigative interview. A second psychiatric technician allegedly falsified a legal document indicating the resident was inside his bedroom during the entire night and was intentionally misleading during her investigative interview. A third psychiatric technician allegedly was dishonest during his investigative interview. A fourth psychiatric technician allegedly falsified legal documents. A fifth psychiatric technician allegedly was negligent in his duties as shift lead, falsified legal documents, interfered in the investigation by contacting other staff and telling them what to say, and was dishonest on numerous occasions during his investigative interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain all of the allegations against each psychiatric technician. The first psychiatric technician received a salary reduction of 5 percent for three months. The psychiatric technician filed an appeal with The State Personnel Board. Prior to State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a letter of reprimand. The psychiatric technician waived back pay and agreed to withdraw his appeal. The OLES concurred with the settlement. The hiring authority determined dismissal was the appropriate penalty for the second psychiatric technician. The second psychiatric technician resigned prior to the imposition of penalty. The third psychiatric technician received a salary reduction of 5 percent for three months. The third psychiatric technician filed an appeal with the State Personnel Board. After an Investigative Hearing, the State Personnel Board upheld the salary reduction. The fourth psychiatric technician received a salary reduction of 5

	percent for three months. The hiring authority determined dismissal was the appropriate penalty for the fifth psychiatric technician. Neither the fourth or fifth psychiatric technicians filed appeals. The OLES concurred with the hiring authority's penalty determinations.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The OLES did not receive written confirmation of penalty discussions nor two of the four draft disciplinary actions. The department failed to notify OLES of the Skelly hearings.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? No. The department did not provide OLES with two of the four draft disciplinary actions. 2. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? No. The department failed to notify OLES when the actions were served and the dates for each of the Skelly hearings.
Department Corrective Action Plan	The Department will ensure that Canyon Springs' Labor Relations Officer will provide draft disciplinary actions and have a consultation with the OLES monitor prior to serving the actions. Canyon Springs' Labor Relations Officer will ensure all notifications of dates and times of the actions served and skelly hearings are communicated to the OLES monitor assigned to each case.

Case Detail	Description
Incident Date	05/28/2019
OLES Case Number	2019-00525-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** No Penalty Imposed
Incident Summary	On May 28, 2019, a psychiatric technician assistant allegedly

	used an unauthorized control hold on a resident.
Disposition	The hiring authority sustained the allegation against the psychiatric technician and determined the appropriate penalty was a letter of reprimand. The OLES concurred. Without consulting the OLES, the hiring authority later decided not to issue a letter of reprimand.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority failed to consult with OLES on the determination to not impose the agreed upon penalty.
Disciplinary Assessment Questions	1. Did the hiring authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision? No. The hiring authority failed to consult with OLES on the determination not to impose the letter of reprimand.
Department Corrective Action Plan	Due to the facility being used for community COVID-19 patients and being in a closure mode, FDC has been short staffed. Consulting with OLES regarding the decision not to impose a letter of reprimand was missed. FDC is in the process of hiring a retired annuitant (RA) to assist the Quality Assurance Section with disciplinary actions and tracking.

Procedurally and Substantively Sufficient Cases

Case Detail	Description
Incident Date	04/25/2019
OLES Case Number	2019-00412-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On April 25, 2019, a psychiatric technician allegedly pushed a resident's face after the resident attempted to bite the psychiatric technician.
Disposition	The hiring authority sustained the allegation and determined the appropriate penalty was dismissal. The OLES concurred. The psychiatric technician resigned before discipline could be imposed.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

	The department sufficiently complied with policies and procedures governing the disciplinary process.

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 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
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, and a second food service worker allegedly failed to timely report she 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 allegations against the first and second food service workers, and determined a letter of reprimand and a letter of instruction, respectively, were the appropriate penalties. The OLES concurred with the findings. The psychiatric technician assistant resigned before discipline could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in his official personnel file. The first food service worker did not file an appeal with the State Personnel Board.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

	The department sufficiently complied with policies and procedures governing the 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:** Suspension
Incident Summary	On December 10, 2019, three psychiatric technicians allegedly failed to follow lockdown policies. 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 hiring authority determined the first psychiatric technician should receive a Letter of Reprimand; however, this case was combined with a second unrelated case and the hiring authority served the first psychiatric technician with a notice of dismissal. The first psychiatric technician filed an appeal with the State Personnel Board. The department entered into a settlement agreement with the first psychiatric technician whereby the department agreed to reduce the penalty from dismissal to a two month suspension and the first psychiatric technician agreed to withdraw his appeal. The OLES concurred with the terms of the settlement agreement. The second and third psychiatric technicians were issued letters of instruction. The OLES concurred with the hiring authority's determinations and penalty assessments.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

	The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix D: Combined Pre-Disciplinary and Discipline Phase Cases

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

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

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

The disciplinary phase is rated for procedural and substantive sufficiency.

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

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	09/13/2019
OLES Case Number	2019-01047-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Suspension **Final:** Suspension
Incident Summary	On September 13, 2019, a psychiatric technician assistant allegedly failed to properly monitor a resident who required enhanced observation.
Disposition	The hiring authority sustained the allegation and determined a ten day suspension without pay was the appropriate penalty; however, the psychiatric technician assistant resigned before disciplinary action could be taken. The OLES concurred.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	03/17/2020
OLES Case Number	2020-00278-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Demotion **Final:** Demotion
Incident Summary	On March 17, 2020, a psychiatric technician allegedly fell asleep while monitoring a resident.
Disposition	The hiring authority sustained the allegation and determined that termination of the psychiatric technician's limited term assignment, and returning him to the position of a psychiatric technician assistant, was the appropriate penalty. The OLES concurred with the determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix E: 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.

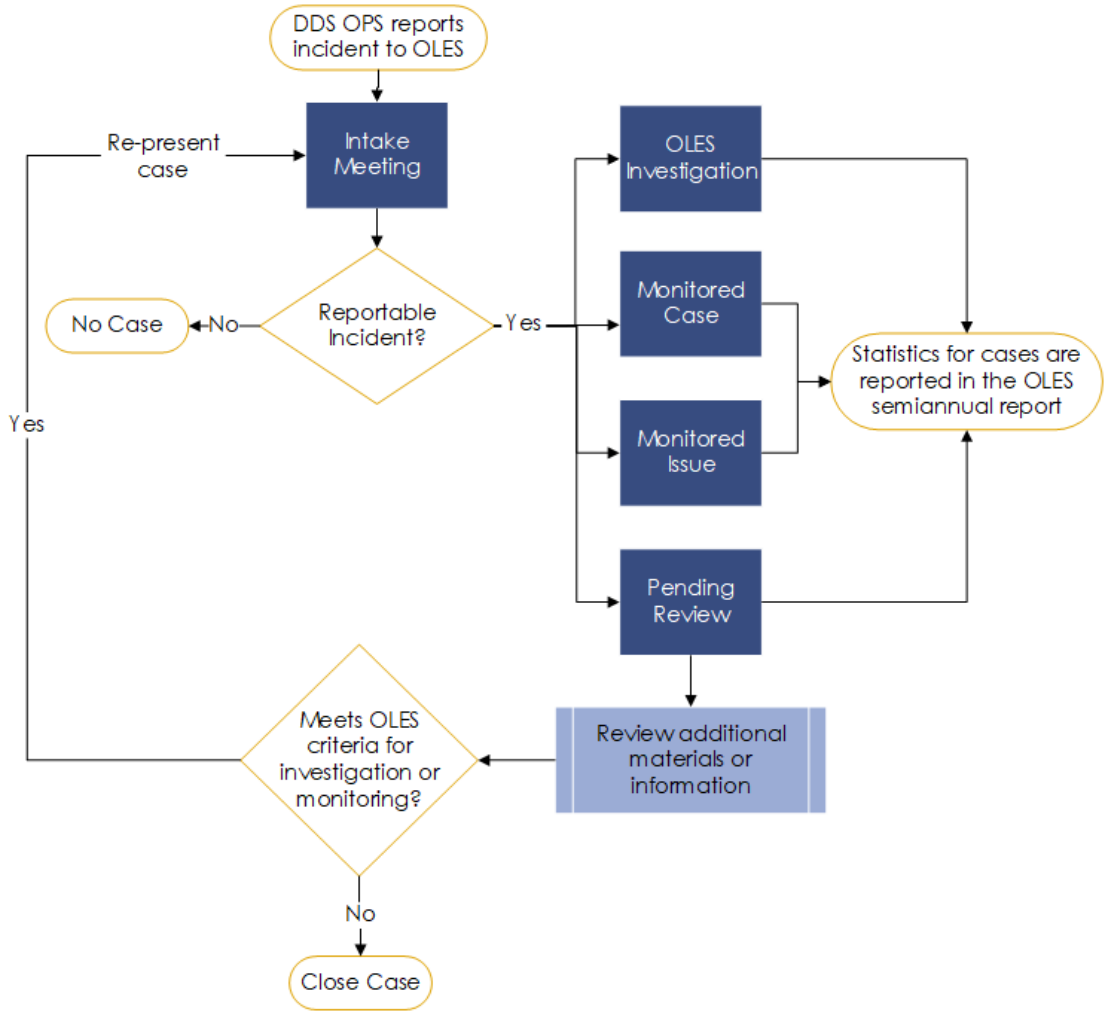
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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 F: OLES Intake Flow Chart



Outline Description

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

Appendix G: 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 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

[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.

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

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

Conclusion

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