Office of Law Enforcement Support

Semiannual Report

January 1, 2021–June 30, 2021

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

Promoting a safe, secure and therapeutic environment

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

Contents

Introduction

I am pleased to present the eleventh 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 January 1 through June 30, 2021.

In this report, the OLES provides details on 122 reported incidents and the results of completed investigations and monitored cases. In response to procedural insufficiencies OLES identified while monitoring cases, the DDS conducted additional follow-up interviews to obtain more detailed statements, assigned specific staff to track allegations reported to OLES, and established a new verification process between the DDS legal division and Office of Protective Services (OPS) to ensure consultation with OLES regarding disciplinary actions.

The OLES congratulates the DDS OPS for achieving Silver level recognition in 2020 as part of the Lexipol Connect Customer Recognition program. The recognition was for delivering a standard of excellence through policy efforts that reduces risk for personnel and residents.

As OLES concludes its sixth year of oversight and monitoring, we remain committed to continuous quality improvement and instilling accountability at DDS.

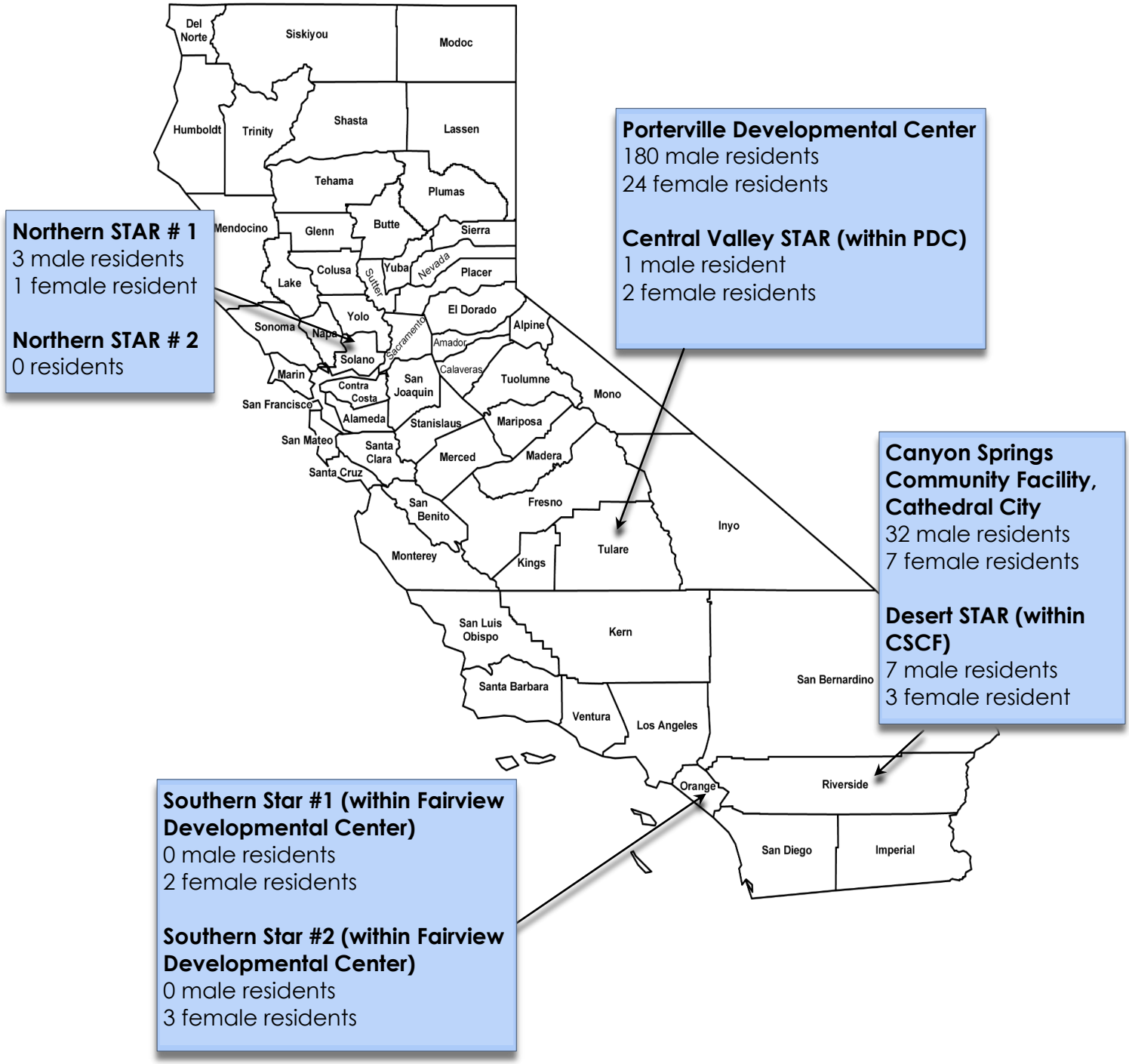
We are grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DDS management and personnel.

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 June 30, 2021, were provided by the department. Residents in DDS receiving acute crisis services are listed in Stabilization, Training, Assistance and Reintegration (STAR) homes.



Northern STAR # 1
3 male residents
1 female resident

Northern STAR # 2
0 residents

Porterville Developmental Center
180 male residents
24 female residents

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

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

Desert STAR (within CSCF)
7 male residents
3 female resident

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

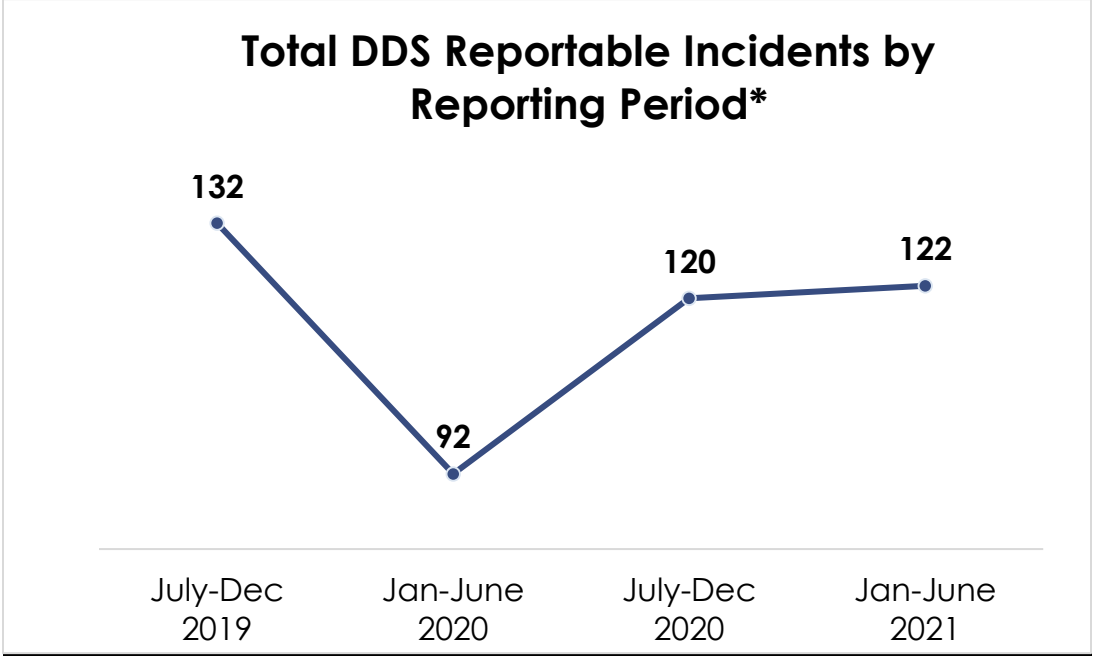
Southern Star #2 (within Fairview Developmental Center)
0 male residents
3 female residents

DDS Facility Population Chart

Facility	Number of Male Residents	Number of Female Residents	Total
Canyon Springs	32	7	39
Porterville	180	24	204
Central Valley STAR	1	2	3
Desert STAR	7	3	10
Northern STAR #1	3	1	4
Northern STAR #2	0	0	0
Southern STAR #1	0	2	2
Southern STAR #2	0	3	3
Total	223	42	265

Executive Summary

During the reporting period of January 1, 2021, through June 30, 2021, the Office of Law Enforcement Support (OLES) received and processed 122 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 two incident reports compared to the prior reporting period, which had 120 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.

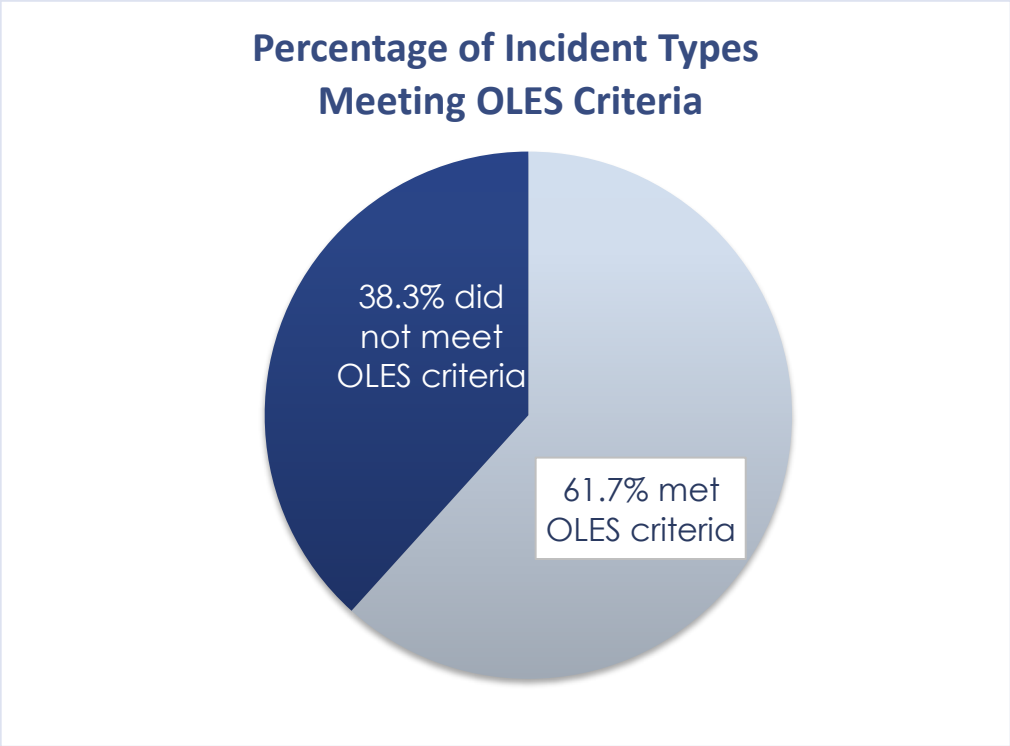
Incident Types Meeting OLES Criteria

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 122 reported incidents, the OLES identified nine incidents with two or more incident types. The DDS reported a total of 133 incident types during this reporting period. Eighty-two, or 61.7 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, misconduct, broken bone of known origin and head or neck injury. Allegations of abuse represented the single largest number of alleged incident types reported by DDS during this reporting period. The OLES received 66 reports of alleged abuse, which accounted for 49.6% of all reported incident types reported by DDS. The DDS reported 21 allegations of sexual assault, making sexual assault the second most frequently reported incident type from DDS. The DDS reported eight allegations of misconduct, which is a 300 percent increase from the number reported in the prior reporting period. Reports of broken bone of known origin rose 75 percent, from four reported incident types in the prior reporting period to seven reported in this reporting period. Reports of the head or neck injury incident type decreased 12.5 percent from eight incident types to seven.

Resident Deaths

The DDS reported one resident death in this reporting period. The death was unexpected and the cause of death is pending an autopsy.

Resident Arrests

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

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

During this reporting period, DDS reported two resident arrests, two more arrests than in the prior reporting period. The resident was arrested on two separate occasions for violating California Penal Code section 653(x), harassing emergency services (911).

Results of Completed OLES Investigations on DDS Law Enforcement

Per statute[3], an OLES investigation is initiated after OLES is notified of an allegation that a DDS law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents. As of June 30, 2021, DDS had 84 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 five sworn staff members. Two investigations involved an incident that allegedly occurred in 2020 and two involved an incident that allegedly occurred in 2021. The OLES submitted two 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 custodial staff.

In Appendix B and D of this report, OLES provides information on seven monitored pre-disciplinary administrative cases and six monitored criminal cases that, by June 30, 2021, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. Four pre-disciplinary administrative cases had sustained allegations and one criminal investigation was referred to a prosecuting agency.

Of the 13 pre-disciplinary phase cases provided in Appendix B and D, three cases were

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

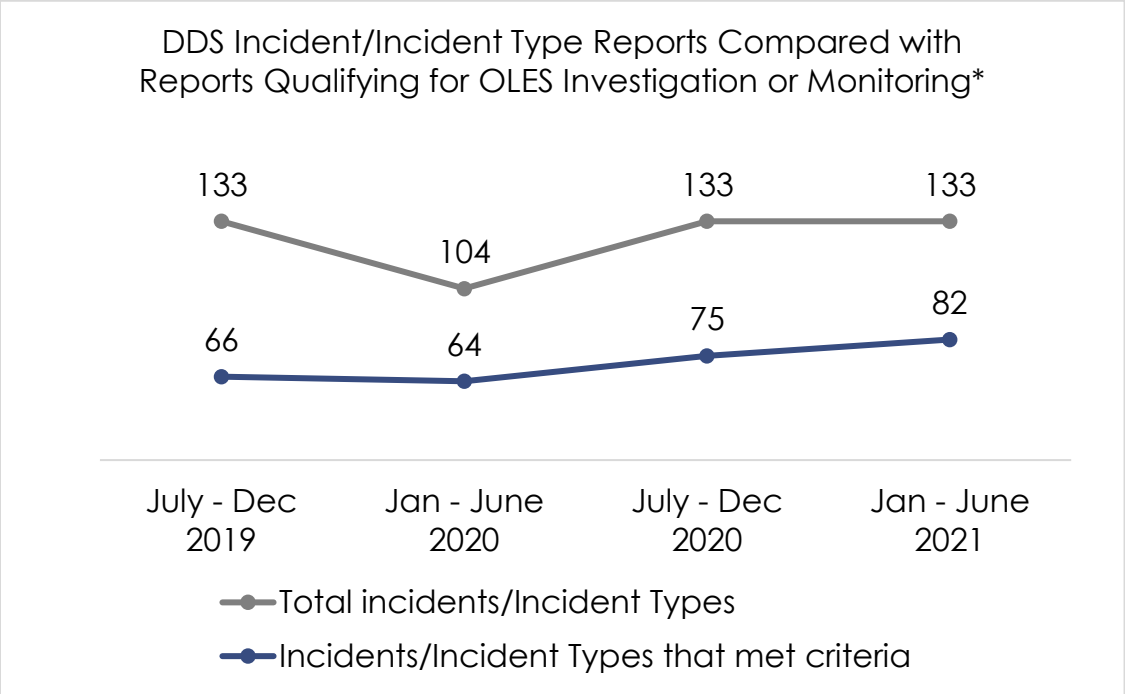
rated as procedurally insufficient only. The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in five administrative cases, which are provided in Appendix C and D. The OLES rated one disciplinary phase administrative case procedurally insufficient.

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 January 1 through June 30, 2021, increased 1.7 percent, from 120 during the prior reporting period to 122 in this reporting period. From the 122 reported incidents, the OLES identified 133 incident types, as nine of the incidents featured two or more incident types. Eighty-two 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, the total number of reported incident types remained the same. However, the total number of incident types meeting OLES criteria increased by seven incident types 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, 109 incident types or 82 percent of all reported incident types fell into the following five categories: abuse, sexual assault, misconduct, broken bone of known origin and head or neck injury. These five incident type categories accounted for 74 incident types or 90.2 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 66 abuse allegations accounted for 49.6 percent of all DDS incident types reported. Fifty-one 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 21 reports. Fourteen alleged sexual assault incident types met criteria for investigation or monitoring. The total number of misconduct incident types rose from two incident types to eight, representing a 300 percent increase. Reports of broken bone of known origin rose by 75 percent, from four reported incident types to seven. Head or neck injuries was reported in the same frequency as broken bone of unknown origin, with seven reports as well. One head or neck incident type met OLES criteria.

Most Frequent Incident Types January 1 through June 30, 2021

Incident Type Categories	Prior Period Incidents Types July 1 through December 31, 2020	Current Period Incident Types January 1 through June 30, 2021	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	51	66	+29.4%	51
Sexual Assault	18	21	+16.7%	14
Misconduct	2	8	+300%	8
Broken Bone (Known Origin)	4	7	+75%	0
Head/Neck	8	7	-12.5%	1

Incident Types by Reporting Period

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

Incident Type Categories	Prior Period January 1- June 30, 2020 (Reported) *	Prior Period January 1 - June 30, 2020 (Meets Criteria) *	Prior Period July 1- December 31, 2020 (Reported)*	Prior Period July 1 – December 31, 2020 (Meets Criteria)*	Current Period January 1- June 30, 2021 (Reported)	Current Period January 1- June 30, 2021 (Meets Criteria)
Abuse	56	43	51	44	66	51
Broken Bone (Known Origin)	4	2	4	1	7	0
Broken Bone	1	1	4	3	2	2

Incident Type Categories	Prior Period January 1- June 30, 2020 (Reported) *	Prior Period January 1 - June 30, 2020 (Meets Criteria) *	Prior Period July 1- December 31, 2020 (Reported)*	Prior Period July 1 – December 31, 2020 (Meets Criteria)*	Current Period January 1- June 30, 2021 (Reported)	Current Period January 1- June 30, 2021 (Meets Criteria)
(Unknown Origin)						
Burn	3	0	9	1	2	0
Death	0	0	1	0	1	1
Genital Injury (Known Origin)	0	0	0	0	0	0
Genital Injury (Unknown Origin)	1	1	2	1	1	0
Head/Neck Injury	7	1	8	0	7	1
Misconduct**	10	9	2	2	8	8
Neglect	4	4	12	11	3	3
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	3	0	4	0
Sexual Assault	12	3	18	10	21	14
Sexual Assault-OJ***	1	0	3	0	0	0
Significant Interest-Attack on Staff******	0	0	4	0	4	2
Significant Interest-Attempted Suicide	0	0	0	0	0	0
Significant Interest-AWOL	1	0	6	0	0	0
Significant Interest-Child Pornography	0	0	0	0	0	0
Significant Interest-	2	0	4	0	4	0

Incident Type Categories	Prior Period January 1- June 30, 2020 (Reported) *	Prior Period January 1 - June 30, 2020 (Meets Criteria) *	Prior Period July 1- December 31, 2020 (Reported)*	Prior Period July 1 – December 31, 2020 (Meets Criteria)*	Current Period January 1- June 30, 2021 (Reported)	Current Period January 1- June 30, 2021 (Meets Criteria)
Other*****						
Significant Interest-Overfamiliarity	0	0	2	2	1	0
Significant Interest-Resident Arrest	1	0	0	0	2	0
Significant Interest-Riot	0	0	0	0	0	0
Totals	104	64	133	75	133	82

*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 stolen vehicle being pursued on departmental grounds or drugs mailed to or found in a state facility.

Incident Types Reported from Developmental Centers or Canyon Springs Community Facility

One hundred and eighteen of the 133 reported incident types came from a developmental center or the Canyon Springs Community Facility (CSCF). The two incidents types reported by Fairview Developmental Center (FDC) 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-AWOL, 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	Total
Abuse	14	0	40	54
Broken Bone (Known Origin)	0	0	7	7
Broken Bone (Unknown Origin)	0	0	2	2
Burn	0	0	2	2
Death	1	0	0	1
Genital Injury (Unknown Origin)	0	0	1	1
Head/Neck Injury	0	0	6	6
Misconduct*	1	1	6	8
Neglect	0	0	1	1
Resident on Resident Assault/GBI	0	0	4	4
Sexual Assault	2	0	19	21
Significant Interest-Attack on Staff**	0	0	4	4
Significant Interest-Other***	0	1	3	4
Significant Interest-Resident Arrest	0	0	2	2
Total	18	2	97	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.

**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 stolen vehicle being pursued on departmental grounds or drugs mailed to or found in a state facility.

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	Southern STAR #1	Southern STAR #2	Total
Abuse	0	7	3	0	2	12
Head/Neck	1	0	0	0	0	1
Neglect	0	1	1	0	0	2
Significant Interest-Over-Familiarity	0	0	1	0	0	1
Total	1	8	5	0	2	16

Distribution of DDS Incident Types

As of June 30, 2021, the DDS population increased by one resident since the last report, with 265 residents. With 265 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	39	18	0.462
Fairview	0	2	-
Porterville	204	97	0.475
Totals	243	117	0.481

* The department provided population numbers as of June 30, 2021.

Reports from STAR homes were reported in the same frequency as the prior reporting period. The average length of stay for a resident in a STAR home during the reporting period was 11 months. In the previous report, DDS reported 22 residents resided in STAR homes on December 31, 2020. During the reporting period, 13 new residents were admitted to the STAR homes. On June 30, 2021, there were 22 residents in STAR homes.

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

DDS STAR Home Population and Total Incident Types

Facility	Number of Residents on December 31, 2020*	Number of Residents Admitted from January 1 through June 2021**	Total Resident Count	Total Incident Types	Ratio of Incident Types to Total Population Count
Central Valley STAR	5	2	7	1	0.143
Desert STAR	10	3	13	8	0.615
Northern STAR #1	4	3	7	5	0.714
Northern STAR #2	0	0	0	0	0
Southern STAR #1	3	1	4	0	0
Southern STAR #2	-	4	4	2	0.500
Total	22	13	35	16	0.457

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

published.
**The department provided population numbers as of June 30, 2021.

Sexual Assault Allegations

Following the abuse incident type, sexual assault was the second most frequently reported incident type from January 1 through June 30, 2021. The 21 alleged sexual assault incident types in this reporting period accounted for 15.8 percent of all reported incident types from DDS. Fourteen sexual assault incident types met OLES criteria for investigation, monitoring or research into systemic department issues. There were no reported incident types under the sexual assault-OJ category. The sexual assault-OJ incident type category includes allegations that implicated family, friends, or others in incidents that occurred when residents were not in a DDS facility.

Of these 21 sexual assault incident types, 19 were reported by Porterville Developmental Center (PDC) and two were reported by CSCF. 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 January 1 through June 30, 2021

Facility	Resident on Resident	Non-Law Enforcement Staff on Resident	Law Enforcement Staff on Resident	OJ*	Total
Canyon Springs	2	0	0	0	2
Porterville	3	14	2	0	19
Totals	5	14	2	0	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

The DDS did not report any significant interest-absent without leave (AWOL) incident types during this reporting period.

Notification of Incident Types

Different incident types require different kinds of notification to OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq., and agreements between OLES and the department, certain serious incident types are required to be reported to OLES within two hours of their discovery. Notification of these "Priority 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 90.9 percent. During this reporting period, DDS timely reporting of incident types to OLES was 96.2 percent. When calculating timeliness, OLES excluded three incident types that involved a resident attack on staff or were reported directly to OLES by an anonymous complainant. Of the 130 incident types evaluated for timeliness, 125 were reported timely and five incident types were not.

All incidents reported from Central Valley STAR, Desert STAR, FDC, and Southern STAR #2 were timely. Northern STAR #2 and Southern STAR #1 did not report any incidents. The following table provides the percentage of timely notifications to OLES for each facility.

Rank	DDS Facility	Number of Incident Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Central Valley STAR	1	1	100%
1	Desert STAR	8	8	100%
1	Fairview	2	2	100%
1	Southern STAR #2	2	2	100%
2	Porterville	95	93	97.9%
2	Canyon Springs	17	15	88.2%
3	Northern STAR #1	5	4	80%
	Total	130	125	96.2%

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 January 1 through June 30, 2021, reporting period, 53 of the total 132 cases opened for DDS incidents that occurred within DDS' jurisdiction or 40.2 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.

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

Cases Opened in January 1 through June 30, 2021

OLES Case Assignments	January 1 – June 30, 2021	Percentage of Opened Cases
Pending Review	53	40.2
Monitored, Criminal	62	47%
Monitored, Administrative	13	9.8%
OLES Investigations, Administrative	3	2.3%
OLES Investigations, Criminal	1	0.8%
Outside Jurisdiction*	0	-
Totals	132	~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, two administrative cases were referred to management for possible discipline of state employees. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted.

The following table shows the results of the 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 January 1- June 30, 2021	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	2	N/A	2	0
Criminal	2	0	N/A	2
Total	4	0	2	2

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 14 completed monitored cases. By the end of the reporting period, one of the six monitored criminal cases was referred to a prosecuting agency. There were seven completed, monitored pre-disciplinary administrative cases. Four of the seven monitored administrative cases had allegations that were sustained during this reporting period. One monitored administrative case had sustained allegations that OLES reported 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	1
Criminal/Not Referred	5
Total Criminal	6
Administrative/With Sustained Allegations	4
Administrative- With Sustained Allegations Reported in the Prior Reporting Period	1
Administrative/Without Sustained Allegations	3
Total Administrative	8
Grand Total	14

The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in five administrative cases, which are provided in Appendix C and D. Of the five disciplinary cases, one was rated procedurally insufficient.

Pre-Disciplinary Phase Cases

Of the 13 DDS pre-disciplinary phase cases in Appendix B and D, the OLES rated three cases procedurally insufficient. The following table provides the type of case and the corresponding number of cases rated procedurally or substantively insufficient.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	0	0
Criminal/Not Referred	3	0
Administrative/With Sustained Allegations	0	0
Administrative/Without Sustained Allegations	0	0
Total	3	0

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

Procedural Deficiencies found in Insufficient Cases

Procedural Deficiency	Potential Consequence
Failure to notify OLES of incident within required timeframe	This prevents OLES from properly processing and classifying or assigning the case. Many reporting requirements are required by statute.
Failure to 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 Procedural 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 deficiencies in pre-disciplinary phase cases are provided in Appendix B and D.

DDS Tracking of Law Enforcement Compliance with Training Requirements

Compliance with POST Training Mandates

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

In April 2021, the DDS reported completing the first quarter of the year and 1/8 of the POST training cycle. Three officers did not complete the required trainings due to being on leave or out of the office. The officers were expected to complete the trainings as soon as possible. At the end of the first quarter, five percent of sworn staff completed the necessary PST and four percent completed CPT.

At the end of the second quarter in June 2021, the DDS reported 34 percent of the 85 total sworn staff completed the necessary PST and 36 percent completed CPT.

Training Mandates and Records

The DDS implemented a new CPT training plan that lists CPT courses law enforcement personnel must take to maintain certifications, are closely related to job duties or have yielded positive feedback by other law enforcement personnel.

The DDS ensures law enforcement personnel comply with training mandates by requiring acknowledgement of policies via the Knowledge Management System within Lexipol. Law enforcement personnel review daily training bulletins and are required to sign training rosters when training bulletins and policy changes are implemented. DDS law enforcement is required to produce certificates when completing a training so that it can be verified in POST or by the training authority that provided the training. All certificates are also stored in the individual's training folder.

The DDS tracks training records for active certifications using multiple methods. The DDS utilizes a Microsoft Excel master training spreadsheet and training grids. The DDS also reviews training on the KMS website and the POST website. The DDS reviews these records on a daily or weekly basis to determine law enforcement personnel who are up to date on their training and those who are deficient.

The DDS provides management a quarterly report that lists completed training and trainings that have not been completed by law enforcement personnel. A training coordinator is assigned at each facility to track the training of law enforcement personnel. Training records are then cross-referenced with the training records at DDS headquarters.

PDC is testing a specialized training management system (TMS) to track records, which may potentially be utilized at all DDS facilities.

Addressing Deficiencies in Training Compliance

The training coordinator or supervisor at each facility is responsible for ensuring compliance with training requirements. Staff, as well as the training coordinators and supervisors, are given a hard deadline to ensure training is completed with proof of completion.

If an officer is out of compliance or deficient in training at the time of a POST audit, POST will notify DDS of the deficiencies and require a plan of correction from the DDS chief of law enforcement.

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	1	1	0	0
Porterville	7	7	0	0
Sonoma	3	3	0	0
Totals	11	11	0	0

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

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

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

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

Criminal Cases against Employees

DDS Facilities	Total Cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Canyon Springs	2	1	1	0
Porterville	1	0	1	0
Totals	3	1	2	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	0	0	0	0
Porterville	60	39	5	16
Totals	60	39	5	16

* 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	3
Fairview	0
Porterville	21
Totals	24

Appendix A: Completed OLES Investigations

The following tables provide information on four investigations completed by OLES in the reporting period of January 1 through June 30, 2021.

Case Detail	Description
Incident Date	09/25/2020
OLES Case Number	2020-01081-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between September 25, 2020, and October 13, 2020, an officer allegedly accessed, improperly used, and shared restricted department promotional testing material.
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	12/16/2020
OLES Case Number	2020-01344-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On December 16, 2020, two officers allegedly used unreasonable force on two private citizens who were contacted on facility grounds.
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	01/01/2021
OLES Case Number	2021-00005-1C
Case Type	Investigative
Incident Type	1. Sexual Assault
Incident Summary	On January 1, 2021, an officer allegedly sexually assaulted a resident.
Disposition	The OLES conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary was provided to the department.

Case Detail	Description
Incident Date	01/09/2021
OLES Case Number	2021-00050-1C
Case Type	Investigative
Incident Type	1. Sexual Assault
Incident Summary	On January 9, 2021, an officer allegedly exposed himself to, and inappropriately touched a resident.
Disposition	The OLES conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary was provided to the department.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on three monitored administrative cases and six monitored criminal cases that, by June 30, 2021, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. The OLES monitored each departmental investigation for both procedural and substantive sufficiency.

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

Criminal-Referred

Case Detail	Description
Incident Date	09/03/2020
OLES Case Number	2020-00913-1C
Case Type	Monitored
Incident Types	1. Burns 2. Neglect
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On September 3, 2020, a psychiatric technician assistant allegedly failed to protect the health and safety of a resident when he walked the resident outside in 110 degree temperatures and had the client stand barefoot on a metal step for several minutes while the psychiatric technician attempted to unlock a door. The temperature of the metal steps was measured as 140 degrees.
Disposition	The Department of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Department of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Criminal-Not Referred

Case Detail	Description
Incident Date	09/03/2020
OLES Case Number	2020-00956-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 3, 2020, a senior psychiatric technician and a psychiatric technician allegedly repeatedly restrained a resident against a wall when the resident refused to work.
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 did not comply with policies and procedures governing the investigative process. The investigating officer did not provide the senior psychiatric technician with the legally required Beheler admonition prior to taking the senior psychiatric technician's statement. The Office of Protective Services did not provide the OLES with a draft copy of the report before the investigation was closed.
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 Office of Protective Services did not provide the OLES with a draft copy of the report before the investigation was closed. 2. Was the investigation thorough and appropriately conducted? No. The investigative officer did not provide the senior psychiatric technician with the legally required Beheler admonition prior to taking the senior psychiatric technician's statement.
Department Corrective Action Plan	In this case, the officer conducted an interview with a suspect who was not in custody for Miranda purposes. The officer should have provided the Beheler Admonition to the suspect before taking a statement. The officer has since been mandated to review OPS policy that requires the rules

	of Beheler to be followed during the interrogation of subjects. The officer will also be required to complete Peace Officer Standard Training (POST) regarding interviews and interrogations to ensure best practices are being followed when interviewing persons out of custody.

Case Detail	Description
Incident Date	09/22/2020
OLES Case Number	2020-00976-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 22, 2020, a psychiatric technician allegedly 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 did not comply with policies and procedures governing the investigative process. The initial interviews conducted by the responding officer of the resident and psychiatric technician were incomplete and lacked sufficient detail.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The initial interviews conducted by the responding officer of the resident and psychiatric technician were incomplete and lacked sufficient detail.
Department Corrective Action Plan	The officer was directed by his supervisor to conduct further follow-up interviews 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.

Case Detail	Description
Incident Date	10/25/2020
OLES Case Number	2020-01125-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act

	4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Incident Summary	On October 25, 2020, a psychiatric technician allegedly injured a resident during a wall containment procedure.
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:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The department did not timely notify the OLES of the alleged incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on October 26, 2020, at 0850 hours, but did not notify the OLES until November 2, 2020, at 1022 hours, over seven days later.
Department Corrective Action Plan	The Watch Commander overlooked the reporting of this Resident injury to OLES and has since been further trained on this issue. At the time of this incident, the Watch Commander was transitioning from supervisory Watch Commander duties to an Investigations position. As a result of the error, the OPS Special Investigations Lieutenant has met with the Investigator (former Watch Commander) to discuss the deficiency and the proper procedure in relation to Priority 1 and Priority 2 OLES Notifications. The Operations Lieutenant will continue to monitor all allegations reported to OPS, to ensure all OLES Notifications are made in a timely manner.

Case Detail	Description
Incident Date	12/01/2020
OLES Case Number	2020-01270-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between December 1, 2020, and December 9, 2020, a senior psychiatric technician allegedly choked and forced a

	resident to the floor.
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	01/22/2021
OLES Case Number	2021-00119-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 22, 2021, a psychiatric technician assistant allegedly hit and forced a resident to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	09/06/2020
OLES Case Number	2020-00979-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Dishonesty 2. Dishonesty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between September 6, 2020, and September 9, 2020, two custodians were allegedly dishonest about their exposure to

	the coronavirus and knowingly exposed residents and staff to the coronavirus.
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.

Case Detail	Description
Incident Date	09/25/2020
OLES Case Number	2020-01081-2A
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	Between September 25, 2020, and October 13, 2020, an officer allegedly accessed, improperly used, and shared restricted department promotional testing material.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	12/16/2020
OLES Case Number	2020-01344-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 16, 2020, two officers allegedly used unreasonable force on two private citizens who were contacted on department property.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Appendix C: Discipline Phase Case

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

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

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

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

Procedurally Sufficient Case

Case Detail	Description
Incident Date	12/11/2018
OLES Case Number	2019-00263-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	On December 11, 2018, a psychiatric technician assistant allegedly slapped a resident.
Disposition	The hiring authority sustained the allegation and determined the appropriate penalty was dismissal. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the evidentiary hearing, the department entered into a settlement agreement with the psychiatric technician, wherein the psychiatric technician agreed to resign in lieu of dismissal. The OLES concurred.

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

Appendix D: Combined Pre-Disciplinary and Discipline Phase Cases

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

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

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

The disciplinary phase is rated for procedural and substantive sufficiency.

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

Procedurally Insufficient in the Disciplinary Phase Only

Case Detail	Description
Incident Date	06/14/2020
OLES Case Number	2020-00613-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	On June 14, 2020, an officer allegedly engaged in a vehicle pursuit in violation of department policy.
Disposition	The hiring authority sustained the allegation and issued a letter of reprimand. The OLES concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. The department entered into a settlement agreement wherein the officer agreed to withdraw his appeal and the department agreed to remove the letter of reprimand from his official personnel file after nine months. The OLES concurred as the settlement was

	reasonable and the letter of reprimand can be utilized for progressive discipline for the full three year time period.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the disciplinary process. The draft disciplinary action was not provided to the OLES for review.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? No. The OLES did not receive a copy of the draft disciplinary action.
Department Corrective Action Plan	OPS' failure to consult and provide OLES with a copy of the draft disciplinary action was an unintentional oversight. A new verification process has been initiated between DDS Legal and OPS to ensure OLES is both consulted and provided copies of draft disciplinary actions.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	01/05/2020
OLES Case Number	2020-00018-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On January 5, 2020, a psychiatric technician allegedly fell asleep while assigned to provide constant observation of a resident. On June 24, 2020, the psychiatric technician was allegedly dishonest during her investigative interview.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. Prior to serving the psychiatric technician with the adverse action, the department served her with a notice of dismissal because she was absent without leave (AWOL). Upon being

	served with the AWOL notice, the psychiatric technician voluntarily resigned. A letter indicating that the psychiatric technician resigned under adverse circumstances was placed in her official personnel file.
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.

Case Detail	Description
Incident Date	04/07/2020
OLES Case Number	2020-00350-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Suspension
Incident Summary	On April 7, 2020, a psychiatric technician allegedly yelled at a resident, used profanities, and threatened to slap the resident. Additionally, a second psychiatric technician allegedly failed to report the resident's allegation of physical abuse.
Disposition	The hiring authority sustained the allegation against the first psychiatric technician and determined the appropriate penalty was dismissal. After a Skelly hearing, the department entered into a settlement agreement wherein the penalty was reduced to a 79 day suspension without pay. The OLES concurred with the terms of the settlement agreement. The hiring authority also sustained the allegation against the second psychiatric technician and determined the appropriate penalty was a letter of reprimand. The OLES concurred. The second psychiatric technician filed an appeal with the State Personnel Board. The State Personnel Board found the department did not prove the allegation and revoked the letter of reprimand.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

	The department 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	06/16/2020
OLES Case Number	2020-00627-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior 2. Insubordination
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On June 16, 2020, an officer was arrested for possession and transportation of narcotics. On October 23, 2020, the officer was allegedly insubordinate when he refused to cooperate during an administrative investigation.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department 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.

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.

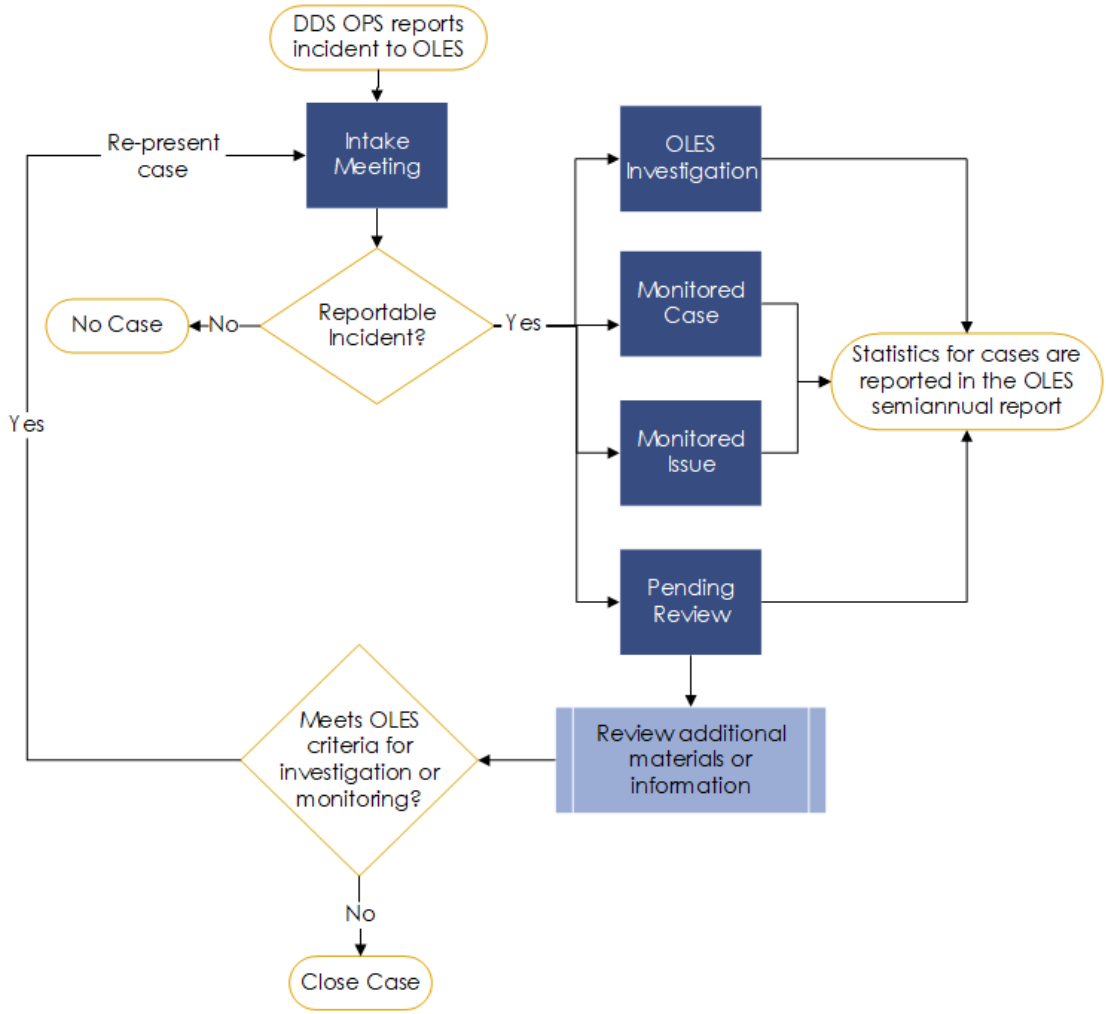
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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
4. Draft investigation report

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

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

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

45 Days

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

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

60 Days

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

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

30 Days

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

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

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

Conclusion

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