Office of Law Enforcement Support

Semiannual Report

January 1, 2022–June 30, 2022

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

Promoting a safe, secure and therapeutic environment

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

Contents

Introduction

I am pleased to present the thirteenth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health & Human Services Agency. This report details OLES's oversight and monitoring of the Department of Developmental Services (DDS) from January 1 through June 30, 2022.

In this report, the OLES provides details on 67 reported incidents and the results of completed investigations and monitored cases.

The OLES rated six completed monitored cases insufficient during this reporting period. In response to a deficiency that OLES identified, DDS reported making a flowsheet to ensure OLES is provided with investigative reports going forward. For the remaining five cases that OLES rated insufficient, DDS failed to submit a corrective action plan by the deadline specified by OLES.

During this reporting period, OLES opened a monitored issue due to concerns with DDS use of force investigations. In response, DDS developed a training module to address the issues identified by OLES and conducted trainings.

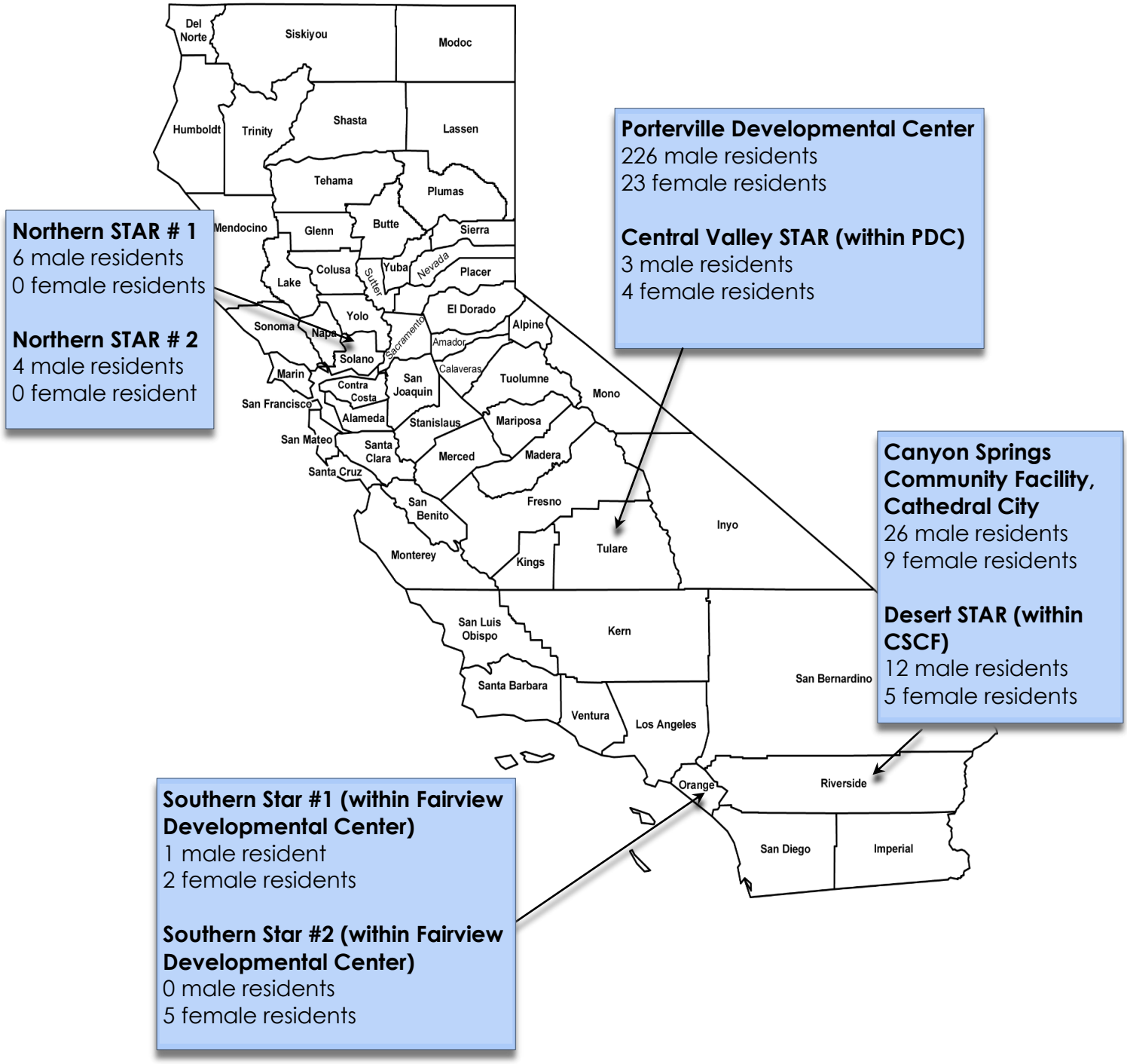
As OLES concludes its seventh year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DDS.

We are grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DDS management and personnel. We welcome comments and questions. Please visit the OLES website at https://www.oles.ca.gov/.

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the DDS facilities below. Population numbers reflect the total residents served from January 1 through June 30, 2022, and were provided by the department. Residents in DDS receiving acute crisis services are listed in Stabilization, Training, Assistance and Reintegration (STAR) homes.



Northern STAR # 1
6 male residents
0 female residents

Northern STAR # 2
4 male residents
0 female resident

Porterville Developmental Center
226 male residents
23 female residents

Central Valley STAR (within PDC)
3 male residents
4 female residents

Canyon Springs Community Facility, Cathedral City
26 male residents
9 female residents

Desert STAR (within CSCF)
12 male residents
5 female residents

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

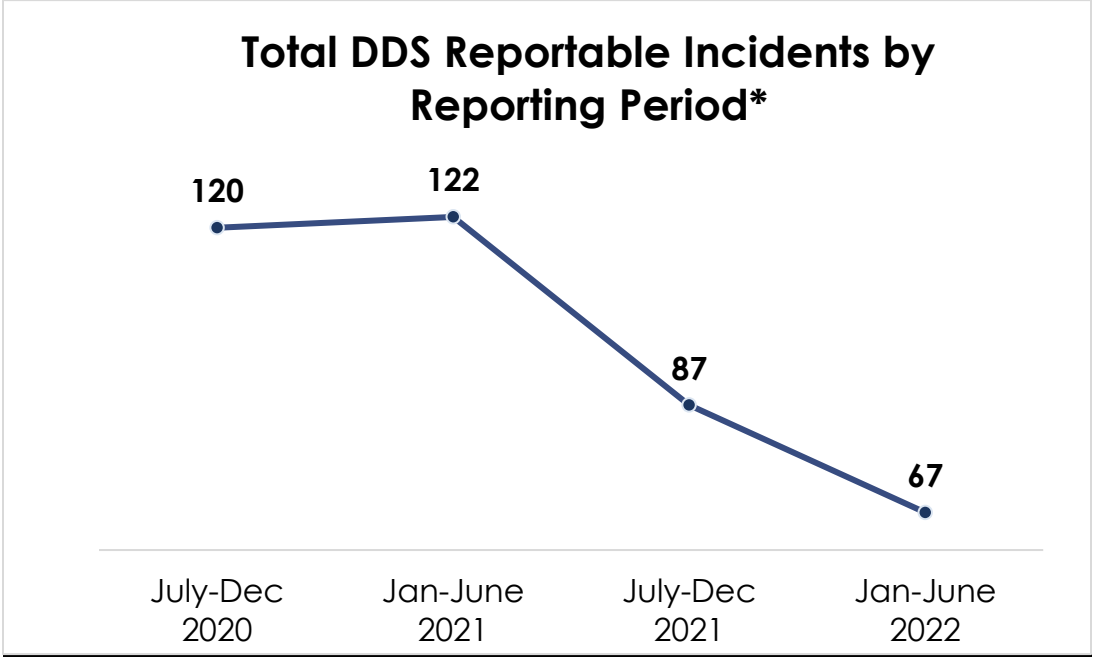
Southern Star #2 (within Fairview Developmental Center)
0 male residents
5 female residents

Total Residents Served by Facility

Facility	Number of Male Residents	Number of Female Residents	Total
Canyon Springs	26	9	35
Porterville	226	23	249
Central Valley STAR	3	4	7
Desert STAR	7	5	12
Northern STAR #1	6	0	6
Northern STAR #2	4	0	4
Southern STAR #1	1	2	3
Southern STAR #2	0	5	5
Total	273	48	321

Executive Summary

During the reporting period of January 1, 2022, through June 30, 2022, the Office of Law Enforcement Support (OLES) received and processed 67 reportable incidents[1] at the Department of Developmental Services (DDS). Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents, resident deaths and other occurrences, per Welfare and Institutions Code, sections 4023, 4023.6 and 4427.5. This is a decrease of 20 incident reports compared to the prior reporting period, which had 87 incident reports. The DDS reported significantly fewer allegations of abuse in this reporting period. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



* Historical numbers are unadjusted and are provided as they were previously published.

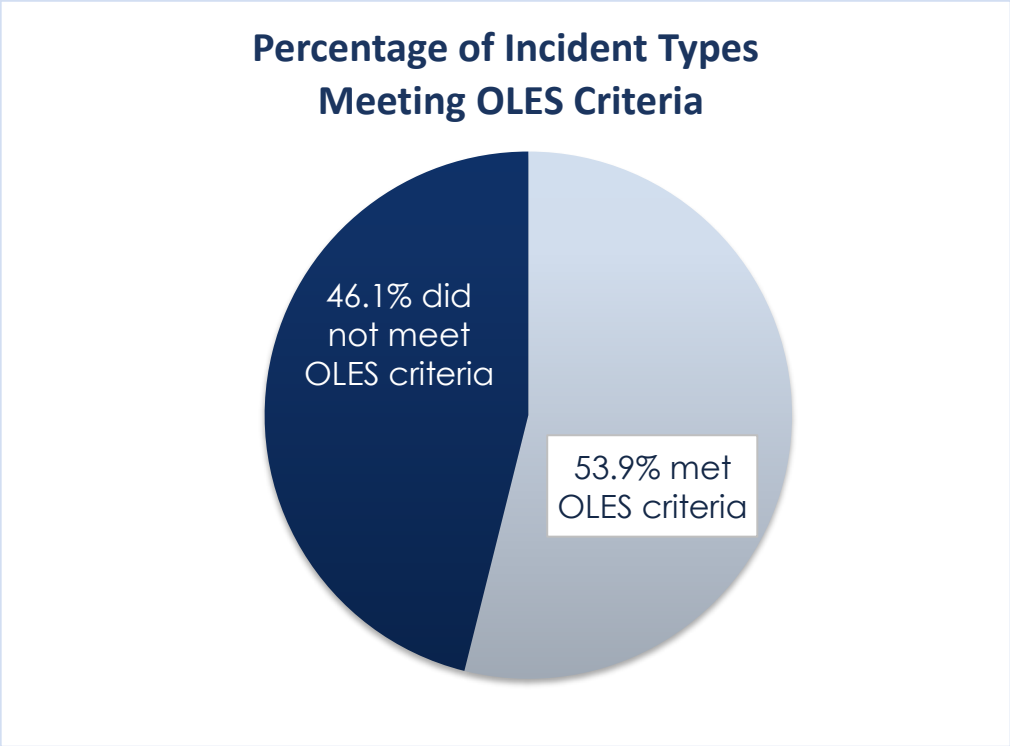
Incident Types Meeting OLES Criteria

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

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

"meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 67 reported incidents, the OLES identified seven incidents with two or more incident types. The DDS reported a total of 76 incident types during this reporting period. Forty-one, or 53.9 percent of the 76 incident types reported by DDS met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported were abuse, attack on staff, sexual assault and misconduct. Allegations of abuse represented the largest number of alleged incident types reported by DDS during this reporting period. The OLES received 22 reports of alleged abuse, which accounted for 28.9 percent of all reported incident types reported by DDS. The DDS reported nine incidents in which a resident attacked staff, eight allegations of sexual assault and eight allegations of peace officer misconduct. Despite DDS reporting fewer incident types, allegations of abuse, sexual assault and misconduct continue to be the most frequently reported incident types.

Resident Deaths

The DDS reported one resident death during this reporting period. The death was unexpected and the cause of death was due to cardiac or respiratory issues.

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. The arrests were for violations of the following statutes.

Statute	Description
Penal Code section 240	assault
Penal Code section 242	battery
Penal Code section 417	brandishing a deadly weapon
Penal Code section 422	criminal threats
Penal Code section 591.5	destruction of wireless emergency communication device

Results of Completed OLES Investigations on DDS Law Enforcement

Per statute[3], an OLES investigation is initiated after OLES is notified of an allegation that a DDS law enforcement officer of any rank committed serious administrative or criminal misconduct. As of June 30, 2022, DDS had 76 sworn staff members.

Appendix A of this report provides information on 10 administrative and two criminal investigations that OLES completed during this reporting period. The OLES submitted nine completed administrative investigations to the Chief of the DDS Office of Protective Services for disposition and monitored the disposition process. In the two criminal cases, OLES found sufficient evidence for a probable cause referral to the district attorney's office.

Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the department and the discipline process for employees involved in misconduct.

In Appendix B and C of this report, OLES provides information on eight monitored pre-disciplinary administrative cases and eight monitored criminal cases that, by June 30, 2022, 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. During this reporting period, DDS did not refer any criminal investigations to a prosecuting agency.

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

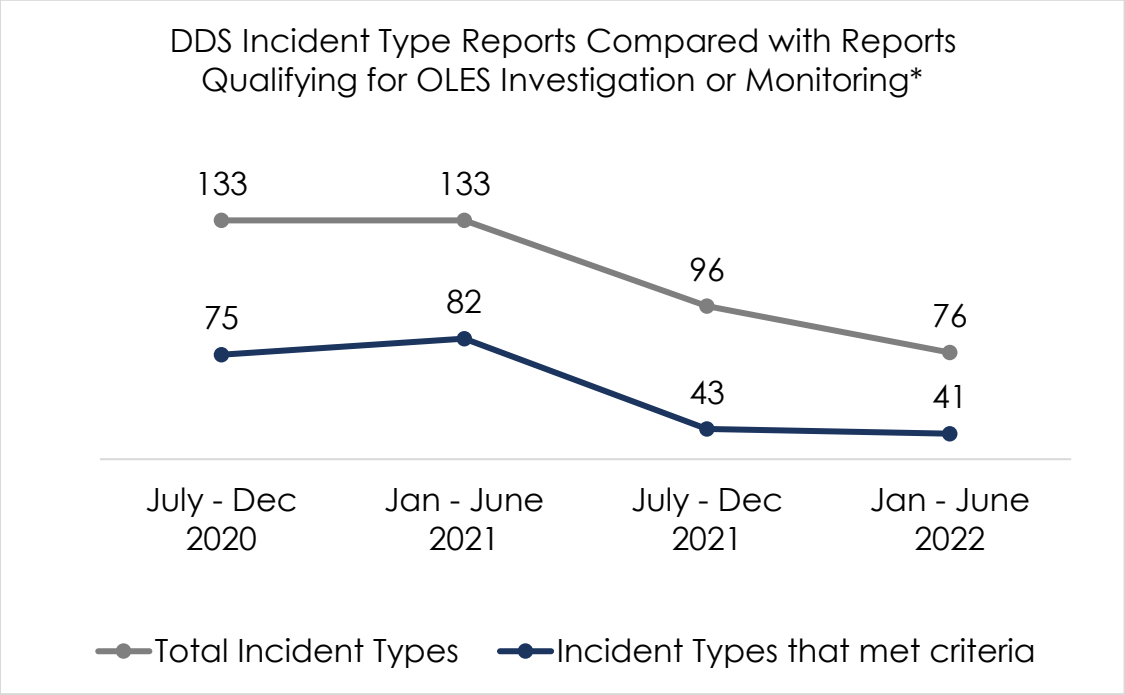
Of the 16 pre-disciplinary phase cases provided in Appendix B and C, the OLES rated six cases insufficient. The OLES monitored the disciplinary action, *Skelly* hearing, settlement and State Personnel Board proceedings in one administrative case, which is provided in Appendix C. The OLES rated the disciplinary phase administrative case sufficient.

Incidents and Incident Types

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

Decrease in Reported Incidents and Incident Types

The number of DDS incidents reported to OLES from January 1 through June 30, 2022, decreased 23 percent, from 87 during the prior reporting period to 67 in this reporting period. From the 67 reported incidents, the OLES identified 76 incident types, as seven of the incidents featured two or more incident types. Forty-one of the 76 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic departmental issue.



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

Most Frequent Incident Types Reported this Period

Of the 76 reported incident types from DDS, 47 incident types or 61.8 percent of all reported incident types fell into the following four categories: abuse, attack on staff, sexual assault and misconduct. These four incident type categories accounted for 29 incident types or 70.7 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 22 abuse allegations accounted for 28.9 percent of all DDS incident types reported. Sixteen abuse allegations met OLES criteria for investigation or monitoring.

Attack on staff represented the second highest category for the number of incident types reported, with nine reports. 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.

Allegations of sexual assault decreased by 20 percent. Allegations of peace officer misconduct decreased by 11.1 percent.

Most Frequent Incident Types January 1 through June 30, 2022

Incident Type Categories	Prior Period Incident Types July 1 through December 31, 2021	Current Period Incident Types	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	37	22	-40.5	16
Attack on Staff	6	9	+50.0%	0
Sexual Assault	10	8	-20.0%	5
Misconduct	9	8	-11.1%	8

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, 2021 (Reported)*	Prior Period January 1- June 30, 2021 (Meets Criteria)*	Prior Period July 1- December 31, 2021 (Reported)*	Prior Period July 1- December 31, 2021 (Meets Criteria)*	Current Period January 1- June 30, 2022 (Reported)	Current Period January 1- June 30, 2022 (Meets Criteria)
Abuse	66	51	37	23	22	16
Broken Bone (Known Origin)	7	0	4	0	1	0
Broken Bone (Unknown Origin)	2	2	4	4	4	4
Burn	2	0	4	0	4	0
Death	1	1	0	0	1	0
Genital Injury (Known Origin)	0	0	2	1	1	0
Genital Injury (Unknown Origin)	1	0	2	2	4	3

Incident Type Categories	Prior Period January 1- June 30, 2021 (Reported)*	Prior Period January 1- June 30, 2021 (Meets Criteria)*	Prior Period July 1- December 31, 2021 (Reported)*	Prior Period July 1- December 31, 2021 (Meets Criteria)*	Current Period January 1- June 30, 2022 (Reported)	Current Period January 1- June 30, 2022 (Meets Criteria)
Head/Neck Injury	7	1	3	0	3	0
Misconduct	8	8	9	6	8	8
Neglect	3	3	5	3	4	3
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
OPS Use of Force	-	-	4	0	0	0
Pregnancy	0	0	0	0	0	0
Resident on Resident Assault/GBI	4	0	0	0	1	0
Sexual Assault	21	14	10	4	8	5
Sexual Assault-OJ**	0	0	3	0	0	0
Significant Interest-Attack on Staff***	4	2	6	0	9	0
Significant Interest-Attempted Suicide	0	0	0	0	0	0
Significant Interest-AWOL	0	0	2	0	1	0
Significant Interest-Child Pornography	0	0	0	0	0	0
Significant Interest-Drugs******	-	-	0	0	0	0
Significant Interest-Other*******	4	0	0	0	1	0
Significant Interest-Overfamiliarity	1	0	1	0	2	2

Incident Type Categories	Prior Period January 1- June 30, 2021 (Reported)*	Prior Period January 1- June 30, 2021 (Meets Criteria)*	Prior Period July 1- December 31, 2021 (Reported)*	Prior Period July 1- December 31, 2021 (Meets Criteria)*	Current Period January 1- June 30, 2022 (Reported)	Current Period January 1- June 30, 2022 (Meets Criteria)
Significant Interest- Resident Arrest	2	0	0	0	2	0
Significant Interest-Riot	0	0	0	0	0	0
Total	133	82	96	43	76	41

*Numbers in this column are unadjusted and provided as they were previously published.
**These incidents occurred outside the jurisdiction of DDS.
***The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department reported to OLES and therefore does not reflect all attacks on staff that may have occurred.
****Beginning in the July 1, 2021, through December 31, 2021, reporting period, the OLES distinguished drug-related allegations and crimes by residents or staff as a separate incident type. These incidents include verified drug offenses by resident and allegations of drug trafficking or smuggling against residents or staff.
*****Any other incident of significant interest, e.g., a civilian death on departmental grounds.

Distribution of DDS Incident Types

The following table compares the total number of residents served by facility to the total number of incident types reported during the reporting period. The DDS reported that the average length of stay for residents who were discharged during the reporting period was 327 days. As of June 30, 2022, the average length of stay for current residents residing in a STAR home is 199 days.

Population and Total Incident Types

Facility	Number of Residents Served*	Total Incident Types
Canyon Springs	34	12
Fairview	0	2
Porterville	249	48
Sonoma	0	2
Central Valley STAR	7	0
Desert STAR	12	3
Northern STAR #1	6	2
Northern STAR #2	4	6
Southern STAR #1	3	1

Facility	Number of Residents Served*	Total Incident Types
Southern STAR #2	5	0

* The DDS provided population numbers as of June 30, 2022.

Reports from PDC decreased by 50.5 percent. This decrease is associated with a significant decrease in allegations of abuse and sexual assault.

Sexual Assault Allegations

The eight alleged sexual assault incident types in this reporting period accounted for 10.5 percent of all reported incident types from DDS. Five sexual assault incident types met OLES criteria for investigation, monitoring or research into systemic department issues. The DDS did not report any incidents under the sexual assault-outside jurisdiction (OJ) category. The sexual assault-OJ incident type category includes allegations that implicated family, friends, or others in incidents that occurred when residents were not in a DDS facility.

Six allegations of sexual assault involved a resident assaulting another resident. Three allegations involved non-law enforcement staff on a resident. The remaining allegation involved a law enforcement staff on a resident.

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

Sexual Assault Allegations Reported January 1 through June 30, 2022

Allegation Type	Total
Resident on Resident	3
Law Enforcement Staff on Resident	0
Non-Law Enforcement Staff on Resident	5
Unknown Person on Resident	0
OJ*	0
Total	8

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

Resident Deaths

The DDS reported one resident death during this reporting period. The death was unexpected and the cause of death was due to cardiac or respiratory issues.

Reports of Head or Neck Injuries

The DDS reported one head or neck injury during this reporting period. This head or neck injury was the result of a resident-on-resident altercation.

Reports of Residents Absent without Leave

The DDS reported one significant interest-absent without leave (AWOL) incident type involving a non-forensic resident. The resident left the facility and threw rocks at passing vehicles. After 10 minutes, the resident returned to the facility. A staff member maintained a line of sight throughout 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.

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

Priority One Notifications – Two Hour Notification

Incident	Description
ADW	An assault with a deadly weapon (ADW) against a resident by a non-resident.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a resident.
Broken Bone (U)	A broken bone of a resident when the cause of the break is undetermined and was not witnessed by staff.
Deadly force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a resident, including a resident that is officially declared brain dead by a physician or other authorized medical professional noting the date and time, or a death that occurs up to 30 days from resident discharge from the DDS facility.
Genital Injury (U)	An injury to the genitals of a resident when the cause of injury is undetermined and was not witnessed by staff.
Physical Abuse	Any report of physical abuse of a resident implicating staff.
Priority 1 Sexual Assault	Any allegation of sexual assault of a resident against staff, law enforcement personnel or unidentified person(s).

Priority Two Notifications – 24 Hour Notification

Incident	Description
Broken Bone (K)	A broken bone of a resident when the cause of the break is known or witnessed by staff.
Burn	Any burns of a resident. This does not include sunburns or

Incident	Description
	mouth burns caused by consuming hot food or liquid unless blistering occurs.
Genital Injury (K)	An injury to the genitals of a resident when the cause of injury is known or witnessed by staff.
Head/Neck Injury	Any injury to the head or neck of a resident requiring treatment beyond first-aid that is not caused by staff or law enforcement. Or any tooth injuries, including but not limited to, a chipped, cracked, broken, loosened or displaced tooth that resulted from a forceful impact, regardless of treatment. Injuries that are beyond treatment of first aid include physical trauma resulting in an altered level of consciousness or loss of consciousness or the use of skin adhesive, staples or sutures.
Neglect	Any staff action or inaction that resulted in, or reasonably could have resulted in a resident death, or injury requiring treatment beyond first-aid.
OPS Use of Force	Any Office of Protective Services staff member within DDS that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject, regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by the subject to the officer or officers.
Resident Arrest	Any arrest of a resident.
Peace Officer Misconduct	Any allegations of peace officer misconduct, whether on or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties. Allegations against a peace officer that include a priority one incident type must be reported in accordance with the priority one reporting requirements.
Pregnancy	A resident pregnancy.
Priority 2 Sexual Assault	Any allegation of sexual assault between two residents. Any allegation of sexual assault that occurred before the resident was in the care of the department (Outside Jurisdiction).
Significant Interest	Any incident of significant interest to the public, including, but not limited to: AWOL, suicide attempt (requiring treatment beyond first-aid), commission of serious crimes by resident(s) or staff, drug trafficking or smuggling, child pornography, riot (as defined for OLES reporting purposes), over-familiarity between staff and residents or any incident which may potentially draw media attention.

Timeliness of Notifications

The DDS decreased in the timely reporting of incident types with 92.3 percent timely reports when compared to the prior reporting period, which had 96.6 percent timely

reports.

When calculating timeliness, OLES excluded 11 incident types from DDS's total incident count. These incident types involved a resident attack on staff or were incidents reported directly to OLES by a resident, family member of a resident, facility staff member or by an outside law enforcement agency. Of the 65 incident types evaluated for timeliness, DDS timely reported 60 incident types. The DDS did not timely report five incident types. The OLES discovered one of the untimely incident types when reviewing the DDS daily logs or incident reports.

Timeliness by Incident Type

The following table provides the percentage of timely notifications by incident type. The table does not include the 11 incident types that were excluded described above.

Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Abuse	22	0	22	100%
Broken Bone (Known Origin)	1	0	1	100%
Broken Bone (Unknown Origin)	4	0	4	100%
Burn	4	0	4	100%
Death	1	0	1	100%
Genital Injury (Known Origin)	1	0	1	100%
Genital Injury (Unknown Origin)	2	2	4	50.0%
Head/Neck	3	0	3	100%
Misconduct	6	1	7	85.7%
Neglect	3	1	4	75.0%
Priority 1: Sexual Assault	7	0	7	100%
Resident on Resident Assault/GBI	0	1	1	0
Significant Interest – AWOL	1	0	1	100%
Significant Interest – Other	1	0	1	100%
Significant Interest – Over-Familiarity	2	0	2	100%
Significant Interest – Resident Arrest	2	0	2	100%
Total	60	5	65	92.3%

The following table compares the percentage of timely notifications by facility. With the exception of Southern STAR #1, all STAR facilities timely reported incidents. When compared to the prior reporting period, CSCF increased in the percentage of timely reports and PDC decreased.

DDS Facility	Number of Timely Notifications	Number of Untimely Notifications	Number of Excluded Incident Types from Timeliness Calculation	Total Reported Incident Types	Percentage of Timely Notifications
Canyon Springs	11	1	0	12	91.7%
Fairview	1	0	1	2	100%
Porterville	39	3	6	48	81.3%
Sonoma	2	0	0	2	100%
Central Valley STAR	0	0	0	0	-
Desert STAR	3	0	0	3	100%
Northern STAR #1	2	0	0	2	100%
Northern STAR #2	2	0	4	6	100%
Southern STAR #1	0	1	0	1	0
Southern STAR #2	0	0	0	0	-
Total	60	5	11	76	92.3%

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, 2022, reporting period, 27 of the total 77 cases opened for DDS incidents that occurred within DDS's jurisdiction or 35.1 percent were assigned a pending review. The OLES opened nine administrative investigations and two criminal investigations. The OLES opened 29 monitored criminal cases and 10 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, 2022

OLES Case Assignments	January 1 – June 30, 2020	Percentage of Opened Cases
Pending Review	27	35.1%
Monitored, Criminal	29	37.7%
Monitored, Administrative	10	13.0%
OLES Investigations, Administrative	9	11.7%
OLES Investigations, Criminal	2	2.6%
Outside Jurisdiction*	0	-
Totals	77	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 10 administrative investigations and two criminal investigations involving DDS law enforcement. If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, OLES submits the investigation to the appropriate prosecuting agency. In this reporting period, the OLES referred two criminal investigations to the district attorney's office.

Nine OLES investigations into administrative wrongdoing or misconduct were forwarded to facility management for review and possible discipline of state employees. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted.

The following table shows the results of the 12 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, 2022	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	10	N/A	9	1
Criminal	2	2	N/A	0
Total	12	2	9	1

OLES Monitored Cases

In this report, OLES provides information on 16 completed monitored cases. The DDS did not refer any monitored criminal cases referred to the district attorney's office. There were eight monitored pre-disciplinary administrative cases. Three of the eight monitored administrative cases had sustained allegations. 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	8
Total Criminal	8
Administrative/With Sustained Allegations	3
Administrative/Without Sustained Allegations	5
Total Administrative	8
Grand Total	16

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

Pre-Disciplinary Phase Cases

Of the 16 DDS pre-disciplinary phase cases in Appendix B and C, OLES rated six cases insufficient. Significant deficiencies found in insufficient cases include, but are not limited to the following.

Procedural Deficiencies found in Insufficient Cases

Deficiency Category	Description
Incident Response	The DDS did not appropriately respond to the incident in two cases. Specific deficiencies include: • Incomplete interview by the responding officer or failure to complete all necessary and relevant interviews by the investigator • Failure to provide required legal admonition prior to taking a statement by responding officer
Lack of Consultation with OLES	The DDS failed to appropriately consult with OLES in six pre-disciplinary phase cases. This includes: • Notifying OLES that the draft or final investigative report is ready for review • Notifying OLES of scheduled interviews

A corrective action plans for deficiencies in a pre-disciplinary phase case is provided in Appendix B. The department did not provide a corrective action plan for the remaining five insufficient cases.

DDS Use of Blue Team/IA Pro

In March 2015, the OLES provided the Legislature with a report that described the challenges faced by law enforcement at DDS along with recommendations to address these challenges. One of the recommendations was for DDS to use an early intervention (EI) system to monitor incidents for selected performance indicators such as use of force and resident complaints. The intent was for the department to use data to proactively identify potential performance problems with law enforcement staff. The DDS selected the IAPro/Blue Team software for its EI system. BlueTeam is the interface of IAPro that allows officers and supervisors to input and manage incidents such as use of force, field-level discipline, complaints and vehicle accidents. The software also allows these incidents to be routed through the chain-of-command with review and approval at each step.

In the OLES semiannual report covering the period of January 1, 2016, through June 30, 2016, OLES recommended DDS review monthly reports from the system to ensure employees with the identified behavior or activities received prompt management attention. The OLES also recommended using the employee trends pinpointed in the system to review whether training was adequate or needed to be updated or supplemented. During the semiannual reporting period of July 1 through December 31, 2016, DDS reported PDC conducted a pilot to test the Blue Team/IA Pro early intervention system. The DDS agreed to track eight incident-types: Use of Force, Resident Complaints, Citizens Complaints, Citizens Complaints-Other, Vehicle Accidents, Administrative Investigation, Censurable Incident Report and Merit Salary Advance Denial.

Due to having only four qualifying incidents at the end of the pilot, DDS determined that the IA Pro portion of the early intervention system could be used alone at DDS headquarters rather than having each facility use Blue Team. When a qualifying incident occurs, DDS headquarters would enter the information into IAPro and the DDS chief of law enforcement would work with the law enforcement command staff at the facilities to review the incidents. As reported in the semiannual report covering January 1, through June 30, 2017, after review and input by OLES, DDS issued its policy and activated the early intervention system in June 2017.

Without consultation or notice to OLES, DDS stopped using the Blue Team/IA Pro database prior to the current OPS Chief's tenure. In December 2021, after OLES confirmed the department's failure in data collection, DDS promptly agreed to resume use of the early intervention system to monitor incidents for selected performance indicators and proactively identify potential performance problems with law enforcement staff. The DDS completed retroactively entering data on May 25, 2022, and reported inputting 11 new entries during the reporting period.

The OLES will continue to monitor the department's usage of Blue Team/IA Pro.

DDS Tracking of Law Enforcement Compliance with Training Requirements

Compliance with POST Training Mandates

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

At the end of the first quarter in March 2022, the DDS reported 28 percent of the 78 total sworn staff completed the necessary PST and 76 percent completed CPT.

At the end of the second quarter in June 2022, the DDS reported 39 percent of the 78 total sworn staff completed the necessary PST and 97 percent completed CPT.

Tracking Methods

The DDS continues to track training compliance with training mandates using the Knowledge Management System within Lexipol, POST, spreadsheets and rosters. The DDS reported that the DDS OPS Training Committee meets regularly to discuss training compliance and training operations.

Additional Mandated Data

The OLES is required by statute to publish data in its semiannual report about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where residents are the perpetrators. All the mandated data for this reporting period came directly from DDS and are presented in the following tables.

Adverse Actions against Employees

Facility	Administrative investigations completed*	Adverse action taken**	No adverse action taken***	Resigned/retired pending adverse action****
Canyon Springs and Desert STAR	1	1	0	0
Northern STAR 1 and 2	9	3	6	0
Porterville and Central Valley STAR	9	9	0	0
Southern STAR 1 and 2	0	0	0	0
Total	19	13	6	0

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

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

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

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

Criminal Cases against Employees

DDS Facilities	Total Cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Canyon Springs and Desert STAR	5	0	5	0
Northern STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR	2	0	2	0
Southern STAR 1 and 2	0	0	0	0
Total	7	0	7	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 and Desert STAR	0	0	0	0
Northern STAR 1 and 2	0	0	0	0
Porterville and Central Valley STAR	65	60	5	18
Southern STAR 1 and 2	0	0	0	0
Total	65	60	5	18

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

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

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

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

Reports of Employee Misconduct to Licensing Boards

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

DDS Facilities	Public Health
Canyon Springs and Desert STAR	2
Northern STAR 1 and 2	0
Porterville and Central Valley STAR	14
Southern STAR 1 and 2	0
Total	16

Monitored Issues

Use of Force

In 2020, the OLES received notification from DDS of a use of force incident involving an officer and a resident. The DDS conducted a use of force review and determined the use of force was within policy and reasonable. The OLES concurred with DDS's determination. However, OLES discovered discrepancies within the DDS reports and other issues that occurred during the investigative process. To protect the anonymity of law enforcement personnel, OLES refers to an officer, sergeant or investigator as an "officer." The rank of lieutenant or above is referred to as "law enforcement supervisor."

Reports

The involved officer injured his hand and could not physically complete a report for the incident. In response, the law enforcement supervisor directed three officers to assist with the investigation and complete the following tasks:

1. *Type a report based on the involved officer's account of the incident, despite the authoring officer not being present for the incident.*

   An officer completed the incident report as directed and submitted it to the supervisor. The involved officer reviewed the report and made changes. The law enforcement supervisor reviewed the report and made inaccurate amendments to the report. The officer who authored the report was directed to sign the report, indicating that contents in the report were from his knowledge or investigation, and attested to by virtue of the signature, to be true and correct.

2. *Interview witnesses*

   The second officer conducted witness interviews and included information he gleaned from the involved officer in a report. There were discrepancies between this report and the incident report that was completed by the other officer.

3. *Assess the UOF for its appropriateness and adherence to policy*

   The third officer reviewed the two reports completed by the officers and did not address the discrepancies. The third officer stated he did not address the discrepancies because the law enforcement supervisor directed him to rely on the two reports and make a determination on whether the use of force was appropriate, rather than interview the involved officer and witnesses to confirm facts.

Evidence

An officer took 61 photos for evidence, however only attached 48 images to the report. The officer who conducted the witness interviews stated he digitally recorded interviews. However, he lost the recordings and could not locate them. This contributed to inconsistencies in the officer's report.

Incident Investigation
The three officers reported they were confused by the law enforcement supervisor's directions and did not understand what they were instructed to do. One officer voiced his concerns and offered suggestions; however, the law enforcement supervisor rejected the suggestions.

The law enforcement supervisor acknowledged that they needed to improve on use of force investigations.

After completing a use of force review of the incident, OLES recommended the following.

1. The DDS review the circumstances and individual deviations from policy and address concerns accordingly with the respective employees as OPS deems appropriate.
2. The DDS review its use of force policies, including the proper procedures for conducting use of force incident investigations. This review should be followed up with extensive training, particularly as it pertains to the supervision and on-scene direction of use of force investigations.

Department Response
The DDS developed a training module to address the issues identified by OLES and conducted trainings.

The OLES will work collaboratively with the department and continue to monitor the department's progress on this issue.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2022. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

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

Case Detail	Description
OLES Case Number	2021-00318-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An on-duty officer allegedly engaged in unauthorized activities, was out of uniform, and was discourteous to a supervisor.
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
OLES Case Number	2021-00387-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly falsified his timesheets.
Disposition	The investigation was completed by the OLES. The time period in which to take disciplinary action had expired; therefore, the case was not submitted the hiring authority for disposition.

Case Detail	Description
OLES Case Number	2021-00759-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly surreptitiously recorded a conversation with supervisors.
Disposition	The OLES conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office.

Case Detail	Description
OLES Case Number	2021-00759-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly surreptitiously recorded a conversation with supervisors.
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
OLES Case Number	2021-01186-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	A law enforcement supervisor allegedly referred to another employee in a disparaging manner.
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
OLES Case Number	2021-01186-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	A law enforcement supervisor allegedly made a discourteous comment to two officers.
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
OLES Case Number	2021-01311-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly mishandled evidence related to a criminal case.
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
OLES Case Number	2021-01427-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly used marijuana and possessed marijuana paraphernalia on facility grounds.

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
OLES Case Number	2021-01466-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Two officers allegedly disseminated an evidentiary photograph, via email, without authorization.
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
OLES Case Number	2022-00014-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An on-duty officer allegedly was armed with a firearm, without authorization.
Disposition	The OLES conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office.

Case Detail	Description
OLES Case Number	2022-00014-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An on-duty officer allegedly was armed with a firearm, without authorization.
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
OLES Case Number	2022-00116-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	A law enforcement supervisor allegedly disclosed confidential information regarding an investigation.
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 monitored administrative cases and monitored criminal cases that, by June 30, 2022, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

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

The Office of Protective Services referenced in this section may include the Department of Police Services or the Office of Special Investigations.

Criminal-Not Referred

Case Detail	Description
OLES Case Number	2021-00254-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A resident was found non-responsive in his bed. Responding staff initiated emergency life-saving measures; however, the resident was declared dead. The cause of death was declared to be Sudden Unexpected Death in Epilepsy.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigator did not timely provide a copy of the autopsy report to the monitor and failed to notify the monitor of a meeting held with law enforcement personnel to discuss the autopsy findings.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES?

	No. The investigator received the autopsy report on August 19, 2021, but did not provide a copy of the report to the monitor until December 1, 2021, over three months later, nor did he advise the monitor of a meeting with the coroner and sheriff's department held on July 29, 2021, to discuss the resident's death and autopsy findings.
Department Corrective Action Plan	The department did not provide a corrective action plan to OLES.

Case Detail	Description
OLES Case Number	2021-01201-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly kicked a resident and allegedly grabbed a second resident and made him stand facing the wall for 30 minutes. A second psychiatric technician allegedly was verbally abusive to residents.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigator did not consult with OLES with regard to an investigative plan, did not notify OLES of all interviews and did not provide OLES with a draft report. The investigation was focused on whether the reporting party was dishonest as opposed to whether the allegations of abuse occurred. The investigator's interview with the reporting party was antagonistic and unproductive. The conclusion of the report was primarily focused on the actions of the reporting party and did not include an appropriate probable cause analysis.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The OPS did not provide OLES with an investigative plan and began conducting interviews prior to consultation with OLES. 2. Were all of the interviews thorough and appropriately conducted?

	No. The investigator was unnecessarily antagonistic in his interview of the reporting party, resulting in the reporting party becoming defensive. 3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. A draft copy of the investigative report was not forwarded to OLES. 4. Was the final investigative report thorough and appropriately drafted? No. The final investigative report was more focused on the actions of the reporting party rather than on the abuse allegations. Furthermore, the report did not include a probable cause analysis.
Department Corrective Action Plan	The department did not provide a corrective action plan to OLES.

Case Detail	Description
OLES Case Number	2021-01401-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A resident with a history of seizures was diagnosed with a fractured hip and shoulder. The resident was unable to describe consistently how the injury may have occurred.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01469-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Unknown Origin)

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a resident to the floor and repeatedly kicked the resident in the chest, causing him to sustain a broken rib.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01494-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly used unnecessary force to place a resident in a restraint chair.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00004-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a resident on the 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 investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Insufficient

	The department did not comply with policies and procedures governing the investigative process. The initial responding officer failed to conduct a thorough and complete interview of the resident thereby requiring a second interview. The second interview conducted by the same officer was equally insufficient. As a result, an investigator was assigned to obtain an adequate interview. The investigator failed to sufficiently consult with OLES and finalized the report and closed the investigation without notice to OLES.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The initial responding officer did not conduct a thorough and complete interview with the resident. As a result, the officer was required to conduct a second interview. That interview was insufficient as well. 2. Was the incident properly documented? No. The initial responding officer did not accurately document the resident's responses in the official report. 3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The investigative report was finalized and closed without consultation with OLES.
Department Corrective Action Plan	The department did not provide a corrective action plan to OLES.

Case Detail	Description
OLES Case Number	2022-00612-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A resident was observed with a small bruise on the upper right side of his buttocks. The resident believed he backed into an object but was unsure as to how or when he sustained the bruise.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services did consult with OLES regarding the sufficiency of the investigative report before finalizing the report and closing the investigation. The final investigative report contained unnecessary opinion and speculation.
Pre-Disciplinary Assessment	1. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES? No. The Office of Protective Services misclassified the incident as an "injury of known origin." 2. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The draft investigative report was not forwarded to OLES prior to being finalized. 3. Was the final investigative report thorough and appropriately drafted? No. The final investigative report contained the investigator's opinion and speculation.
Department Corrective Action Plan	The department did not provide a corrective action plan to OLES.

Case Detail	Description
OLES Case Number	2022-00629-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A resident alleged that a psychiatric technician had inappropriately touched him over his clothes. The resident also alleged that on an undetermined date, a senior psychiatric technician pulled his jacket.
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 of the investigation was provided to the department.
Investigative	**Case Rating:** Insufficient

Assessment	The department did not comply with policies and procedures governing the investigative process. The officer did not provide the two suspect employees with the legally required Beheler admonition prior to taking their statements. Interviews of the resident were incomplete. The officer's report was finalized and the investigation closed without consultation with OLES.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. While the responding officer interviewed the relevant parties, several of the interviews were insufficient. The officer did not provide the two psychiatric technicians with the legally required Beheler admonition prior to taking their statements. The second interview of the resident was incomplete. The officer failed to question the resident about the scope of his recantation and only discussed the allegations against one of the psychiatric technicians. As a result, the officer had to re-interview the resident for a third time to determine whether the resident was also recanting his allegation against the second psychiatric technician. The third interview of the resident did not fully test the credibility of the resident's recanted statement. The Office of Protective Services did not conduct any further interviews of the resident to ensure his recantation of the allegations against the second psychiatric technician to ensure the recantation was knowing and freely made, despite OLES' recommendation. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The report was finalized and investigation closed without consultation with OLES.
Department Corrective Action Plan	The department did not provide a corrective action plan to OLES.

Administrative-With Sustained Allegations

Case Detail	Description
OLES Case Number	2021-00318-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling

Incident Summary	An officer allegedly engaged in unauthorized activities, was out of uniform, and was discourteous to a supervisor.
Disposition	The hiring authority sustained the allegations and issued the officer a memorandum of direction. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00014-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	An on-duty officer allegedly was armed with a firearm, without authorization.
Investigative Assessment	The hiring authority sustained the allegation. However, the officer retired before disciplinary action could be imposed. A letter was placed in the officer's official personnel file indicating he retired under adverse circumstances.

Administrative-Without Sustained Allegations

Case Detail	Description
OLES Case Number	2021-00671-1A
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	A psychiatric technician allegedly pulled a resident's hair to stop the resident from hitting her head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The department did not adequately communicate with the OLES monitor regarding the process for reviewing the draft investigative report and did not inform the OLES monitor when the final investigative report was forwarded to the

	hiring authority for review. The hiring authority did not timely consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The hiring authority received the investigative report on August 31, 2021, but did not hold the disposition meeting with OLES until December 30, 2021,121 days later. 2. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The department did not adequately communicate with the OLES monitor regarding a review of the draft investigative report, did not provide the OLES monitor with the final investigative report, and did not notify the OLES monitor when the final report was sent to the hiring authority for review.
Department Corrective Action Plan	The OPS has made a flowsheet to ensure OLES is provided with the investigative report.

Case Detail	Description
OLES Case Number	2021-01186-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement supervisor allegedly made a discourteous statement about another state employee.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01186-4A
Case Type	Monitored
Incident Types	1. Misconduct

Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement supervisor allegedly made a discourteous comment to two peace officers.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01427-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly used marijuana and possessed marijuana paraphernalia on facility grounds.
Disposition	The hiring authority determined the allegation was unfounded. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00116-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Insubordination
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement supervisor allegedly disclosed confidential information regarding an investigation.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases

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

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

The disciplinary phase is rated for sufficiency based on timely consultation with OLES during the disciplinary process, and whether the entire disciplinary process was conducted in a timely fashion, the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
OLES Case Number	2021-00217-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	An officer allegedly asked a department employee to run a vehicle registration inquiry on a vehicle for personal reasons.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 5 percent for four months was the appropriate penalty. The OLES concurred with the hiring authority's determination. The sergeant filed an appeal with the State Personnel Board. The department entered into a settlement agreement whereby the sergeant agreed to withdraw his appeal and the department agreed to early removal of the disciplinary action from his personnel file. The OLES concurred as the penalty remained the same and the settlement was not unreasonable.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and

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

Appendix D: Monitored Issues

Case Details	Description
OLES Case Number	2020-01285-2MI
Case Type	Monitored Issue
Incident Types	1. Misconduct 2. Significant Interest - Attack on Staff 3. Significant Interest - Attack on Staff 4. Significant Interest - Attack on Staff 5. Use of Force Review
Incident Summary	The Office of Law Enforcement Support received notification from the Department of Developmental Services of a battery on a peace officer involving an officer and a resident. The OLES conducted a use of force review and discovered discrepancies within the reports involving the officer's use of force. As a result, OLES initiated an investigation into potential peace officer misconduct. During the investigation OLES identified policy violations regarding the documentation of uses of force.
Disposition	The OLES recommended that the department review the circumstances and individual deviations from policy and address accordingly with the respective employees as appropriate. The OLES also recommended that the department review its use of force policies, including the proper procedures for conducting use of force investigations. This review should be followed up with extensive training, particularly as it pertains to the supervision and on-scene direction of investigations. In response, the department developed a training module to address the issues identified by OLES.

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.

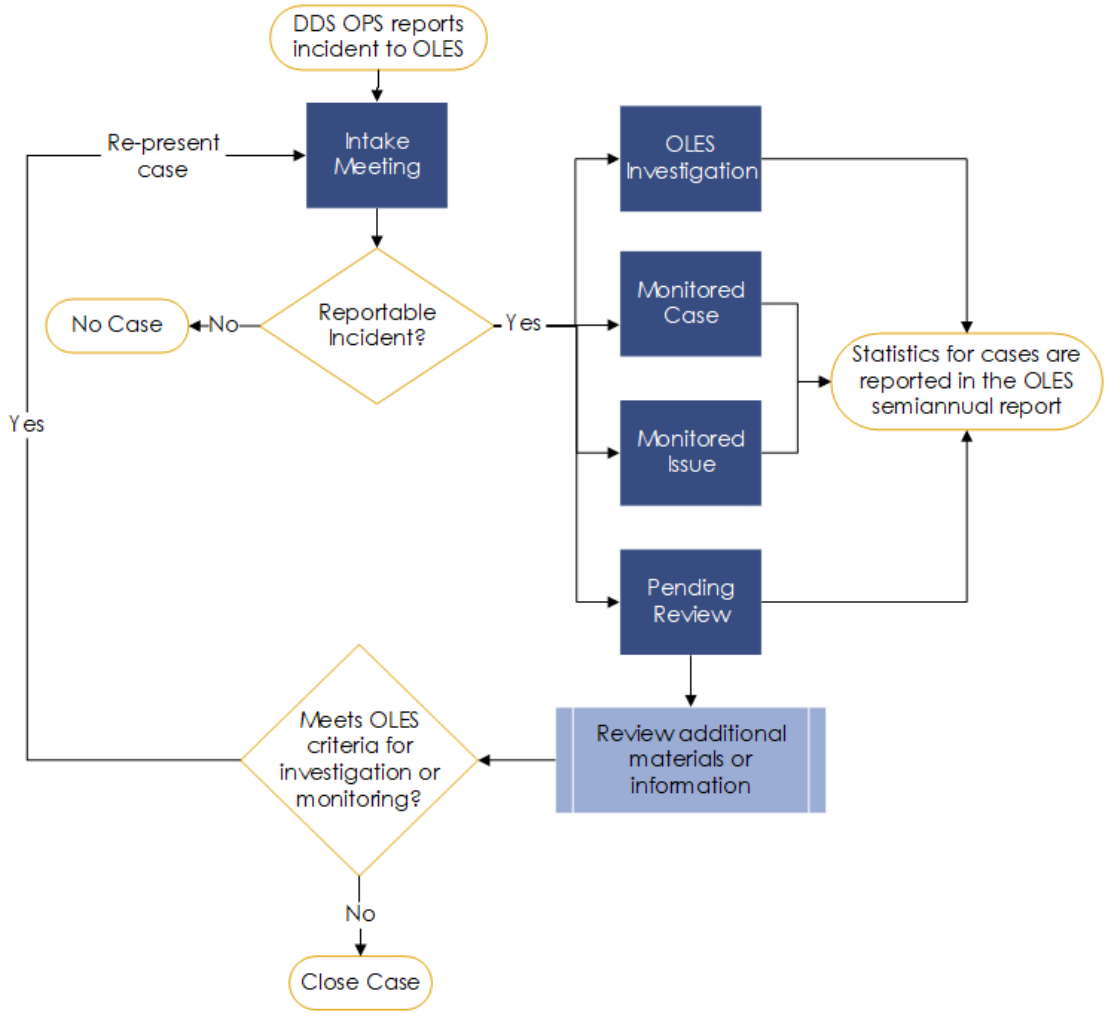
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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.