Office of Law Enforcement Support

Semiannual Report

July 1, 2024 - December 31, 2024

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 semiannual report (SAR) by the Office of Law Enforcement Support (OLES) in the California Health & Human Services Agency. This report details OLES's oversight and monitoring of the Department of Developmental Services (DDS) from July 1 through December 31, 2024.

In this report, OLES provides details on 34 reported incidents and the results of completed investigations and monitored cases.

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

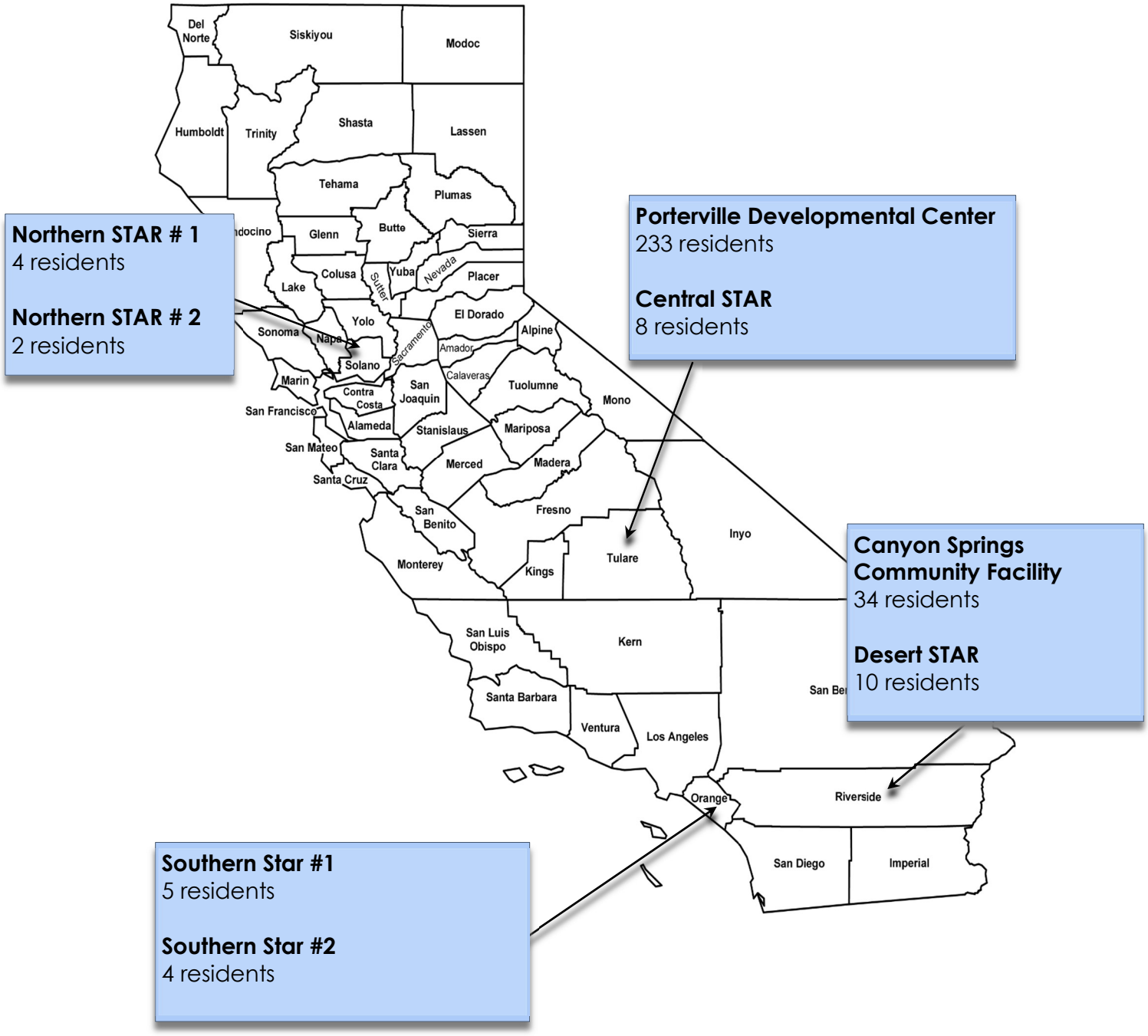
DDS timely reporting of mandated incidents for the period of July 1 through December 31, 2024, was 97.1 percent.

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

Christine Allen
Acting Chief
Office of Law Enforcement Support

Facilities

OLES provides oversight and conducts investigations for the DDS facilities below. Population numbers reflect the total residents served as of December 31, 2024, and were provided by the department. Residents in DDS receiving acute crisis services are listed in Stabilization, Training, Assistance and Reintegration (STAR) homes.

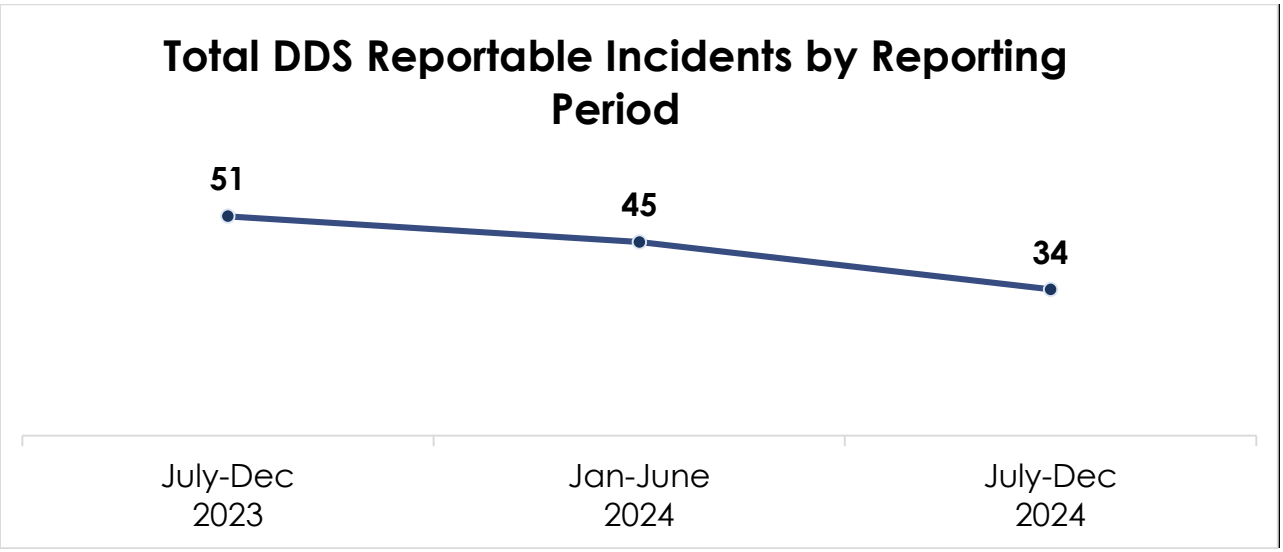


Total Residents Served by Facility

Facility	Total
Canyon Springs	34
Central STAR	8
Desert STAR	10
Northern STAR #1	4
Northern STAR #2	2
Porterville	233
Southern STAR #1	5
Southern STAR #2	4
Total	300

Executive Summary

During the reporting period of July 1 through December 31, 2024, OLES received and processed 34 reportable incidents[1] at DDS facilities. Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is a decrease of 11 incident reports compared to the prior reporting period, which had 45 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior two reporting periods.



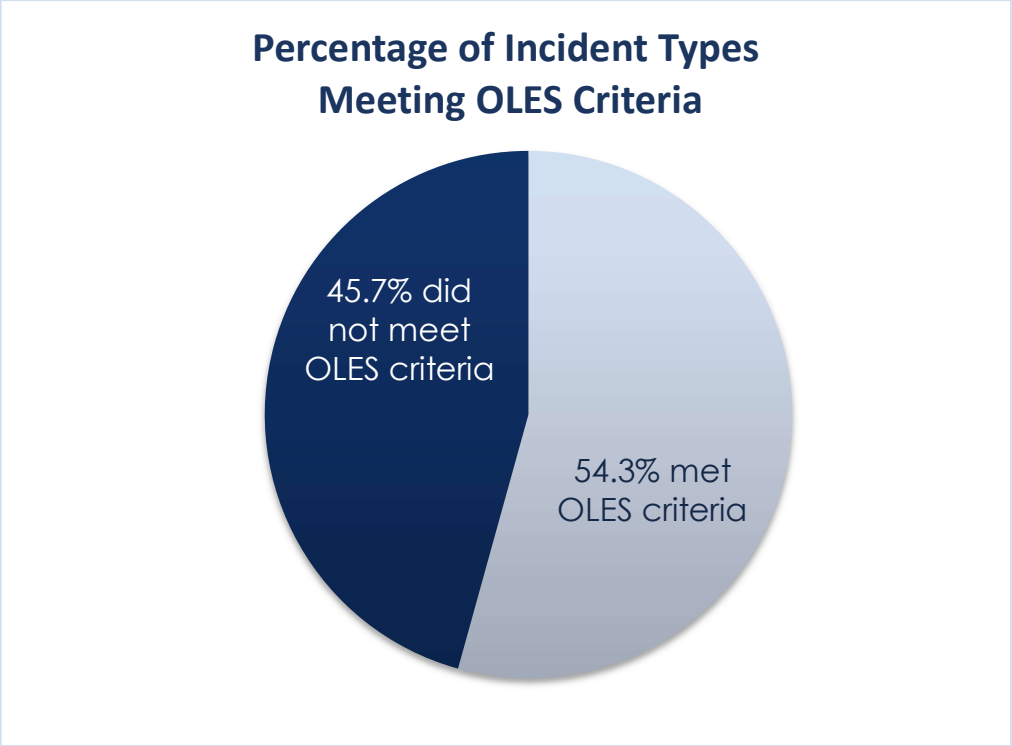
Numbers are unadjusted and are provided as they were previously published.

Incident Types Meeting OLES Criteria

DDS reports to OLES any incidents and associated reportable incident 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 OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 34 reported incidents, OLES identified one incident with two or more incident types. DDS reported a total of 35 incident types during this reporting period. Nineteen, or 54.3 percent, of the 35 incident types reported by DDS met OLES criteria.

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

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



Most Frequent Incident Types

The most frequent incident types reported were abuse, sexual assault and OPS use of force. Allegations of abuse represented the largest number of alleged incident types reported by DDS during this reporting period. OLES received 17 reports of alleged abuse, which accounted for 48.6 percent of all reported incident types reported by DDS. DDS reported four allegations of sexual assaults and four OPS use of force incidents.

Resident Deaths

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

Resident Arrests

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

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

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

Results of Completed OLES Investigations on DDS Law Enforcement

Per statute,[3] an OLES investigation is initiated after OLES is notified of an allegation that a DDS law enforcement officer of any rank committed serious administrative or criminal misconduct. As of December 31, 2024, DDS had 68 sworn staff members. During this period, OLES completed one investigation involving DDS sworn personnel.

Results of Completed OLES Monitored Cases

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

In Appendix B and C of this report, OLES provides information on two monitored pre-disciplinary administrative cases and four monitored criminal cases that, by December 31, 2024, had sustained or not sustained allegations, or a decision whether to refer the case to a prosecuting agency. The two pre-disciplinary administrative cases each had sustained allegations. During this reporting period, out of the four criminal investigations, DDS had one criminal investigation referred to a prosecuting agency.

Of the two pre-disciplinary phase cases provided in Appendix C, OLES rated each case insufficient. OLES monitored the disciplinary actions, in both administrative cases, which is provided in Appendix C. OLES rated the two disciplinary phase administrative cases sufficient.

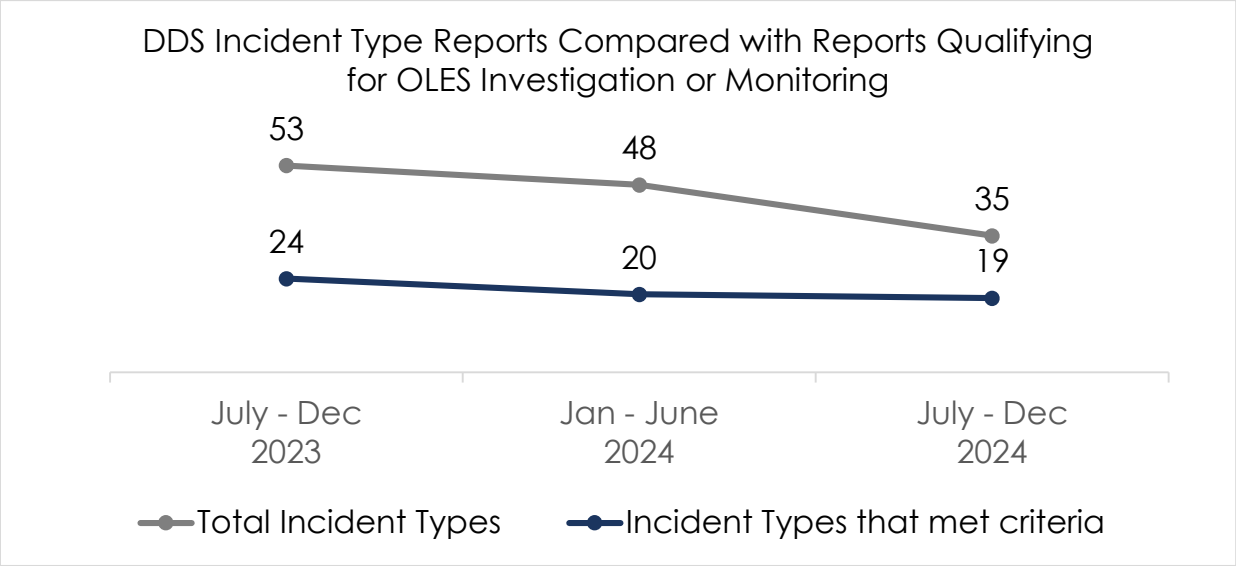
[3] Welfare and Institutions Code sections 4023, 4023.6, and 4427.5 (see Appendix D).

Incidents and Incident Types

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

Decrease in Reported Incidents and Incident Types

The number of DDS incidents reported to OLES from July 1 through December 31, 2024, decreased, from 45 during the prior reporting period to 34 in this reporting period. From the 34 reported incidents, OLES identified 35 incident types, as one of the incidents featured two or more incident types. Nineteen of the 35 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 35 reported incident types from DDS, 77.1 percent of all reported incident types fell into the following three categories: abuse, sexual assault and OPS use of force. These three incident type categories accounted for 14 incident types or 73.7 percent of all DDS reportable incident types that met the criteria for OLES to investigate or monitor.

Alleged abuse was the most frequent DDS incident type reported in this reporting period. The 17 abuse allegations accounted for 48.6.3 percent of all DDS incident types reported. Fourteen abuse allegations met OLES criteria for investigation or monitoring. Sexual assaults and OPS use of force represented the two second highest category for the number of incident types reported, with four reports each.

Most Frequent Incident Types July 1 through December 31, 2024

Incident Type Categories	Prior Period Incident Types January 1 through June 30, 2024	Current Period Incident Types July 1 through December 31, 2024	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	16	17	+ 6.1	14
OPS Use of Force	7	4	- 54.5	1
Sexual Assault	4	4	0	3

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 July 1-December 31, 2023 (Reported)	Prior Period July 1-December 31, 2023 (Meets Criteria)	Prior Period January 1-June 30, 2024 (Reported)	Prior Period January 1-June 30, 2024 (Meets Criteria)	Current Period July 1-December 31, 2024 (Reported)	Current Period July 1-December 31, 2024 (Meets Criteria)
Abuse	20	15	16	15	17	14
Attack-on-Staff [1]	0	0	0	0	0	0
AWOL	1	0	1	0	0	0
Broken Bone (Known Origin)	4	0	2	0	0	0
Broken Bone (Unknown Origin)	0	0	1	0	0	0
Burn	1	0	1	0	1	0
Child Sexual Abuse Material	0	0	0	0	0	0
Death	0	0	0	0	0	0
Drugs [2]	0	0	3	0	0	0
Genital Injury (Known Origin)	4	0	2	0	0	0
Genital Injury (Unknown Origin)	4	3	5	1	1	0
Head/Neck Injury	7	0	3	0	3	0
Misconduct [3]	1	1	1	1	2	2
Neglect	1	1	1	1	0	0
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
OPS Use of Force	2	0	7	0	4	0
Over-Familiarity	0	0	0	0	0	0
Pregnancy	0	0	0	0	0	0

Incident Type Categories	Prior Period July 1-December 31, 2023 (Reported)	Prior Period July 1-December 31, 2023 (Meets Criteria)	Prior Period January 1-June 30, 2024 (Reported)	Prior Period January 1-June 30, 2024 (Meets Criteria)	Current Period July 1-December 31, 2024 (Reported)	Current Period July 1-December 31, 2024 (Meets Criteria)
Resident Arrest	0	0	0	0	0	0
Resident-on-Resident Assault/GBI	2	0	0	0	0	0
Riot	0	0	0	0	0	0
Sexual Assault	6	4	4	2	4	3
Sexual Assault-Outside Jurisdiction [4]	0	0	1	0	2	0
Significant Interest [5]	0	0	0	0	1	0
Suicide (Attempted)	0	0	0	0	0	0
Total	53	24	48	20	35	19

[1] 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.
[2] Beginning in the July 1, 2021, through June 30, 2023, reporting periods, OLES distinguished drug-related allegations and crimes by residents or staff as a separate incident type. These incidents include verified drug offenses by residents and allegations of drug trafficking or smuggling against residents or staff.
[3] The misconduct statistics were allegations which did not involve residents.
[4] Outside Jurisdiction sexual assault occurred outside the jurisdiction of DDS.
[5] Significant Interest is an incident that may draw media attention.

Distribution of DDS Incident Types

The following table compares the total number of residents served by facility to the total number of incident types reported during the reporting period.

Population and Total Incident Types

Facility	Number of Residents Served	Total Incident Types
Canyon Springs	34	11
Central STAR	8	0
Desert STAR	10	1
Northern STAR #1	4	0
Northern STAR #2	2	0
Porterville	233	23
Southern STAR #1	5	0
Southern STAR #2	4	0
Totals	300	35

The DDS provided population numbers as of December 31, 2024.

Sexual Assault Allegations

The four alleged sexual assault incident types in this reporting period accounted for 11.4 percent of all reported incident types from DDS. Three sexual assault incident types met OLES criteria for investigation, monitoring or research into systemic department issues.

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

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

Sexual Assault Allegations Reported July 1 through December 31, 2024

Allegation Type	Total
Resident-on-Resident	1
Law Enforcement Staff-on-Resident	0
Non-Law Enforcement Staff-on-Resident	3
Unknown Person-on-Resident	0
Outside Jurisdiction [1]	2
Total	6

[1] Sexual assault-outside jurisdiction 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 Resident Deaths

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

Reports of Head or Neck Injuries

The DDS reported three head or neck injuries during this reporting period. Two head or neck injuries were the result of resident falls. One head or neck injury was the result of a patient-on-patient fight.

Reports of Residents Absent without Leave

The DDS reported no incidents of absence without leave (AWOL).

Notification of Incident Types

Different incident types require different kinds of notification to OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq., and agreements between OLES and the department, certain serious incident types are required to be reported to OLES within two hours of their discovery. Notification of these Priority 1 incident types was deemed to be satisfied by a telephone call to OLES hotline in the two-hour period and the receipt of a detailed report within 24 hours of the time and date of discovery of the reportable incident. Priority 2 threshold incidents require notification within 24 hours of the time and date of discovery. Priority 1 and 2 threshold incident types are shown in the tables below.

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 1 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 1 and 2 incident types are listed in the tables below.

Priority 1 Notification Descriptions

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.
Sexual Assault	Any allegation of sexual assault of a resident against staff, law enforcement personnel or unidentified person(s).

Priority 2 Notification Descriptions

Incident	Description
AWOL	A resident is AWOL when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in police intervention to recover the resident.
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 mouth burns caused by consuming hot food or liquid unless blistering occurs.
Drugs	Drug trafficking or smuggling.
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.

Incident	Description
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.
Over-Familiarity	Over-familiarity between staff and residents.
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 1 incident type must be reported in accordance with the Priority 1 reporting requirements.
Pregnancy	A resident pregnancy.
Resident Arrest	Any arrest of a resident.
Riot	As defined for OLES reporting purposes.
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).
Serious Crimes	The commission of serious crimes by resident(s) or staff.
Significant Interest	Any incident of significant interest to the public or any incident which may potentially draw media attention.
Suicide (Attempted)	A resident suicide attempt requiring treatment beyond first aid.

Timeliness of Notifications

The DDS had one untimely report and achieving 97.1 percent in timely reporting. The prior reporting period had 95.8 percent in timely reports.

The following table compares the percentage of timely notifications by facility. All facilities were timely with reporting of incidents, except for Canyon Springs.

DDS Facility	Total Reported Incident Types	Number of Timely Notifications	Number of Untimely Notifications	Percentage of Timely Notifications
Canyon Springs	11	11	0	100
Central STAR	0	0	0	N/A
Desert STAR	1	1	1	100
Northern STAR #1	0	0	0	N/A
Northern STAR #2	0	0	0	N/A
Porterville	23	22	1	95.7
Southern STAR #1	0	0	0	N/A
Southern STAR #2	0	0	0	N/A
Total	35	34	1	97.1

Intake

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

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

For the July 1 through December 31, 2024, reporting period, 16 of the total 36 cases opened for DDS incidents that occurred within DDS's jurisdiction or 44.4 percent were assigned a pending review. OLES opened no administrative investigations. OLES opened 19 monitored criminal cases and no monitored administrative cases.

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

Cases Opened from July 1 through December 31, 2024

OLES Case Assignments	July 1 - December 31, 2024	Percentage of Opened Cases
Pending Review	16	44.4
Monitored, Criminal	19	52.8
Monitored, Administrative	0	0
OLES Investigations, Administrative	1	2.8
OLES Investigations, Criminal	0	0
Totals	36	100.0

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

Completed Investigations and Monitored Cases

OLES has several statutory responsibilities under the California Welfare and Institutions Code section 4023 et seq. (see Appendix D). These include:

- Investigate allegations of serious misconduct by DDS law enforcement personnel. These investigations can involve criminal or administrative wrongdoing, or both.
- Monitor investigations conducted by DDS law enforcement into serious misconduct allegations against non-law enforcement staff at the departments. These investigations can involve criminal or administrative wrongdoing, or both.
- Review and assess the quality, timeliness and completion of investigations conducted by the departmental police personnel.
- Monitor the employee discipline process in cases involving staff at DDS.
- Review and assess the appropriateness of disciplinary actions resulting from a case involving an investigation and report the degree to which OLES and the hiring authority agree on the disciplinary actions, including settlements.
- Monitor that the agreed-upon disciplinary actions are imposed and not inappropriately modified. Note that this can include monitoring adverse actions against employees all the way through *Skelly* hearings, State Personnel Board proceedings and lawsuits.

OLES Investigations

During this reporting period, OLES completed one investigation involving DDS law enforcement misconduct. The investigation was administrative and forwarded to facility management for review. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted.

OLES Monitored Cases

In this report, OLES provides information on six completed monitored cases. Four investigations were criminal, and two investigations were administrative. The DDS referred one monitored criminal case to a district attorney's office. Both 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	1
Criminal/Not Referred	3
Total Criminal	4
Administrative/With Sustained Allegations	2
Administrative/Without Sustained Allegations	0
Total Administrative	2
Grand Total	6

Pre-Disciplinary Phase Cases

Of the six pre-disciplinary phase cases provided in Appendix B and C, OLES rated two cases insufficient. Deficiencies found in insufficient cases include, but are not limited to, incomplete investigations, failure to consult with the OLES monitor, and untimely investigations. Corrective action plans for deficiencies in pre-disciplinary phase cases are provided in Appendix B.

Disciplinary Phase Cases

OLES monitored the disciplinary action, Skelly hearings, settlements, and State Personnel Board proceedings in two administrative cases. Both cases were deemed sufficient. Details regarding the monitoring of these cases are in Appendix C of this report.

DDS Use of Blue Team/IAPro

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

During the semiannual reporting period of July 1 through December 31, 2016, DDS reported PDC conducted a pilot to test the Blue Team/IAPro early intervention system. The DDS agreed to track eight incident-types: Use of Force, Resident Complaints, Citizens Complaints, Citizens Complaints-Other, Vehicle Accidents, Administrative Investigation, Censurable Incident Report and Merit Salary Advance Denial. Due to

having only four qualifying incidents at the end of the pilot, DDS determined that the IAPro portion of the EIS could be used alone at DDS headquarters rather than having each facility use Blue Team. As reported in the semiannual report covering January 1, through June 30, 2017, after review and input by OLES, DDS issued its policy and activated the EIS in June 2017.

After learning in December 2021 that DDS had stopped using the system, discussions led to its reinstatement, with retroactive data entry completed. In 2022, DDS arranged training to ensure all relevant personnel were familiar with the system and could utilize it effectively.

During this SAR period, OLES requested data from DDS regarding the use of force incidents entered in the Blue Team/IAPro system. Between June 1, 2024, and December 31, 2024, DDS reported four incidents were entered, corresponding to the same use of force incidents reported to OLES.

Additionally, DDS indicated that training has been provided to all staff responsible for entering data into Blue Team/IA Pro.

DDS Tracking of Law Enforcement Compliance with Training Requirements

Compliance with POST Training Mandates

The Department of Developmental Services (DDS) Office of Protective Services (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 Continuing Professional Training (CPT) per 11 CCR §1005. The current POST two-year training cycle started January 1, 2022, and ends December 31, 2024.

At the end of the current POST training cycle in December 2024, one hundred percent of sworn staff completed the necessary CPT requirements.

Training Mandates and Records

CPT is intended to maintain, update, expand, and/or enhance an individual's knowledge and/or skills. Per 11 CCR §1005, every peace officer shall satisfactorily complete the CPT requirement of 24 or more hours of POST-qualifying training during every two-year CPT cycle. Of the 24-hour CPT requirement, a minimum of 18 hours shall consist of Perishable Skills training (Arrest and Control, Driver Training/Awareness, Firearms, Use of Force, and Communications). The Perishable Skills training is required for all peace officers below the middle management position.

The training coordinator(s) and/or supervisor(s) at each facility schedule Perishable Skills training for the law enforcement personnel at their respective facility ensuring staffing

needs are met. The Training Manager and POST Training Coordinator at headquarters assign and enroll all law enforcement personnel in two CPT courses every quarter amounting to four hours of CPT every quarter. Upon completion of each CPT course, law enforcement personnel are required to complete a short quiz to provide proof of understanding.

The Department also requires daily training bulletins, policy, and policy updates to be reviewed and acknowledged by all OPS personnel via the Knowledge Management System within Lexipol. Quarterly audit reports are run to determine and ensure compliance.

The POST Training Coordinator at headquarters works with the facility training coordinator(s) and/or supervisor(s) to ensure compliance and provide transparent record keeping through cloud-based tracking sheets. Additionally, quarterly reports are provided to management outlining our current CPT compliance. Relevant training certificates are centrally maintained on a web-based platform by the POST Training Coordinator as well.

The DDS OPS Training Committee meets quarterly to discuss training compliance and training operations. Per the DDS OPS 2020-2025 Strategic Plan, the DDS OPS is developing in-house training that aligns with POST CPT guidelines to offer customized training relevant to our department and to significantly reduce training and associated travel costs.

Addressing Deficiencies in Training Compliance

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

Additional Mandated Data

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

Adverse Actions against Employees

Facility	Administrative investigations completed [1]	Adverse action taken [2]	No adverse action taken [3]	Resigned/retired pending adverse action [4]
Canyon Springs and Desert STAR	6	4	0	2
Northern STAR 1 and 2	0	0	0	0
Porterville and Central STAR	15	15	0	1
Southern STAR 1 and 2	0	0	0	0
Total	21	19	0	3

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

2 Adverse action taken refers to a notice of adverse action being served to an employee after an investigation (direct action) was completed. Direct adverse action taken refers to a notice of adverse action being served to an employee without the completion of an investigation. These numbers may include rejecting employees during their probation periods.

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

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

Criminal Cases against Employees

DDS Facilities	Total Cases [1]	Referred to prosecuting agencies [2]	Not referred [3]	Rejected by prosecuting agencies [4]
Canyon Springs and Desert STAR	4	0	4	0
Northern STAR 1 and 2	1	1	0	0
Porterville and Central STAR	3	1	2	1
Southern STAR 1 and 2	0	0	0	0
Total	8	2	6	1

1 Employee criminal cases include criminal investigations of any employee. Numbers are for investigations which were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.
2 Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to an outside prosecuting agency.
3 Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by a prosecuting agency.
4 Cases rejected by prosecuting agencies are criminal cases that were submitted to a prosecuting agency and rejected for prosecution by that agency. This column includes rejected cases that were referred from prior reporting periods. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

Resident Criminal Cases

DDS Facilities	Total Cases [1]	Referred to prosecuting agencies [2]	Not Referred [3]	Rejected by prosecuting agencies [4]
Canyon Springs and Desert STAR	1	0	1	0
Northern STAR 1 and 2	0	0	0	0
Porterville and Central STAR	26	19	7	11
Southern STAR 1 and 2	0	0	0	0
Total	27	19	8	11

1 Resident criminal cases include criminal investigations involving residents. Numbers are for investigations that were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.
2 Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to outside prosecuting agencies.
3 Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by prosecuting agencies.
4 Cases rejected by prosecuting agencies are criminal cases that were submitted to prosecuting agencies and rejected for prosecution. This column includes rejected cases that were referred from prior reporting periods. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

Reports of Employee Misconduct to Licensing Boards

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

DDS Facilities	Public Health
Canyon Springs and Desert STAR	0
Northern STAR 1 and 2	0
Porterville and Central STAR	6
Southern STAR 1 and 2	0
Total	6

Appendix A: Completed OLES Investigations

Case Details	Description
Incident Date	06/05/2024
OLES Case Number	2024-00830-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An off-duty officer was arrested for allegedly driving while under the influence of alcohol.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Appendix B: Pre-Disciplinary Cases Monitored by OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by December 31, 2024, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

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

Case Details	Description
Incident Date	11/13/2023
OLES Case Number	2023-01596-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A resident sustained a large bruise on his abdomen due to an undetermined cause.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/03/2024
OLES Case Number	2024-00207-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician assistant allegedly repeatedly hit a resident.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. An administrative investigation was not opened because the psychiatric technician assistant was rejected on probation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/21/2024
OLES Case Number	2024-01446-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a resident on the knee.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of

	Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/28/2024
OLES Case Number	2024-01580-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pulled a resident to the ground and kicked the resident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases

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

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

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

Case Details	Description
Incident Date	04/16/2023
OLES Case Number	2023-00535-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	A senior psychiatric technician allegedly shoved a resident, causing her to hit her head on the wall. The senior psychiatric technician also allegedly threw his departmental keys on the ground and closed the door to the resident's room, leaving him alone in the bedroom with the resident.

Disposition	The hiring authority found insufficient evidence to sustain the allegation that the senior psychiatric technician abused the resident, but found sufficient evidence to sustain the remaining allegations, and determined a letter of reprimand was the appropriate discipline. The OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The hiring authority predetermined the subjects and allegations to be investigated without consulting the monitor. Also, the investigation was not completed until 197 days after the district attorney elected not to file criminal charges against the senior psychiatric technician. This delay was in part due to the hiring authority and Office of Protective Services chain of command's disagreement with the investigator's recommendation that a preponderance of the evidence existed to support a finding that the senior psychiatric technician abused the resident.
Pre-Disciplinary Assessment	1. Was the investigation thorough and appropriately conducted? • No The hiring authority pre-determined the subjects of the investigation, as well as the potential allegations to be investigated, without consulting the monitor. In addition, the hiring authority and the Office of Protective Services chain of command unnecessarily delayed the issuance of the investigative report due to their disagreement with the investigator's recommendation that a preponderance of the evidence existed to support a finding that the senior psychiatric technician abused resident. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 197 days after the district attorney elected not to file criminal charges against the senior psychiatric technician.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the disciplinary process.
Department Corrective Action Plan	The hiring authority and OPS will work diligently to communicate and work cooperatively with OLES before initiating and throughout the course of an administrative investigation. This case required significant involvement between numerous DDS divisions, which slowed the completion of the case. The hiring authority and DDS OPS will work diligently to mitigate barriers delaying the review and/or the decision-making process associated with investigation outcomes.

Case Details	Description
Incident Date	07/21/2023
OLES Case Number	2023-01062-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Other
Incident Summary	A psychiatric technician assistant allegedly repeatedly slammed a resident's head against the wall during a containment procedure and aggressively pulled the resident by his arms onto the restraint bed. The psychiatric technician also allegedly slammed a second resident against a wall minutes after the first incident.
Disposition	The hiring authority sustained the allegation, and determined dismissal was the appropriate penalty; however, the psychiatric technician assistant was non-punitively terminated due to licensing certification issues. The OLES did not object to the hiring authority's decision.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The

	investigation was not completed in a timely manner.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 139 days after the investigation was opened.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The Special Investigations Unit (SIU) is in the process of onboarding new investigators, which may have contributed to the delay in the completion of this investigation. The SIU manager will continue to closely monitor caseloads and investigative time frames to improve efficiency. The OPS PDC Commander will continue to meet with SIU weekly to get investigative status updates and will closely monitor investigative tracking mechanisms.

Appendix D: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

(a) The Office of Law Enforcement Support shall be responsible for contemporaneous oversight of investigations that (1) are conducted by the State Department of State Hospitals and involve an incident that meets the criteria of section 4023, and (2) are conducted by the State Department of Developmental Services and involve an incident that meets the criteria of section 4427.5.

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

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

(4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise

made available to the public upon their release to the Governor and the Legislature.

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

California Welfare and Institutions Code 4427.5

4427.5.

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

(A) A death.

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

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

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

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

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

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

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

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

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

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

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

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

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

California Welfare and Institutions Code 4023

4023

(a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of section 4900 the following incidents involving a resident of a state mental hospital:
  (1) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
  (2) Any allegation of sexual assault, as defined in section 15610.63, in which the alleged perpetrator is an employee or contractor of a state mental hospital or of the Department of Corrections and Rehabilitation.
  (3) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in section 15610.63, in which a staff member is implicated.

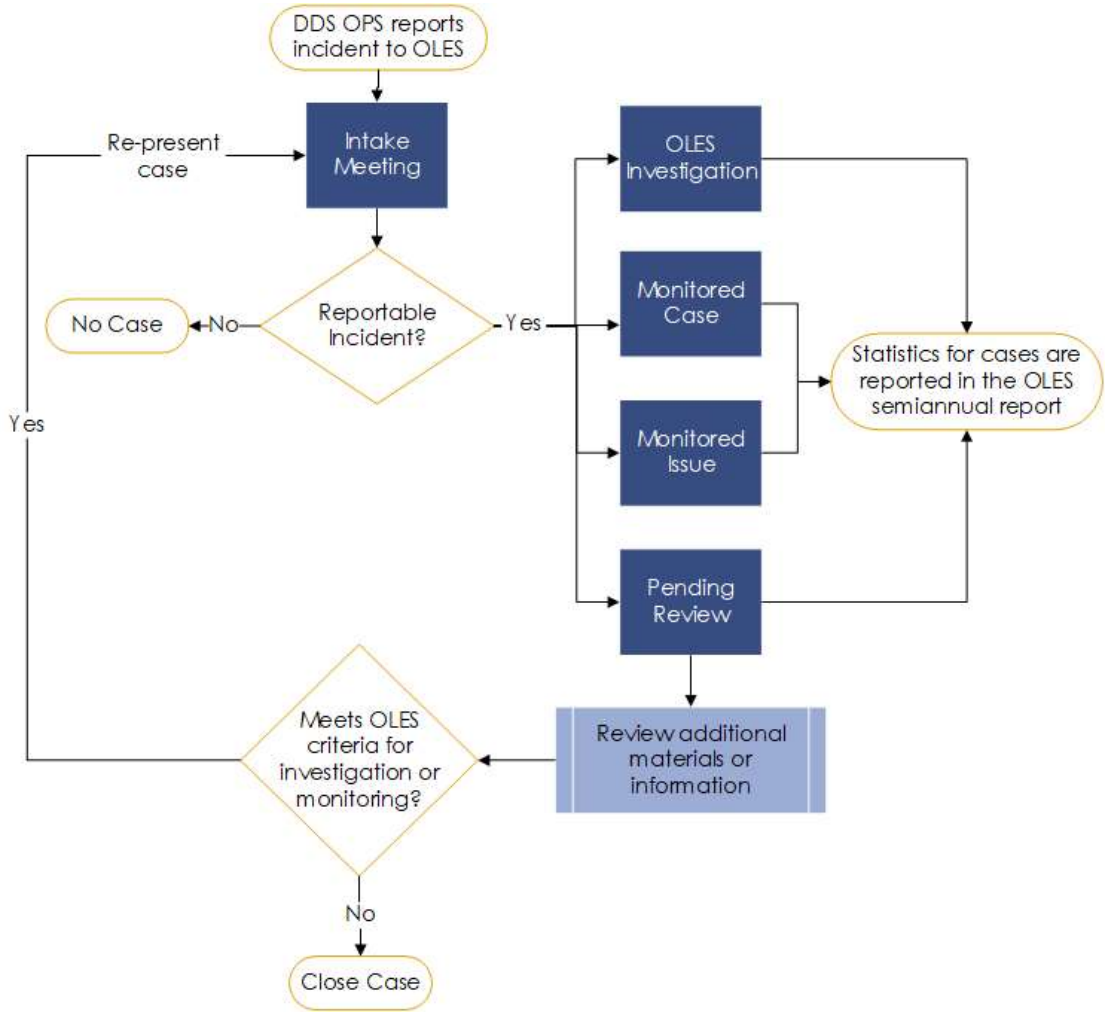
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

(a) Assault, as defined in section 240 of the Penal Code.
(b) Battery, as defined in section 242 of the Penal Code.
(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in section 245 of the Penal Code.
(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
(e) Sexual assault, that means any of the following:
  (1) Sexual battery, as defined in section 243.4 of the Penal Code.
  (2) Rape, as defined in section 261 of the Penal Code.
  (3) Rape in concert, as described in section 264.1 of the Penal Code.
  (4) Spousal rape, as defined in section 262 of the Penal Code. (5) Incest, as defined in section 285 of the Penal Code.
  (6) Sodomy, as defined in section 286 of the Penal Code.
  (7) Oral copulation, as defined in section 288a of the Penal Code.
  (8) Sexual penetration, as defined in section 289 of the Penal Code.
  (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of section 288 of the Penal Code.
(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
  (1) For punishment.
  (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
  (3) For any purpose not authorized by the physician and surgeon.

Appendix E: OLES Intake Flow Chart



Outline Description

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

Appendix F: Guidelines for OLES Processes

If an incident becomes an OLES internal affairs investigation involving serious allegations of misconduct by DDS law enforcement officers, it is assigned to an OLES investigator. Once the investigation is complete, OLES begins monitoring the disciplinary phase. This is handled by a monitoring attorney (AIM) at OLES.

If, instead, an incident is investigated by DDS but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DDS investigator and the department attorney, if one is designated[5], throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

1. Department notifies OLES of an incident that meets OLES reporting criteria.
2. OLES reviews the incident and makes a case determination.
3. If the case is monitored by OLES, the OLES AIM meets with the 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. 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.