State of California
HEALTH AND HUMAN SERVICES AGENCY
Office of Law Enforcement Support

Plan To Improve Law Enforcement In California's State Hospitals and Developmental Centers

March 2015

EXECUTIVE SUMMARY

This report details the critical and pragmatic analysis of and recommendations to improve the Office of Protective Services (OPS) within the Department of State Hospitals (DSH) and the Department of Developmental Services (DDS).

The California Health and Human Services (CHHS) Agency placed several experienced law enforcement administrators from outside agencies into key positions within DSH and DDS. Their roles were to evaluate law enforcement practices in OPS in order to identify critical deficiencies. Based on this in-depth analysis, systemic improvements must be made to OPS law enforcement operations.

The CHHS law enforcement consultant subsequently developed a comprehensive plan that focuses on the use of multilateral integrated best practices consistent with nationally recognized law enforcement standards. This integration is the structural fiber that is essential to building sustainable law enforcement operations. The Office of the Inspector General, California Department of Corrections and Rehabilitation, and other stakeholders assisted in the refinement of this plan through extensive consultation. The plan also details recommended best practices from nationally and internationally accepted standards identified by the International Association of Chiefs of Police, Commission on Accreditation for Law Enforcement Agencies, U.S. Department of Justice, California Commission on Peace Officer Standards and Training, and other respected law enforcement improvement and development organizations.

As a result of the recommendations from a myriad of resources and more than a year of analysis and observations, CHHS has developed an OPS improvement framework for DSH and DDS that addresses the following interrelated critical law enforcement functions:

- Standardized policy development
- Standardized testing, hiring, background investigations, and intra-departmental transfer practices
- Standardized training plan; development and monitoring
- Use-of-Force reporting; development and monitoring
- Early intervention system; development and monitoring
- Employee discipline and professional standards accountability
- Criminal and administrative investigation monitoring, review, and auditing

The Office of Law Enforcement Support was created to provide independent oversight of the employee disciplinary process, criminal and administrative investigations, and use-of-force. This Office will monitor all essential law enforcement functions for DSH and DDS including organizational development, critical investigation monitoring and analysis, and active involvement in the departments' disciplinary processes. The Office will conduct compliance reviews through audits to ensure sustainability.

The methods of improving law enforcement competencies while maintaining clinical integrity are based on five components: personnel, policy, training, supervision, and discipline. Each component is addressed through Office oversight. In order to maintain sustainable change, there must be a cultural shift, not simply a more strict control of the culture. Each phase of this report applies best practices found in general law enforcement and suggests modifications to them to meet the unique challenges of the state hospitals and developmental centers.

TABLE OF CONTENTS

LEGISLATIVE MANDATE

As defined in Penal Code Section 830.38(c) and Welfare and Institutions Code Section 4023.5(a) the Secretary of California Health and Human Services Agency shall provide the fiscal and appropriate policy committees of the Legislature a report with specific and detailed recommendations on improving law enforcement functions in a meaningful and sustainable way that assures safety and accountability in the State Hospital and Developmental Center systems.

PENAL CODE SECTION 830.38

(c) In consultation with system stakeholders, the agency shall develop recommendations to further improve the quality and stability of law enforcement and investigative functions at both developmental centers and state hospitals in a meaningful and sustainable manner. These recommendations shall be submitted to the budget committees and relevant policy committees of both houses of the Legislature no later than January 10, 2015.

WELFARE & INSTITUTIONS CODE SECTION 4023.5

(a) The Secretary of California Health and Human Services shall, no later than January 10, 2015, provide to the fiscal and appropriate policy committees of the Legislature a report, together with specific and detailed recommendations, reviewing and evaluating best practices and strategies, including independent oversight, for effectively and sustainably addressing the employee discipline process, criminal and major incident investigations, and the use of force within state hospitals and psychiatric programs run by the State Department of State Hospitals. The secretary may consult with the Department of the California Highway Patrol, the Department of Corrections and Rehabilitation, the Office of the Inspector General, and any other resource identified by the secretary as valuable to the analysis. It is the intent of the Legislature that the report and recommendations reflect a critical and pragmatic analysis of the department's current practices and policies, and [to] include meaningful recommendations describing how current practices and policies should be revised and reformed to assure safety and accountability in the state hospital system.

INTRODUCTION

California Health and Human Services Agency utilized an experienced law enforcement professional who is a retired assistant chief from the California Highway Patrol (CHP) to conduct a critical and pragmatic analysis of the Offices of Protective Services (OPS) within DDS and DSH. Additional active and retired senior law enforcement management personnel were also integrated into the law enforcement structure of DSH and DDS to identify deficiencies and make immediate progressive changes to improve performance. The evaluation process included:

- Conducting a pragmatic analysis of current practices and policies
- Reviewing reports completed by the Office of the Attorney General[1] and the California State Auditor[2]
- Conducting extensive discussions with department executives and OPS employees at all levels
- Touring facilities to evaluate all aspects of law enforcement operations and observe clinical practices unique to each
- Engaging patient/resident advocates and union representatives
- Consulting extensively with law enforcement experts, including the OIG
- Researching and evaluating law enforcement best practices

The evaluation revealed that despite facing detailed external audits, extensive legislative scrutiny, a period of federal monitoring, and a significant loss of federal funding and certifications, the departments did not properly or thoroughly address many of the past problems. Oversight and accountability needed to be improved in both departments. Overall, law enforcement operations were in need of immediate improvements and a significant paradigm shift within the organizational culture.

Changes that are already underway promise widespread and important impact. In law enforcement, accountability necessarily revolves around policies and procedures. Thus, when the new law enforcement management professionals arrived at DSH and DDS, they immediately began a thorough review of the departmental law enforcement policies – many of which have not been updated in years. By July 1, 2015, the two departments will not only have fully up-to-date policies that are best practices in today's law enforcement, they will institute training on the new policies for OPS staff to make sure everyone understands what the policies are and how to follow them. Systems that will be put into place in the coming months will help track staff adherence to the policies and spur management action when policies are not followed. Accountability and a permanent change in cultural behavior will be monitored by the agency-level Office of Law Enforcement Support.

Simply stated, a lack of meaningful and sustainable change increases risk to patients, residents, and employees. This plan provides a framework to make substantive changes to the entire organizational culture, significantly improve overall law enforcement competency, and avert potentially greater consequences in the future.

[1] Office of the Attorney General: Policing in the Department of Developmental Services, A Review of the Organization and Operations 2000-2001, March 2002
[2] California State Auditor: Developmental Centers, July 2013, Report 2012-107

BACKGROUND

OFFICE OF PROTECTIVE SERVICES OVERVIEW

The Department of Developmental Services and the Department of State Hospitals both maintain facility-specific law enforcement and investigation units. These units provide overall facility security and investigation services to the developmental centers and state hospitals. The law enforcement offices for DDS and DSH are referred to as the Office of Protective Services (OPS).

The Office of Protective Services within each of the developmental centers and state hospitals are staffed with sworn officers, investigators, supervisors, and managers. Hospital Police officers conduct facility security and are first responders to incidents requiring law enforcement intervention. Investigators perform subsequent followup inquiries to initial police reports and provide primary documentation on complex investigations. Supervisory and management staff provide oversight for law enforcement functions and are responsible for the accountability of subordinate law enforcement staff.

The Department of Developmental Services has established a 13-member, headquarters-level OPS command structure consisting of a chief, supervising special investigators, investigators, and non-sworn support staff. The individual OPS commanders assigned to each of the developmental centers manage law enforcement operations at the facilities and work closely with the facility executive directors to ensure adequate protective services. The OPS commanders, however, take direction and report to the OPS chief[3] in headquarters. The headquarters OPS chief is responsible for overall department OPS services and manages law enforcement support functions such as Peace Officers Standards and Training (POST) training coordination, professional standards, and background investigations.

The Department of State Hospitals has begun to create a 14-member, headquarters-level support structure. A headquarters chief of police was appointed by DSH Sacramento in April 2014, and staff is being allocated to fill support positions. Currently, each hospital OPS works independently. The hospital police chief at each facility reports to either the hospital administrator or the executive director and does not have reporting responsibilities to the headquarters chief of police. The absence of an OPS command structure within DSH has proven problematic and has resulted in inconsistent training, policies and hiring standards as well as poor quality control of investigations. It has also failed to create adequate accountability through an experienced law enforcement administrator capable of managing and directing law enforcement best practices. Conflicting legislative statutes[4] have also contributed to this problem and have provided the basis for maintaining an ineffective reporting structure that jeopardizes meaningful improvements.

[3] Welfare and Institutions Code 4415.5(a)(b)
[4] Welfare and Institutions Code section 4311 and 4313; 11 CCR § 1950

DEPARTMENT OF DEVELOPMENTAL SERVICES OVERVIEW

The Department of Developmental Services provides statewide services and support to individuals with developmental disabilities, including intellectual disability, cerebral palsy, epilepsy, autism, and related conditions. These developmental center residents are some of the most vulnerable members of our society. Many have no physical means of defending themselves or seeking assistance through verbal communication. Approximately 4,000 staff assigned to three state-operated developmental centers and one community center provide services to nearly 1,200 residents.

Court-ordered clients are provided services in the Porterville Secure Treatment Program. This highly functioning and increasingly violent population requires well-trained officers to manage the behaviors of a far more criminally sophisticated group of clients than has been served previously.

DEPARTMENT OF DEVELOPMENTAL SERVICES CHALLENGES

The Department of Developmental Services has been under intense scrutiny for a lack of investigative oversight involving acts of alleged abuse, neglect, and mistreatment towards residents of the developmental centers for many years. There has been significant criticism of OPS for improperly investigating allegations of abuse. The past failures of OPS have resulted in intense media attention, increased legislative scrutiny, and a loss of federal funding.

In 2002, the California Attorney General's Office released an 82-page report, "Policing in the Department of Developmental Services, A Review of the Organization and Operations 2000-2001." This report detailed 28 recommendations necessary to improve law enforcement operations. The recommendations, in part, included the following:

- Attract and recruit the most qualified employees
- Complete a policy and procedures manual
- Develop and implement a new organization plan
- Institute a relevant, specialized training program
- Bifurcate criminal and administrative investigations

In July 2013, the California State Auditor released a report[5] requested by the Joint Legislative Audit Committee concerning resident safety at developmental centers. This report concluded that poor leadership, poor-quality investigations, outdated policies, staffing problems, and untimely licensing reviews put residents at risk. Particular problems discovered included:

- No cohesive recruitment plan
- Vacancy rates of approximately 43 percent resulting in excessive overtime usage
- Outdated or underdeveloped policies and procedures
- Inadequate training resulting in deficiencies impacting investigation competency
- No procedures for tracking investigations
- Investigation deficiencies that may allow for continued abuse of residents

[5] http://www.bsa.ca.gov/pdfs/reports/2012-107.pdf

Over the course of many years, OPS failed to investigate serious allegations properly, thereby jeopardizing resident and staff safety. Despite direct recommendations made during the 2002 Attorney General's review, many of the same issues were reported unresolved 11 years later in the 2013 State Auditor's report. The critical law enforcement functions necessary to create meaningful and sustainable improvements have not been made.

In addition, DDS has struggled to fill law enforcement positions over the years. Inefficiencies in hiring practices as well as pay disparity compared with the California Department of Corrections and Rehabilitation (CDCR) have led to fewer and less-qualified law enforcement employees at DDS.

DEPARTMENT OF STATE HOSPITALS OVERVIEW

The Department of State Hospitals operates five state hospitals. There are also three psychiatric treatment centers located within CDCR institutions under the responsibility of DSH. Cumulatively, DSH employs more than 11,000 staff and provides care for nearly 7,000 patients.

The composition of the patient population at the state hospitals has dramatically changed over the past 20 years from being primarily civil[6] commitments to overwhelmingly forensic[7] commitments, with forensic patients now comprising 92 percent of the current population. These patients are often unpredictable and can be very violent. This volatility creates a significantly more dangerous environment for staff and other patients. For example, there were 2,586 assaults on staff in 2013 requiring medical attention beyond first aid. The need for a well-trained, highly professional law enforcement operation has become even more critical to ensure the safety and well-being of staff and patients.

DEPARTMENT OF STATE HOSPITALS CHALLENGES

An increasing number of patients enter the state hospital system after serving time in a state prison; many have an extensive history of criminal behavior. After serving decades where they were considered high-risk inmates, these individuals are reclassified as forensic patients when they transfer to a state hospital. They leave a prison environment of confinement and strict rules for an open setting commingling with many other patients some of whom cannot defend themselves against aggressive acts. The therapeutic environment at DSH facilities results in a delicate balance between treatment and security where, if the balance is off, consequences can be serious and life threatening.

The Office of Protective Services has the challenge of providing safety and security without compromising clinical practices. When a patient becomes agitated, or displays premeditated violent behavior, it is the clinical staff that must first make every attempt to calm the patient through clinical techniques before direct intervention by law enforcement is allowed. It is often difficult to clearly determine when clinical practices have failed and law enforcement interventions are necessary.

CHHS conducted an in-depth analysis of OPS operations within DSH which revealed the following critical deficiencies:

[6] The Lanterman-Petris-Short Act is a California law governing involuntary civil commitments of gravely disabled patients for psychiatric treatment.
[7] Patients committed via the criminal justice system through a court order

- Inability to recruit, hire, and retain qualified personnel
- Inconsistent and outdated policies and procedures
- Inadequate supervision and management oversight
- Inconsistent and inadequate training
- Inconsistent and deficient disciplinary processes
- Lack of independent oversight, review, and analysis of investigations
- Inadequate headquarters-level infrastructure
- Lack of experienced law enforcement oversight

The problems identified at the state hospitals were similar to those identified at the developmental centers in previous reports. It is apparent that the deficiencies discovered at DSH are systemic and significantly impact law enforcement's ability to perform its job at a sustained level of proficiency. Additionally, inefficiencies in hiring practices and pay disparity led to fewer and less qualified employees. Due to fewer employees, hospital police worked more than 270,000 hours of overtime at a cost of $10.1 million in 2013. These hours are the equivalent of 152 full-time positions. Officer pay disparity ranges between $1,500 and $2,000 a month, on average, when compared with local law enforcement agencies. Many qualified applicants are accepting employment elsewhere. Adding to this problem is the pay difference between CDCR and DSH officers of more than $1,200 a month. The result is a lack of experienced long-term officers and dependence on less experienced officers at DSH.

IMPROVEMENT FRAMEWORK: WHAT HAS BEEN DONE

OFFICE OF LAW ENFORCEMENT SUPPORT

The Office was established in 2014 under the leadership of the CHHS and will be managed directly by a chief, who is in the process of being hired. When fully staffed, the Office will provide independent oversight and be directly involved in all matters involving OPS operations. The intent of establishing the Office is to change the OPS culture through a comprehensive multidisciplinary approach affecting critical law enforcement functions. A special consulting team consisting of CHP and OIG staff is assisting the Office in the development of these specialized units. The perspective contributed by this team will ensure unit staff move forward in a timely manner under the leadership of experienced law enforcement professionals.

The following sections and their subordinate units comprise the organizational structure of the Office that have begun to hire staff:

<u>Organizational Development Section</u>

- Training and Policy Development Unit
- Selections and Standards Unit

<u>Professional Standards Section</u>

- Serious Misconduct Review Team
  - Use-of-Force Monitoring

Staff has been hired and is working in the Training and Policy Development Unit and in the Selections and Standards Unit. The supervisor for these units is assisting while undergoing the required background check before coming aboard full time. These initial Office of Law

Enforcement Support staff are working with committees comprised of DDS and DSH managers and staff to analyze primary critical functions and identify the merits and faults of each of the current systems in a manner that provides a clear and concise understanding of needed improvements. The results will assist the Office in working with the departments to bring about meaningful improvements in a timely manner. The Office will conduct ongoing audits and evaluations to ensure sustainable improvements continue over time.

Specific, direct, independent oversight for the following critical law enforcement functions is underway:

- Standardized policy development
- Standardized testing, background investigations, hiring, and intra-departmental transfer practices
- Standardized training plan; development and monitoring
- Use-of-Force reporting; development and monitoring
- Investigation monitoring, review, and auditing

Additionally, with the assistance of the CHP professionals put in place in the DDS and DSH structures, the Office is overseeing the development of the critical procedures to ensure uniformity between the departments. This effort will significantly improve the quality and stability of law enforcement and investigative functions at all developmental centers and state hospitals while assuring safety and accountability.

Office of Law Enforcement Support Procedures

- Administrative Investigation Procedures
- Employee Disciplinary Matrix
- Criminal Investigation Procedures

The California Health and Human Services Agency will ensure the Office maintains independence from the departments. The Office units will maintain direct involvement with each department's OPS by providing expertise and guidance. The Office will also implement milestones and monitor department progress through quarterly evaluations. A bi-annual improvement and accountability report to the CHHS Agency Secretary will detail this progress.

ORGANIZATIONAL DEVELOPMENT SECTION

The Organizational Development Section (ODS) is the first section staffed in the Office and is beginning to provide direct operational support to OPS command staff involving training, policy development, and recruitment, testing, background investigations, hiring, and transfers. This section works cooperatively with DSH and DDS but retains final approval authority on all matters related to its oversight. Conflicts that may arise between OPS and ODS will be resolved through the chief of the Office.

TRAINING AND POLICY DEVELOPMENT UNIT

The Training and Policy Development Unit is responsible for coordinating with OPS chiefs, the California Commission on Police Officers Standards and Testing, and other stakeholders to develop and maintain a formal training plan. A training needs assessment is being conducted to

identify the training needs and requirements for each law enforcement classification. Emphasis is on providing appropriate training, specifically dedicated to educating OPS employees on how to work with and investigate incidents involving persons with developmental disabilities and mental health treatment needs. Training plans will indicate specific training for each classification based on the following categories:

- Mandated (required by federal or state law, or by POST)
- Essential (specific to working in a developmental center or state hospital)
- Necessary (assignments requiring specialized training; e.g., canine units
- Desirable (career development training to improve overall performance)

The International Association of Chiefs of Police and the U.S. Justice Department have conducted extensive research on the topic of police training protocols. The consistent and overriding factor of their studies is that law enforcement must make a cultural paradigm shift from a reactive response to one that is proactive.

The Training and Policy Development Unit will proactively identify training needs. The departments will be responsible for the initial training as well as identified periodic updates to ensure continued competency. Already, between June 2014 and September 2014, DDS OPS worked with a consultant to develop in-house training related to Autism and Law Enforcement. DSH staff as well as other outside law enforcement agencies participated in this course. In addition, OPS staff participated in the development of a training course for law enforcement: "Investigations within Mental Health/Developmental Center Facilities." The Office of Law Enforcement Support will monitor the departments' law enforcement training outcomes to ensure that the funding adequately addresses training requirements.

The Training and Policy Development Unit will also be responsible for oversight of law enforcement policy development for DSH and DDS. The departments, however, will be responsible for selecting workgroups to participate and will have a significant role in policy and procedure development. The Training and Policy Development Unit will have the primary responsibility to ensure that each policy is properly written, legally vetted, compliant with federal or state law, and meets law enforcement best practices. The Training and Policy Development Unit will also ensure ongoing verifiable training pertaining to law enforcement policy and procedures is provided to each law enforcement employee on a daily basis.

A contract with an outside vendor is providing legal support for policy oversight. Policies at DSH and DDS are being cross-referenced and categorized to ensure legal requirements and best practices are met. New policy manuals will be ready for use by July 1, 2015. Daily Training Bulletins will provide the policy training component necessary to train and test employees on policies and procedures. The Daily Training Bulletins consist of a brief scenario illustrating realistic circumstances officers typically encounter. Each scenario is linked to a specific policy, which puts it in an operational context and helps sworn personnel understand why the policy exists and how it applies to their daily tasks. The Daily Training Bulletins system includes a brief test the officer must pass and creates a digital record of the officer's review and training of each policy. The departments can also create their own customized bulletins in the system for additional training needs, and the training component allows OPS to track training by officer, topic, and policy. Electronically archived training can be used to generate reports for administrative support.

SELECTIONS AND STANDARDS UNIT

The Selections and Standards Unit (SSU) coordinates all recruitment, testing, background investigations, hiring and transfers of OPS employees. The Selections and Standards Unit will work cooperatively with the developmental centers, state hospitals, respective Human Resources sections, and the California Department of Human Resources to establish a diverse workforce. Recruitment efforts will include an active Internet, Intranet, and social media presence. The Office of Law Enforcement Support will coordinate law enforcement recruitment needs from a central location and will provide oversight of the departments' hiring practices.

Although the Office of Law Enforcement Support, executive directors, hospital administrators, and police chiefs/commanders will actively participate in the selection process, each department's Chief of OPS will oversee the department's law enforcement recruiting, testing, background investigations, hiring, and transfers. Policies and procedures that standardize testing, background investigations, hiring and transfers will be established by July 1, 2015. This standardization will, among other things, improve the efficiency of the hiring process for law enforcement at DSH/DDS and ensure that new hires consistently meet requirements. At a minimum, the standardization will include the following:

- A written or other approved testing method conducted quarterly
- Oral interviews as part of the law enforcement hiring process using a multidisciplinary approach (medical, administrative, and law enforcement management personnel)
- Applicants will indicate where they are willing to work within the DSH or DDS facilities prior to completion of the testing process
- The intra-departmental transfer process for state hospitals and developmental centers will be simplified to allow for an efficient and effective movement of OPS employees
- All law enforcement applicants will meet minimum standards

SERIOUS MISCONDUCT REVIEW TEAM

To improve the quality of DDS and DSH criminal investigations, the Serious Misconduct Review Team (SMRT) is being established; potential staff members have been interviewed and are in the process of being hired. This specialized review team is responsible for reviewing all criminal investigations completed by department OPS personnel associated with alleged acts of abuse, neglect, or mistreatment. Criminal investigations meeting the following criteria will be reviewed prior to submission to a District Attorney:

- Death
- Sexual assault
- Assault with a deadly weapon
- Assault with force likely to produce great bodily injury
- Injury to the genitals when the cause is undetermined
- Broken bone when the cause is undetermined

The Serious Misconduct Review Team will accomplish the following:

- Provide oversight independent from the departments on all major criminal investigations
- Identify and correct critical criminal investigation deficiencies before submission to the district attorney, when possible
- Provide quality control to identify investigation weaknesses and training deficiencies

- Monitor criminal investigations meeting identified critical thresholds to ensure timely completion

USE-OF-FORCE MONITORING

The Serious Misconduct Review Team will work cooperatively with OPS to develop a comprehensive use-of-force policy defining force options consistent with state and federal law and incorporating best practices. The Office of Law Enforcement Support will monitor use-of-force incidents including any level of force used to restrain any person in order to overcome resistance during an arrest or to prevent injury to a patient, resident, citizen, or employee. Use-of-force includes the use of any of the following:

- Any weapon
- Electronic restraint device
- Chemical agents such as pepper spray
- Punch, hit, kick, or other physical action directed at another person

Although handcuffing is normally not considered a reportable use-of-force in general law enforcement operations, use of restraints by OPS personnel resulting in injury will be a reportable use-of-force within the state hospitals and developmental centers.

Policy will also identify immediate notification procedures to the Office of Legal Affairs (OLA) when use-of-force threshold incidents occur. The Serious Misconduct Review Team will work with OPS to record and track all use-of-force incidents. The Office of Law Enforcement Support will monitor the system to identify trends and provide oversight for corrective action. Emphasis on increasing employee and patient/resident safety, reducing liability to the state, and properly addressing the unique needs of persons with developmental disabilities and mental health treatment needs is a priority.

Reporting requirements will ensure that all OPS employees involved in a use-of-force incident complete an electronic use-of-force report before the end of their shifts. Law enforcement management personnel will review and approve each use-of-force report. System integration between DSH, DDS, and the Office of Law Enforcement Support will ensure proper oversight.

IMPROVEMENT FRAMEWORK: NEXT STEPS

PROFESSIONAL STANDARDS SECTION

The Serious Misconduct Review Team is the initial part of a proposed, larger Professional Standards Section of the Office of Law Enforcement Support. The full Professional Standards Section is needed to ensure that proper, well-documented and complete investigations at the facilities are conducted.

To accomplish this goal, the Professional Standards Section will provide direct administrative investigation services on complex investigations and comprehensive analysis of all major investigations within DSH and DDS, not just of criminal cases. However, criminal and administrative investigations will be clearly bifurcated using two separate investigative teams.

The Professional Standards Section will be responsible for coordinating with DSH and DDS to develop effective procedures for both criminal and administrative investigations. Administrative investigations involve potential employee misconduct that could lead to disciplinary action. The Professional Standards Section will monitor and provide direct oversight to ensure DSH and DDS compliance with established procedures. Compliance will be accomplished through direct monitoring and review, as well as through quarterly audits.

The full, proposed Professional Standards Section will contain three primary units:

1. Special Investigations Unit
2. Investigations Analysis Unit
    - Serious Misconduct Review Team
3. Vertical Advocate Unit

SPECIAL INVESTIGATIONS UNIT

The Special Investigations Unit will monitor and assist with complex investigations involving employee misconduct associated with the following critical incident threshold criteria:

- Death
- Sexual assault
- Assault with a deadly weapon
- Assault with force likely to produce great bodily injury
- Injury to the genitals when the cause is undetermined
- Broken bone when the cause is undetermined

The unit will also assist or conduct, as appropriate, investigations under the following circumstances:

- Serious allegations of misconduct involving law enforcement personnel; for example, dishonesty, moral turpitude, misuse of position, excessive use-of-force
- Other incidents at the discretion of the Office of Law Enforcement Support chief
- Other incidents requested by the department's respective Chief Deputy Director

Personnel assigned to the Special Investigations Unit will be trained to be subject matter experts with the capability to investigate identified threshold incidents successfully. Additionally, clinical staff consultants, trained to assist with complex investigations, may assist with investigations that require extensive clinical expertise. This balance of experience will allow for a broader perspective during investigations. Clinical staff consultants will meet the following criteria:

- Supervisory or management-level staff at or above the level of the subject of the investigation
- Provided with essential training to understand investigation processes and provide effective court testimony
- Selected from an uninvolved facility, when necessary
- Not permanently assigned and used only as needed

Each department will establish the structure and scope of the advisory team using input from the medical directors, executive directors, department level OPS chiefs/commanders, and department administrators.

INVESTIGATIONS ANALYSIS UNIT

The Investigations Analysis Unit is needed, in essence, for quality control of major administrative investigations. Staff in this unit will conduct detailed analysis of all threshold administrative investigations, summarizing and noting the strengths and weaknesses of each case. The unit will also evaluate policy and procedures that may have been violated or contributed to the incident and ensure each alleged government code violation is factually supported.

The Investigation Analysis Unit will review all administrative investigations meeting the following criteria:

- All administrative investigations associated with acts of misconduct resulting in criminal filings and specifically involving allegations defined by statute[8]
- All allegations that, if proven true, could reasonably result in a recommended penalty of termination or demotion
- Other administrative investigations[9] at the discretion of the Office of Law Enforcement Support chief or at the request of the department Chief Deputy Director
- All serious allegations of misconduct involving law enforcement personnel
    - For example, dishonesty, moral turpitude, etc., and may begin prior to a conviction for a criminal offense with criminal investigating agency concurrence
- Any other acts of misconduct, as directed by CHHS through the Office likely to result in an adverse action

EARLY INTERVENTION SYSTEM

The Early Intervention (EI) System is a needed tool to help management identify potential behavior problems with OPS staff. The data-based computer system monitors incidents for selected performance indicators such as use-of-force, complaints, civil litigation involving

[8] Welfare and Institutions Code section 4427.5
[9] May include all administrative investigations completed by OPS as workload and staffing allow

officers, resisting arrest charges and sick leave usage and compares them to established thresholds. This automated data analysis is available through an electronic dashboard for the employee's supervisor and manager.

The Office of Law Enforcement Support will work with DSH and DDS to establish specific performance indicators and corresponding thresholds. The thresholds will determine three notification warning levels within the dashboard:

- Level 1 (green) performance is within established thresholds
- Level 2 (yellow) requires supervisory review: possible low-level intervention may be necessary
- Level 3 (red) requires immediate evaluation by OLES; high-level intervention may follow

The following organizations recommend the use of the EI system: U.S. Department of Justice, U.S. Civil Rights Commission, Commission on Accreditation for Law Enforcement Agencies, and the International Association of Chiefs of Police.

In recent years, EI has become accepted as a "best practice" throughout public safety. Early intervention programs have played a critical role in minimizing risk, upholding integrity, and supporting professional development throughout the nation. EI systems have also been included in consent decrees and memoranda of understanding settling lawsuits brought by the Civil Rights Division of the U.S. Justice Department under the "pattern or practice" clause of the 1994 Violent Crime Control Act. Early Intervention systems are mandated in the agreements related to the Pittsburgh Police Bureau; the New Jersey State Police; the Metropolitan Police Department of Washington, D.C.; the Los Angeles Police Department; and the Cincinnati Police Department.[10]

The EI system focuses on individual staff members with the goal of correcting employees who appear to be having performance problems or abusing their authority. The EI system also reorients the role of the supervisor by providing the supervisor with documentary evidence of an employee's performance. This documentation permits both a detailed analysis of an individual employee and comparisons with other employees. The EI system engages supervisors and managers in a non-traditional model of problem solving and can lead to significant changes in organizational culture. The EI system will generate performance information through a dashboard feature that communicates out-of-standard performance at a glance, and histogram-based analysis shows frequency of officer-involved indicators.

[10] The various consent decrees and memoranda of understanding, along with other documents, are available at www.usdoj.goc/crt/split/

VERTICAL ADVOCATE UNIT

The proposed Vertical Advocate (VA) Unit is necessary to ensure that investigations into allegations of employee misconduct are conducted with the thoroughness required for successful prosecution. The VA model was recommended to CHHS as essential oversight by the California Office of the Inspector General and directed to be instituted within CDCR by a Federal magistrate. This is a best practices model used by district attorneys who provide legal consultation and monitoring as investigations are developed and facts uncovered. Currently in DSH and DDS, administrative investigations and disciplinary efforts may not involve legal staff until late in the process. This can lead to weak cases that legal staff members are unable to prosecute. The addition of attorneys who monitor investigations will also end the practice where non-legal staff at DSH and DDS makes conclusions about employee misconduct before legal staff have an opportunity to review the cases. Additionally, early attorney involvement allows for immediate correction of investigative errors, thus ensuring that the strongest possible case is presented for prosecution.

Each VA is an employment advocacy and prosecution team attorney assigned to a regional location that allows for a rapid response after a high-risk critical incident occurs at a DSH/DDS facility. The VA will advise facility Special Investigations Units and the Office of Law Enforcement Support staff on the scope and thoroughness needed for each investigation. The VA also will discuss the investigation findings and disciplinary decisions with facility executive directors and department executives.

Among the specific VA duties are:

- For all designated cases, providing legal consultation to the assigned investigator(s) including information on the elements of a thorough investigation and assistance in the preparation of investigative interviews and the scheduling of witness and subject interviews
- Reviewing interview questions and participating in critical witness interviews
- Providing ongoing feedback to the investigator(s), including whether additional investigation is needed
- Calculating statute of limitations expiration dates
- Providing legal consultation to the Executive Director and Chief Deputy Director in all identified administrative investigation cases regarding the application of the disciplinary matrix to determine an appropriate penalty
- Approving Preliminary Notices and Notices of Adverse Action for all designated administrative investigation cases and ensuring these notices are served in a timely manner
- Attending Skelly hearings and negotiating settlement agreements for all designated cases during the hearings
- Retaining expert witnesses, as needed
- Representing the department for identified cases in disciplinary matters before the State Personnel Board
- Drafting settlement agreements for all identified cases
- Conducting legal research and analyzing latest court decisions, statutes and regulations that relate to employee misconduct cases

ADMINISTRATIVE INVESTIGATION PROCEDURES

Current administrative investigations procedures are not standardized in the departments, so sometimes, not all parties are interviewed. In addition, notification up the chain of command about an incident is not consistent in who is notified and when. Going forward, the OPS chief will direct the facility's Special Investigations Unit to conduct all administrative investigations involving threshold incidents and all incidents involving OPS personnel that rise to the level of adverse action. The Office of Law Enforcement Support will complete investigations meeting higher thresholds, as appropriate. The facility Special Investigations Unit supervisor will assign an investigator and notify the appropriate VA. The investigator will develop a working relationship and coordinate with the VA throughout the investigation.

The VA will contact the Office whenever the investigation is determined to be too complex for the skillset of the available resources or just requires additional personnel. The Professional Standards Section will provide specially trained investigators to assist with the administrative investigations, when requested. In circumstances meeting certain established thresholds, PSS will conduct the administrative investigations exclusively. The Office will work with the departments to determine thresholds and develop policies and procedures for direct PSS involvement.

Department-level OPS chiefs/commanders will coordinate with the Office Special Investigations Unit to develop a standardized administrative investigation format that accurately documents investigative facts in a well-organized manner. Additionally, the data system will allow electronic tracking of all administrative investigations.

Administrative and criminal investigations may be completed concurrently with the written approval of the law enforcement chief responsible for the criminal investigation and the concurrence of the VA. The DSH chief of police or DDS commander will assure complete bifurcation between the criminal and administrative investigations. Also, strict interpretation of Labor Code section 432.7 will be considered when a criminal investigation is used to support an administrative investigation involving a non-sworn employee.

EMPLOYEE DISCIPLINARY MATRIX

There is a significant need to standardize the employee disciplinary process within DDS and DSH. Employee discipline is currently at the discretion of each facility executive director. Therefore, penalties for similar acts of misconduct may vary considerably between facilities. It is, at times, perceived by employees that relationships, rather than the facts of a case, drive the penalty. Although the vast majority of cases do not involve preferential treatment, the perception of favoritism may still be present. This attitude negatively impacts the credibility of the disciplinary process.

Before any disciplinary action is taken against an employee, sufficient evidence establishing preponderance is necessary. The employee disciplinary matrix is a foundation for all disciplinary action considered and imposed by the respective department. Penalty baselines are derived directly from the disciplinary matrix. The matrix provides a base penalty within a specified penalty range. The base penalty represents the starting point for an action. The department would impose the base penalty unless aggravating or mitigating factors warrant a change. The department is not required to impose an identical penalty in each case.

There is often a variety of factors that may influence the authority to impose a more severe penalty in one case than in another. A variety of factors affect the penalty decision, such as, the extent to which the employee's conduct resulted in harm to public service; the circumstances surrounding the misconduct; and the likelihood of recurrence.

CRIMINAL INVESTIGATION PROCEDURES

Current criminal investigations procedures are not uniform, and notification up the chain of command about an incident is not consistent in who is informed and when. Going forward, a facility OPS officer will initially respond to all reports of abuse, neglect, and mistreatment. If the officer believes that a threshold incident reasonably occurred, the officer will immediately notify an OPS supervisor. The supervisor will be responsible for scene management, including the preservation of evidence pending the assignment of a facility Special Investigations Unit investigator. The supervisor will also inform the Office of Law Enforcement Support Special Investigations Unit and VA[11] within 30 minutes of the event. The VA will subsequently notify the involved department's OLA within two hours. The Office of Law Enforcement Support Special Investigations Unit will deploy an investigations monitor to oversee the investigation and provide assistance, as necessary.

If the officer determines that the incident does not meet the threshold criteria, or likely did not occur as reported, notification procedures to the VA and the Office of Law Enforcement Support as stated above will still be followed. The on-duty OPS supervisor will respond to ensure proper incident evaluation. Regardless of the initial findings, the officer will immediately notify the Special Investigations Unit supervisor and forward a report to the supervisor for review. Supervisors will also report the incident to allied law enforcement agencies as required by law (W&I Code section 4427.5). If the allied agency declines to accept the criminal investigation, the investigation will be assigned to a facility Special Investigations Unit investigator or an Office of Law Enforcement Support investigator, depending on the severity of the incident.

Departments will coordinate with the Office of Law Enforcement Support to establish procedures for a cohesive chain-of-command within the law enforcement branches of DSH and DDS. The Office is responsible for ensuring that the departments place an emphasis on creating an appropriately integrated law enforcement branch within the DSH and DDS systems. This integration, however, will not interfere with the level of independence necessary to provide objective investigations. The departmental chief of police/commander will coordinate with the facility administrator on all matters associated with safety and security. The Office will provide active oversight to ensure the law enforcement branches are providing the highest level of safety, service, and security to the facilities they serve.

[11] The notification to the VA and OLA during criminal investigations is for situational awareness only. The VA will not typically be involved in criminal investigations.

RECOMMENDATIONS

As detailed in this report, work has started on making specific and detailed improvements to OPS law enforcement functions in a meaningful and sustainable way at DDS and DSH. The creation of the Office of Law Enforcement Support provides structure to what otherwise might become disparate and temporary efforts on longstanding issues such as recruiting, hiring, training, development of updated policies and procedures, and the institution of best practices. Further, the Office serves as an important monitor to keep OPS progress from lapsing and to ensure accountability and consistency in both administrative and criminal investigations involving OPS staff. Quality oversight from the Office will continually press for quality law enforcement services for patients, residents, state employees, and visitors at the DSH and DDS facilities.

Much work remains to be done. The departments have been working to review and update policies, and the new policy manuals will be completed by July 1, 2015. At that point, the task of monitoring OPS staff adherence to the best-practices policies will begin and usher in the next phase of oversight that is critical to ensure that policies do not just reside in manuals, but are consistently applied to the law enforcement duties performed at DSH and DDS facilities. Thus, the Office recommends the following:

- Establish a Professional Standards Section's Special Investigations Unit so the Office can monitor critical incidents, such as those involving sexual assault or other major assaults, and assist with complex investigations involving employee misconduct at state hospitals and developmental centers. This unit will ensure these incidents are investigated thoroughly, consistently and in a timely manner across all facilities. This does not occur in the present structure.

- Establish a Professional Standards Section's Investigations Analysis Unit so the Office can provide quality control and analyses of administrative cases. These investigators will constantly evaluate policy and procedure and ensure that proper re-training is provided where applicable. The current structure does not allow for this type of refinement and improvement or consistency in investigations.

- Hire Vertical Advocates who will ensure that investigations into allegations of employee misconduct are conducted with the thoroughness required for prosecution. Without this oversight, the current practices at DSH and DDS will continue to result in a wide disparity of consequences for similar acts of misconduct and in misconduct cases that are not prosecuted. The addition of Vertical Advocates will provide for fair proceedings, reduce settlement costs, reduce negligent retention liability, and increase success rates at administrative proceedings.

- Independent, comprehensive staffing studies of law enforcement duties and needs at the state hospitals and developmental centers should be conducted and overseen by OLES. DSH and DDS have conducted few law enforcement staffing studies over the years, even as the types of residents on their premises have changed. At the same time, the departments struggle with large overtime expenses. A thorough analysis of how law enforcement staff is deployed at the facilities should be conducted to determine proper staffing levels and appropriate law enforcement duties.