Informational Hearing:
Examining Investigative Practices Within Developmental Centers

Senate Human Services Committee

State Capitol, Room 3191
March 13, 2012
1:30 – 4:00 pm

Background Paper

California's four state-owned and operated Developmental Centers care for approximately 1,800 people with developmental disabilities. These facilities lie on large campuses with various residential units that were built, in many cases, more than a century ago to house individuals who were unable to remain at home. Each Developmental Center has a mix of units that are licensed as skilled nursing facilities, general acute care hospitals or intermediate care facilities. Housing within the units is based on specific resident needs. In addition, the state operates a smaller, state-owned community facility, Canyon Springs, in Riverside County.

The Developmental Centers are part of a system of care overseen by the Department of Developmental Services (DDS). With a proposed budget of $4.7 billion for 2012-2013, DDS is responsible for coordinating care and providing services for individuals in Developmental Centers, as well as for approximately 250,000 people with developmental disabilities who receive services and supports to live in their communities. A developmental disability is defined as a severe and chronic disability that is attributable to a mental or physical impairment that begins before age 18. These disabilities include mental retardation, cerebral palsy, autism, epilepsy and other similar conditions.

The first Developmental Center opened originally as the Agnews Insane Asylum in 1888, and residents were typically co-mingled with patients who had mental illness. Over the next 70 years, increased awareness of the unique needs of individuals with developmental disabilities prompted a change in focus, as well as the establishment of other state facilities specifically for people with developmental disabilities. At their peak in 1967, the state's Developmental Centers housed more than 13,000 people.

But this trend began to reverse as therapeutic strategies were developed that allowed people to keep their family members at home, with services and supports in place. The

shift to community-based care was given weight by the U.S. Supreme Court, which ruled in Olmstead vs LC (1999) that a lack of community supports was not legal grounds for denying someone a move from an institution to a community setting. Doing so, they said, was a violation of individual civil rights. Soon after the ruling, many states began shutting down their institutions and developing additional community-based services.

California already had closed two institutions in the years preceding the Olmstead decision. In 1995, the state shuttered the Stockton State Hospital, and two years later followed with the shut-down of Camarillo State Hospital which housed clients with both mental illness and developmental disabilities. In 2009, DDS shut down Agnews Developmental Center, and the state now is in the process of closing one of its five remaining DDS institutions, the Lanterman Developmental Center in Pomona. Since January 2008, California's Developmental Center population has declined by about 20 percent to nearly 1,800 residents today.

According to DDS, care in the Developmental Centers has become more focused on serving individuals with severe behaviors, autism, co-occurring mental health disorders and those with hearing and vision deficits. In 2011, the population living in Developmental Centers included individuals with the following diagnosis. Residents may be reflected in more than one category:

- 87% were diagnosed with medical conditions requiring treatment
- 69% had severe to profound mental retardation
- 60% had a dual diagnosis of both developmental disability and mental health condition (an increase of over 10% since 2008)
- 54% required support to walk/move about their environment
- 46% had severe behavior conditions
- 45% of the total population had visual deficits

Nearly half of the residents living in Developmental Centers are aged 52 or older, including 17 percent who are 62 or older. [1]

Protecting Clients in the Developmental Centers

The creation of a protective force within the Developmental Centers is included in early statutes, which initially gave peace officer authority to the hospital administrator and allowed that person to appoint part-time officers from the ranks of hospital employees.

Over the years, additional statutes conferred upon the hospital administrator the responsibility for preserving the peace in hospital buildings and grounds and to make arrests. Current statute confers peace officer status upon police officers in the Developmental Centers and authorizes them to enforce the rules and regulations of the hospital, preserve peace and order and protect the property of the state "when and as directed by the hospital administrator."[2] Among the typical duties of an OPS officer are

[1] www.DDS.ca.gov

[2] Welfare and Institutions Code 4493, added in 1977

the investigation of thefts, investigating trespassing and suspicious persons reports, responding to missing client calls, serving legal documents and enforcing restraining orders on grounds of the Developmental Center, as well as responding to other emergency calls. Investigators at OPS are split into three tiers. Per the DDS duty statement for investigators, their responsibilities include:

> "… conducting independent criminal, civil, and/or administrative investigations to identify violations of Federal, State, and/or local laws and facility policies; develop and implement an investigative plan. Conduct and complete investigations within established guidelines as set forth in the Office of Protective Services (OPS) Law Enforcement manual. Investigations will include but are not limited to: client deaths; allegations of abuse and neglect; fraud; embezzlement; and criminal history investigations based on a subsequent arrest or DOJ/FBI notification. Collect and verify evidence. Complete clear, concise, and accurate reports. May conduct undercover or surveillance operations. Cooperate with outside law enforcement agencies.
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> May appear as a witness in court or administrative hearings; may be assigned to work odd hours under varying conditions; may be asked to respond and support uniformed officers during a critical incident; may be asked to assist in search operations of missing persons (AWOL).
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> Works closely with facility and Quality Assurance staff to insure a thorough review of incidents is completed and meets all investigative criteria.
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> Investigation responsibilities at range B are expected to be more complex and require a broader knowledge and application of investigative techniques and procedures. Incumbents conduct complex criminal, civil, and/or administrative investigations; serve subpoenas, inspection warrants, search warrants, and/or other official papers.
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> Investigation responsibilities at range C will lead and/or review the work of a small group/staff of investigators in the performance of field operations; detect or verify suspected multiple violations of laws, rules, regulations and facility policies; independently conduct the most difficult and complex investigations. May be assigned to conduct high profile or sensitive investigations; may participate in multi-agency investigations or assignments, and/or in an investigatory program (i.e. workgroups, focused investigations, development of a training program). Perform program or policy development.
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> Investigators assigned to Headquarters (Professional Standards Branch) will follow all of the above responsibilities and in addition to those above, may conduct Internal Affairs (IA) investigations and Background (BG) investigations for OPS applicants and subsequent arrest notifications on current OPS employees.

Currently the Office of Protective Service (OPS) employs 94 sworn officers, including 20 investigators. Over the past several decades, the duties and responsibilities of the Office of Protective Services has evolved into something that resembles the general law enforcement duties performed by municipal, county and university campus law enforcement officers. Yet, those familiar with OPS and the Developmental Centers are quick to point out that the environment and investigative skills needed to work with

clients who are victims and witnesses is significantly different than what a municipal law enforcement officer would encounter.[3]

This need for specialized experience in working with clients in Developmental Centers has preserved the Office of Protective Services' role, despite prior concerns about investigatory outcomes. The force has some similarities to the internal police force that works for the state hospitals within the Department of Mental Health, although there are key differences.

Perhaps the most significant difference is that OPS officers receive training at the same Peace Officers Standards and Training academies that municipal police and sheriff's departments use. (attachment) Officers in the state mental hospitals do not receive POST training, but are trained through other methods.

The need for an effective investigative body is especially critical for individuals in Developmental Centers. People with Developmental Disabilities are at disproportionately high risk to become victims of abuse and neglect. A number of studies have documented high rates of violence and abuse, and some experts estimate that people with disabilities are at a minimum four times more likely to be victimized than people without disabilities. Individuals with an intellectual disability are at the highest risk of victimization.[4] Some studies have shown that the rates of victimization are higher for people living in institutions than for those who live in the community.[5]

Public Controversy

This hearing marks the second time that the Office of Protective Services has been the focus of Legislative oversight prompted by media reports. In 2000, a series of articles in the Sonoma-Index Tribune outlined specific cases of physical or sexual assault at the Sonoma Developmental Center, questioned why the cases remained unsolved and whether they were covered up. The newspaper reported that investigators were under-qualified and inadequately trained and that site administrators were called into incident scenes before investigators arrived and questioned whether the there was a conflict of interest with investigators working for the facility they are charged with investigating.

Although the stories focused just on the one facility, they called into question the adequacy of the Office of Protective Services, which polices all DDS institutions. In May of that year, then-Sen. Wesley Chesbro, chair of the Senate Select Committee on Developmental Disabilities and Mental Health, requested the California Attorney General's office investigate the matter.

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[3] DuChesne, Loren and Thomas H. Simms, Consultants, California Attorney General's office, "Policing in the Department of Developmental Services: A Review of the Organization and Operations," 2002

[4] Sobsey, Dick and Tanis Doe. "Patterns of Sexual Abuse and Assault," Sexuality and Disability, Vol. 9, No. 3, 1991

[5] Sorensen, Daniel D. "The Invisible Victims," Prosecutor's Brief: the District Attorney's Association Quarterly Journal, (updated) Aug. 9, 2002.

That report is summarized below. The legislature, in AB 430, that year's budget health bill, mandated that each developmental center immediately report all resident deaths and serious injuries of unknown origin to the appropriate law enforcement agency that may, at its discretion, conduct an independent investigation. It required the department to annually provide written information to every developmental center employee regarding their mandate to report suspected abuse, penalties for failure to report abuse and the telephone numbers for investigators within DDS and in local law enforcement.[6]

In February 2012, a series of reports by California Watch (an independent, non-profit online investigative reporting center), outlined questionable investigative practices in several major crime investigations, including suspicious deaths, at various developmental centers.

The series, which launched online on February 23, 2012, questioned the training and qualifications of investigators and specifically of the OPS chief, who is a former firefighter at the Sonoma Developmental Center. It cites cases of suspicious injuries and deaths in which charts were altered and also points at poor police work as a reason for a lack of prosecutions in major cases. Additionally, the stories cite an increase in complaints reported to the state Department of Public Health, as indicators that abuse is increasing at a time that the population of the Developmental Centers is declining. (attachment)

Oversight and Advocacy Reports Cite Historic and Ongoing Concerns

There have been numerous reports by oversight entities and advocacy groups outlining concerns about investigative practices within the Developmental Centers.

California Attorney General Review

In 2002 the California Attorney General's office, acting upon the Senate subcommittee's request, released a report prepared by two expert consultants who evaluated investigative practices within the Developmental Centers. The 82-page paper, "Policing in the Department of Developmental Services, A Review of the Organization and Operations 2000-2001," found a number of the same concerns that have been raised in more recent reports. (attachment)

Among the findings by the consultants, Loren W. DuChesne and Thomas Simms, were a need for more clearly defined duties for law enforcement officers and a need for consistency in reporting incidents that require attention from law enforcement. This lack of structure resulted in conflicts with clinical staff which undermined the law enforcement process. They also underscored a need for specific ongoing training to bolster the lack of training and experience of the OPS staff, and they recommended that

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[6] AB 430, (Cardenas) Health: budget implementation (Chapter 171, Statutes of 2001)

DDS establish relationships with outside law enforcement agencies and implement a policy of reporting certain types of incidents to those agencies.

> Consultants found "the majority of (law enforcement) personnel lack the training, experience and proper equipment to completely preserve and collect crime scene evidence. While there is a critical need to train personnel, there should also be pre-arranged agreements with outside agencies to take over the evidence processing upon request." (P. 3)

Despite significant reservations about the investigators' experience, independence from site management and the department's ability to track individual officer's cases, the consultants stopped short of recommending that DDS eliminate its police force and investigative functions.

> "Due to the ever-increasing specialized protective services required by its clientele, the Consultants concluded there is no viable substitute for the Law Enforcement Division. Thus, the DDS should continue to maintain its own law enforcement professionals." (P. 2)

Instead, it recommended establishing Memorandums of Understanding with local law enforcement agencies that provide authority for those agencies to independently review investigations completed by OPS, and create a process for local agencies to assist or take over investigations that are in progress. The Attorney General's report also contained 28 specific recommendations for improvement, including:

- Pursing all means to recruit the highest qualified employees
- Creating an executive management position to head the Law Enforcement Division and then hire a highly qualified and experienced law enforcement candidate
- Establish policies and procedures to immediately notify local law enforcement of deaths or suspicious injuries of unknown origin.
- Develop and use standard criteria to determine which cases are referred to local prosecutors for review
- Establish a joint committee within each DC to review all DDS death investigations
- Prioritize investigation assignments based on system-wide standardized criteria
- Change the current practice of merging criminal and administrative investigations involving the same circumstance and employee
- Develop a field training officer program for all new law enforcement hires
- DDS should exercise its authority to provide firearms and authorize peace officers to carry them while on duty

It should be noted that in the wake of the report, DDS made a number of changes, including strengthening the command structure by removing investigators from the chain of command within individual Developmental Centers and having them report to a chief in the office of the DDS director.

At the time the report was published, the Attorney General's office included several investigative bureaus, which oversaw the research and production of this report. However, recent budget cuts have significantly curtailed the number of investigators in the Attorney General's office. Currently, the Attorney General's office has no prosecutor with special training in handling cases of abuse within Developmental Centers, according to a department liaison.

Civil Rights of Institutionalized Persons Act investigation

In 2004, the federal Department of Justice opened an investigation under the Civil Rights for Institutionalized Persons Act (CRIPA) into practices at Lanterman Developmental Center. Under the CRIPA statute, enacted in 1980, U.S. Attorney General's Special Litigation Section investigates state- and locally run facilities to determine whether there is a pattern or practice of violations of residents' federal rights. The Act does not authorize investigators to represent individuals or to address specific individual cases.

Two years later, the U.S. Attorney General outlined findings in a 57-page letter to then-Gov. Arnold Schwarzenegger. Among the specific concerns were findings that residents of Lanterman Developmental Center suffer significant harm and risk of harm due to the facility's failure to keep them safe, provide them with adequate behavioral and mental health services and provide them with adequate health care.

The federal investigators found that "an inadequate incident reporting and investigative system" often hampers resolution of cases of assault by one client upon another.[7] The letter to Schwarzenegger also labeled as "troubling" the high number of injuries of unknown origin recorded by staff. In a 13-month period, almost half of all incidents recorded were listed as having unknown origin, or more than 760 cases. Investigators also noted concerns about inconsistent documentation that made it very difficult to track like-type cases throughout the institution and over time.

Among the seven pages of "minimal remedial measures," was a recommendation to develop and implement procedures regarding timely and complete incident reporting and the conduct of investigations of serious incidents. DDS was able to work with CRIPA investigators and no further federal action has been taken to this point in time.

Disability Rights California reviews

In 2005, what was then Protection and Advocacy Inc., published a 54-page report outlining incidences of genital lacerations within the Sonoma Developmental Center. That report, "A Series of Suspicious Genital Lacerations at one Developmental Center: Did DDS Respond Properly?" raised concerns about investigators lack of recognition of the pattern of injuries, and lack of action in investigating them as a potential series of crimes. Protection and Advocacy Inc. has since been renamed Disability Rights

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[7] January 4, 2006 letter to Gov. Arnold Schwarzenegger from Wan J. Kim, Assistant U.S. Attorney General, Civil Rights Division, Special Litigation Section

California, and is the non-profit legal organization responsible for advocating for residents of California's Developmental Centers.

The report was prompted by five incidents occurring over five years to residents within a single program. Each injury required sutures. Each was described in reports as un-witnessed and unexplained by staff. Of concern to advocates was the fact that nobody within the institution appeared to recognize the unusual series of occurrences as potential abuse, or a potentially linked pattern. Photographs were not taken, physical evidence was not collected, victims did not receive thorough medical examinations to look for other indications of abuse and not all witnesses were interviewed. The report found that the investigations were hampered by delays in reporting the incidents and the subsequent destruction of physical evidence.

Disability Rights California also released a report in 2003, "Abuse and Neglect of Adults with Developmental Disabilities: A Public Health Priority for the State of California," questioning the sufficiency of training of OPS officers, among other issues. It noted that the hiring criteria for local law enforcement agencies includes a six-month course at a police academy while OPS officers are required to complete a 40-hour basic course in arrest, search and seizure within the first 90 days of employment. It recommended that qualifications of investigators within the Developmental Centers must be raised to "approach standards" required by local law enforcement agencies.

The report also raised concerns about the lack of training for officers in local police and sheriff's departments in investigating cases involving people with developmental disabilities. Police academies include a six-hour course in interacting with people who have either mental or developmental disabilities, although the bulk of that training is focused on intervening with people who are in psychiatric crisis. It recommended that local prosecutors and other investigators be required to take the same training.

It recommended that California create a tracking system to document the frequency of abuse or neglect for individuals with developmental disabilities across all settings. Such data is not currently collected, yet research indicates there are high rates within this population. And it recommended that the Legislature designate a lead agency with authority and responsibility to coordinate system reform.

Consortium for Innovative Practices

In 2010, DDS hired a consulting group in response to the federal CRIPA investigation. According to DDS, the Consortium for Innovative Practices was recommended by federal investigators to assist the department in structuring training, protocols and evaluation mechanisms for its police force. The report was not released by the time this background paper was published.

With this hearing, the Senate Human Services Committee highlights both the immediate and historic concerns about investigative practices at DDS and provides a foundation for future conversations and legislation.