IN THE WRONG HANDS

BASED ON THE AWARD-WINNING INVESTIGATIVE SERIES BROKEN SHIELD

HOW A POLICE FORCE FAILED CALIFORNIA’S MOST VULNERABLE CITIZENS

BY RYAN GABRIELSON
NOTES ON THIS BOOK

Decades ago, California created a unique police force to investigate crimes and unexplained injuries inflicted upon some of society’s most vulnerable citizens—men and women with severe autism, cerebral palsy and other intellectual disabilities living in taxpayer-funded institutions. This police force, the Office of Protective Services, patrols exclusively at five state developmental centers where patients have been beaten, tortured and raped by staff members.

California Watch investigative reporter Ryan Gabrielson found, however, that the state force does an abysmal job bringing perpetrators to justice.

Van Ingraham (left), then 6 years old, rides on the shoulders of his older brother, Larry Ingraham, in this 1963 photo. Van Ingraham lived at the Fairview Developmental Center for 42 years. Timothy Lazzini, seen with his mother, Donna, lived at the Sonoma Developmental Center. Both men died under suspicious circumstances at the developmental centers. COURTESY OF LARRY INGRAHAM, LEFT; COURTESY OF THE LAZZINI FAMILY
This book is the result of an 18-month investigation by
Gabrielson for California Watch and its parent organization, the
Center for Investigative Reporting, a nonprofit and independent
news organization. Gabrielson’s reporting exposed how sworn
officers and detectives wait too long to start investigations, fail to
collect evidence and ignore key witnesses—leading to an alarm-
ing inability to solve crimes.

His 2012 series, Broken Shield, prompted public outrage and
far-reaching change that included a criminal investigation, new
laws, shifts in policy and personnel shake-ups—all intended to
better protect men and women with intellectual disabilities liv-
ing in state developmental centers. Some have IQs in the single
digits. Many have no family members to care for them. In every
sense, they are wards of the state—and among the most vulnera-
ble wards at that.

Many of the victims chronicled by California Watch are so dis-
abled they cannot utter a word. Gabrielson’s reporting gave them
a resounding voice.

“This is the type of reporting that ends up actually saving lives,”
wrote Patricia L. McGinnis, executive director of California
Advocates for Nursing Home Reform, in thanking Gabrielson
and California Watch.

Our initial series ran in February 2012, but Gabrielson uncovered
more problems throughout the year, putting additional pressure
on the state to initiate reforms. None of the reporting came eas-
ily. Gabrielson encountered one reluctant source after another.
Police officials closed ranks.

In producing our ongoing series, California Watch published on
every platform. Eight of the state’s biggest newspapers ran our
stories on their front pages. Some ran editorials decrying the
state’s failures. Broadcast versions produced by our in-house
video team aired in every major market and on public radio sta-
tions. Gabrielson worked with senior multimedia producer Carrie
Ching to create haunting videos that zeroed in on two especially
horrific cases of abuse.

The 1,600 patients at these centers deserve every ounce of our
efforts. We are extremely proud that Broken Shield spurred
reforms that will ensure greater protections and justice for every
one of them.

MARK KATCHES,
EDITORIAL DIRECTOR,
CENTER FOR INVESTIGATIVE REPORTING
JENNIFER’S BODY WAS A CRIME SCENE. Deep blue bruises shaped like handprints covered her breasts. Bite marks broke the skin on her arms and back.

It was August 2006, and Jennifer, then a 31-year-old patient with mental retardation and bipolar disorder living at the Sonoma Developmental Center, said a caregiver molested her.
The center has its own internal police force, the Office of Protective Services, which opened an investigation. But detectives did hardly any investigating, failing even to check for physical evidence with a “rape kit” medical exam. The allegation relied on the word of a woman with intellectual disabilities. Case closed.

A few months later, court records show, officials at the center had indisputable evidence that a crime had occurred. Jennifer was pregnant.

For Jennifer’s parents, the reaction has been disbelief and anger. They are now raising a 5-year-old boy who Jennifer is incapable of mothering. The child is precocious and strongly resembles his maternal grandmother.

“Every time, I just imagine her being raped and screaming and crying for me,” said the woman’s mother, whose name is being withheld to protect Jennifer’s identity. “It just kills me.”

For her mother, Jennifer’s whole life has been a struggle to keep her daughter safe and emotionally content. Both tasks proved impossible.

Jennifer was born in 1975 in California. Her mother believed Jennifer was not progressing normally when the girl was 6 months old. As the baby grew into a toddler and adolescent, Jennifer showed intellectual delays.

“Sometimes I say, ‘Hi, baby, hi,’ ” the mother said, to which Jennifer responds, “Don’t touch me, move your hand.”

For most of Jennifer’s childhood, her mother said, doctors struggled to pinpoint what drove her daughter’s outbursts. When angered, she would scream and slap herself and anyone else within reach. Other times, she was sweet, even overjoyed when surrounded by her parents and siblings, her mother said.
Years later, doctors gave Jennifer what is called a “dual diagnosis,” a combination of intellectual disability and mental illness that makes treatment and care of the individual exponentially harder. Such patients often lack the cognitive tools to help manage their emotional woes. They don’t understand how their brain chemistry drives their behavior.

When her bipolar disorder brought her low, Jennifer abhorred contact, even with loved ones. “Oh, she’s not that friendly—no, you can’t touch her,” her mother said.

Jennifer lived peacefully enough in one group home until she was about 14. Her behavior turned unstable, and the teenager was regularly moved among privately run homes in the community that proved ill-equipped to care for her.

“She started (going) from group home to group home to group home,” her mother said.

Patient advocates had told Jennifer’s mother that the best way to diagnose and treat her daughter’s behavioral conditions would be to admit her to an institution. She would be observed at all times, they told her; developmental center staffs are far more experienced at prescribing drugs to tame disorders.

Her mother said she was wary and resisted the advice—initially. But she also was exhausted from years of strain overseeing Jennifer’s care without a complete diagnosis. She relented in 2002, and Jennifer, then 27, moved into the Sonoma Developmental Center.

“To have her on the right course of medication, that was the only reason to have her there,” Jennifer’s mother said.
The main building at the Sonoma Developmental Center was erected in 1908 as California’s largest institution for the developmentally disabled. MONICA LAM/ CALIFORNIA WATCH
At the time, the Sonoma center housed about 850 patients and was the nation's largest institution for the profoundly developmentally disabled. Built more than 100 years ago in wine country, it is an open campus, flush with green lawns and walking paths.

From outside, Sonoma’s residences resemble single-family homes more than dormitories, featuring front stoops and yards. Patients lounge together on porch swings.

Sonoma administrators assigned Jennifer to the Corcoran Unit, a peach-colored building tucked in the center’s far eastern end. Its red tile roof is covered with dead leaves and branches from the towering oak tree that shades the residence’s main entrance.

Everything was fine for a few years, Jennifer’s mother said. Her daughter came home many weekends. At times, however, her mother noticed injuries.

Bruises were not necessarily alarming. Jennifer would occasionally hurt herself. At one point, Jennifer cut her scalp badly. The Sonoma caregivers explained that she had been banging her head against the wall, her mother said. The center put Jennifer in her own bedroom, padded the walls and fitted her with a helmet.

In 2006, Jennifer’s injuries changed. Bite marks broke her skin, and bruises surfaced on her back and breasts. Court records show Jennifer accused a Sonoma caregiver of touching and bruising her. She showed the center’s employees and her mother the resulting injuries.

Her mother said someone clearly had been grabbing Jennifer’s breasts with violent force. The bruises were unlike anything she had ever seen on her daughter.

“I can tell if a bruise was an accident because she bruises easily; I bruise easily,” she said. “That’s not a big deal. But I
could tell when a bruise is really not a bruise, you know what I mean?"

A social worker at the Sonoma center told the mother that the Office of Protective Services had investigated the matter thoroughly, but detectives couldn’t prove Jennifer’s allegation that the caregiver had bruised her.

During the next visit home, Jennifer’s mind fixated on her alleged attacker. “She would mention his name, maybe 100 times every day,” her father said.

“Of course, it’s her word against his,” Jennifer’s mother said. “Nothing was done.”

In December 2006, the mother said doctors at the Sonoma center decided to change Jennifer’s medication regimen. They asked to keep her at the center full time for observation for more than two months. The family agreed.

Nothing seemed amiss until seven months later, when Jennifer spent the first evening of a weekend, a Friday night, at her family’s home in July 2007 with diarrhea. After several bowel movements, Jennifer’s mother noticed her daughter’s abdomen had swollen into a large, hard mound.

The mother said she thought it might be a tumor before she considered the possibility that Jennifer was pregnant. Her parents drove Jennifer back to the Sonoma center on Sunday and demanded their first-born daughter be tested for all manner of conditions.

Doctors at the institution had an answer two days later. The patient was 26 weeks pregnant, well into her second trimester.

“My world fell apart,” Jennifer’s mother said.
The Corcoran Unit at the Sonoma Developmental Center houses higher-functioning female patients. All 11 cases of sex assault reported at Sonoma from 2009 to 2012 were among patients housed in that unit. MIKE KEPKA
SAN FRANCISCO CHRONICLE / POLARIS
In April, when Jennifer was at least two months pregnant, a Sonoma center gynecologist performed a Pap smear on her. But the doctor either overlooked the signs of pregnancy or ignored them.

Jennifer could not understand what was happening inside her body. However, she knew she didn’t approve.

“She would crawl on the ground with her stomach, she would hit her stomach,” her mother said.

At a routine checkup at the UC San Francisco hospital, Jennifer “went crazy,” her mother said. “She was hitting everything, banging everything. She hit the nurse with her foot, kicking.”

Hospital physicians estimated that Jennifer was impregnated between Jan. 15 and Feb. 15, 2007. A Sonoma center employee leaked to the family documentation showing Jennifer was at the institution that entire period.

Jennifer’s disabilities make her incapable of giving consent to sex. Under state law, any sexual intercourse with a patient lacking the intellectual capacity to consent is considered rape.

Jennifer’s son was born by cesarean section in October. No one was arrested in Jennifer’s rape.

“I was a hands-on mom, and I fought for my daughter’s security,” Jennifer’s mother said. “And I still wasn’t able to protect her. Who protects these people?”

The month that Jennifer gave birth, the Office of Protective Services received a letter from a whistle-blower that named a janitor as the alleged rapist, but didn’t inform the Sonoma County Sheriff’s Office about the lead for three months, according to court records from a lawsuit Jennifer’s family filed against the state.
By then, the accused janitor had fled the country, court records said.

Regardless, the institution’s officers did not request a physical examination that might have supported a criminal prosecution. The mother said the sheriff’s office collected DNA samples from employees at the center and from the men in her family, though never tested for paternity.

Jennifer now lives in her own apartment. Her mother, family members and a hired caregiver take care of her. They are all women.

To Jennifer’s son, his grandmother serves as his mom, grandfather as dad and his biological mother is like a sister.

“I don’t know how that kid came out healthy; that’s really a miracle,” Jennifer’s mother said. “He’s a perfect kid. You should see him—he stops in the street and he spells any word he sees. He spells, and he knows all his alphabet, big letters, the little letters.”

Watch videos from our investigation at californiawatch.org/broken-shield
CALIFORNIA HAS ASSEMBLED A UNIQUE police force to protect patients like Jennifer—men and women who require round-the-clock monitoring and protection from abuse.

But as the investigation by California Watch found, detectives and patrol officers at the state’s five board-and-care institutions in Los Angeles, Orange, Sonoma, Riverside and Tulare counties routinely failed to conduct basic police work even when patients died under mysterious circumstances.
Federal audits and investigations by disability rights groups, as well as thousands of pages of case files, government data and lawsuits dating to 2000, show caregivers and other facility staff allegedly involved in choking, shoving, hitting and sexually assaulting patients. None of these cases was prosecuted.

Cases investigated as possible crimes include the death of a severely autistic man whose neck was broken. Three medical experts said the 50-year-old patient, Van Ingraham, likely had been killed. But the developmental center’s detective, a former nurse who’d never handled a suspicious death, failed to identify how the fatal injury occurred. No arrest was made in the case.

The 90-member Office of Protective Services often learns about potential criminal abuse hours or days after the fact—if it finds out at all. Of the hundreds of abuse cases reported at the centers since 2006, California Watch could find just two cases where the department made an arrest.

The Los Angeles County district attorney’s office, which oversees the Lanterman Developmental Center, couldn’t identify a single criminal case referred from the center’s police force. District attorneys in Tulare, Orange and Riverside counties also reported no prosecutions for patient abuse in the past decade. Sonoma County prosecuted a single caregiver who was caught exposing himself to a patient.

The precise number of times nurses, janitors or staff supervisors have been implicated in patient abuse cases is unknown; the state has censored thousands of pages of documents detailing the cases.
California spends more than $550 million a year to operate the centers, or roughly $340,000 per patient. More than 5,200 people work in the institutions—roughly 3.25 staff members for each patient. The $4.5 billion Department of Developmental Services is responsible for patients at the five centers.

Critics of the state Department of Developmental Services, which oversees the institutions and the Office of Protective Services, have said the tight-knit relationships between the in-house police and staff makes it difficult to create a separation between the investigators and the investigated.

In a few cases, caregivers have been hired to work for the Office of Protective Services in the same facility. The commander at the Lanterman Developmental Center worked there as a primary caregiver. The force’s former police chief was a longtime firefighter at the Sonoma Developmental Center.

The police force also suffers from a convoluted chain of command, interviews and records show. Detectives cannot make arrests without checking with department lawyers in Sacramento. Local police must be informed when serious injuries or deaths occur, but most defer investigations to the Office of Protective Services.

“It seems like something is not working in California. And that’s probably a major understatement,” said Tamie Hopp, an official with the national organization Voice of the Retarded, who noted that the volume of abuse cases in California, and the lack of prosecutions, is cause for alarm.

The developmental centers have been the scene of 327 patient abuse cases since 2006, according to inspection data from the California Department of Public Health. Patients have suffered an additional 762 injuries of “unknown
“origin”—often a signal of abuse that under state policy should be investigated as a potential crime.

The list of unexplained injuries includes patients who suffered deep cuts on the head; a fractured pelvis; a broken jaw; busted ribs, shins and wrists; bruises and tears to male genitalia; and burns on the skin the size and shape of a cigarette butt.

Timothy Lazzini, a quadriplegic cerebral palsy patient at the Sonoma Developmental Center, died in 2005 after he swallowed 4-inch swabs that shredded his esophagus. After his death, Lazzini’s doctor and a pathologist concluded it was highly unlikely that Lazzini could have placed the swabs in his own mouth.

But records show detectives waited too long to start their investigation. If any physical evidence was left in Lazzini’s room, it had been removed by the time investigators arrived. His death, and the slow response by the Office of Protective Services, has left Lazzini’s family heartbroken and without a conclusive answer as to how he was killed.

“He is gone, and they really haven’t given us as a family the information that we need to be at peace,” said Stephanie Contreras, Lazzini’s sister. “There is no peace at all.”
CHAPTER 3

THEIR LAST REFUGE

THE FAIRVIEW DEVELOPMENTAL CENTER in Costa Mesa is near the Orange County fairgrounds and surrounded by strip malls and a golf course. The Lanterman Developmental Center is wedged between train tracks and a highway east of Los Angeles.

Next door to a Cathedral City cemetery, the tiny Canyon Springs Developmental Center could be mistaken for an office park. Of the five sites, the Porterville Developmental Center, southeast of Visalia, does have the look of an institution. Among the 500 patients, the facility houses about 200 developmentally disabled patients who have committed crimes or are under arrest.
Although the centers’ populations are dwindling, California still maintains one of the largest and most expensive board-and-care hospital systems in the country for this vulnerable population.

The patients here live in a different world from most Californians. Some have spent decades in the centers, from childhood to death. Some cannot form words and have IQ scores in the single digits.

Primary caregivers, called psychiatric technicians, guide patients from place to place, feeding them and distributing medication. Each patient communicates differently, and the units are filled with shouts, groans, shrieks and crying. Patients share bedrooms. Some are crowded with stuffed animals, posters and family pictures. Others are empty, save for the full-sized beds and a cabinet.

Parents and siblings can visit every week for hours at a time.

More than two-thirds of patients are diagnosed with profound mental disabilities, according to research from UC San Francisco. The institutions have whole units for patients who are emotionally volatile, prone to striking themselves and others.

“They come to us after they’ve burned every bridge in the community,” said Erinn Kanney, a program manager at Fairview.

The disabled population adds greater complexity to criminal investigations. For a host of reasons, their observations can be tainted by fantasies and falsehoods. Their emotions veer from happy to inconsolable without warning. Patients slap and punch at their faces and legs, and at each other.

Outside of California, local or state police most often are responsible for investigating criminal cases at institutions. But city and county law enforcement agencies inside the
state have not shown an interest in developmental center cases and don’t have funding to expand their scope, according to Terri Delgadillo, director of the Department of Developmental Services.

“Oftentimes, local law enforcement does not want to get involved,” said Delgadillo, who once worked for the California Department of Corrections and Rehabilitation as a manager in the juvenile justice division. The $4.5 billion Department of Developmental Services is responsible for patients at the five centers.

Yet local police or sheriff’s deputies can act more independently than an internal police force responsible for probes into their colleagues and bosses, said Jane Hudson, senior staff attorney for the National Disability Rights Network, a patient advocacy organization.

“If there’s a crime committed,” Hudson said, “you let the criminal investigators go in first rather than the institution bagging the bloody shirt.”

In one particularly disturbing case, multiple errors were made.

Six days before he died in 2007, Van Ingraham was found on the floor of his room. His neck was broken, his spinal cord crushed and disfigured. The injury was so severe, medical experts said it looked like he could have been put in a headlock or hanged.

But even if Ingraham knew how he’d been injured, his severe autism prevented him from revealing it. He’d never uttered a word in his life—only his injuries could speak for him.

Solving the mystery of Ingraham’s death in the summer of 2007 was left to the detectives at Fairview, where Ingraham lived in a sterile room. A tiny window allowed only a sliver of light into his world.
Ingraham’s family sent him to Fairview when he was 8 years old. He lived under the care of the state for 42 years. Restless, he would sprint through hallways. He would urinate on himself when upset. At his worst, he would strike at his own face, though never at his three roommates or others around him.

The coarseness of Ingraham’s life at Fairview was matched only by the sloppiness of the investigation into his death.

The police force at Fairview failed to collect blood samples, fingerprints and other physical specimens from his room. On the day of the injury, an officer took one photograph—a headshot of Ingraham, 50, as he lay on a stretcher, his eyes open and glassy, an abrasion above his left brow.

Later, Fairview detectives noted that Ingraham’s caregiver had changed the institution’s log documenting what the patient was doing at the time of the injury. But they never pressed the issue.

The lead detective, a former nurse, had minimal police training and no experience investigating suspicious deaths.

In the case file, she left out the opinion from a biomechanical specialist that Ingraham’s death “was likely a homicide”—one of three medical experts to raise alarms about the injury. Two of those experts concluded that Ingraham likely had been put in a headlock.

In their efforts to find the person responsible, Fairview detectives eventually focused on another patient without proof he was near the scene. The key testimony leading detectives down that road came from a blind patient.

The detectives also surmised that Ingraham could have fallen out of his bed, which was about two feet off the ground. Medical experts said that scenario was highly unlikely, given the force required to produce Ingraham’s injury.
Larry Ingraham protests outside the Fairview Developmental Center in 2011. Ingraham’s brother, Van Ingraham, died as a result of a broken neck in June 2007.

COURTESY OF LARRY INGRAHAM
No arrests have been made in the case, and the Fairview caregiver last seen with Ingraham continues to work at the center. In the end, Ingraham’s family received $800,000 in a settlement with the state.

“This incompetent, horrendous organization called Office of Protective Services, takes it and just makes a mess, just a complete mangled mess of the investigation,” said Larry Ingraham, the patient’s older brother and a veteran of the San Diego Police Department.

California Watch enlisted homicide detectives from the Seattle and Chicago police departments to review hundreds of pages from case files on the Fairview investigation. The two investigators each pinpointed six mistakes made by officers and detectives at Fairview—the most significant of which came in the hours and days after Van Ingraham was discovered on the floor of his room.

The Seattle and Chicago detectives, who have a combined 51 years of experience in law enforcement, noted that Fairview police did not secure Ingraham’s room to protect evidence, did not promptly interview witnesses and did not realize that the patient’s broken neck should have been investigated immediately.

Even after the Office of Protective Services learned that Ingraham’s neck had been broken, investigators waited five days to begin witness interviews. This “gave several people the opportunity to speak about the events,” Detective Mark Czworniak of the Chicago Police Department wrote of the delay, which could have potentially undermined witness statements.

“It is my belief that the initial responders,” Detective Al Cruise of the Seattle Police Department wrote, “did not recognize the scene as a potential crime scene.”
CHAPTER 4

LAVISH PAYCHECKS

THE OFFICE OF PROTECTIVE SERVICES has existed in various forms and names since the late 19th century, when California opened its first institution for the developmentally disabled. The San Jose facility was first known as the Agnews Insane Asylum. It opened in 1885 and closed in 2009.

Interviews with current and former Office of Protective Services employees suggest the organization’s structure from its beginning has contributed to its dysfunction.
Patrol officers dress much like those at any other police department. They wear tan and green uniforms with gold badges. Handcuffs are hooked to their belts. They drive marked squad cars. But there are key differences.

Officers and caregivers are confined together in a 24-hour facility monitoring an unpredictable, sometimes uncontrollable population. Beyond a paycheck, the job is mostly thankless and hidden from the public. Officers are not allowed to carry guns; many carry pepper spray instead. They often work their shifts alone.

Greg Wardwell, a sergeant who spent more than 20 years patrolling the Sonoma Developmental Center before retiring in 2011, said the state has undermined its own police force through neglect and incompetence.

“You can look like a cop and we’ll call you a cop, but you don’t really have any way of being a cop,” Wardwell said. “Because we’re not going to train you, we won’t provide safety equipment. The salary will be so bad that we won’t be able to recruit anybody of talent.”

Salaries for the roughly 90 sworn officers are half of what police earn in the state’s big city departments. Yet, many officers within the Office of Protective Services have been among the best compensated in California law enforcement, with much of their pay gained through overtime. One officer’s income topped $200,000 a year.

Families must rely on the Office of Protective Services to provide evidence for lawsuits when their relatives are harmed or killed at a developmental center. Records show the state paid out nearly $9 million in legal settlements—out of 68 separate lawsuits—from 2004 to 2010.

In 2005, Disability Rights California issued a report on a pattern of unexplained genital lacerations suffered by male
patients at an unnamed developmental center. The cases were treated as potential sex assaults, but the investigations were woefully incomplete, documents show.

“Photographs were not taken,” the report states. “Not all witnesses, nor all key witnesses, were interviewed. Physical evidence was not collected. Victims did not receive thorough medical workups to look for other indications of abuse.”

Leslie Morrison, director of investigations at Disability Rights California, said the report showed how the developmentally disabled can be treated as second-class citizens.

“If this had happened to 3-year-old boys in a day care center, people would have been alarmed, police would have been called, there would have been an outrage,” Morrison said. “It wouldn’t have just been treated as just, ‘Oh, look, there’s a cut, we better sew that up.’”

Even while it has botched investigations, the Office of Protective Services has lavishly rewarded its rank-and-file members.

Compared to other police forces in California, an unusually high number of police officers at the board-and-care facilities have doubled their salaries with overtime, enabling some to earn more than $150,000 a year. The Office of Protective Services in 2011 paid about $2 million in overtime to 80 of its officers.

Twenty-two officers, about one-fourth of the entire police force, have claimed enough overtime to double their salaries—a rare occurrence at other police
agencies, both big and small. The average salary for the 22 officers is about $124,000 a year.

The base pay for the force averages about $44,000—relatively low compared with departments of similar size. At the Vallejo Police Department, for example, the average base pay is $98,000.

One patrolman at the Fairview Developmental Center in Costa Mesa, Daniel Butler, regularly collected more money from overtime than from his base pay. He worked for 14 years at the facility, but netted at least $60,000 a year in overtime from 2007 until his retirement in March 2011. A Porterville officer, Rick Shannon, had paychecks that included $114,000 from claiming extra hours in 2008.

Police overtime is supposed to serve a law enforcement purpose, protecting people or investigating crimes, said Leonard Matarese, a criminal justice consultant at the International City/County Management Association.

Matarese, a retired Florida police chief, said departments should account for extra hours on a weekly, if not daily, basis. The number of extra hours alone at the Office of Protective Services—65,000 a year on average from 2008 to 2010—raises alarms about the institution.

“As a police chief, I just wouldn’t allow that,” Matarese said. “It sounds like it’s completely out of control.”

Thomas Lopez, an entry-level patrolman at the Porterville Developmental Center, owns seven houses worth a
combined $1.2 million, scattered across Porterville and the Los Angeles area.

In the garage of his main residence, he keeps two pristine 1956 Chevrolet Bel Airs, collectors’ items that gleam with the original factory paint colors of Tropical Turquoise and Sierra Gold. Each car is worth at least $50,000, or about the same as Lopez’s base salary.

His paychecks have included at least $80,000 in overtime every year for much of the past decade, state data show.

The vast majority of extra hours at the Office of Protective Services have been for patrol shifts, with officers waiting for calls about incidents or circling the institutions’ parking lots, rather than investigating potential abuse cases.

“At night, it gets a little bit slow. It’s hard not to doze off sometimes,” Lopez said. “You try to stay up. But you better take your calls, and you better take your reports. It’s hard because that time drags.”

When asked if he sometimes sleeps during overtime shifts, Lopez replied, “Yes.”
ON SEPT. 26, 2011, Jim Rogers received a message on his answering machine from a man whose voice he didn’t recognize revealing a dark secret.

As executive director of the Sonoma Developmental Center, Rogers had responsibility over hundreds of patients with severe intellectual disabilities living in the facility. What he heard was horrific—a crime against several of the men under Rogers’ care.
On the other end, the man accused a caregiver at the Sonoma center of using a stun gun on patients living in the facility’s Judah Unit, home to more than two dozen patients.

What happened after Rogers was tipped off is a tale of bureaucratic delay that opens a window into profound problems at the Office of Protective Services.

An investigation would later reveal 12 patients—all men ranging in age from 33 to 61 years old—with painful thermal burns on their buttocks, arms, legs and backs. The precise burn marks on the victims’ bodies indicate that the Taser was used at close range on the victims—almost like a cattle prod.

The burn marks came in pairs, roughly a half-inch apart. On some patients, some injuries were fresher, while others were healing into scars, suggesting the attacker had abused them more than once, over several days, if not weeks.

All of the injured patients were treated at the center’s own acute care clinic. Initially, police had thought seven patients living at the Judah Unit had been assaulted, licensing records and internal correspondence show. Nurses examined every Judah patient and discovered three others with the circular burn marks.

The Office of Protective Services had a suspect from the start. The anonymous whistle-blower had accused caregiver Archie Millora of abusing the profoundly disabled men with high-voltage probes. Detectives found burn injuries on the patients. Only one of the victims is able to speak. He named Millora and used the word “stun”
when interviewed by a detective at the center, according to a state licensing record.

The following morning, the Office of Protective Services discovered a Taser and a loaded handgun in Millora’s car at the Sonoma center. On Millora’s Facebook page, he posted several photos featuring firearms. One shows an assault rifle beside a Glock, outfitted with an extended clip and sight. In another picture, Millora poses at a firing range, looking into the camera while holding an assault rifle.

Millora started at the center as an assistant psychiatric technician in 1998, earning $50,000 a year as a primary caregiver for as many as a dozen patients. His duties involved watching over patients, bathing and grooming them, and protecting them from harm.

The office received word of the abuse at 4 p.m. Sept. 26, 2011, and deployed patrol officers to the Judah Unit residence within 30 minutes. They immediately found patients with burn marks. It was Millora’s day off, so the in-house police decided to stop the caregiver on his way in to work the following day.

But the officers missed the start of Millora’s shift at 6:30 a.m., according to state records. The caregiver was on a break when police arrived shortly before 8 a.m. They intercepted Millora as he returned to the Judah Unit and received his consent to search his car, according to records.

That’s when officers discovered his weapons. They found a Glock semi-automatic pistol and a magazine containing ammunition. Stashed inside a compartment on the driver-side door, Millora had a Taser C2.

When discharged, the Taser C2 shoots two probes forward that attach themselves to the body in two spots separated by a foot or more. It sends more than 1,000 volts into the intended target.
Archie Millora, seen above at a firing range, was a Sonoma center caregiver suspected of abuse. He had other weapons posted on his Facebook page, including an assault rifle (top) and a Glock handgun fitted with a sight.

FACEBOOK.COM
However, the Taser C2 has a second setting, called “drive-stun,” said Steve Tuttle, a spokesman for Taser International. In this mode, the probes are stationary and deliver an electric shock directly to the skin. “It would cause impairment and would be painful,” he said.

Despite discovering the stun gun hidden in Millora’s car, the Office of Protective Services did not take Millora into custody for questioning. Rather, officers turned him over to administrators. Rogers put Millora on “administrative time off,” according to internal records, and the caregiver apparently left the institution at about 10 a.m. that day.

Millora’s job was in jeopardy, the licensing and administrative records show, but not his freedom.

Eleven hours after Millora was put on administrative leave, police commander Bob Lewis called Corey Smith, then the police chief of the Office of Protective Services, for instructions, according to an internal chronology of events that was created by Sonoma center officials.

Smith told Lewis to alert the California Highway Patrol, and the commander later said he made the call sometime before 10 p.m.

But highway patrol officials say they have no record of that call or any other notification from protective services during that timeframe. And even if they had been notified, the highway patrol does not handle patient abuse cases. The Sonoma County sheriff has jurisdiction over the developmental center, and it has teams of investigators with experience in aggravated assault cases.
Lewis had taken command at the Sonoma center just four weeks earlier. He’d previously worked for several years as a detective and supervisor at the Porterville Developmental Center in Tulare County. Lewis alerted the sheriff’s office the next morning, Sept. 28, about “the weapons recovered from an employee’s vehicle and the allegation of abuse,” according to the center’s chronology.

Sonoma County Assistant Sheriff Lorenzo Dueñas said Lewis never disclosed the center had confirmed patients had been attacked. “We offered to assist in their investigation, but we were told that they didn’t need our help,” he said.

The investigation continued that day, when Office of Protective Services detectives provided pictures of the patients’ injuries to a forensic pathologist for analysis. Doctors concluded that the same weapon had injured all the victims in the Judah Unit over the course of at least two weeks, according to the citation reports. “The ... patterned injuries on seven clients were strongly suggestive of and consistent with electrical thermal burns ranging in age of 36 to 48 hours up to greater than two weeks,” the citation said.

After reviewing Millora’s work schedule, medical staff found he also had contact with patients living in three other residences. Subsequently, two more patients were identified with stun gun injuries in those units, according to records.

Leslie Morrison, head of investigations for Disability Rights California, said she was surprised that the Office of Protective Services kept control of the Taser abuse cases. Someone at the police force “should have immediately picked up the phone
and called outside law enforcement,” Morrison said. “We’ve got a serial abuser here.”

At the same time, the Office of Protective Services might have thwarted a criminal investigation by local authorities, records show.

On Oct. 5, 2011, more than a week after officials received the tip about the stun gun incidents, the Sonoma center’s top administrators met with an inspector from the state Department of Public Health investigating the injuries, according to an internal memo. The inspector, Ann Fitzgerald, asked whether the attacks were a criminal case.

“It could be,” Lewis said, according to the memo.

But police at the center took steps that might have discouraged the Sonoma County Sheriff’s Office from opening its own investigation. Lewis downplayed the series of attacks against patients, telling the sheriff’s office that there was an abuse allegation, not a dozen confirmed cases, the internal correspondence shows.

Sonoma County Lt. Dennis O’Leary said Lewis informed them “just that there was some suspicion that there may have been some abuse to the patients.”

On its face, the mounting evidence looked strong. But after days of delay, the Office of Protective Services eventually referred a criminal charge against Millora for carrying a concealed firearm, a misdemeanor, according to Sonoma County Superior Court records. He pleaded no contest to the charge in April 2012 and received 20 days of electronic monitoring, plus three years’ probation and a $190 fine.

Millora was fired in November 2011, state controller records show. He did not respond to multiple interview requests made by phone and in person at his home. In January 2012,
the Department of Developmental Services said Sonoma Executive Director Jim Rogers had retired.

“There’s absolutely no excuse for allowing that to happen like that without any ramifications,” Assemblywoman Connie Conway, the Republican leader from Tulare, said of the stun gun assaults.

Terri Delgadillo, director of the state Department of Developmental Services, said the center’s investigation “included interviews of over 100 individuals, including the suspect who was interviewed on three separate occasions and terminated from employment.” She said the department took the matter seriously and continued to investigate nearly a year after the abuse occurred.

Sonoma center officials accepted responsibility for the stun gun abuses in June 2012, when the state Department of Public Health issued the facility a “Class A” citation. The penalty included a $10,000 fine for violations that put patients at serious risk of harm or death.

**Nobody has been charged for the alleged abuse of a dozen patients.**
FORENSIC EXPERTS SAY the first hours following a crime are critical. A person walking through a crime scene can ruin fingerprints, DNA samples and other evidence, said Dennis Kilcoyne, a Los Angeles Police Department homicide detective. Witness statements can change with time, especially after they’ve conferred with others, he said.

“People’s emotions are in play, and they may say things that, after they’ve thought about it or consulted with an attorney, (they) won’t say a week from now,” said Kilcoyne, a 27-year veteran.
Although no public records exist showing how frequently the Office of Protective Services receives late notification of potential abuse cases, California Watch was able to identify at least a dozen incidents in which delays from 24 hours to several days occurred.

Delays have hurt criminal investigations and given the developmental centers’ employees time to alter and destroy evidence, records and interviews show.

That’s what happened in the case of Timothy Lazzini, a 25-year-old quadriplegic patient with cerebral palsy, who coughed up a bloody glycerin swab at the Sonoma Developmental Center. He died from internal bleeding that night, Oct. 22, 2005.

Three swabs—each 4 inches long and twice as thick as a Q-tip—had torn Lazzini’s esophagus. He coughed out one, but two others remained lodged in his stomach, autopsy records show.

At that point in his life, Lazzini’s disabilities had left him mostly paralyzed, and he received food through a tube in his abdomen.

Someone at the developmental center likely put the swabs in his mouth before he died. Dr. Ken Christensen, Lazzini’s doctor, told Office of Protective Services investigators that it was possible for Lazzini to swallow the swabs, but “it is unlikely for him to be able to pick it up and put it into his mouth.” The pathologist who performed Lazzini’s autopsy noted the same thing.
Stephanie Contreras (above) reads through the case file on her brother, Timothy Lazzini, a 25-year-old quadriplegic patient. Lazzini (right) died of internal bleeding in 2005. An autopsy revealed two large, Q-tip-like swabs stuck in his stomach. MONICA LAM/CALIFORNIA WATCH, ABOVE; COURTESY OF THE LAZZINI FAMILY
The Office of Protective Services assigned the case to one of its detectives more than 24 hours after a caregiver discovered Lazzini bleeding from the mouth, the police file shows. By then, if any evidence was available at the scene, it was gone.

“I noted the area was cleaned up,” Rod Beck, the detective, wrote in his report. “I did not note G-swabs in the bedroom area and none were seen in the drawers of his dresser.”

The glycerin swabs are lemon flavored and intended to moisten a patient’s mouth, but caregivers were not supposed to use them on Lazzini, according to the case file. The patient did not have the physical ability to remove the swabs himself, one of Lazzini’s doctors told police.

During his interviews with caregivers, Beck learned that some technicians had been using the glycerin swabs as a pacifier for Lazzini, putting them in his mouth when he “got vocal.”

Lazzini’s caregivers all denied ever putting swabs in his mouth, however. Only one of the seven questioned by police admitted to using them on any patient.

Records that might have proven otherwise were destroyed, according to the police report. Daily caregiver notes from the previous week went missing. Someone blacked out information in two separate logs documenting patient care on the day Sonoma employees discovered Lazzini bleeding.

“The initials were heavily lined out,” Beck wrote.

Mark Czworniak, a Chicago Police Department homicide detective, reviewed the Lazzini case file for California Watch. He said that without records, crime scene evidence or corroborating statements from witnesses, there is no way to link anyone to the swabs that killed Lazzini.

It might have been multiple caregivers, Czworniak wrote, “or a completely unobservant health care worker, supplying
Timothy L. with the G-swab one after another, not noticing, or caring where each swab disappeared to, and not surmising that Timothy L. was swallowing them.”

Lazzini’s sister, Stephanie Contreras, who lives in the Sonoma County town of Windsor, and other family members sued the state in 2006 over Lazzini’s death and settled two years later for $100,000.

The state Department of Public Health also fined the Sonoma Developmental Center $90,000 in August 2007, citing “mistreatment, neglect or misappropriation of resident property”—the failure to prevent Lazzini from swallowing the swabs.

But the Office of Protective Services closed the Lazzini case without determining what had happened.
At most police departments investigating sexual assault allegations, using a “rape kit” to collect evidence would be considered routine. The procedure, performed by specially trained nurses, is widely regarded as the best way to find evidence of sexual abuse. Without physical evidence, it can be nearly impossible to solve sex crimes, especially those committed against people with cerebral palsy and profound intellectual disabilities.

But for the Office of Protective Services, the usual procedures for investigating potential sex crimes have rarely applied.
Records and interviews show patients have accused caretakers of molestation and rape 36 times from 2009 to 2012, but police assigned to protect them did not complete even the simplest tasks associated with investigating the alleged crimes. The Office of Protective Services failed to order a single hospital-supervised rape examination for any of these alleged victims between 2009 and 2012.

In the three dozen cases of sexual abuse, documents reveal that patients suffered molestation, forced oral sex and vaginal lacerations. But for years, the state-run police force has moved so slowly and ineffectively that predators have stayed a step ahead of law enforcement or abused new victims, records show.

Much of the alleged sexual abuse in the California institutions has occurred at the Sonoma Developmental Center, where female patients have been repeatedly assaulted, internal incident records show. In one case, a caregiver was cleared by the police department of assault and went on to molest a second patient.

The Office of Protective Services did not collected physical evidence to back up cases. In situations involving developmentally disabled patients, DNA and other physical evidence are even more important because statements from alleged victims often are treated as unreliable. Some have IQs in the single digits and cannot speak—making DNA evidence all the more important.

Detectives at city and county police departments are trained to send sexual assault victims to an outside hospital for the specialized rape examination. But the doctors and nurses at the state’s developmental centers—in Sonoma, Los Angeles, Orange, Riverside and Tulare counties—were not trained in dealing with sexual assault victims, records and interviews show.
California Watch shared details of the developmental center sex abuse cases with two outside police detectives who specialize in such assault investigations. The detectives said they were dismayed by the state’s actions.

“How can you do a sexual assault investigation and not do an exam?” said Roberta Hopewell, a detective at the Riverside Police Department and president of the California Sexual Assault Investigators Association.

According to interviews with former detectives and patrol officers at three of the state’s developmental centers, the Office of Protective Services did not assign its own detectives to cases that should have been investigated—nor did the force seek expert help from outside law enforcement.

One former patrol officer said administrators were afraid of bad publicity.

“They didn’t want anything to get out, so they handled it internally. They call the shots,” said Joe Guardado, a former patrol officer at the Porterville Developmental Center in Tulare County who retired in 2010.

Studies of crimes against the developmentally disabled have found that as many as 80 percent of women in this population are sexually assaulted during their lives. Many victims suffer repeated attacks.

At the Sonoma Developmental Center, which houses about 500 men and women, two patients accused a caregiver of forcing them to perform oral sex on him.

The Office of Protective Services was first alerted in
February 2009. “Client reported to staff that she saw (the caregiver’s) genitals and was asked to perform oral sex for a dollar,” the records said. “Client reports that she did.”

However, the Office of Protective Services quickly closed the case, the records indicate, because the suspect was not listed as having worked in the patient’s unit, called Corcoran, on the day of the alleged abuse. The accused caregiver did often work in that unit, though, internal records show.

Months later, the mother of a second patient alerted the center that her daughter had said she had licked the same caregiver’s penis.

But by then, the accused caregiver was gone. He is not identified by his full name in state records. The center’s incident log noted that the psychiatric technician suspected of the abuse was “no longer employed” but “did work on the unit.”

In 2012, Leslie Morrison, head of the investigations unit at Disability Rights California, examined dozens of case files in which a patient accused a center employee of sexual abuse from 2009 to mid-2012. Morrison performed the review at the request of the state Department of Developmental Services. She said these cases involved only patients capable of speaking and therefore able to report an assault.

Disability Rights, a protection and advocacy organization, has access to full patient files under state and federal law. Many of these records are confidential, but California Watch was able to obtain through other sources some of the documents provided to Disability Rights.

Morrison said she found 36 cases in which victims likely should have received a rape kit medical exam and interview with a trained nurse. But, she said, the Office of Protective Services investigations were incomplete and at times deeply flawed.
“We’re not sure they have the training to do these very delicate, sensitive interviews,” Morrison said.

Disability Rights argues that outside law enforcement and forensic nurses—who have years of experience interviewing victims and identifying physical evidence—should have taken over the institutions’ sex crime cases.

“You’re better off referring it to the specially trained people whose job it is to do that and only that,” Morrison said.

Statewide, the Office of Protective Services referred just three sex crime cases to county district attorneys for prosecution since 2009, said Morrison with Disability Rights California. In those cases, officers did not collect any physical evidence to determine whether crimes occurred. Just one of those cases led to an arrest.

In one incident from January 2012 at the Sonoma Developmental Center, caregivers noticed that two female roommates appeared to have injuries suggesting abuse—bruises on their faces and arms. The caregivers told the Office of Protective Services, but there was no detailed investigation.

A few months later, in May, another employee caught a long-time caregiver, Rue Denoncourt, exposing himself to one of those female patients in a bathroom. The colleague reported the incident to the Office of Protective Services, which then notified the Sonoma County Sheriff’s Office.

The sheriff’s office interviewed Denoncourt, who confessed to exposing himself and sexually abusing the victim’s roommate, forcing her to touch him while he masturbated.

Even after Denoncourt admitted to the abuse, records from the state Department of Public Health show neither the sheriff’s office nor the Office of Protective Services sent the victims to receive sexual assault examinations. If evidence
of other assaults was available, it was lost.

No investigation took place into the bruises that were discovered on both women in January, although the health department raised suspicions about Denoncourt in its report.

Denoncourt pleaded no contest to a lewd conduct charge in August and was sentenced to an eight-month prison term.

Three former members of the Office of Protective Services allege that administrators and other employees at developmental centers have interfered with abuse investigations.

Pete Araujo, a former investigator at the Fairview Developmental Center in Orange County, said his commander refused to approve sex assault exams for victims. Araujo said his superiors provided no explanation for denying the exams, and no one within the force challenged the decisions.

“Their word was final,” said Araujo, who is now an investigator for the California State Lottery Commission. “They were the managers.”

Employees at the institutions have delayed notifying police of alleged sexual abuse for days, said Greg Wardwell, a 20-year veteran patrol officer and sergeant at the Sonoma center. The lost time can leave physical evidence open to contamination and witnesses vulnerable to coercion.

Wardwell, who retired in March 2011, said center administrators did not punish employees for
withholding information about abuse.

“It’s very frustrating at the point that someone is genuinely victimized and you didn’t find out about it for four or five days,” Wardwell said. “There is no sanction at the point that somebody sits on the information.”

The Office of Protective Services’ own policy has made it difficult for officers to order sexual assault exams. For patients to receive an exam, the guidelines require that “a sexual assault occurred within the preceding 72 hours and there is potential for recovery of physical evidence of the recent sexual assault.” The “and” is underlined and italicized in the written policy.

Experts on sex assault investigations said using the words “potential for recovery” threatens to shut off an investigation before it starts. Detectives cannot determine what evidence is present before a medical exam.

“That latter part shouldn’t even be in there,” said Linda Ledray, a forensic nurse and director of the Sexual Assault Resource Service in Minneapolis. “I mean, that’s crazy.”

Kim Lonsway, research director for End Violence Against Women International, agreed that the Office of Protective Services’ sex assault policy could undermine investigations.

“The tone of this is the exams are going to be the exception rather than the rule,” Lonsway said.

Further, the 72-hour time limit is outdated, said Hopewell, the Riverside police detective who heads the California Sexual Assault Investigators Association. Hopewell said physical evidence sometimes is recoverable two weeks after an assault. She will request a medical exam even in cases in which a victim was attacked two years earlier, because scars can be shown to support allegations.
Terri Delgadillo, director of the state Department of Developmental Services, implemented the Office of Protective Services’ first policy on investigating sex assault in 2008. The department had no specific guidelines for police on investigating sex abuse before then, only that they be required to complete a state minimum of four hours of training.

Experts said many cases have been hampered because some investigators, administrators and even family members distrust allegations by the intellectually disabled. Detectives investigating sex crimes against the disabled often need special training in the nuances of extracting evidence from these types of patients. Such training has never been offered to the state police force.

Joan R. Petersilia, a criminology professor at UC Irvine, concluded in a 2001 study that disabled victims often are “thought to be fantasizing or to have merely misinterpreted what occurred.”

“This leaves the person with a disability continually vulnerable to victimization,” Petersilia said, “because perpetrators come to learn they may victimize them without fear of consequences.”
FOR MUCH OF ITS HISTORY, the Office of Protective Services was fragmented, with officers reporting only to administrators at their own facility.

Then, after a series of critical stories about the Sonoma Developmental Center in the local Index-Tribune newspaper in 2000, Sacramento officials took greater control of the Office of Protective Services. They created a statewide police chief and borrowed veteran officers from the California Highway Patrol to fill the job.
In 2006, the U.S. Justice Department’s Civil Rights Division criticized the care at the Lanterman Developmental Center in Pomona in a letter sent to Gov. Arnold Schwarzenegger. It noted a failure to properly collect evidence, inadequate witness interviews, delays in beginning investigations and the inability to close unsolved cases.

The Justice Department’s audit outlined the case of a patient, identified only as A.Z., who died Aug. 7, 2002. The audit did not include details of the case but said the patient “died of multiple blunt force trauma after being stomped repeatedly in his bedroom at Lanterman.”

The Office of Protective Services identified two suspects—the patient’s caregiver and a roommate. Although there was evidence pointing to both men, the audit said, Lanterman police concluded that the roommate had committed the crime but was too mentally impaired to face charges.

“Regardless of who was responsible,” the auditors wrote, “the fact that A.Z. suffered severe pain and ultimately died at Lanterman, in spite of the state’s obligation to keep him safe, is deeply disturbing.”

Patricia Flannery, the state official responsible for developmental center operations, said Lanterman has remedied the deficiencies documented by the Justice Department. “We haven’t heard from them in two years,” she said in early 2012.

During the Schwarzenegger administration, however, the state Department of Developmental Services hired less-experienced candidates to run the developmental centers’ police force.

In 2007, the department hired Nancy Irving, a longtime government labor mediator, analyst and program manager, as the force’s interim police chief. She had not been certified as a law enforcement officer. The next police chief was indicted on embezzlement charges and left the department in 2010.
The interiors of California’s developmental centers look like nursing homes or long-term care hospitals. At the Lanterman Developmental Center in Pomona, a caregiver assists a patient.

CARLOS PUMA/CALIFORNIA WATCH
Corey Smith, a firefighter for two decades, became the next police chief. He had less law enforcement experience than a majority of the patrol officers beneath him. He hadn’t worked on criminal investigations until 2006, when the department made him the Sonoma center’s police commander.

At other levels, a lack of experience in law enforcement hasn’t stopped employees from moving up in the Office of Protective Services.

Victor Davis started at Lanterman as a part-time psychiatric technician in 1989, working his way up to supervising caregiver. In 1998, the Department of Developmental Services put him on the police force as an investigator, jumping him over two ranks of police officers despite his lack of law enforcement background.

Today, Davis is Lanterman’s commanding officer, in charge of all criminal investigations. Davis declined to comment in detail, and attempts to interview him during a tour of Lanterman were cut off by a top-level official with the department.

The police force in 2008 added its first policies on investigating abuse and neglect, closing investigations, responding to sex assault and responding to a crime scene or emergency. But to this day, policies on managing investigations and collaborating with outside law enforcement remain unwritten.

Detectives have not had the authority to send investigations to prosecutors themselves. In most other police departments, officers and detectives begin working with prosecutors in the early stages of an investigation. Some district attorneys send their prosecutors to work hand in hand with police at crime scenes.
But the Office of Protective Services follows a different playbook. The agency’s manual states that detectives and commanders must clear cases with administrators and civil attorneys at the Sacramento headquarters before sharing cases with local police or prosecutors.

The department’s legal team exists to protect the state from civil liability claims, a fact that raises concerns among patient advocates and legal experts who say prosecutions and arrests for abuse of patients have taken a back seat.

Terri Delgadillo, director of the Department of Developmental Services, said the Office of Protective Services submits cases to department lawyers first to ensure “the investigation and the information is as complete as possible.”

Since 2006, state regulators have confirmed 21 patient abuse cases and 173 injuries of unknown origin at the Lanterman Developmental Center in Pomona. But the Los Angeles County district attorney’s office was unable to find a single case referred by Lanterman investigators in the past decade.

And the head of the L.A. district attorney’s elder abuse and dependent adult section, Robin Allen, said she didn’t know the developmental center had its own officers and detectives. With more than 300 patients, Lanterman is one of the largest elder caregivers in Los Angeles County.

Department of Developmental Services officials provided California Watch with the case numbers for six incidents they claim were forwarded to prosecutors in Los Angeles County. The district attorney’s office said the case numbers didn’t match anything in their records.
Even cases of brazenly documented abuse have ended without criminal charges.

In 2005, a caregiver at Lanterman took a cellphone picture of her co-worker with his hands wrapped around the neck of a 48-year-old male patient with mental disabilities.

In the photo, the patient’s “facial expression showed that he was not enjoying the action,” a state Department of Public Health inspector wrote in a report about the incident.

The photograph, taken May 5, 2005, was emailed to the phones of multiple Lanterman employees—itself a violation of patient privacy laws. Another caregiver witnessed the choking and anonymously reported it a week later in a letter to public health officials and Lanterman administrators.

But the Office of Protective Services did not arrest the employees involved or forward the case to prosecutors. Inspection records don’t say whether the caregivers were reprimanded or fired, but Lanterman itself was fined by the Department of Public Health—a fine of $800.
CHAPTER 9

VAN INGRAHAM

AS A BABY, VAN INGRAHAM DIDN’T RESPOND TO voices. His parents feared their youngest son was deaf.

Ingraham’s ears worked. His true disabilities would prove far more challenging. At 18 months, when most children are mobile, he wasn’t walking. He made sounds but could not form words.
“Right away, I started noticing things about him as a tiny baby,” said Jane Robert, Ingraham’s mother, now 90 years old. “He didn’t want me to hold him and cuddle him. He would stiffen up when I would try to hold him.”

But as he grew, Ingraham was giddy in his love for play.

A black-and-white family picture now fading shows him, about 6 years old, riding piggyback on his older brother’s shoulders in their San Diego neighborhood. Both are smiling, but Van’s mouth is open wide, like a kid screaming joyfully on a roller coaster.
“We had a big family living in a small house,” said his mother, who stayed at home to take care of her two sons and four daughters.

Ingraham’s impulses grew more difficult to tame. He suffered severe seizures. When he was 8, Jane took him to a doctor specializing in a relatively new disorder called autism.

The doctor diagnosed him as being on the severe end of the autism spectrum. The conclusion was not so painful as the specialist’s advice, which was “put him away; forget you had him,” said Larry Ingraham, Van’s older brother by six years.

“And that was the beginning of the nightmare,” his mother recalled. “Because my husband said, ‘Never, we’ll never do that!’ And I ran outside of the room. It was the worst day of my life.”

They tried their own methods. When Van Ingraham finally started to walk, and had a tendency to bolt from the house, his family painted the walls of his bedroom yellow, his favorite color, in the hope it might induce him to stay put.

Less than a year after the diagnosis, Ingraham became agitated one day while his mother was caring for him alone. The door to the boy’s bedroom locked only from the outside, so they could contain him. But Ingraham ran out of the room ahead of his mother and slammed the door, locking her in.

Van Ingraham was discovered hours later, naked and running down the middle of the street, following the yellow lane dividers.

It was too much. Jane first tried placing her son in a private group home. That arrangement lasted just 24 hours, as a distraught Van tore down curtains and nearly broke free from the facility.
The Fairview Developmental Center was a last resort and a welcome salvation from the stress of caring for a disabled child. A doctor had recommended the facility to Ingraham’s family.

On a clear and cool April 20, 1964, Ingraham’s parents loaded up their car and drove their youngest son to Costa Mesa, the suburban enclave in Orange County where five years earlier the state’s newest institution for the developmentally disabled had been built on 752 acres.

Van Ingraham was 8.

From outside the fenced-in campus, Fairview now looks like a school built for thousands of children, with low-slung buildings painted blue and white. Patients wander the drab halls and common areas, which are serviced by the institution’s own power plant and an industrial kitchen.

Richard “Dick” Ingraham, an executive at the defense contractor General Dynamics for 43 years, and Jane believed their son was safer at Fairview, protected and watched round the clock.

Jane co-founded the parents organization—Fairview Family & Friends—that assists the institution to this day and embraces a philosophy that “all people have value as human beings and as members of the human family.”

Over the years, the family would bring their son home on weekends. On one occasion when Ingraham was 9 years old, Jane said she noticed during a bath that he had “bite marks on his little penis.” She said Fairview did not explain the marks.

The toll of institutionalizing the boy was deeply painful to the Ingrahams. Larry Ingraham said he believes it contributed to his parents’ divorce a few years after Van Ingraham first entered Fairview.
Van Ingraham suffered a broken neck in his bedroom at the Fairview Developmental Center on June 6, 2007.

COURTESY OF LARRY INGRAHAM
Jane Robert said that once her son became a teenager, bringing him home on weekends became too stressful for the family.

“Finally, there came a day my husband said, ‘Don’t bring him home anymore,’” Jane said, her voice quivering. “It was just too much for him. You know, he worked hard all week.”

Ingraham grew into a healthy man at the institution. To control his moods, Fairview physicians prescribed him lithium and risperidone. Both medications are used to calm the behaviors of the severely autistic, according to the National Institutes of Health.

He stood 5 feet 9 inches, with the lean muscular build of a day laborer and a full head of dark brown hair. He was social, though he avoided physical contact with others. This made grooming him a chore. Pictures that Larry Ingraham had taken show his brother with stubble visible along his jawline and chin.

His tastes and activities changed little, a 2006 assessment by Fairview caregivers shows. Ingraham guzzled soda and generally preferred sweet foods. He “likes hot cereal with LOTS of sugar and cocoa,” the assessment states. Larry Ingraham keeps a photograph of his brother chugging a plastic bottle of Sprite.

His communication skills developed, but they were basic. When Van Ingraham wanted someone to leave his room, he’d nudge them toward the exit with his elbow. But impulse control would bedevil Ingraham until the day he was paralyzed.
SOMETIME BETWEEN 4:30 AND 5 A.M. ON June 6, 2007, Johannes Sotingco, the Fairview Developmental Center caregiver on duty that morning, found Van Ingraham urinating in his pants. According to Sotingco’s recollection to police, Ingraham then pushed his pants down to his ankles to get the wetness away.

Sotingco ordered him to pull up his pants, but he refused. He said Ingraham was standing.
About this time, a supervisor down the hall said she heard Ingraham scream. The supervisor, Florens Limbong, rushed to Ingraham’s bedroom to check on the patient.

Opening the door, she saw Sotingco standing over Ingraham. The light was on in the room—it was always on, because Ingraham was afraid of the dark. Ingraham was lying face up on the floor.

Van Ingraham slept in a sterile room at Fairview Developmental Center, which he shared with three other men.

That night, the roommates were asleep, accustomed to Ingraham roaming around. It’s unclear from the record how Ingraham ended up on the floor.

“Is he OK?” Limbong asked.

“Yeah, he is OK,” Sotingco replied, pulling the patient’s pants back up while he was on the ground. “He doesn’t want to wear his pants.”

Limbong turned and left without further inquiry. She told investigators that she saw nothing more than Ingraham on his back, and said she trusted Sotingco’s assertion that the patient was fine.

“No more problem, you know. I mean I don’t hear any more screaming,” she told the detectives.

Sotingco was on her heels, heading out the door. In a later interview with detectives, Sotingco insisted that he hadn’t injured the patient during the predawn incident and claimed Ingraham had stood up before he left the room.

Ingraham, according to Sotingco, was checked again at 5:15 a.m. and was marked in a log as “R”—resting in his bed.

Sotingco wrote in another of the center’s log—which
Fairview officials labeled the Journal of Falls—that he first discovered Ingraham’s injury when he made his rounds again. This was about 5:45 a.m.

In his interview with police, Sotingco said he found Ingraham lying face up on the floor—the same spot where Limbong had seen him more than an hour earlier. The patient couldn’t lift his head. There was a cut above his left brow and tears welled in his eyes.

The record shows Sotingco quickly called for help in lifting Ingraham. Another caregiver, Alvin Tan, grabbed one side of Ingraham’s body, witness interviews show, as they pulled the patient onto his mattress. Ingraham was dead weight.

With Limbong and Tan in the room, Sotingco theorized that Ingraham had slipped and fallen from his bed.

At 6:38 a.m., Sotingco picked up the phone and called Fairview police officer Pete Araujo. They chatted for about 20 minutes, but Sotingco did not mention a neck injury. He reported Ingraham had suffered an abrasion. Araujo said Sotingco did not have an urgent tone.
PETE ARAUJO, THE ONLY FAIRVIEW OFFICER ON duty that morning, arrived at Van Ingraham’s room just as an ambulance was pulling up. He quickly left to give the medics directions to the room, returning as they were wheeling Ingraham into the hallway.

Before paramedics left, Araujo took a single picture of Ingraham’s face, Fairview police records show. Araujo gathered no other evidence. He didn’t question possible witnesses or take custody of the Sleep Log, which documents what patients are doing every 30 minutes throughout the night.
Ingraham was rushed to the emergency room at Hoag Memorial Hospital Presbyterian in Newport Beach. X-rays taken at the hospital documented a hyperflexion injury in his neck, akin to that found on people who’ve been hanged.

Ingraham would be paralyzed, at best, and most likely would die.

That morning, Larry Ingraham, a retired San Diego police officer, received a call from a supervisor at Fairview saying his brother had suffered a minor injury. He walked into the hospital room to find his brother confined with a head brace and with tubes running in and out of his nose and arms.

While there, Larry Ingraham said a neurosurgeon took him aside and surmised: “Somebody did this to your brother.”

“I knew this was no minor fall like they’d said,” Larry Ingraham said in an interview. “... Because being a cop all those years, being in the line of work I’ve been in, I knew there’s a person out there right away that had done this to him.”

The next day, Larry Ingraham decided to go to Fairview. He talked his way into the area where his brother had lived and asked to speak to a supervisor. He was told by a staff member to wait in an office.

“She went to find the supervisor,” Larry Ingraham said, “and I started checking through files.” He said he found the Journal of Falls noting his brother had suffered a slip out of bed.

“And I already knew that was not true,” he said. “So I took it.”

Armed with that information, and caregiver Johannes Sotingco’s name, Larry Ingraham filed an abuse allegation with the Office of Protective Services.
After spending six days in a Newport Beach hospital, Van Ingraham died just minutes after midnight on June 12, 2007.

COURTESY OF LARRY INGRAHAM
Back at Fairview, Sotingco changed the Sleep Log entries for his rounds.

Originally, Sotingco had written that Van Ingraham was using the bathroom at 4:45 a.m., and then sleeping at 5:15 a.m. He would tell Fairview police that he changed the sleeping and bathroom notations to say Ingraham was resting and awake in bed on both occasions.

Fairview detectives waited five days to start interviewing Sotingco, Florens Limbong and other witnesses. Sotingco and Limbong did not respond to interview requests from California Watch, including notes left at Sotingco’s home in Anaheim and repeated calls to Limbong.

Theresa DePue, a former nurse and Fairview’s lead detective investigating Ingraham’s death, asked Sotingco why he changed the Sleep Log, according to the police case file. The caregiver said he’d just tried to make it more accurate.

“So that was just a—an error?” DePue said.

Sotingco replied yes, and the detective moved on. DePue did not investigate the alteration as potential evidence tampering. And she didn’t press him on what Limbong had reported seeing, records show.

Later, during a deposition in a civil lawsuit over Van Ingraham’s death, Sotingco was asked if he’d put him in a headlock. He replied: “No. I don’t do that.”

Before joining Fairview, Sotingco had worked at Metropolitan State Hospital in Los Angeles County, where he’d been investigated four times in alleged patient abuse cases, police records show. All four allegations were closed as unsubstantiated. The state hospital would not release the details of those cases.
An X-ray of Van Ingraham's neck shows a severe spinal break that three medical experts said most likely came at the hands of another person, probably caused by a headlock. 

COURTESY OF LARRY INGRAHAM
In her interview with Limbong, DePue appeared skeptical about whether Ingraham had fallen out of bed, as Sotingco had speculated.

“There are some pretty big concerns, because of the fact that the injury you are telling me doesn’t really match up to the client’s injury,” DePue said.

“OK,” Limbong said.

“…Any indication that somebody physically caused these injuries? Nothing?” DePue asked her.

“No. No, I don’t. No.”
AT THE NEWPORT BEACH HOSPITAL, Larry Ingraham decided to take his brother off the machines that had been keeping him alive. Van Ingraham died just minutes after midnight on June 12, 2007, six days after his neck was broken.

At the autopsy that day, Dr. Richard Fukumoto theorized Ingraham’s shattered spine “could have been caused by a blow to the back of the neck using a soft object,” the Fairview Developmental Center police case file shows. Fukumoto was then Orange County’s chief forensic pathologist.
Another staff pathologist, Dr. Aruna Singhania, thought it looked like a whiplash injury sustained in a car accident.

A day after Ingraham died, the Office of Protective Services finally asked for help from an outside agency.

On June 13, Peter Mastrosimone, a Fairview detective assisting Fairview lead detective Theresa DePue, sent an email to the Orange County Sheriff’s Department asking officers to check Ingraham’s bedroom “for anything of evidentiary value,” according to police records.

The sheriff’s office replied “that due to the time lapse and the day-to-day business in the room (routine cleaning and presence of clients and staff) and the possibility of subsequent contamination, no evidence could be recovered that would be of evidentiary value.”

Both Mastrosimone and DePue declined requests for interviews from California Watch.

Ingraham’s case was DePue’s first suspicious death investigation. In fact, DePue had no police experience when the developmental center hired her as a detective in 2002, personnel records show. She’d previously worked as a Medicare inspector for the state Department of Health Care Services.

Mastrosimone joined the Fairview police force as a patrol officer in 1996, after more than 10 years as an unpaid volunteer reserve for the Alhambra Police Department, near Los Angeles.

Matt Murphy, a prosecutor with the Orange County district attorney’s office, said he’s worked with Mastrosimone multiple times over the years. While the Fairview detective doesn’t have the skills of a city police detective, Murphy said Mastrosimone takes direction well.
“Pete is a man with no ego,” Murphy said. “He does whatever I tell him to do.”

Roughly a month into Fairview’s investigation, a tip came in from another staff member that a patient, who was blind, had come forward. He claimed that on the morning of Ingraham’s injury, a third patient was seen coming out of Ingraham’s room. He said this third patient came up to him and whispered, “Don’t tell anyone.”

The detectives pursued the lead, questioning the patients, their doctors and psychologists, police records show.

This worried Carol Risley, a patient advocate at the state Department of Developmental Services.

“I am beginning to feel as though the other resident is becoming the target as it will reduce liability,” Risley wrote to department executives in an email, “since he probably cannot be held responsible for his actions.”

Detectives focused on the patient because they believed he had a violent history at Fairview. But it turned out, he didn’t. He’d been prone to taking credit for things he’d not done, like once saying he’d broken another patient’s arm.

The Fairview detectives subjected the two developmentally disabled men—the allegedly violent patient and his blind accuser—to a voice stress test to determine if they were lying. The results were inconclusive. Detectives asked caregiver Johannes Sotingco to participate in the test, but he declined.

There were other delays. It took months for a coroner’s office investigator to tell the Office of Protective Services that Fukumoto had ruled out an accidental fall as a possible cause of the injury.
In October 2007, Fairview detective Mastrosimone wrote in an email to his commander to convey the autopsy results: “The injury was most likely caused by force associated with a half nelson or some type of head lock.”

During its own investigation, the Orange County sheriff-coroner’s office was debating whether to rule Ingraham’s death a homicide or an accident, said Jacque Berndt, the chief deputy coroner. Berndt asked Thay Lee, a biomechanical engineering professor at UC Irvine, to examine the evidence. Berndt directed Lee not to speak with California Watch about the Ingraham case.

“It is my opinion the manner of death was likely a homicide,” Lee wrote in his report to the Orange County coroner and Office of Protective Services, which was filed in December 2007. The force that broke the Fairview patient’s neck had to have come from another person, he ruled.

Lee’s presentation included X-ray images of Ingraham’s neck juxtaposed with the neck of a person who had jumped headfirst into a shallow pool. Ingraham was clearly in worse shape, his top vertebrae at unnatural angles, his spinal cord a set of derailed tracks.

Regardless, Berndt listed the manner of death as “undetermined.”

DePue, the Fairview detective, noted in the file that she had received Lee’s report. But she omitted from the record his conclusion that Ingraham’s death was likely a homicide. She also failed to document that the county’s chief pathologist determined Ingraham couldn’t have broken his neck in an accidental fall.

Instead, DePue wrote, “the possibility of a fall or accident could not be ruled out.” The developmental center detectives also maintained that another patient might have broken Ingraham’s neck.
In 2009, the state paid Ingraham's family $800,000 to settle a wrongful death lawsuit Larry Ingraham had filed two years earlier. In finally closing the case, DePue and Mastrosimone listed the allegedly violent patient as a “suspect.” Sotingco was listed as a “subject.”

As far as the Office of Protective Services was concerned, that was the end of it.

Watch videos from our investigation at CALIFORNIAWATCH.ORG/BROKEN-SHIELD
A DAY AFTER CALIFORNIA WATCH PUBLISHED its story in November 2012 about sexual abuse at the Sonoma Developmental Center, state regulators sent an inspection team to the facility.

What the Department of Public Health found was disturbing. Over two visits in late November and early December, the team “documented incidents of abuse constituting immediate jeopardy, as well as actual serious threats to the physical safety of female clients in certain units.”

Within days, regulators with the state Department of Public Health took action. The Sonoma center lost its license to operate all but its skilled nursing facility, effectively ending tens of millions of dollars in federal support. The state also announced it would put an experienced California Highway Patrol officer in charge of the Office of Protective Services at the Sonoma center.
The state’s threat of closure and management shake-up at Sonoma mark the most significant sanctions to date against the facility. And it ultimately could lead to reforms that benefit patients there and their families.

This is the kind of impact that California Watch strives to achieve.

Throughout its Broken Shield project, California Watch has shared its findings with state officials in charge of these facilities and the care for this vulnerable population.

Terri Delgadillo, director of the Department of Developmental Services, has said her department has a zero-tolerance policy that includes reporting any injuries, even those remotely suspicious, to the state Department of Public Health. She said the department is committed to conducting thorough investigations.

“For the department, the priority is to make sure that we’re doing the best job providing consumer safety and services,” Delgadillo said in an interview. “And if there are issues that need to be addressed—and there’s always room for improvement—we’re looking to do that.”

She has hired a consulting group, the Consortium on Innovative Practices based in Alabama, to review the methods and training of her police force. The nonprofit group was recommended by the U.S. Department of Justice, which issued a scathing critique of the Department of Developmental Services in 2006.

The department said that from January 2008 to January 2012, 67 developmental center employees were fired for “client-related” offenses. But officials declined to say how many of those, if any, were dismissed for abusing patients, where they worked or if any of them had been arrested. Delgadillo also declined to comment on specific cases of
alleged abuse or mistreatment at the developmental centers, citing patient privacy laws. Corey Smith, the former firefighter who became police chief, said he was not permitted to speak with reporters for this series. Smith was demoted to second-in-command in August 2012.

Delgadillo, director of the Department of Developmental Services since 2006, said the police agency follows state standards for evidence collection.

Delgadillo said she has reorganized the force so that police commanders answer to Sacramento rather than local administrators at the developmental centers. This move, which was fully enacted in 2007, is intended to protect against interference by employees and officials who might be implicated in wrongdoing, she said. Delgadillo acknowledged the old policy had been a potential conflict of interest.

“They’re reporting directly up to us to make sure that there’s no conflict between the developmental center and the investigation that’s actually being conducted,” Delgadillo said.

California Watch provided state officials with documents, interviews and data from its investigation into Van Ingraham’s death. But Department of Developmental Services officials declined to comment on the case, citing patient privacy laws. Key players in the case, including Fairview Developmental Center detectives and officials with the Orange County sheriff-coroner’s office, declined to comment or were instructed to remain silent. The circumstances of Ingraham’s death were reconstructed based on interviews, police case files, autopsy examinations and other public records.

In March 2012, state officials announced that they had hired an independent manager for the Office of Protective Services to oversee new training guidelines.
In response to California Watch’s stories, lawmakers introduced two bills that would require the state to notify outside law enforcement agencies and disability rights groups when it receives allegations of violent crimes against patients and mandate that an experienced law enforcement officer lead the Office of Protective Services. The bills passed the Legislature and were signed by Gov. Jerry Brown in September 2012.
ABOUT THE AUTHOR

Pulitzer Prize winner Ryan Gabrielson covers public safety for California Watch and its parent organization, the Center for Investigative Reporting. He was a 2009-2010 investigative reporting fellow at UC Berkeley. Previously, he was a reporter at the East Valley Tribune in Mesa, Ariz. In 2009, he and Tribune colleague Paul Giblin won a Pulitzer Prize for stories that showed immigration enforcement by the Maricopa County Sheriff’s Office undermined investigations and emergency response. Gabrielson’s work has received numerous national and state honors, including a George Polk Award, an Online Journalism Award for investigative reporting and a Sigma Delta Chi Award. A Phoenix native, he studied journalism at the University of Arizona and began his career at The Monitor in McAllen, Texas.

CREDITS

A large team led by CIR’s managing editor, Robert Salladay, helped produce the Broken Shield investigation, upon which this e-book is based. Other members of the team include editorial director Mark Katches; senior data analyst Agustin Armendariz; senior multimedia producer Carrie Ching; copy editor Nikki Frick; intern Emily Hartley; video producer Monica Lam; copy chief Christine Lee; Vic Lee, reporter for KGO-TV; reporters Joanna Lin and Michael Montgomery; Jessi Rymill, app designer with Closed Mondays; and senior online editor Mia Zuckerkandel.
ABOUT THE CENTER FOR INVESTIGATIVE REPORTING

In the summer of 2009, the independent, nonpartisan Center for Investigative Reporting launched a new reporting initiative called California Watch, the largest group of journalists dedicated to investigative reporting in the state.

The team at California Watch pursues in-depth, high-impact reporting on issues such as education, public safety, health care and the environment. Our reporters also produce stories that hold those in power accountable, while tracking government waste and the mis-spending of taxpayer resources.

We place a major emphasis on solution-oriented reporting intended to have an impact on the quality of life for Californians and our communities. We engage the public by providing tools and resources.

We distribute our stories as widely as possible through collaborative relationships with local and regional news organizations and through social media. California Watch has established working relationships with California news organizations of all kinds—newspapers, online publications, television, radio, ethnic media and other new forms of media—to help localize and distribute our reporting. In 2010, we launched the California Watch Media Network, which includes some of the largest newspapers and TV stations in the state.

We have a unique relationship with KQED Public Radio, which shares the costs of a reporter working for both news organizations. We also publish unique, original content on our website that isn’t available anywhere else. Many of our stories are translated into other languages—including Spanish, Vietnamese, Korean and Chinese.

California Watch is supported by major grants from the James Irvine Foundation, The William and Flora Hewlett Foundation, The California Endowment, the John S. and James L. Knight Foundation, and the Wyncote Foundation. We have offices in the Bay Area, Sacramento and Southern California.

Founded in 1977, the Center for Investigative Reporting is the nation’s oldest nonprofit investigative news organization.