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**OFFICE OF  
LAW ENFORCEMENT SUPPORT**

# Semi-Annual Report

Independent review and assessment  
of law enforcement and employee misconduct  
at the California State Hospitals  
and Developmental Centers  
January 1, 2016, – June 30, 2016

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

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# Introduction

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I am pleased to distribute the first semi-annual report prepared by the Office of Law Enforcement Support (OLES). This report covers January 1, 2016, through June 30, 2016, and details the OLES's oversight of law enforcement programs and employment misconduct at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS).

The OLES mission is to provide oversight and support with two main goals. The first is to protect the rights and security of some of the most vulnerable people in our society – the mentally ill and the developmentally disabled, who are served at our state facilities. The second is to improve the law enforcement, investigation and discipline functions at both departments.

The OLES is grateful for the invaluable insight and consultation received from various stakeholders and partners, including Disability Rights California, the Association of Regional Center Agencies, Fairview Family and Friends, the Parent Hospital Association of the Sonoma Developmental Center, Metro Family and Friends Support Group, the DSH-Atascadero Community/Advisory Group, California Highway Patrol and the Office of the Inspector General.

The mission of the OLES was expanded in statute in July 2015. In addition to the support and evaluation functions, the OLES was tasked with conducting internal investigations of the DSH and DDS police personnel and providing contemporaneous oversight (monitoring) of all serious, non-police employee misconduct investigations conducted by the departments. The monitoring and support provided by the OLES seeks to achieve best practices in policing, employment law investigations, and discipline in the departments.

The OLES is fortunate to have highly experienced staff, including investigators who were sheriff's detectives and veteran city police officers, senior employees from California government departments, and attorneys with decades of litigation, trial and monitoring experience. The OLES also contracts with subject matter experts from the California Office of the Inspector General, the California Highway Patrol and the California Department of Corrections and Rehabilitation. I am honored and privileged to leverage my 25 years of law enforcement experience to lead this team.

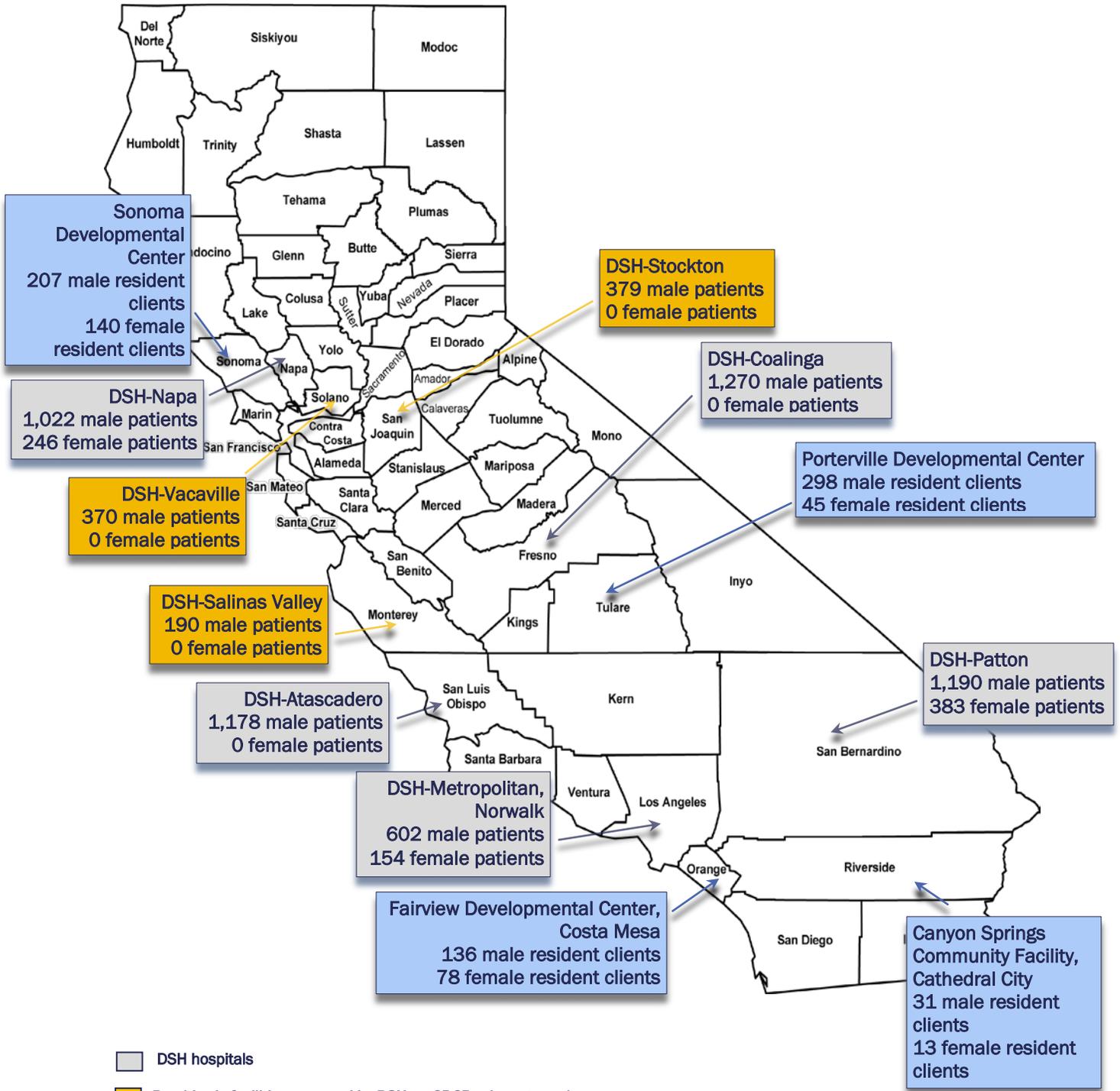
I also am pleased to announce that the OLES has been accepted as a member of the National Association for Civilian Oversight of Law Enforcement. This organization helps set the standard for law enforcement oversight, accountability and transparency.

I welcome your comments and questions. Please visit the OLES website at [www.oles.ca.gov](http://www.oles.ca.gov) to contact us.

*Ken Baird*  
*Chief, Office of Law Enforcement Support*

# Facilities

The DSH and DDS facilities where the OLES conducts investigations and provides contemporaneous oversight (monitoring) are shown below.



Grey box: DSH hospitals

Yellow box: Psychiatric facilities operated by DSH on CDCR prison grounds

Blue box: Developmental centers operated by DDS

Note: June 30, 2016, population numbers were from the departments.

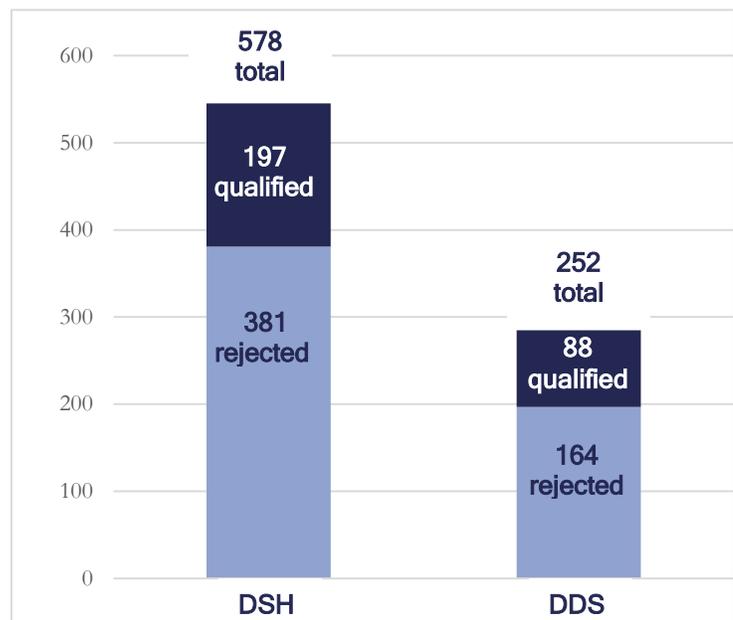
# Executive Summary

From January 1, 2016, through June 30, 2016, the Office of Law Enforcement Support (OLES) reviewed 830 reports of prescribed incidents<sup>1</sup> at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Prescribed incidents included alleged misconduct by state employees, reports of pregnancies in the facilities' populations and serious offenses reported between patients/clients, among other occurrences. The 830 reports in the first half of 2016 amounted to an average of 4.6 reported incidents per day, seven days a week, and was roughly double the number projected for the OLES as it began first-time monitoring of DSH and DDS law enforcement and the departments' investigations in January 2016.

The vast majority of the incidents – 578, or 70 percent – involved DSH facilities. This distribution was not unexpected because the department had approximately seven times as many patients at its eight facilities during the period as DDS had clients in its four state-operated developmental centers.<sup>2</sup>

It is important to note that 545 of the 830 total incidents – 65.7 percent – were rejected by the OLES for not meeting the statutory requirements for the OLES to undertake investigations and/or monitoring.<sup>3</sup> As shown in the adjacent chart, the remainder – 285 incidents, or 34.3 percent of the 830 total that the OLES received during the first half of 2016 – qualified for investigation and/or monitoring by the OLES.

**Review of DSH and DDS reported incidents**



## Investigations and monitoring

An OLES investigation commenced after the OLES was notified of an allegation that a DSH or DDS law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents. Per the statute,<sup>4</sup> an OLES investigation also could commence when ordered by the California Health and Human Services Secretary, Undersecretary or the OLES Chief. The OLES opened 28 investigations in the six-month period, and 14 were completed by June 30, 2016. Of the 14 completed investigations, nine were administrative cases and five

<sup>1</sup> Prescribed incidents were pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix F)

<sup>2</sup> Patient and client populations for the period were DSH and DDS numbers.

<sup>3</sup> Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix F).

<sup>4</sup> Welfare and Institutions Code Section 4023.6 (2). (See Appendix F).

involved criminal allegations. The nine administrative cases were referred to the departments. None of the criminal cases led to criminal charges. Synopses of all closed investigations are in Appendix A.

In addition, the OLES began monitoring investigations conducted by the departmental police (also known as the DSH and DDS Offices of Protective Services) into serious criminal misconduct or serious administrative misconduct alleged to have been committed by non-law enforcement state employees involving certain threshold incidents. The OLES monitors these cases through the conclusion of the employee discipline process. During the six-month reporting period, the OLES began monitoring 170 cases at DSH and 87 at DDS. Through June 30, 2016, the OLES had assessments for 70 completed cases. Of the 70 completed cases, 54 were monitored administrative investigations, which resulted in 12 sustained allegations. The remaining 16 monitored investigations were criminal in nature and resulted in one referral to a prosecuting agency.

In the course of its monitoring, the OLES not only reports on the outcomes of investigations, it assesses the adequacy of each investigation. Of the 70 completed cases in the reporting period, 24 were assessed by the OLES as having some type of insufficiency. Note that through June 30, 2016, the OLES had assessments for only 27 percent of the DSH and DDS cases that began being monitored in the first half of the year. This is because the majority of cases had not reached a conclusion by June 30, 2016, and were continuing to be monitored by the OLES. Results for these continuing cases will be presented in subsequent reports. Synopses for the cases that were completed in the January 1, 2016, through June 30, 2016, period are in Appendices B, C and D.

## Types of incidents

At both DSH and DDS, the single largest category of incidents that came to the OLES involved allegations of abuse<sup>5</sup> of patients and clients. A full 38 percent of the DSH incidents – or 220 of the 578 incidents – cited abuse of patients that did not involve sexual assault. At DDS, abuse that did not involve sexual assault was cited in 47.6 percent, or 120 of the 252 total incidents, that came to the attention of the OLES in the first half of 2016.

Most Frequent DSH Incidents Jan. 1-June 30	Number of Reports	Number Meeting OLES Criteria
Abuse	220	65
Sexual Assault	89	19
Head/Neck Injury	66	3
Neglect	57	15
Death	32	6

The OLES tracked sexual assault<sup>6</sup> allegations separately, and they accounted for the second largest category of incidents reported at DSH. The OLES received 89 incidents alleging sexual assault, or 15.4 percent of the DSH total, in the six-month period. This was an average of nearly one sexual assault allegation every other day during the six-month period. Of the 89 incidents reported, 34 involved allegations against state employees.

Most Frequent DDS Incidents Jan. 1-June 30	Number of Reports	Number Meeting OLES Criteria
Abuse	120	52
Head/Neck Injury	38	3
Broken Bone	24	7
Death	20	3
Neglect	18	12

<sup>5</sup> Initial reports were descriptions of allegations. During its intake process, the OLES determined, for the purposes of OLES investigation and monitoring, whether the described allegations met the statutory definitions for physical abuse and sexual assault in Welfare and Institutions Code Section 15610.63.

<sup>6</sup> Allegations of sexual assault included those that did not involve state employees.

At DDS, sexual assault allegations were far fewer, involving nine incidents, or 3.6 percent of all DDS incidents from the period. Thus, sexual assault was not among the five most frequent incidents reported at DDS. Of the nine reported sexual assaults at DDS in the first six months of 2016, two involved allegations against state employees.

The second-most frequent type of incident, after abuse, to be received by the OLES concerning DDS clients was head and/or neck injuries that required treatment beyond first aid. There were 38 of these incidents that came to the OLES in the first half of 2016, accounting for 15.1 percent of all DDS incidents. This amounted to an average of one head/neck injury at DDS reported to the OLES approximately every five days. The OLES required notification of head and/or neck injuries from the departments because such injuries can cause lasting health impairment or death and may be indicative of assault, battery or neglect.

## **Sources of incidents**

The OLES became aware of incidents in several ways. The departments were required to notify the OLES when they learned of prescribed incidents. The OLES also received and reviewed the daily logs that police units at each facility maintained and which document their activities as well as General Event Reports that clinical staff prepared at DDS. Additionally, the OLES can receive allegations from the public, patients, clients, their families and friends and from advocacy groups. During the first half of 2016, nearly all of the 830 incidents that the OLES received came from the departments. Note that during the first half of 2016, the OLES did not have an auditing capability that could have helped verify that all required incidents were being reported to the OLES.

## **Insight from families and advocates**

The OLES is thankful to work with the families, friends and advocates of the patients at DSH facilities and the clients at the DDS developmental centers. In 2015 and 2016, the OLES met with groups such as Disability Rights California (DRC), the Association for Regional Center Agencies, Fairview Family and Friends, the Parent Hospital Association of the Sonoma Developmental Center, Metro Family and Friends Support Group and the DSH-Atascadero Community/Advisory Group and listened to their concerns. And, following a recommendation from DRC, an OLES investigator served on a California Commission on Peace Officer Standards and Training (POST) workgroup that was developing training for community law enforcement so they are better skilled at approaching people suffering mental crises. The OLES also received one inquiry from DRC in the six-month period that led to a DSH case being monitored.

## **Additional mandated data**

The statute<sup>7</sup> requires the OLES to compile and report statistics on criminal and administrative investigations and notifications to state licensing boards. This information, which had not been publicly released on a regular basis before, is contained in tables on pages 22, 23 and 24.

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<sup>7</sup> Welfare and Institutions Code Section 4023.8.

## **Monitored issues**

In the course of its reviews, the OLES observed potential patterns, shortcomings, problematic protocols and other issues of concern at the departments. As a result, in addition to its case-by-case analyses, the OLES provided information to the departments on these associated issues and requested responses back within a specific time. In most instances, the OLES also asked the departments for corrective action plans. The OLES labeled these items “monitored” issues and identified 11 of them during the first half of 2016. Of the 11, five monitored issues were communicated to and discussed with DSH and one with DDS during the reporting period, and the departments’ responses to the OLES were assessed as “sufficient.” This information is in Appendix E. As of June 30, 2016, the remaining five monitored issues from the first half of 2016 were still open, either because the OLES continued to research them or because the OLES was waiting to hear back from the departments. The OLES will report on these monitored issues in subsequent reports.

## **Foundational challenges at DSH and DDS**

The OLES also examined foundational challenges that impede progress in law enforcement and discipline. Some of these issues detailed in this report are organizational structure, recruitment and retention, inconsistent policies and procedures, and lack of data tracking.

# Incidents

Every OLES case started with a report of an incident. Reports of incidents – alleged, inferred or actually witnessed at the facilities – can arrive at the OLES from many sources 24/7.

## Sources of incidents

Nearly all incidents in the first half of 2016 came directly from the departments. (The departments agreed in late 2015 to provide direct notifications to the OLES when they become aware of certain prescribed incidents.) Incidents were commonly reported by departmental law enforcement through telephone calls to the OLES administrator of the day on the OLES hotline, in daily police logs that came from the department facilities, and in emails to the OLES. The OLES also could receive reports of incidents from the public, families, patients/clients and advocates.

During the first half of 2016, the OLES became aware of one DSH incident because DRC, an agency mandated by federal law to protect and advocate for Californians with disabilities, inquired whether the OLES received notification of the incident. The OLES had not, and contacted the department and began monitoring the case. Note that the OLES did not have an auditing capability that could have helped verify that all prescribed incidents were coming to its attention.<sup>8</sup>

## Incidents reported this period

The OLES developed 20 categories classifying the incidents in the first half of 2016. The tables below show all incidents reported, inclusive of allegations against staff, patients and clients.

DSH Incidents Jan. 1-June 30	Number of Reports	Number Meeting OLES Criteria
Abuse	220	100
Sexual Assault	89	22
Head/Neck Injury	66	6
Neglect	57	25
Death	32	7
Misconduct	25	13
Use of Force	19	7
Law Enforcement	17	8
AWOL	14	0
Broken Bone	11	3
Other, Significant	11	1
Pregnancy	4	3
Attack on Staff	3	0
Attempted Suicide	3	1
Burns	2	0
Child Pornography	2	0
Genital Injury	1	0
Riot	1	0
Professional Board Violation	1	1
<b>Totals</b>	<b>578</b>	<b>197</b>

DDS Incidents Jan. 1-June 30	Number of Reports	Number Meeting OLES Criteria
Abuse	120	55
Head/Neck Injury	38	3
Broken Bone	24	8
Death	20	4
Neglect	18	12
Sexual Assault	9	2
Genital Injury	4	1
AWOL	4	0
Use of Force	3	0
Misconduct	3	1
Burns	3	0
Attempted Suicide	1	0
Attack on Staff	1	0
Law Enforcement	1	1
Professional Board Violation	1	1
Non-Resident Assault	1	0
Other, Significant	1	0
<b>Totals</b>	<b>252</b>	<b>88</b>

<sup>8</sup> At the time of this report, the OLES did not have an auditing staff.

It is important to note that while “abuse” was how certain incidents were described when they arrived at the OLES, the determination of whether each incident met the threshold for the OLES’s purposes of investigation and monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.<sup>9</sup> It is also critical that every incident reported by mental health patients and the developmentally disabled be given thorough and objective review.

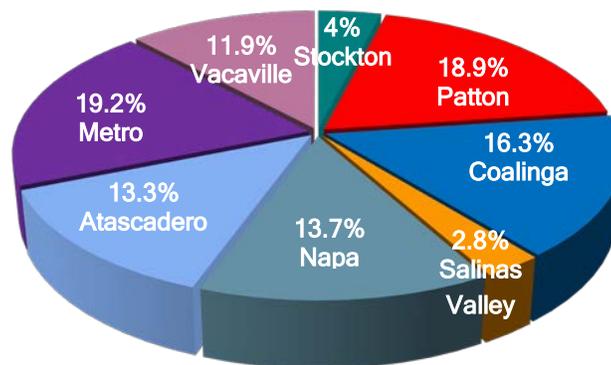
## Distribution of incidents at DSH

With 578 incidents reported to the OLES, DSH accounted for more than two-thirds of all reports. DSH-Metropolitan in Norwalk had the highest number of reports – 111. The DSH-Salinas Valley psychiatric program facility on the grounds of the state Department of Corrections and Rehabilitation Salinas Valley State Prison in Monterey County had the fewest incidents reported at 16. The charts below show the distribution of reported incidents at the eight DSH facilities.

### All Reported Incidents - DSH

Facility	Number of Patients*	Incidents Reported Jan. 1 - June 30	Incidents Per 100 Patients
DSH-Metropolitan	746	111	14.88
DSH-Patton	1,569	109	6.95
DSH-Coalinga	1,268	94	7.41
DSH-Napa	1,240	79	6.37
DSH-Atascadero	1,168	77	6.59
DSH-Vacaville	362	69	19.06
DSH-Stockton	358	23	6.42
DSH-Salinas Valley	198	16	8.08
<b>Total</b>	<b>6,909</b>	<b>578</b>	<b>8.37</b>

\*DSH average daily census January through June 2016.



<sup>9</sup> Welfare and Institutions Code section 15610.63, states, in pertinent part: “Physical abuse” means any of the following: (a) Assault, as defined in Section 240 of the Penal Code. (b) Battery, as defined in Section 242 of the Penal Code. (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code. (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water. (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code. (2) Rape, as defined in Section 261 of the Penal Code. (3) Rape in concert, as described in Section 264.1 of the Penal Code. (4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code. (6) Sodomy, as defined in Section 286 of the Penal Code. (7) Oral copulation, as defined in Section 288a of the Penal Code. (8) Sexual penetration, as defined in Section 289 of the Penal Code. (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code. (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment. (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given. (3) For any purpose not authorized by the physician and surgeon.

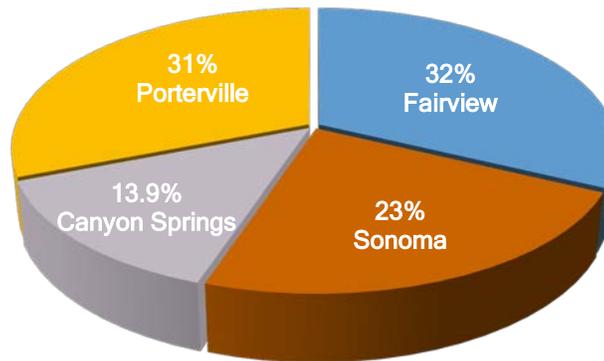
## Distribution of incidents at DDS

At DDS, the Fairview Developmental Center in Costa Mesa accounted for 32 percent of the DDS incident reports to the OLES. The Canyon Springs Community Facility in Cathedral City, with a small number of resident clients, had the fewest incident reports. Details are shown in the following charts.

### All Reported Incidents - DDS

DDS Facility	Number of Residents*	Incidents Reported Jan. 1 - June 30	Incidents Per 100 Residents
Fairview	232	81	34.91
Porterville	349	78	22.35
Sonoma	360	58	16.11
Canyon Springs	47	35	74.47
<b>Total</b>	<b>988</b>	<b>252</b>	<b>25.51</b>

\*DDS average of resident clients January 1, 2016 – July 1, 2016.



## Most frequent types of incidents reported at DSH

At DSH, the most abuse incidents reported to the OLES came out of DSH-Patton, while the DSH-Napa had the most reports of sexual assaults. The chart below shows the distribution of the top five incident categories at DSH. These categories amounted to 80 percent of the total incidents reported at the department.

Facility	Abuse Reports	Sexual Assault Reports	Head/Neck Injury Reports	Neglect Reports	Death Reports
DSH-Metropolitan	48	8	17	11	7
DSH-Patton	51	17	8	8	6
DSH-Coalinga	32	18	7	6	7
DSH-Atascadero	23	10	12	16	3
DSH-Napa	20	19	6	6	9
DSH-Vacaville	31	13	5	10	0
DSH-Stockton	6	4	10	0	0
DSH-Salinas Valley	9	0	1	0	0

## Most frequent types of incidents reported at DDS

At DDS, the Fairview Developmental Center had the most abuse incidents reported to the OLES, while the Porterville Developmental Center<sup>10</sup> had the most reports of head/neck injuries. The chart below shows the distribution of the top five incident categories at DDS. These categories accounted for 88.1 percent of the total incidents reported at the department.

DDS Facility	Abuse Reports	Head/Neck Injury Reports	Broken Bone Reports	Death Reports	Neglect Reports
Fairview	41	11	7	7	7
Porterville	39	13	5	2	4
Sonoma	15	12	10	11	7
Canyon Springs	25	2	2	0	0

## Deaths at DSH and DDS

During the first half of 2016, the OLES received 52 reports of deaths at the two departments combined. The OLES reviews all deaths that are reported, and the departments classify each as “expected” or “unexpected”.<sup>11</sup> The OLES either investigates deaths that are classified as “unexpected” or the OLES monitors the departments’ investigations into “unexpected” deaths.

## Response to incidents

The OLES response was based upon the timeliness of the notification, the severity of the incident/allegation as reported and the quality of the information that was reported to the OLES. An OLES staff member was on call 24/7, and the OLES had the capability of arriving at any hour to the scene of a reported incident at a facility.

It was key for the OLES to receive appropriate information in order to make suitable responses. To help improve the quality and completeness of initial information coming in, the OLES developed and distributed to the departmental law enforcement personnel certain report outlines that list pertinent information that should be provided to the OLES at the initial notification. Such information included a description of any injuries suffered, the commitment type of the patient or patients involved and the facility case number for the incident.

## Incident notifications

Different types of incidents required different kinds of notification to the OLES. Based on legislative mandates found in Welfare and Institutions Code sections 4023 and 4427.5 et seq. (in Appendix F), and agreements between the OLES and the departments, certain serious incidents were required to be reported to the OLES within two hours of their discovery. Notification of these Priority 1 incidents was deemed to be satisfied by a telephone call to the OLES hotline in the two-hour period. Priority 2 threshold incidents required notification within one day. Priority 1 and 2 threshold incidents are shown in the tables on the next page.

<sup>10</sup> Reports were from both the general treatment area at Porterville and the Secure Treatment Program.

<sup>11</sup> The classification of “expected” or “unexpected” was based on the departments’ assessment of a patient’s or client’s pre-existing health before the death. The classification also was assigned before a coroner’s report was issued.

## Priority 1 Threshold Incidents

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### PRIORITY 1 NOTIFICATIONS - 2-HOUR NOTIFICATION

- Any **death** involving a resident
  - Any allegation of **sexual assault** involving a resident
  - An **assault with a deadly weapon** or an assault with force likely to produce great bodily injury, involving a resident by a non-resident or, as described in Penal Code Section 245
  - Any report of **physical abuse** of a resident implicating a staff member
  - An injury to the **genitals** of a resident when the cause of injury is undetermined
  - A **broken bone** of a resident when the cause of the break is undetermined
  - Any **use of deadly force**, including any strike to the head or neck, by an employee or contractor occurring within a DSH- or DDS-operated facility or a DSH psychiatric center located within a California Department of Corrections and Rehabilitation institution
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## Priority 2 Threshold Incidents

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### PRIORITY 2 NOTIFICATIONS - 1-DAY NOTIFICATION

- A **pregnancy** involving a resident
  - Any **injury to the head or neck** of a resident requiring treatment beyond first aid
  - Any **burns** of a resident, regardless of whether the cause is known, requiring treatment beyond first aid
  - Any **riot** occurring within the jurisdiction of the department and as defined in Penal Code Section 404
  - Any incident of **significant interest** to the public; e.g., escapes, "AWOL", commission of serious crimes by a resident or patient off facility grounds, attempted suicide (requiring treatment beyond first aid), etc.
  - Any incident by a staff member or contractor affecting the health, safety or well-being of a resident that reasonably could have resulted in **serious or great bodily injury, abuse or neglect**, or death
  - Any allegations of DSH/DDS law enforcement personnel **misconduct**, whether on-duty or off-duty
  - Any allied **law enforcement agency contact with DSH/DDS** law enforcement personnel, with the exception of routine traffic infractions, that are outside the scope of departmental policing official duties
-

## Timeliness of incident notifications

The DSH and DDS were informed by the OLES of the notification requirements on November 10, 2015, and the departments were invited to participate in a six-week test before the official January 1, 2016, start date. Additionally, the OLES chief met with executive directors at the facilities to explain the upcoming OLES activities. Starting January 1, 2016, the OLES tracked the timeliness of the incident notifications<sup>12</sup> from the departments. During the first half of 2016, the OLES was notified of 73.5 percent of the DSH reportable incidents within the required time. During the same period, the OLES was notified of 78.6 percent of the DDS reportable incidents within the required time. The charts below show details for each facility.

### Timely Notifications at DSH

DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
DSH-Stockton	358	23	22	95.7%
DSH-Atascadero	1,168	77	67	87%
DSH-Vacaville	362	69	56	81.2%
DSH-Metropolitan	746	111	89	80.2%
DSH-Coalinga	1,268	94	64	68.1%
DSH-Patton	1,569	109	72	66.1%
DSH-Napa	1,249	79	48	60.8%
DSH-Salinas Valley	198	16	7	43.8%
<b>DSH Totals</b>	<b>6,909</b>	<b>578</b>	<b>425</b>	<b>73.5%</b>

\*DSH average daily census January through June 2016.

### Timely Notifications at DDS

DDS Facility	Number of Residents*	Number of Incidents Reported**	Number of Timely Notifications	Percentage of Notifications That Were Timely
Canyon Springs	47	35	32	91.4%
Sonoma	360	58	51	87.9%
Fairview	232	81	60	74.1%
Porterville**	349	78	55	70.5%
<b>DDS Totals</b>	<b>988</b>	<b>252</b>	<b>198</b>	<b>78.6%</b>

\*DDS average of resident clients January 1, 2016 - July 1, 2016.

\*\*Included general treatment area and Secure Treatment Program.

<sup>12</sup> Whenever it was reasonably believed that employee misconduct may have occurred, it was the responsibility of the hiring authority (department facility) to report the conduct in a timely manner, per the notification schedules on the previous page, to the OLES for investigation or monitoring. Each reported incident was reviewed by the OLES during a daily intake meeting where it was determined if the report was timely and contained adequate information.

# Intake

All incidents received by the OLES during the six-month period were reviewed by an OLES panel at a daily intake meeting. Based on statutory requirements, the panel determined whether allegations against law enforcement officers warranted an internal affairs investigation by the OLES. If the allegations were against other DSH or DDS staff members, the panel determined whether the allegations warranted OLES monitoring of the departmental investigation. A flowchart of all the possible OLES outcomes from intake is shown in Appendix G.

## Rejections

Every incident that was rejected by the OLES received a preliminary review – an extra step to ensure that incidents that initially appeared to not fit the criteria<sup>13</sup> for OLES involvement were being properly rejected. Sometimes, allegations were unclear, and additional information needed to be obtained to finalize an initial intake decision, which sometimes involved significant delays in getting additional information. As an example, an alleged abuse case could require the OLES to review video files or digital recordings of a particular hallway, day room or staff area where a patient or client was located. It could take time for the OLES to get the recordings from a facility and view them. Once the additional material/information was obtained and scrutinized by the OLES staff, the decision to initially reject an incident for not meeting the OLES criteria was reviewed again and could be reversed. In the first half of 2016, 381 incidents at DSH were rejected by the OLES, amounting to nearly two-thirds of all incidents received involving the department. At DDS, 164 incidents were rejected during the six-month period, which also amounted to nearly two-thirds of all incidents received that involved DDS. The charts below show details.

Disposition of DSH Incidents from Jan. 1 - June 30	Number	Percentage of Reported Incidents
Rejected	381	65.9%
Monitored, Administrative	117	20.2%
Monitored, Criminal	45	7.8%
OLES Investigations, Administrative	21	3.6%
Monitored Issues	8	1.4%
OLES Investigations, Criminal	6	1.0%
<b>Totals</b>	<b>578</b>	<b>100%</b>

Disposition of DDS Incidents from Jan. 1 - June 30	Number	Percentage of Reported Incidents
Rejected	164	65.1%
Monitored, Administrative	46	18.3%
Monitored, Criminal	38	15.1%
Monitored Issues	3	1.2%
OLES Investigations, Administrative	1	0.4%
OLES Investigations, Criminal	0	0%
<b>Totals</b>	<b>252</b>	<b>100%</b>

<sup>13</sup> Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix F).

# Investigations and Monitoring

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

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

## **OLES-conducted investigations this period**

The OLES conducted 14 investigations that closed by June 30, 2016. The vast majority – nine – of the 14 OLES investigations involved administrative cases and all were at DSH. The other five OLES investigations involved criminal allegations and all were at DSH. None of the five criminal investigations led to criminal charges. Three of the nine administrative investigations also determined insufficient evidence for the cases to proceed. Details are in the case synopses in Appendix A.

Not all investigations that the OLES started in the first six months of 2016 were finished by June 30, 2016. This explains why there were 14 other investigations that the OLES still had under way on that date. These open investigations were not included in this report.

An investigation conducted by the OLES is just the start of the process. If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, the OLES submits the investigation to a prosecuting agency. The OLES then monitors the outcome of the submittal to the prosecutor. All OLES investigations into cases of administrative wrongdoing/misconduct are forwarded to facility management for review and disposition. If the facility management imposes discipline, the OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if necessary.

## Monitored departmental investigations this period

The OLES monitored 66 cases that, by June 30, 2016, had completed the only pre-disciplinary phase, which are the investigations conducted by the departments. By the end of the reporting period, these departmental investigations either had not yet entered the discipline phase or resulted in no disciplinary action. Fifty-four of these 66 monitored investigations involved allegations of administrative misconduct by staff members, such as failing to maintain one-on-one supervision, as required, for a certain patient who harmed himself. Only 12 of the 54 DSH and DDS monitored administrative investigations, or 22 percent, were sustained, meaning sufficient evidence was found to exist for discipline to be considered. In addition, only one of the 16 criminal investigations that the OLES monitored was referred to a prosecuting agency. The synopses for both administrative and criminal investigations completed by the departments are in Appendix B.

Note that two other cases that the OLES monitored completed both the pre-disciplinary phase (departmental investigation) and the discipline phase. These cases, in Appendix D, have assessments for each phase.

As discussed, the OLES monitors both criminal and administrative investigations that are conducted by departmental law enforcement personnel. The criminal investigations are monitored to their conclusion, which can be closure at the departmental level or referral to a prosecuting agency. Administrative investigations are monitored by the OLES through the conclusion of the discipline process. This can include State Personnel Board proceedings and civil litigation, if necessary. For guidelines on these processes, please see Appendix H.

The OLES assesses every investigation for both procedural and substantive sufficiency. Procedural sufficiency is assessing the notifications to the OLES, consultations with the OLES and investigation activities for timeliness, among other things. Substantive sufficiency is assessing the quality, adequacy and thoroughness of the investigative interviews and reports, among other things. The charts below show the number of insufficient investigations at each facility during the reporting period. The synopses of these cases can be found in Appendices B, C and D.

Each department had insufficiencies procedurally and substantively during the reporting period. The DSH had 12 insufficient cases, of which 11 were procedural and one was substantive. Note that one of the procedurally insufficient cases was also substantively insufficient. At DDS, there were 12 insufficient cases, and all 12 were procedurally insufficient and four also were substantively insufficient.

Note that as of June 30, 2016, the OLES continued to monitor more than 100 cases that had not yet reached completion. These cases will be presented in subsequent reports.

## Monitoring the discipline phase

When an administrative investigation – by the department or by the OLES – is completed, an investigation report with facts about the allegations is sent to the facility management where the state employee works. The discipline phase commences as the facility management decides whether to sustain any allegations against the employee or exonerate the employee. This decision is

based upon the evidence presented. If the evidence shows the allegations are unfounded, the facility management can determine that the allegations are not sustained or can exonerate the employee. If there is sufficient evidence or a preponderance of evidence showing the allegations are factual, the facility management can sustain the allegations. If one or more allegations are sustained, the facility management must impose an appropriate disciplinary penalty. Two cases that the OLES monitored during the reporting period have assessments of the discipline phase only, and these are in Appendix C.

The OLES assesses every discipline phase case for both procedural and substantive sufficiency. Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion. Substantive sufficiency assesses the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

### **OLES recommendations for discipline phase**

During the first half of 2016, the OLES observed that neither DSH nor DDS had written, statewide standardized policies and procedures for how to assess investigation facts and impose appropriate discipline on employees on a consistent, statewide basis. Instead, each DSH and DDS facility had its own process for reviewing investigation reports and evaluating the merits of cases. Some institutions, such as DSH-Metropolitan and the DDS facilities, brought investigation reports to a committee composed of managers and human resources personnel at the facility. The group made recommendations to the facility executive director, or the panel made the decision jointly on what to do with the investigation results. At other facilities, such as DSH-Napa, the executive director read every investigation report to decide the merits of each case. During the first half of 2016, DSH had drafted a policy and procedures for standardizing the assessment of investigation facts and the imposition of appropriate discipline. But by June 30, 2016, the policy and procedures had not been finalized and distributed. The OLES recommends that both departments implement policies and procedures by December 1, 2016.

To assist in standardizing discipline penalties statewide, the OLES in 2015 presented to the departments a disciplinary matrix that was previously utilized by DSH-Salinas Valley and DSH-Vacaville. A pre-set matrix helps set consistent penalties statewide. But by June 30, 2016, DSH and DDS had failed to implement written, standardized penalty matrices. The OLES recommends that standardized penalty matrices be completed and implemented at the departments, preferably by December 1, 2016.

The OLES also recommended in 2015 that an executive review process be implemented to address cases where facility management, departmental labor attorneys and/or the OLES monitoring attorneys disagree about the imposition of discipline. The DSH had drafted a policy and procedures for a standardized executive review process, but by June 30, 2016, they had not been finalized and distributed. The DDS had not promulgated any standardized policy and procedures. The OLES

recommends that departments institute statewide, standardized policy and procedures no later than December 1, 2016.

Additionally, the OLES recommends that DSH and DDS attorneys be assigned to all cases to guide the investigators, assist with interviews and gathering of evidence, and to give advice and counsel to facility management during the discipline phase of cases. During the six-month reporting period, few cases, if any, had departmental attorneys assigned at the outset. The best practice is to have employment law attorneys involved, and this practice is followed at California's CDCR. Neither DSH nor DDS had the staff to dedicate to this best practice. The OLES recommends that departments assess and pursue resources with a goal for implementation of best practices by December 2017.

# Additional Mandated Data

The OLES is required by statute to put into its semi-annual reports specific data about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where patients or resident clients are the perpetrators. All the mandated data for the first six months of 2016 came directly from DSH and DDS and is presented in the following tables.

## DSH Mandated Data - Adverse Actions Against Employees

DSH Facilities	Formal administrative investigations completed*	Adverse action taken**	Direct adverse action taken**	No adverse action taken	Resigned/retired pending adverse action***
DSH-Atascadero	38	10	7	1	1
DSH-Coalinga	34	66	23	46	0
DSH-Metropolitan	39	12	8	0	0
DSH-Napa	18	30	13	5	5
DSH-Patton	47	29	20	0	2
DSH-Salinas Valley	4	2	2	0	0
DSH-Stockton	2	3	3	0	0
DSH-Vacaville	1	4	0	0	0
<b>Totals</b>	<b>183</b>	<b>156</b>	<b>76</b>	<b>52</b>	<b>8</b>

## DDS Mandated Data - Adverse Actions Against Employees

DDS Facilities	Formal administrative investigations completed*	Adverse action taken**	No adverse action taken	Resigned/retired pending adverse action***
Fairview	71	11	60	0
Porterville	39	10	29	1
Sonoma	16	7	9	1
Canyon Springs	16	2	12	2
<b>Totals</b>	<b>142</b>	<b>30</b>	<b>110</b>	<b>4</b>

\***Administrative investigations completed** includes all formal investigations that resulted in or could have resulted in an adverse action. All numbers are for investigations that were completed during the OLES reporting period and do not necessarily reflect when the employee misconduct occurred. For DDS, an investigation was considered complete when an employee was served with a Notice of Adverse Action or when it was determined that no adverse action would be taken. For DSH, an investigation was considered complete when the case was submitted to the hiring authority. These numbers do not include background investigations, Equal Employment Opportunity investigations or progressive discipline of minor misconduct that did not result in an adverse action against an employee.

\*\***Adverse action taken** refers to a Notice of Adverse Action being served to an employee after a formal investigation was completed. **Direct adverse action taken** refers to a Notice of Adverse Action being served to an employee after an informal investigation was completed. These numbers include rejecting employees during their probation period.

\*\*\***Resigned or retired pending action** refers to employees who resigned or retired prior to being served with an adverse action.

### DSH Mandated Data - Criminal Cases Against Employees\*

DSH Facilities	Referred to a prosecuting agency**	Rejected by a prosecuting agency***	Not referred****	Totals
DSH-Atascadero	0	0	11	11
DSH-Coalinga	1	0	1	2
DSH-Metropolitan	0	0	0	0
DSH-Napa	1	1	1	2
DSH-Patton	5	3	0	5
DSH-Salinas Valley	0	0	0	0
DSH-Stockton	0	0	0	0
DSH-Vacaville	0	0	0	0
<b>Totals</b>	<b>7</b>	<b>4</b>	<b>13</b>	<b>20</b>

### DDS Mandated Data - Criminal Cases Against Employees\*

DDS Facilities	Referred to a prosecuting agency**	Rejected by a prosecuting agency***	Not referred****	Totals
Fairview	0	0	1	1
Porterville	1	0	0	1
Sonoma	0	0	13	13
Canyon Springs	0	1	9	10
<b>Totals</b>	<b>1</b>	<b>1</b>	<b>23</b>	<b>25</b>

\***Employee criminal cases** include criminal investigations of any employee. Numbers are for investigations which were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

\*\***Cases referred to a prosecuting agency** are criminal cases where the investigations were completed and were then referred to an outside prosecuting entity.

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

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

Note: In the table above, the one Canyon Springs case that was rejected by a prosecuting agency during the reporting period was referred in December 2015, before the OLES monitoring began.

### DSH Mandated Data - Patient/Client Criminal Cases\*

DSH Facilities	Referred to a prosecuting agency**	Rejected by a prosecuting agency***	Not referred****	Totals
DSH-Atascadero	212	136	242	590
DSH-Coalinga	58	3	253	314
DSH-Metropolitan	46	4	408	458
DSH-Napa	19	0	520	539
DSH-Patton	147	105	135	387
DSH-Salinas Valley	0	0	0	0
DSH-Stockton	0	0	0	0
DSH-Vacaville	0	0	0	0
<b>Totals</b>	<b>482</b>	<b>248</b>	<b>1,558</b>	<b>2,288</b>

### DDS Mandated Data - Patient/Client Criminal Cases\*

DDS Facilities	Referred to a prosecuting agency**	Rejected by a prosecuting agency***	Not referred****	Totals
Fairview	0	0	1	1
Porterville	18	4	9	31
Sonoma	0	0	0	0
Canyon Springs	0	0	0	0
<b>Totals</b>	<b>18</b>	<b>4</b>	<b>10</b>	<b>32</b>

\***Patient/client criminal cases** include criminal investigations involving patients or resident clients. Numbers are for investigations which were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

\*\***Cases referred to a prosecuting agency** are criminal cases where the investigations were completed and were then referred to an outside prosecuting entity.

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

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

### DSH Mandated Data - Reports of Employee Misconduct to Licensing Boards\*

DSH Facilities	Registered Nursing	Vocational Nursing	Medical Board	Pharmacy	Public Health	Behavioral Science	Psychology
DSH-Atascadero	0	5	0	0	0	0	0
DSH-Coalinga	1	2	0	0	0	0	0
DSH-Metropolitan	0	2	0	0	0	0	0
DSH-Napa	1	2	0	0	0	0	1
DSH-Patton	1	2	0	0	0	1	0
DSH-Salinas Valley	0	0	0	0	0	0	0
DSH-Stockton	0	0	0	0	0	0	0
DSH-Vacaville	0	0	1	0	0	0	0
<b>Totals</b>	<b>3</b>	<b>13</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>

### DDS Mandated Data - Reports of Employee Misconduct to Licensing Boards\*

DDS Facilities	Registered Nursing	Vocational Nursing	Medical Board	Pharmacy	Public Health
Fairview	2	7	0	0	10
Porterville	0	0	0	0	10
Sonoma	0	2	0	0	9
Canyon Springs	0	1	0	0	0
<b>Totals</b>	<b>2</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>29</b>

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

## Gathering and analyzing mandated data

The statute<sup>14</sup> requires the OLES to provide assessments on the adequacy of the systems used by the departments to track and monitor outcomes of investigations and analyze them for trends. At the start of the six-month reporting period, neither department had a central point where all investigation outcomes statewide were being tracked and analyzed.

The DSH, in particular, struggled during the six months to gather all the mandated data in a timely manner and submit it to the OLES. Much of the data resided at DSH facilities across the state. Some was maintained within human resources, and the OLES was directed to work with human resources to obtain the data.

## OLES recommendations

The OLES recommends that DSH establish department-wide policies and procedures so tracking and reporting of all the mandated data involving employee discipline becomes centralized and arrives in a timely manner. The policies also should address organization and maintenance of the data records for audit purposes. The DDS implemented these policies in early 2016. Both DDS and DSH should also have policies for documenting their analysis for trends and patterns in the data.

At both DSH and DDS, the OLES observed a lack of robust statewide database systems. DDS uses several spreadsheets, at different units in the department, to capture discipline cases, and DSH continued to work on a method to capture and analyze this kind of data in a timely fashion. The OLES recommends that a centralized discipline tracking system be developed at each department to allow real-time documentation on employee misconduct investigations and allow staff who are involved in the process, such as investigators, human resource personnel and legal staff, to monitor in real time the cases and the activity on them, including key decisions and due dates. This system, which could be permission-based to maintain confidentiality, would track every investigative request, case acceptances and rejections, formal investigations as well as direct adverse actions. It also would track all administrative actions and could contain all referrals to licensing boards.

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<sup>14</sup> California Welfare and Institutions Code Section 4023.8 (a) (2) (I).

# Monitored Issues

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In the course of its oversight duties, the OLES observed some issues – potential patterns, shortcomings, problematic protocols, etc. -- at the facilities during the six-month period. The chief of the OLES instructed OLES staff to research and document the issues. The issues were then brought to the attention of the departments, along with requests for responses back to OLES within a specific time. In most instances, the OLES asked for corrective plans. These issues were labeled “monitored” issues and are included in Appendix E.

The OLES, for example, recommended a 360-degree approach to the departments’ review of use of force. This 360-degree approach not only examines whether the force used was within policy and met training protocols, it identifies what created the situation in the first place that led to the need for force. It also determines if policy was followed after the event in terms of patient/client interviews, medical examination and clearance and if police report documentation was thorough and complete. The OLES also recommended that policy, procedure and training be instituted for all department personnel to teach them the importance of retaining evidence. As an example, anonymous notes slipped under a supervisor’s door must not be thrown into the trash. They should be turned over to law enforcement and properly handled as evidence.

Five monitored issues were documented and discussed with DSH and one with DDS. Once informed of the issues, the departments responded appropriately and were then rated as sufficient in how they addressed the matters.

# Foundational Challenges

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As required by statute,<sup>15</sup> the OLES in March 2015 provided the Legislature with a report that described the challenges faced by law enforcement at DSH and DDS. Since then, the OLES has tracked the issues and identified others that hamper efforts to standardize best practices across law enforcement at the departments' facilities.

## Significant DSH law enforcement challenge

At DSH, the organizational structure fragments, rather than consolidates, the department's law enforcement authority. In the first half of 2016, the chiefs of police at each facility did not report to the department's chief of law enforcement,<sup>16</sup> who had been a sworn peace officer for 25 years under California Penal Code 830. Instead, each facility chief of police reported directly to a non-law enforcement facility hospital administrator.

A key reason was California Welfare and Institutions Code Section 4311 which states DSH hospital administrators are "responsible for preserving the peace" at the state-owned mental facilities "and may arrest or cause the arrest ... of all persons who attempt to commit or have committed a public offense thereon." Hospital administrators, however, are not required to have law enforcement experience and not required to undergo the training that POST advises for sworn peace officers under Penal Code 832. But the hospital administrators at DSH can "designate, in writing, as a police officer one or more of the bona fide employees of the hospital" under the Welfare and Institutions Code Section 4313. In essence, the facilities' executive management, rather than the chief of law enforcement for DSH, has the power to select and appoint the law enforcement chiefs at the facilities.

In the DSH organization charts for the first half of 2016, each facility law enforcement chief reported to the facility hospital administrator who reported to the facility executive director who then reported to the DSH director. Meanwhile, the DSH chief of law enforcement reported to the DSH director separately and had no direct authority to impose policy over the other chiefs.

In contrast, DDS maintained its established hierarchy where the headquarters chief of law enforcement directed law enforcement policies and processes for all the developmental centers. The DDS chief of law enforcement had direct supervision of the top law enforcement official, a commander, at each facility.

## OLES recommendation

The Legislature last addressed Section 4311 of the Welfare and Institutions Code in 1976. It gave arrest powers to hospital administrators who also handled accounting, budgeting, personnel and food services. At the time, residents at the facilities were primarily mentally ill patients who did not have criminal records. Today, however, more than 90 percent of the DSH patients come from the

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<sup>15</sup> Penal Code Section 830.38(c) and Welfare and Institutions Code Section 4023.5(a).

<sup>16</sup> Per DSH organization charts and policy manual.

criminal justice system. While a DSH administrative letter dated December 1, 2015, sought to clarify the role of the department's chief of law enforcement by stating he "recommends and coordinates the implementation of best practices across the system," the 40-year-old law remains intact that prevents him from directly ordering best practices and directly supervising the law enforcement staff who would have to implement the improvements. The OLES recommends that best law enforcement practice be followed and new legislation be written to consolidate all law enforcement authority and law enforcement budgeting at the department level under the DSH sworn peace officer chief.

## Significant DDS law enforcement challenges

At DDS, the most significant challenge to sustained law enforcement best practices is the insufficient DDS efforts to recruit new hires at the same time that virtually all of the state-owned facilities for the developmentally disabled are planning to close. The closures, which will come as developmentally disabled residents are moved to care and treatment facilities in communities by the end of 2021, make it difficult to fill, and keep filled, vacant law enforcement positions.

As of the end of June 2016, 39 percent of the DDS law enforcement positions were vacant, and several recommendations from 2015 by the OLES to boost DDS efforts at outreach and recruitment were not implemented. As examples, DDS still maintained a nearly 3-year-old job posting<sup>17</sup> on the state's [www.jobs.ca.gov](http://www.jobs.ca.gov) website seeking investigators at the Sonoma Developmental Center, where law enforcement vacancies stood at 34 percent at the end of June 2016.<sup>18</sup> Another DDS law enforcement job posting, for peace officers at Porterville, was nearly 2 years old<sup>19</sup> even as the vacancy rate for law enforcement at Porterville was 39.6 percent as of the end of June 2016.<sup>20</sup> As the OLES pointed out in 2015, would-be applicants, particularly top-quality applicants, generally refrain from responding to such stale job postings.

During the six-month period, DDS added online self-certification examinations for several law enforcement classifications. But online efforts to get prospective job seekers to the DDS exams website continued to lag. Through June 30, 2016, DDS did not widen its online law enforcement job postings to military websites or broader general employment websites as the OLES had recommended in 2015. Nor did the department expand its job postings to other law enforcement sites other than the one for the California POST, according to responses provided to the OLES by DDS. During the reporting period, DDS had no Facebook or Twitter presence dedicated to law enforcement recruitment

## OLES recommendations

Recruiting for law enforcement positions can be challenging, but there are still more than five years where law enforcement personnel will be needed to ensure the safety and security of the DDS residents, staff and the facilities. The OLES recommends that DDS expend more effort for outreach and recruitment for new law enforcement personnel and institute the recommendations that the OLES provided more than a year ago, including expanding the number and types of employment

<sup>17</sup> Sonoma investigator position #507-562-8610-008 at [www.dds.ca.gov/JobBulletin/index.cfm](http://www.dds.ca.gov/JobBulletin/index.cfm).

<sup>18</sup> DDS spreadsheet titled "Office of Protective Services Recruiting and Hiring Efforts Reporting Through June 30, 2016" dated July 19, 2016.

<sup>19</sup> Porterville peace officer position #515-561-1954-101 at [www.dds.ca.gov/JobBulletin/index.cfm](http://www.dds.ca.gov/JobBulletin/index.cfm).

<sup>20</sup> DDS spreadsheet titled "Office of Protective Services Recruiting and Hiring Efforts Reporting Through June 30, 2016" dated July 19, 2016.

websites where law enforcement openings are posted, using social media to draw applicants, upgrading law enforcement recruitment materials and establishing a policy that job postings will no longer languish unchanged online for two or three years. The OLES also recommends that DDS to expand its outreach to more POST academies, consider incentives for current law enforcement staff who bring aboard new hires, explore with CalHR the addition of a law enforcement cadet job classification and work with CalHR and DSH on a transition plan for DDS staff who would be interested in moving to DSH law enforcement openings as the developmental centers close.

## DSH law enforcement recruiting

Implementing several recommendations from the OLES, DSH improved its outreach and recruitment for law enforcement personnel during the first half of 2016. The department invested in new presentation and booth materials specifically to attract law enforcement candidates. DSH attended 40 recruitment fairs/events by June 30, 2016, and produced a website just for law enforcement recruitment. The department also broadened the list of employment websites where it posts jobs, and it uses Twitter and Facebook to announce law enforcement jobs that are available at facilities across the state.

An analyst reporting to the DSH law enforcement chief compiled and analyzed statistics on the status of the recruitment efforts and as applicants go through the department’s hiring process. As a result, the department is pursuing ways to increase the number of job candidates and the number who matriculate from application to graduation as a hospital police officer – a process that can take a year or more. The chart below from the 2014-15 fiscal year illustrates how many job applicants can be lost along the way – from voluntarily withdrawing, not meeting criteria or not passing tests.

Hospital Police Officer Hiring Process	Number of Candidates*	Percentage of Initial Applicants
Applications received	970	100%
Applicants who showed up for written test	379	39.1%
Passed written test	279	28.8%
Passed background investigation	86	8.9%
Passed medical screening	74	7.6%
Passed physical fitness abilities test	71	7.3%
Passed psychological exam	44	4.5%
Accepted job assignment	29	3.0%
Graduated from DSH academy	24	2.5%

\*Data is from 2014-15 fiscal year.  
Source: DSH.

## DSH standardized training

The DSH developed standardized training protocols for all its peace officers statewide and implemented standardized training plans by January 1, 2016, at its DSH-Atascadero academy. Since January 1, 2016, the DSH-Atascadero academy has used a standardized curriculum that incorporates training scenarios that relate to all the DSH facilities while ensuring that incoming law enforcement personnel receive the same basic training at the start of their DSH careers, thus making it statewide training. In addition, the 548 hours of instruction time at the academy for the new hires is substantial – more than the 480 hours for state correctional officers but less than the

1,275-plus hours for California Highway Patrol officers – and reflects the inclusion of mental health training so officers better understand the DSH patients. But the mental health training component for the new hires was being provided by a police officer, not clinical personnel. As of June 30, 2016, DSH provided the OLES with academy lesson plans but was to resubmit them in a standardized format no later than December 1, 2016.

Current DSH law enforcement personnel were receiving continued professional training that meets the POST requirement of 24 hours every two years. But each DSH facility was choosing which courses to offer and approve. The OLES was awaiting standardized lesson plans for this continued professional training, and the training should incorporate both mental health and law enforcement topics. The OLES recommends that these standardized continued professional training lesson plans be completed and submitted to the OLES by December 31, 2016.

### **OLES training recommendations for DSH**

A major concern for the OLES in the first half of 2016 was the retraining of some new hires that was occurring after they completed the academy. During the reporting period, law enforcement at the DSH-Napa hospital were being taught, after they graduated from the DSH statewide academy, a different protocol for arrest and control than what they had just learned. The DSH-Napa and DSH-Coalinga hospitals also were training graduates on use of the PR-24 batons because these are the batons given to staff at the two facilities. But the academy was teaching techniques for the Armament Systems and Procedures Inc. (ASP) baton, which was being used at the other DSH facilities.

While it is important that staff be properly trained for the tools that they are provided on the job, the DSH goal should be to have standardized training and standardized tools statewide. The OLES recommends that by December 1, 2016, DSH decide on one police baton statewide, excluding specialized and tactical police teams, and require that all purchases from that date be only for the one baton.

The OLES also points out that while the 548 hours of law enforcement instruction at the academy had been standardized, the 400 hours of subsequent field training that DSH academy graduates experience after leaving the academy were not. As of June 30, 2016, the OLES was waiting for completion of a DSH plan to create consistent law enforcement field training objectives, evaluation methods and passing standards across the department.

Finally, the OLES recommends that trained mental health personnel be involved in the mental health training for both new and current law enforcement staff. The OLES also recommends that this training be completed for current hires within 18 months.

### **DDS standardized training**

The DDS had standardized training in the six-month period because all sworn staff must successfully complete a law enforcement academy certified to the standards of the California POST and obtain a Regular Basic Certificate prior to hire. The POST audits DDS for compliance. The POST requirements satisfy the law enforcement training requirements for both existing and newly hired DDS staff. Once

hired, sworn staff receive additional specialized training for homicide/death investigations and sexual assault investigations. For the future, DDS said it has agreed to send all its law enforcement staff to a 24-hour critical incident training course to be run by DSH at its DSH-Atascadero academy. However, during the reporting period, no curriculum for this training course was developed and it was unclear when this training would start. Additionally, the field training for law enforcement at the DDS facilities was not standardized.

## **OLES training recommendations for DDS**

As of June 30, 2016, the OLES was waiting for completion of a DDS plan to create consistent law enforcement field training objectives, evaluation methods and passing standards across the department. Additionally, the OLES was awaiting a plan from DDS to incorporate mental health training, conducted by mental health staff, into training for all DDS law enforcement personnel.

## **Tracking DSH and DDS training compliance**

The OLES is required by statute to assess the adequacy of DSH and DDS systems for tracking employee compliance with training requirements. The OLES found that DSH tracks compliance at the facilities level and only began submitting this information to DSH law enforcement headquarters for centralized tracking in the first half of 2016. DDS already had a centralized approach. The DDS law enforcement headquarters in Sacramento tracks training compliance of all sworn staff in the department.

## **Tracking on-the-job law enforcement behavior**

An Early Intervention System (EIS) was purchased by DSH and DDS to flag potentially problematic behavior among law enforcement staff at each department and help management pinpoint trends and address issues early, before serious misconduct occurs. The system operates by providing e-mail alerts to law enforcement and facility management when the database detects a law enforcement employee has been involved in a certain number of threshold activities or incidents. In the first half of 2016, DSH and DDS were making adjustments to the threshold incidents and activities that the EIS software would track. Once the programming changes are complete, DSH and DDS law enforcement units are to test the system at two beta sites: DSH-Atascadero and the Porterville Developmental Center. The system is slated to be operational at every DSH and DDS facility by December 31, 2016.

## **OLES recommendations for on-the-job monitor system**

The EIS is useful only if its information is acted upon by management. To this end, the OLES recommends that the chiefs of law enforcement at the departments review monthly reports from the system and check that employees with the identified behavior and/or activities are receiving prompt management attention. Further, the OLES recommends that the DSH and DDS chiefs of law enforcement use the employee trends that are pinpointed by the system to review whether training is adequate or needs to be updated and/or supplemented. Any training updates should be reviewed in advance by the OLES.

## **Policies and procedures**

In law enforcement, accountability revolves around policies and procedures that all uniformed personnel are to follow. It is critical, therefore, to have up-to-date, legally vetted and complete policy manuals. DSH and DDS worked with a vendor that is a leader in law enforcement policy development to implement up-to-date policy manuals on July 1, 2015. The manuals contained, for the first time ever, standardized policies across each department.

Additionally, for the first time, all law enforcement staff could access the policies via computer and via a smartphone app. The easy access and the daily distribution of online “scenario training” lessons – called Daily Training Bulletins – that continuously review the policies with staff have greatly enhanced staff knowledge of departmental policies. Through the first half of 2016, a combined 97 percent of law enforcement staff at DSH and DDS had stayed current with the training bulletins. In comparison, in 2015, some 50 percent of DSH law enforcement personnel reported in a survey that they had “never or rarely” referred to or cited department policies in the previous year.<sup>21</sup>

Policies are the overarching guide for law enforcement personnel, while procedures are the step-by-step processes to implement the policies. With the updated policies in place, the two departments worked to update procedures specific to each facility. In the first half of 2016, DSH uploaded the procedures for four of its five hospitals into its digital policy manual. The DDS had developed procedures, and the chief of law enforcement e-mailed them to the DDS facility commanders on June 30, 2016. But no procedures were uploaded into a digital manual during the six-month period.

## **OLES recommendations on policies and procedures**

The OLES observed a lack of consistency in the law enforcement policies and procedures at the three psychiatric program facilities at DSH-Vacaville, DSH-Stockton and DSH-Salinas Valley. These facilities are unique in the DSH system, and best practice dictates that policies and procedures should be standardized among the three facilities.

During the reporting period, the OLES became aware of a law enforcement policy change that was implemented verbally within DDS. Verbal policy changes that lack written documentation cause confusion among staff members who are not aware of the new, unwritten policy and are still following the older, written policy. And, verbal policies that are not brought to the attention of the OLES hinder the ability of the OLES to document and properly investigate and monitor the department. Failure to follow proper protocol in instituting new policies also does not give the OLES the opportunity to review a new policy before it is implemented. The OLES requested that DDS refrain from verbal policy changes and that the OLES be notified before any new policy is implemented.

The OLES recommends that procedures for all facilities at both departments be completed by December 31, 2016, and uploaded into the digital policy manuals. The OLES further recommends that once the new procedures are in place, the OLES be notified before any law enforcement procedure at DSH and DDS is changed. The OLES plans to assess the adequacy of the DSH and DDS

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<sup>21</sup> Surveys of DSH and DDS law enforcement staff who attended training on the Daily Training Bulletins from July 1, 2015, to Oct. 31, 2015.

policies and procedures in an ongoing manner through inspection of the applicable policies and practices involved in the cases that the OLES investigates and monitors.

Last but not least, the OLES recommends the departments ensure that all equipment necessary for law enforcement to follow policies is available for sworn personnel. During the six-month period, the OLES discovered an occasion where law enforcement staff could not comply with policy requiring videotape equipment be used because the equipment was not available.

### **Standardized investigations reports**

It is law enforcement best practice to write investigation reports in a standardized fashion, with the use of standardized formats that help ensure that all pertinent facts are gathered, documented and presented in an organized and consistent way. The departments worked with the OLES in 2015 to streamline 24 different investigation formats and, by the first half of 2016, DSH's five hospitals were using the new report formats, which were incorporated into a computerized report management system

The DDS started using the standardized formats and then chose to delay their use until the department gets a computerized report management system like the one at DSH. As of June 30, 2016, the DDS law enforcement chief was projecting that such a computer system would be operational with the standardized formats by January 2017. The OLES did not agree and recommends that DDS law enforcement implement standardized formats during 2016. This will help staff become familiar with the headings, layout and information needed for the standardized reports, and the learning curve in 2017 will only involve the use of computerized versions of the reports.

# Appendix A

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## OLES investigations

## Appendix A Investigations

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
11/21/2015	2016-00012A	Misconduct
<p><b>Incident Summary</b></p> <p>On November 21, 2015, a lieutenant allegedly failed to properly handle evidence. It was alleged that the lieutenant left the several boxes of evidence unattended while he walked into the office to get assistance in moving the boxes.</p>		
<p><b>Disposition</b></p> <p>The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
01/08/2016	2016-00019A	Use of Force
<p><b>Incident Summary</b></p> <p>On January 8, 2016, an officer allegedly failed to report he struck a patient with his baton during an altercation.</p>		
<p><b>Disposition</b></p> <p>The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
01/05/2016	2016-00029A	Misconduct
<p><b>Incident Summary</b></p> <p>On January 5, 2016, several officers allegedly engaged in a room extraction of patient and failed to video record the incident.</p>		
<p><b>Disposition</b></p> <p>The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
11/13/2013	2016-00033A	Misconduct
<b>Incident Summary</b> On July 14, 2015, a supervising special investigator alleged that a chief helped another supervising special investigator with the promotional testing and interview process by providing her confidential information based on their close personal relationship. The supervising special investigator also alleged the chief initiated and influenced an internal affairs investigation.		
<b>Disposition</b> The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
01/09/2016	2016-00042A	Misconduct
<b>Incident Summary</b> On January 9, 2016, a patient allegedly attacked a psychiatric technician. Hospital police officers responded, aided in subduing the patient, and conducted an investigation into the incident. A hospital police officer allegedly submitted an insufficient incident report thereby compromising a followup investigation and criminal prosecution.		
<b>Disposition</b> The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
01/26/2016	2016-00174C	Sexual Assault
<b>Incident Summary</b> On January 26, 2016, a patient alleged a hospital police officer had been harassing him with music, tried to "set him up," and alleged to have felt anal sexual penetration causing a burning sensation.		
<b>Disposition</b> The OLES conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
03/15/2016	2016-00314A	Misconduct
<b>Incident Summary</b> <p>On March 15, 2016, a patient alleged that hospital police officers searched his living area and left it in disarray. The patient further alleged he was being retaliated against because of a previous incident.</p>		
<b>Disposition</b> <p>The OLES conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
08/26/2015	2016-00411C	Death
<b>Incident Summary</b> <p>On August 26, 2015, a patient died while in the custody of the California Department of Corrections and Rehabilitation. The patient had been transferred from a state hospital facility five days prior to his death. The initial coroner's report identified the cause of death was due to lack of nourishment.</p>		
<b>Disposition</b> <p>An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. An amended coroner's report identified the cause of death was hypoglycemia. A memorandum was sent to the warden at the California Department of Corrections facility where the patient died and to the Office of Protective Services detailing the information reviewed by the OLES.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
03/10/2016	2016-00469C	Sexual Assault
<b>Incident Summary</b> <p>On March 10, 2016, a patient alleged that he was sexually assaulted by medical technical assistants when they forcibly medicated him and removed contraband from his rectum.</p>		
<b>Disposition</b> <p>The OLES conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
04/18/2016	2016-00517A	Abuse
<b>Incident Summary</b> <p>On April 18, 2016, several patients alleged a doctor failed to provide them adequate medical care. Additionally, the patients' alleged inadequate medical care may have been a contributing factor in the deaths of two patients.</p>		
<b>Disposition</b> <p>The OLES conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
03/01/2015	2016-00544A	Death
<b>Incident Summary</b> <p>On February 13, 2015, a patient became upset and struck his head against a wall, causing a fracture to his spine. The patient was taken to an outside hospital where he underwent surgery and was later transferred to a sub-acute health care center. On March 1, 2015 the patient died. An autopsy ruled the manner of death was accidental and the cause of death was from complications due to the spinal fracture.</p>		
<b>Disposition</b> <p>The investigation was completed by the OLES and submitted to the hiring authority for disposition.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
05/07/2016	2016-00567C	Sexual Assault
<b>Incident Summary</b> <p>On May 7, 2016, it was alleged a medical technical assistant engaged in inappropriate sexual conduct with a patient.</p>		
<b>Disposition</b> <p>The OLES conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
05/07/2016	2016-00612A	Neglect
<b>Incident Summary</b> On May 7, 2016, a patient alleged he was denied medical treatment after he swallowed two needles.		
<b>Disposition</b> The OLES conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
05/10/2016	2016-00633C	Sexual Assault
<b>Incident Summary</b> On May 10, 2016, a patient alleged he was verbally, physically, and sexually harassed by a medical technical assistant. The patient also alleged he was bitten on his buttocks by invisible people.		
<b>Disposition</b> The OLES conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.		

# Appendix B

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## **Pre-disciplinary cases monitored by the OLES**

On the following pages are the departmental investigations that the OLES monitored for both procedural and substantive sufficiency.

- Procedural sufficiency is assessing the notifications to the OLES, consultations with the OLES and investigation activities for timeliness, among other things.
- Substantive sufficiency is assessing the quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

**Appendix B  
Pre-Disciplinary Cases**

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
01/04/2016	2016-00005MC	1. Criminal Act	1. Referred		
<b>Incident Summary</b> On January 4, 2016, a psychiatric technician allegedly used unnecessary force when putting a patient in full bed restraints.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.			<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient		
<b>Disposition</b> The Office of Special Investigations conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The district attorney's office declined to file charges. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Suspension	FINAL Suspension
01/01/2016	2016-00016MA	1. Inefficiency 2. Inefficiency 3. Inefficiency 4. Inefficiency	1. Sustained 2. Sustained 3. Unfounded 4. Unfounded		
<b>Incident Summary</b> On January 1, 2016, a psychiatric technician allegedly failed to properly supervise a client during a period of direct observation. Allegedly, the client swallowed a mobile phone battery during that time. Furthermore, two other psychiatric technicians allegedly failed to properly supervise other clients because they were impermissibly using their mobile phones.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.			<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient		
<b>Disposition</b> The hiring authority determined there was sufficient evidence to sustain the allegations against the first psychiatric technician and imposed a two working-day suspension without pay. The hiring authority determined allegations against the other two psychiatric technicians were unfounded. The OLES concurred with the determinations.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/06/2016	2016-00018MA	1. Discourteous treatment	1. Unfounded	No Penalty Imposed	No Change
<b>Incident Summary</b> On January 6, 2016, a psychiatric technician allegedly placed her hands around a client's neck.					
<b>Overall Assessment</b> <b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.					
<b>Disposition</b> The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/05/2016	2016-00020MA	1. Incompetency	1. Not Sustained	No Penalty Imposed	No Change
<b>Incident Summary</b> On January 5, 2016, a registered nurse allegedly fell asleep during a period of direct observation of a patient thereby providing the patient an opportunity to punch another patient.					
<b>Overall Assessment</b> <b>Procedural Rating:</b> Insufficient <b>Substantive Rating:</b> Sufficient The hiring authority failed to comply with the department's policies and procedures governing the pre-disciplinary process. The Office of Protective Services did not complete the investigation in a timely manner. The incident occurred on January 5, 2016; however, the investigation was not complete until May 2, 2016.					
<b>Pre-Disciplinary Assessment</b> 1. Did the hiring authority timely notify the department's legal office of the incident? • No The hiring authority did not notify the department's legal office because the incident did not meet the criteria for notification.  2. Was a department attorney assigned to assist with the case development? • No A department attorney was not assigned to assist with the case development because the case did not meet the criteria for assignment to an attorney.  3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The incident occurred on January 5, 2016; however, the OPS did not complete its investigation until May 2, 2016.					
<b>Disposition</b> The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.					

## Department Corrective Action Plan

No corrective action plan was necessary. A sufficient portion of the investigation was completed to determine the allegation was not going to be sustained and the remainder of the report was delayed to work on higher priority cases, due to a high case load at the time.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
12/27/2015	2016-00025MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change
<b>Incident Summary</b> On January 1, 2016, it was alleged a psychiatric technician used excessive force on a patient, resulting in a broken rib.					
<b>Overall Assessment</b> The department sufficiently complied with policies and procedures governing the pre-disciplinary process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/10/2016	2016-00036MA	1. Inexcusable neglect of duty	1. Unfounded	No Penalty Imposed	No Change
<b>Incident Summary</b> On January 10, 2016, a patient unexpectedly died while in the care of an outside hospital.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority determined that staff misconduct did not occur. The OLES concurred.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
12/21/2015	2016-00038MA	1. Other failure of good behavior 2. Dishonesty	1. Not Sustained 2. Not Sustained	No Penalty Imposed	No Change

### Incident Summary

On December 21, 2015, it was alleged that a psychiatric technician touched a patient's hair, back and buttocks and made inappropriate comments. It was further alleged that the psychiatric technician was untruthful during his investigatory interview.

### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

### Disposition

The hiring authority determined there was insufficient evidence to sustain the allegations that the psychiatric technician engaged in misconduct and was dishonest. The OLES concurred in the findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/10/2016	2016-00047MC	1. Criminal Act	1. Not Referred	Other	No Change

### Incident Summary

On January 10, 2016, a registered nurse allegedly abused a patient by cleaning the patient's colostomy bag and stoma in an aggressive manner.

### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The department substantially complied with policies and procedures governing the investigative process.

### Disposition

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/13/2016	2016-00057MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change

### Incident Summary

On January 13, 2016, a patient alleged a psychiatric technician choked her and then pushed her onto a bed.

### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

### Disposition

The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/12/2016	2016-00059MA	1. Discourteous treatment 2. Discourteous treatment	1. Unfounded 2. Unfounded	No Penalty Imposed	No Change

### Incident Summary

On January 12, 2016, a psychiatric technician allegedly threatened and assaulted a client. Another psychiatric technician allegedly witnessed the incident but failed to intervene.

### Overall Assessment

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department's pre-disciplinary process did not sufficiently comply with policies and procedures. The hiring authority and the OPS did not confer with the OLES during the investigation.

### Pre-Disciplinary Assessment

1. Did the hiring authority adequately consult with the OLES regarding the incident? • No  
The OPS failed to adequately consult with the OLES regarding the incident by not including the OLES in the investigative process.
2. Did the hiring authority notify outside law enforcement of the incident within the specified time frames required by law? • No  
The hiring authority did not notify outside law enforcement of the incident.
3. Did the hiring authority timely notify the department's legal office of the incident? • No  
The hiring authority did not notify the department's legal office of the incident.
4. Was a department attorney assigned to assist with the case development? • No  
A department attorney was not assigned to assist with the case development.
5. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS failed to confer with the OLES upon case initiation and prior to finalizing the investigative plan.
6. Did OPS adequately consult with the OLES, the department attorney (if designated), and the appropriate

prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? • No

The OPS did not consult with the OLES to determine if an administrative investigation should be conducted concurrently with a criminal investigation.

7. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No

The OPS did not cooperate with and provide real-time consultation with the OLES.

8. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No

The hiring authority did not cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase because OPS did not confer with the OLES upon case initiation or at any point during the investigation.

### Disposition

The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred.

### Department Corrective Action Plan

In March 2016, OPS established a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/14/2016	2016-00061MA	1. Inexcusable neglect of duty	1. Exonerated	No Penalty Imposed	No Change

### Incident Summary

On January 14, 2016, a patient alleged that two psychiatric technicians used excessive force during a containment procedure, which caused him to hit his head on the floor. The patient sustained a head injury, requiring five sutures.

### Overall Assessment

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department failed to sufficiently comply with procedures governing the pre-disciplinary phase by failing to consult with the OLES regarding the investigation and the investigative findings.

### Pre-Disciplinary Assessment

1. Did the hiring authority timely notify the department's legal office of the incident? • No

The hiring authority did not notify the department's legal office of the incident.

2. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No

The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.

3. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No

The hiring authority did not consult with the OLES adequately during the pre-disciplinary/investigative phase.

**Disposition**

The hiring authority exonerated the two psychiatric technicians for allegedly using excessive force. The OLES was not consulted.

**Department Corrective Action Plan**

The hiring authority will implement procedures to ensure consultation with the OLES during the pre-disciplinary phase and regarding the sufficiency of future investigations and investigative findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
12/25/2015	2016-00062MA	1. Inexcusable neglect of duty	1. Exonerated	No Penalty Imposed	No Change

**Incident Summary**

It was alleged that on December 25, 2015, a psychiatric technician struck and tackled a patient, breaking the patient's hip.

**Overall Assessment**

**Procedural Rating:** Sufficient

**Substantive Rating:** Sufficient

The department sufficient complied with policies and procedures governing pre-disciplinary process.

**Disposition**

The hiring authority determined that misconduct did not occur and exonerated the psychiatric technician. The OLES concurred with the determination.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/15/2016	2016-00063MA	1. Other failure of good behavior 2. Other failure of good behavior	1. Sustained 2. Sustained	Dismissal	No Change

**Incident Summary**

On January 15, 2016, a food service technician allegedly kissed and engaged in an inappropriate relationship with a patient.

**Overall Assessment**

**Procedural Rating:** Insufficient

**Substantive Rating:** Sufficient

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to consult with the OLES regarding the sufficiency of the investigation and investigative findings.

**Pre-Disciplinary Assessment**

1. Did the hiring authority timely notify the department's legal office of the incident? • No  
The hiring authority did not timely notify the department's legal office of the incident.
2. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the

investigative findings.

3. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not consult with the OLES regarding investigative findings.

**Disposition**

The hiring authority determined there was sufficient evidence to sustain the allegations and served a notice of dismissal on the food service technician. The OLES was not consulted.

**Department Corrective Action Plan**

The hiring authority will implement procedures to ensure consultation with the OLES during the pre-disciplinary phase and regarding the sufficiency of investigations and investigative findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
01/15/2016	2016-00073MA	1. Discourteous treatment	1. Unfounded		

**Incident Summary**

On January 15, 2016, a psychiatric technician assistant allegedly became angry with a client, threw straws at her and scratched her finger.

**Overall Assessment**

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department sufficient complied with policies and procedures governing pre-disciplinary process. The hiring authority and OPS did not confer with the OLES during the investigation.

**Pre-Disciplinary Assessment**

1. Did the hiring authority adequately consult with the OLES regarding the incident? • No  
The OPS failed to adequately consult with the OLES regarding the incident by not including the OLES in the investigative process.
2. Did the hiring authority timely notify the department’s legal office of the incident? • No  
The hiring authority did not notify the department’s legal office of the incident because the incident did not meet the criteria for notification.
3. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS failed to confer with the OLES upon case initiation or prior to finalizing the investigative plan.
4. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The OPS did not cooperate with and provide continued real-time consultation with the OLES.
5. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase because OPS did not confer with the OLES upon case initiation or at any point during the investigation.

**Disposition**

The hiring authority determined that staff misconduct did not occur. The OLES concurred with the determination.

### Department Corrective Action Plan

OPS did make the required notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
01/16/2016	2016-00078MC	1. Criminal Act	1. Not Referred		

#### Incident Summary

On January 16, 2016, a psychiatric technician allegedly struck a patient on the side of the head after the patient refused to remove his headphones.

#### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The department substantially complied with policies and procedures governing the investigative process

#### Disposition

The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with this determination. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.

INCIDENT	OLES CASE #	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
01/19/2016	2016-00084MC	1. Criminal Act	1. Not Referred		

#### Incident Summary

On January 19, 2016, a psychiatric technician allegedly grabbed a wheelchair-bound patient after the patient ran over another psychiatric technician's foot.

#### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The department substantially complied with policies and procedures governing the investigative process.

#### Disposition

The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
01/13/2016	2016-00102MA	1. Inexcusable neglect of duty	1. Not Sustained		
<b>Incident Summary</b> On January 13, 2016, a patient alleged a unit supervisor slammed his head against a wall during a containment procedure.					
<b>Overall Assessment</b> The department did not sufficiently comply with the procedures governing the pre-disciplinary/investigative process. The department did not consult with the OLES regarding the investigation and the investigative findings. <b>Procedural Rating:</b> Insufficient <b>Substantive Rating:</b> Sufficient					
<b>Pre-Disciplinary Assessment</b> 1. Did the hiring authority timely notify the department's legal office of the incident? • No The hiring authority did not notify the legal department. 2. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The hiring authority did not consult with the OLES after reviewing the investigation report. 3. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No The hiring authority did not adequately consult with the OLES during the pre-disciplinary/investigative phase.					
<b>Disposition</b> The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES was not consulted.					
<b>Department Corrective Action Plan</b> The hiring authority or designee will conduct training on recognizing possible patient abuse situations. If an abuse situation is suspected, the proper paperwork will be completed and the OLES will be notified per requirements. The hiring authority will notify the OLES Monitor of the final determination once the case has been reviewed.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/02/2016	2016-00106MA	1. Inexcusable neglect of duty	1. Not Sustained		
<b>Incident Summary</b> On February 2, 2016, a psychiatric technician allegedly ordered a client to grab the genitalia of other staff members, with the threat of harm if the client failed to comply with the order.					
<b>Overall Assessment</b> Although the department did not consult with the OLES regarding the investigation and investigative findings and the investigative report contained administrative and criminal findings, they complied with policies and procedures in all other respects. <b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient					

**Disposition**

The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES was not consulted.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
01/22/2016	2016-00121MA	1. Inexcusable neglect of duty	1. Exonerated		

**Incident Summary**

On January 22, 2016, a registered nurse allegedly failed to conduct a nursing assessment of a patient.

**Overall Assessment**

**Procedural Rating:** Insufficient

**Substantive Rating:** Sufficient

The department failed to comply with the procedures governing the pre-disciplinary process by failing to consult with the OLES regarding the investigation and the findings.

**Pre-Disciplinary Assessment**

1. Did the hiring authority timely notify the department's legal office of the incident? • No  
The hiring authority did not notify the department's legal office of the incident.
2. Did the investigator adequately prepare for all aspects of the investigation? • No  
This case was not investigated because it was closed based on the initial police report.
3. Was the draft investigative report provided to the OLES for review thorough and appropriately drafted?  
• No  
The case was closed based on the initial police report which was thorough and appropriately drafted.
4. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
5. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not consult with the OLES during the pre-disciplinary/investigative phase.

**Disposition**

The hiring authority determined that the alleged misconduct did not occur and exonerated the registered nurse. The OLES was not consulted.

**Department Corrective Action Plan**

The hiring authority will implement procedures to ensure consultation with the OLES during the pre-disciplinary phase and regarding the sufficiency of investigations and investigative findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/28/2016	2016-00124MA	1. Dishonesty	1. Sustained	Dismissal	Dismissal
<b>Incident Summary</b> On January 28, 2016, a registered nurse allegedly intentionally falsified medical documents. Furthermore, it was alleged that the registered nurse was dishonest during the investigatory interview.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the registered nurse. The OLES concurred in the determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/28/2016	2016-00128MC	1. Criminal Act	1. Not Referred	No Penalty Imposed	No Change
<b>Incident Summary</b> On January 28, 2016, a psychiatric technician allegedly punched a client in the stomach.					
<b>Overall Assessment</b> Overall, the department sufficient complied with policies and procedures governing pre-disciplinary process, despite the department's failure to timely notify the OLES about the incident. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
02/02/2016	2016-00133MA	1. Inexcusable neglect of duty	1. Sustained	Dismissal	Dismissal
<b>Incident Summary</b> On February 2, 2016, a psychologist allegedly verbally threatened and physically abused a patient during a containment procedure.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority sustained the allegations and dismissed the psychologist. The OLES concurred with the determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
02/02/2016	2016-00138MA	1. Inexcusable neglect of duty	1. Unfounded	No Penalty Imposed	No Change
<b>Incident Summary</b> On February 2, 2016, it was alleged that a psychiatric technician taunted a client with crackers during the patient's dialysis appointment.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority determined the allegation was unfounded. The OLES concurred.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
02/04/2016	2016-00140MA	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty	1. Unfounded 2. Unfounded	No Penalty Imposed	No Change
<b>Incident Summary</b> On February 4, 2016, two psychiatric technicians allegedly touched a client in a sexually inappropriate manner.					
<b>Overall Assessment</b> The department's pre-disciplinary process did not sufficiently comply with policies and procedures. The hiring authority and OPS did not confer with the OLES during the investigation. <p style="text-align: right;"><b>Procedural Rating:</b> Insufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Pre-Disciplinary Assessment</b> <ol style="list-style-type: none"> <li>Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to the OLES? • No The hiring authority did not properly characterize the nature and scope of the incident during his/her notification to the OLES.</li> <li>Did the hiring authority adequately consult with the OLES regarding the incident? • No The department completed its investigation without notification to or consultation with the OLES.</li> <li>Was the notification made to outside law enforcement recorded in the report? • No It was not recorded in the report whether notification was made to outside law enforcement.</li> <li>Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No The OPS failed to confer with the OLES upon case initiation or prior to finalizing the investigative plan.</li> <li>Did OPS adequately consult with the OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? • No</li> </ol>					

The OPS did not consult with the OLES to determine if an administrative investigation should be conducted concurrently with a criminal investigation.

6. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
OPS did not cooperate with and provide continued real-time consultation with the OLES.

7. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No

The hiring authority did not cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase because the OPS did not confer with the OLES upon case initiation or at any point during the investigation.

### Disposition

The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

### Department Corrective Action Plan

OPS did make the required notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/04/2016	2016-00141MA	1. Criminal Act	1. Unfounded		
<b>Incident Summary</b>					
On February 4, 2016, a patient alleged she was sexually assaulted while she was asleep by an unknown assailant.					
<b>Overall Assessment</b>					
<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient					
Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.					
<b>Disposition</b>					
The hiring authority determined the allegation was unfounded. The OLES concurred in the determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/02/2016	2016-00145MA	1. Discourteous treatment	1. Not Sustained		
<b>Incident Summary</b>					
On February 2, 2016, a psychiatric technician allegedly referred to a patient in a sexually derogatory manner and threatened to have someone insert a stick into the patient's rectum.					

<b>Overall Assessment</b>	<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient
The department sufficiently complied with policies and procedures governing the pre-disciplinary process.	
<b>Disposition</b>	
The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.	

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/04/2016	2016-00146MA	1. Incompetency	1. Unfounded		
<b>Incident Summary</b>					
On February 4, 2016, a patient alleged that three psychiatric technicians failed to timely respond to a fight between him and another patient.					
<b>Overall Assessment</b>			<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient		
The department sufficiently complied with policies and procedures governing the pre-disciplinary process.					
<b>Disposition</b>					
The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Training	FINAL Training
02/04/2016	2016-00148MA	1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained		
<b>Incident Summary</b>					
On February 4, 2016, a senior psychiatric technician and three other psychiatric technicians allegedly injured an aggressive client while attempting to contain the client and place him in restraints. The client sustained abrasions to his hands.					
<b>Overall Assessment</b>			<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient		
Although the department did not timely notify the OLES about the incident, nor consult with the OLES regarding the investigation and investigative findings, and the investigative report contained administrative and criminal findings, they complied with policies and procedures in all other respects.					

**Disposition**

The hiring authority determined there was insufficient evidence to sustain the allegations but determined additional training was necessary for staff. The OLES was not consulted.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
02/06/2016	2016-00152MA	1. Inexcusable neglect of duty	1. Unfounded	No Penalty Imposed	No Change

**Incident Summary**

On February 6, 2016, a psychiatric technician allegedly struck a client in the face, wall-contained the client two times in the same day, and placed the client in five-point restraints. The client sustained bruising and swelling to her right eye area.

**Overall Assessment**

**Procedural Rating:** Sufficient

**Substantive Rating:** Sufficient

Although the department did not timely notify the OLES about the incident and did not consult with the OLES regarding the investigation and investigative findings, it substantially complied with policies and procedures in all other respects.

**Disposition**

The hiring authority determined the allegations were unfounded. The OLES was not consulted.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
02/11/2016	2016-00177MC	1. Criminal Act	1. Not Referred	Other	No Change

**Incident Summary**

On February 11, 2016, a non-verbal client was found to have a broken ankle of unknown origin.

**Overall Assessment**

**Procedural Rating:** Insufficient

**Substantive Rating:** Sufficient

The Office of Protective Services failed to comply with the department's policies and procedures governing the investigative process of notifications and consultations with the OLES.

**Pre-Disciplinary Assessment**

1. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No

The OPS did not adequately confer with the OLES regarding the case initiation and investigative plan.

2. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No

The OPS failed to notify the OLES of critical interviews.

**Disposition**

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

### Department Corrective Action Plan

OPS did make the required notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/08/2016	2016-00178MA	1. Discourteous treatment	1. Unfounded		

### Incident Summary

On February 8, 2016, a psychiatric technician allegedly slammed a door on a client's finger.

### Overall Assessment

**Procedural Rating:** Insufficient

**Substantive Rating:** Sufficient

The department sufficiently complied with policies and procedures governing the pre-disciplinary process. The hiring authority and OPS did not confer with the OLES during the investigation.

### Pre-Disciplinary Assessment

1. Did the hiring authority adequately consult with the OLES regarding the incident? • No  
The OPS failed to adequately consult with the OLES regarding the incident by not including the OLES in the investigative process.
2. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS failed to confer with the OLES upon case initiation and prior to finalizing the investigative plan.
3. Did OPS adequately consult with the OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? • No  
The OPS did not consult with the OLES to determine if an administrative investigation should be conducted concurrently with a criminal investigation.
4. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The OPS did not cooperate with and provide continued real-time consultation with the OLES.
5. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase because the OPS did not confer with the OLES upon case initiation or at any point during the investigation.

### Disposition

The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

### Department Corrective Action Plan

OPS did make the required notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator

shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately.”

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/10/2016	2016-00179MC	1. Criminal Act	1. Not Referred		
<b>Incident Summary</b>					
On February 10, 2016, a patient alleged a senior psychiatric technician hit his shoulders while he was using a urinal.					
<b>Procedural Rating:</b> Sufficient					
<b>Overall Assessment</b>					
<b>Substantive Rating:</b> Sufficient					
Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.					
<b>Disposition</b>					
An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Salary Reduction	FINAL No Change
01/24/2016	2016-00182MA	1. Dishonesty 2. Incompetency	1. Sustained 2. Sustained		
<b>Incident Summary</b>					
On January 24, 2016, a psychiatric technician allegedly failed to properly supervise a client who was on a one-to-one level of supervision. The client was able to grab and insert a plastic spoon into her vagina while under the care of the psychiatric technician. It was further alleged that the psychiatric technician was dishonest during her investigatory interview.					
<b>Procedural Rating:</b> Sufficient					
<b>Overall Assessment</b>					
<b>Substantive Rating:</b> Sufficient					
Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.					
<b>Disposition</b>					
The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a five percent salary reduction for six months. The OLES concurred.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/04/2016	2016-00185MA	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty	1. Sustained 2. Sustained 3. Sustained	Letter of Reprimand	No Change

### Incident Summary

On January 4, 2016, a psychiatric technician allegedly twisted the arm and wrist of a patient while placing the patient in full-bed restraints. The patient complained of pain but had no visible injuries.

### Overall Assessment

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES regarding the investigative findings and disposition conference.

### Pre-Disciplinary Assessment

1. Was a department attorney assigned to assist with the case development? • No  
A department attorney was not assigned during the investigation.
2. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
3. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not consult with the OLES regarding the investigative findings and disposition.

### Disposition

The hiring authority sustained the allegations and determined the appropriate penalty was a letter of reprimand. The OLES was not consulted.

### Department Corrective Action Plan

The hiring authority will implement procedures to ensure consultation with the OLES during the pre-disciplinary phase and regarding the sufficiency of investigations and investigative findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/10/2016	2016-00187MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change

### Incident Summary

On January 10, 2016, it was alleged a registered nurse was abusive towards a patient by aggressively cleaning his stoma and colostomy bag.

### Overall Assessment

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department failed to sufficiently comply with the procedures governing the pre-

disciplinary/investigative process by failing to consult with the OLES regarding the investigation and the investigative findings.

**Pre-Disciplinary Assessment**

1. Did the hiring authority timely notify the department’s legal office of the incident? • No  
The hiring authority did not notify the department's legal office of the incident.
2. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
The hiring authority did not consult with the OLES regarding the sufficiency of the investigation or the investigative findings.
3. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not adequately consult with the OLES during the pre-disciplinary/investigative phase.

**Disposition**

The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES was not consulted.

**Department Corrective Action Plan**

The hiring authority will implement procedures to ensure consultation with the OLES during the pre-disciplinary phase and regarding the sufficiency of investigations and investigative findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
02/17/2016	2016-00198MC	1. Criminal Act	1. Not Referred		

**Incident Summary**

It was alleged that on February 17, 2016, a teacher's aide was discourteous to a client when he spoke to him in an unprofessional manner. It was further alleged that a teacher physically abused a client when she poked his arm three to four times with her fingers.

**Overall Assessment**

**Procedural Rating:** Insufficient  
**Substantive Rating:** Insufficient

The Office of Protective Services conducted the investigation and closed the matter prior to consulting with the OLES. The investigation was conducted and completed prior to the OLES being notified. The investigator asked a critical witness to classify this case as administrative or criminal, even though the investigator was conducting a criminal investigation.

**Pre-Disciplinary Assessment**

1. Did the hiring authority timely notify the department’s legal office of the incident? • No  
The legal department was not notified.
2. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS did not confer with the OLES in this case.
3. Were all of the interviews thorough and appropriately conducted? • No  
The investigator continually asked a critical witness to make a legal determination regarding the

allegations.

4. Upon completion of the investigation, was a draft copy of the investigative report forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No  
The OLES only received the completed reports after a determination was made to close the case without a referral to the prosecuting agency.

5. Was the final investigative report thorough and appropriately drafted? • No  
The report concluded there was a lack of policy violations; however, the matter was a criminal investigation.

6. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The case was closed without any consultation with the OLES.

7. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
The matter was not forwarded to the hiring authority for review. The hiring authority was contacted by the investigator during the course of the investigation and the matter was closed after that consultation.

8. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not consult with the OLES.

**Disposition**

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

**Department Corrective Action Plan**

In this case, an uninvolved third party clinical staff member misreported an allegation of abuse. An OPS Peace Officer responded and contacted the only critical witness, who was also identified by the clinical staff member as the original reporting party of the alleged allegation and is also a California Department of Public Health (CDPH) Investigator. The OPS Peace Officer determined from the CDPH Investigator that there was no allegation of any type of abuse either criminally or as a violation of department policy. The preliminary investigation/ interviews conducted by the OPS Peace Officer were thorough, complete and appropriate. Based on the fact that there was no allegation of abuse made, this incident did not qualify as either an OLES Priority 1 or Priority 2 incident and did not require OPS to report the incident to the OLES. In the future, OPS will not report incidents to the OLES that do not meet reporting criteria.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
02/17/2016	2016-00199MC	1. Criminal Act	1. Not Referred		

**Incident Summary**

It was alleged that on February 17, 2016, a psychiatric technician forcibly grabbed a client's arm to help him get up and forcibly assisted him with putting on his jacket.

**Overall Assessment**

**Procedural Rating:** Insufficient  
**Substantive Rating:** Insufficient

The Office of Protective Services conducted the investigation and closed the matter prior to consulting with the OLES. The investigation was conducted and completed prior to the OLES being notified. The investigator asked a critical witness to classify this case as administrative or criminal; even though the investigator was conducting a criminal investigation.

## Pre-Disciplinary Assessment

1. Did the hiring authority timely notify the department's legal office of the incident? • No  
The legal department was not notified.
2. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS did not confer with the OLES in this case.
3. Were all of the interviews thorough and appropriately conducted? • No  
The investigator continually asked a critical witness to make a legal determination regarding the allegations.
4. Upon completion of the investigation, was a draft copy of the investigative report forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No  
The OLES only received the completed reports after a determination was made to close without a referral to the prosecuting agency.
5. Was the final investigative report thorough and appropriately drafted? • No  
The report concluded there was a lack of policy violations; however, the matter was a criminal investigation.
6. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The case was closed without any consultation with the OLES.
7. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
The matter was not forwarded to the hiring authority for review. The hiring authority was contacted by the investigator during the course of the investigation and the matter was closed after that consultation.
8. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not consult with the OLES.

## Disposition

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

## Department Corrective Action Plan

In this case, an uninvolved third party clinical staff member misreported an allegation of abuse. An OPS Peace Officer responded and contacted the only critical witness, who was also identified by the clinical staff member as the original reporting party of the alleged allegation and is also a California Department of Public Health (CDPH) Investigator. The OPS Peace Officer determined from the CDPH Investigator that there was no allegation of any type of abuse either criminally or as a violation of department policy. The preliminary investigation/ interviews conducted by the OPS Peace Officer were thorough, complete and appropriate. Based on the fact that there was no allegation of abuse made, this incident did not qualify as either an OLES Priority 1 or Priority 2 incident and did not require OPS to report the incident to the OLES. In the future, OPS will not report incidents to the OLES that do not meet reporting criteria.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/19/2016	2016-00206MA	1. Incompetency	1. Unfounded		
<b>Incident Summary</b> <p>On February 16, 2016, a client was admitted to an outside hospital for treatment for a medical condition. On February 19, 2016, while still at the outside hospital, the client's medical condition deteriorated. However, life-saving measures were not initiated pursuant to the client's wishes. The client was pronounced dead by a physician.</p>					
<b>Overall Assessment</b> <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient</p> <p style="text-align: right;"><b>Substantive Rating:</b> Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.</p>					
<b>Disposition</b> <p>The hiring authority determined that staff misconduct did not occur. The OLES concurred with the determination.</p>					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/20/2016	2016-00224MA	1. Inexcusable neglect of duty	1. Not Sustained		
<b>Incident Summary</b> <p>On February 20, 2016, a patient alleged that two weeks earlier, a psychiatric technician grabbed and twisted his left arm causing pain and bruising. The patient alleged the psychiatric technician grabbed his arm to prevent him from fighting another patient.</p>					
<b>Overall Assessment</b> <p style="text-align: right;"><b>Procedural Rating:</b> Insufficient</p> <p style="text-align: right;"><b>Substantive Rating:</b> Sufficient</p> <p>The Office of Special Investigations failed to substantially comply with policies and procedures. Although the investigative interviews were completed timely, the investigative report was not completed until 84 days later. Also, a draft copy of the investigative report was not provided to the OLES for review prior to the investigative report being submitted to the hiring authority.</p>					
<b>Pre-Disciplinary Assessment</b> <p>1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No The hiring authority received a copy of the final report before the OLES had an opportunity to review it.</p> <p>2. Was the draft investigative report provided to the OLES for review thorough and appropriately drafted? • No The OLES was not provided with a draft investigative report.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The incident was reported on February 20, 2016, and the investigative interviews were completed within a few days. However, the investigative report was not completed until May 18, 2016.</p>					
<b>Disposition</b> <p>The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.</p>					

### Department Corrective Action Plan

The hiring authority will implement procedures to ensure consultation with the OLES during the investigative process and prior to the case closure and distribution.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/25/2016	2016-00232MA	1. Inexcusable neglect of duty	1. Unfounded		
<b>Incident Summary</b> <p>On February 25, 2016, it was alleged staff neglect contributed to the death of a patient. The patient had choked while eating at the facility and then was sent to an outside hospital where she subsequently died of a brain injury.</p>					
<b>Overall Assessment</b> <p>Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.</p> <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> <p>The hiring authority determined the allegation was unfounded. The OLES concurred in the determination.</p>					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
02/27/2016	2016-00240MA	1. Inexcusable neglect of duty	1. Unfounded		
<b>Incident Summary</b> <p>On February 27, 2016, an unknown staff member allegedly abused a non-communicating client, which resulted in a fractured arm.</p>					
<b>Overall Assessment</b> <p>Although the department did not consult with the OLES regarding the investigation and investigative findings and the investigative report contained administrative and criminal findings, they complied with policies and procedures in all other respects.</p> <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> <p>The hiring authority determined the allegation of abuse was unfounded. The OLES was not consulted.</p>					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
02/26/2016	2016-00251MC	1. Criminal Act	1. Not Referred		

### Incident Summary

On February 26, 2016, a client was observed limping, and the following day his foot was swollen. After an examination, it was determined that the client had a fractured toe.

### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The Office of Protective Services substantially complied with the department's policies and procedures governing the investigative process of notifications and consultations with the OLES.

### Disposition

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Training	FINAL Training
02/22/2016	2016-00254MA	1. Inexcusable neglect of duty	1. Not Sustained		

### Incident Summary

On February 22, 2016, a registered nurse allegedly failed to ensure a physician's line-of-sight order was included in a patient's transfer paperwork. The doctor issued the order due to the patient being a danger to others.

### Overall Assessment

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and investigative findings.

### Pre-Disciplinary Assessment

1. Did the hiring authority timely notify the department's legal office of the incident? • No  
The department's legal office was not notified.
2. Was a department attorney assigned to assist with the case development? • No  
A department attorney was not assigned during the pre-disciplinary process.
3. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
4. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not consult with the OLES regarding the findings and penalty conference.

**Disposition**

The hiring authority determined there was insufficient evidence to sustain the allegation. The registered nurse was given training regarding the process to complete the paperwork. The OLES was not consulted.

**Department Corrective Action Plan**

The hiring authority will implement procedures to ensure consultation with the OLES during the pre-disciplinary phase and regarding the sufficiency of investigations and investigative findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
03/03/2016	2016-00261MA	1. Discourteous treatment	1. Unfounded	No Penalty Imposed	No Change

**Incident Summary**

On March 3, 2016, a teacher's assistant allegedly punched a client.

**Overall Assessment**

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The department's pre-disciplinary process sufficiently complied with policies and procedures.

**Disposition**

The hiring authority determined that staff misconduct did not occur. The OLES concurred with the determination.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
03/01/2016	2016-00262MA	1. Discourteous treatment	1. Unfounded	No Penalty Imposed	No Change

**Incident Summary**

On March 1, 2016, three psychiatric technicians allegedly threatened to assault a client.

**Overall Assessment**

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department's pre-disciplinary process did not sufficiently comply with policies and procedures. The hiring authority and OPS did not confer with the OLES during the investigation.

**Pre-Disciplinary Assessment**

1. Did the hiring authority adequately consult with the OLES regarding the incident? • No  
The department completed the investigation without consultation with the OLES.
2. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS failed to confer with the OLES upon case initiation or prior to finalizing the investigative plan.
3. Did OPS adequately consult with the OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? • No  
The OPS did not consult with the OLES to determine if an administrative investigation should be

conducted concurrently with a criminal investigation.

4. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The OPS did not cooperate with and provide continued real-time consultation with the OLES.

5. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase because the OPS did not confer with the OLES upon case initiation or at any point during the investigation.

**Disposition**

The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred.

**Department Corrective Action Plan**

OPS did make the required notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
03/04/2016	2016-00273MA	1. Discourteous treatment 2. Discourteous treatment	1. Unfounded 2. Unfounded	No Penalty Imposed	No Change

**Incident Summary**

On March 4, 2016, two psychiatric technicians allegedly pulled a client's arm and hair.

**Overall Assessment**

**Procedural Rating:** Insufficient

**Substantive Rating:** Sufficient

The department's pre-disciplinary process did not sufficiently comply with policies and procedures. The hiring authority and OPS did not confer with the OLES during the investigation.

**Pre-Disciplinary Assessment**

1. Did the hiring authority adequately consult with the OLES regarding the incident? • No  
The OPS failed to adequately consult with the OLES regarding the incident by not including the OLES in the investigative process.
2. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS failed to confer with the OLES upon case initiation and prior to finalizing the investigative plan.
3. Did OPS adequately consult with the OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? • No  
The OPS did not consult with the OLES to determine if an administrative investigation should be conducted concurrently with a criminal investigation.
4. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The OPS did not cooperate with and provide continued real-time consultation with the OLES.

5. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
 The hiring authority did not cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase because OPS did not confer with the OLES upon case initiation or at any point during the investigation.

**Disposition**

The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred.

**Department Corrective Action Plan**

OPS did make the required notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
01/19/2016	2016-00277MA	1. Inexcusable neglect of duty	1. Unfounded		

**Incident Summary**

On January 19, 2016, a psychiatric technician allegedly grabbed a wheelchair-bound patient after the patient ran over another psychiatric technician's foot.

**Overall Assessment**

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department did not sufficiently comply with the procedures governing the pre-disciplinary/investigative process because the hiring authority failed to consult with the OLES regarding the investigation and the investigative findings.

**Pre-Disciplinary Assessment**

1. Did the hiring authority timely notify the department's legal office of the incident? • No  
 The legal department was not notified of the incident.
2. Did the hiring authority timely consult with the OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No  
 The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
3. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
 The hiring authority did not adequately consult with the OLES during the pre-disciplinary/investigative phase.

**Disposition**

The hiring authority determined the allegation was unfounded. The OLES was not consulted.

## Department Corrective Action Plan

The hiring authority will implement procedures to ensure consultation with the OLES during the pre-disciplinary phase and regarding the sufficiency of investigations and investigative findings.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
02/01/2016	2016-00307MA	1. Discourteous treatment 2. Inexcusable neglect of duty 3. Insubordination	1. Not Sustained 2. Sustained 3. Sustained	Dismissal	No Change
<b>Incident Summary</b> On February 1, 2016, it was alleged that a psychiatric technician engaged in an inappropriate relationship with a patient.					
<b>Overall Assessment</b> The department sufficiently complied with policies and procedures governing the pre-disciplinary process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority determined there was sufficient evidence to sustain the allegations against the psychiatric technician and rejected the psychiatric technician while on probation. The OLES concurred with the determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
03/18/2016	2016-00329MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change
<b>Incident Summary</b> On March 18, 2016, a registered nurse observed a bruise on a patient's arm. The patient alleged she was struck by a staff member but then stated she injured herself.					
<b>Overall Assessment</b> The Office of Protective Services substantially complied with the department's policies and procedures governing the investigative process of notifications and consultations with the OLES. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The Office of Protective Services conducted a thorough investigation and was unable to identify a subject. The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
03/18/2016	2016-00331MC	1. Criminal Act	1. Not Referred		
<b>Incident Summary</b>					
On March 18, 2016, a client was observed with a genital injury.					
<b>Overall Assessment</b>					
<p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p> <p>Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.</p>					
<b>Disposition</b>					
An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Salary Reduction	FINAL No Change
02/23/2016	2016-00343MA	1. Other failure of good behavior 2. Inexcusable neglect of duty	1. Sustained 2. Sustained		
<b>Incident Summary</b>					
It was alleged that on February 23, 2016, a medical technical assistant provided a urine sample that tested positive for a controlled substance.					
<b>Overall Assessment</b>					
<p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Insufficient</p> <p>The Office of Protective Services failed to comply with the department's policies and procedures governing the investigative process of notifications and by not providing the OLES a copy of the draft investigative report to review prior to submitting the report to the hiring authority. Also, the final report was not appropriately drafted based on the inclusion of information that was not relevant and the conclusions of the investigator.</p>					
<b>Pre-Disciplinary Assessment</b>					
<p>1. Did the hiring authority timely notify the OLES of the incident? • No The hiring authority failed to notify the OLES of this incident within two working days, as required by procedures.</p> <p>2. Did the hiring authority timely notify the department's legal office of the incident? • No The legal department was not notified.</p> <p>3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No The OLES was not provided a copy of the draft report for review.</p> <p>4. Was the final investigative report thorough and appropriately drafted? • No The final report contained information that was not relevant to the investigation, as well as a conclusion that the subject violated a labor contract.</p>					

**Disposition**

The hiring authority sustained the allegation and imposed a salary reduction of ten percent for 12 months. The OLES concurred.

**Department Corrective Action Plan**

The hiring authority will address notification, reporting requirements, and draft report issues through in-service training with the assigned investigator and all staff involved in the reporting process to prevent reoccurrence. Further, the investigator will be retrained on the appropriate information to be included in the investigation report.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
03/26/2016	2016-00352MC	1. Criminal Act	1. Not Referred		

**Incident Summary**

On March 26, 2016, a client was observed with a swollen right ankle. After a medical evaluation, it was determined the client had a fractured right ankle.

**Overall Assessment**

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The department's pre-disciplinary process sufficiently complied with policies and procedures.

**Disposition**

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
03/26/2016	2016-00362MA	1. Discourteous treatment	1. Unfounded		

**Incident Summary**

On March 26, 2016, a client alleged that a psychiatric technician hit him on the head with a deodorant spray can.

**Overall Assessment**

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The department's pre-disciplinary process sufficiently complied with policies and procedures.

**Disposition**

The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determination.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
03/26/2016	2016-00363MC	1. Criminal Act	1. Not Referred		
<b>Incident Summary</b> On March 26, 2016, it was alleged that a psychiatric technician force-fed a client.					
<b>Overall Assessment</b> The Office of Protective Services substantially complied with the department's policies and procedures governing the investigative process of notifications and consultations with the OLES. <b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient					
<b>Disposition</b> An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
04/03/2016	2016-00384MA	1. Discourteous treatment	1. Not Sustained		
<b>Incident Summary</b> On April 3, 2016, a client alleged that a psychiatric technician threw a shoe at her.					
<b>Overall Assessment</b> The department's pre-disciplinary process sufficiently complied with policies and procedures. <b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient					
<b>Disposition</b> The hiring authority determined that there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL Other
04/05/2016	2016-00398MC	1. Criminal Act	1. Not Referred		
<b>Incident Summary</b> On April 5, 2016, a patient alleged that a staff member touched his penis and buttocks while he slept.					
<b>Overall Assessment</b> The Office of Protective Services substantially complied with the department's policies and procedures governing the investigative process of notifications and consultations with the OLES. <b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient					

### Disposition

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
04/10/2016	2016-00420MA	1. Incompetency 2. Incompetency 3. Discourteous treatment	1. Unfounded 2. Sustained 3. Unfounded	Suspension	No Change

### Incident Summary

On April 10, 2016, two psychiatric technicians allegedly were negligent when they failed to properly monitor a client who was on a direct observation level of supervision during the evening shift. The client swallowed a mobile phone battery. A third psychiatric technician allegedly threatened to choke the client.

### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

The department's pre-disciplinary process sufficiently complied with policies and procedures.

### Disposition

The hiring authority determined there was sufficient evidence to sustain the allegations against one of the psychiatric technicians who supervised the client during the evening shift and imposed a two-day suspension without pay. The hiring authority determined allegations against the other two psychiatric technicians were unfounded. The OLES concurred with the determinations.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
04/15/2016	2016-00454MA	1. Discourteous treatment	1. Unfounded	No Penalty Imposed	No Change

### Incident Summary

On April 15, 2016, a client alleged that a psychiatric technician kicked and threatened her.

### Overall Assessment

**Procedural Rating:** Sufficient

**Substantive Rating:** Sufficient

Overall, the department's pre-disciplinary process sufficiently complied with policies and procedures.

### Disposition

The hiring authority determined the investigations conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
04/18/2016	2016-00470MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change
<b>Incident Summary</b> On April 18, 2016, a patient alleged a rehabilitation therapist scratched him on his ear, causing two lacerations.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority did not sustain the allegation of physical abuse by the rehabilitation therapist. The OLES concurred with the determination. However, the hiring authority identified additional potential misconduct by the rehabilitation therapist of dishonesty and neglect of duty and referred the matter to another facility department to address.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
04/26/2016	2016-00505MA	1. Discourteous treatment	1. Unfounded	No Penalty Imposed	No Change
<b>Incident Summary</b> On April 26, 2016, a client alleged that a psychiatric technician choked her.					
<b>Overall Assessment</b> The department substantially complied with policies and procedures governing the investigative process. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient</p>					
<b>Disposition</b> The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.					

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
04/26/2016	2016-00516MC	1. Criminal Act	1. Not Referred	Other	No Change
<b>Incident Summary</b> On April 26, 2016, a client alleged a senior psychiatric technician punched him.					

<b>Overall Assessment</b>	<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient
Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.	
<b>Disposition</b>	
An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.	

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
04/30/2016	2016-00525MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change

**Incident Summary**

On April 30, 2016, a client alleged a psychiatric technician slammed her against a door and dragged her down a hallway.

<b>Overall Assessment</b>	<b>Procedural Rating:</b> Insufficient <b>Substantive Rating:</b> Insufficient
The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely notify the OLES of the incident. The OPS did not confer with the OLES concerning any aspect of the investigation, including the sufficiency of the final report. The subject was interviewed by the responding officer and the investigator without first being admonished about her legal rights. The responding officer did not audio tape any of the interviews. The criminal and administrative investigations were not bifurcated. The investigatory interviews were neither detailed nor thorough. The final report contained irrelevant and prejudicial information.	

**Pre-Disciplinary Assessment**

1. Did the hiring authority timely notify the OLES of the incident? • No  
The allegation was discovered on April 30, 2016, at 23:35 hours; however the hiring authority did not notify the OLES until May 1, 2016, at 06:00, more than two hours after discovery.
2. Was the hiring authority's response to the incident appropriate? • No  
The OPS investigated the matter as a criminal incident. The responding officer did not audio record interviews. The responding officer interviewed the subject of the criminal allegation without providing the subject a legal admonition of rights.
3. Did the hiring authority timely notify the department's legal office of the incident? • No  
The hiring authority did not notify the department's legal office of the incident.
4. Was a department attorney assigned to assist with the case development? • No  
A department attorney was not assigned to the case.
5. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The investigator did not consult with the OLES at any time during the investigation.
6. Did OPS adequately consult with the OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? • No  
It does not appear the OPS consulted with the OLES or the prosecuting agency concerning the manner in which the criminal and administrative investigations were conducted.

7. Was the administrative and criminal investigation properly and completely bifurcated? • No  
It appears the criminal and administrative investigations were conducted simultaneously by the same investigator.
8. Were all of the interviews thorough and appropriately conducted? • No  
Neither the responding officer nor the investigator provided the subject with an admonition of her legal rights prior to questioning her about the allegation. During the course of the investigation, a possible motive for the alleged misconduct was provided but was not explored in the subject interview.
9. Upon completion of the investigation, was a draft copy of the investigative report forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No  
The investigator did not provide the OLES with a draft copy of the report.
10. Was the final investigative report thorough and appropriately drafted? • No  
During the course of the investigation, a possible motive for the alleged misconduct was provided but was not explored or captured in the final investigative report. The report contained prejudicial information concerning past actions of the client that were only marginally relevant to the current allegations.
11. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The OPS completed the investigation and report without consultation with the OLES.
12. Was the investigation thorough and appropriately conducted? • No  
Neither the responding officer nor the investigator provided the subject with an admonition of the subject's legal rights prior to interview.
13. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The hiring authority did not adequately consult with the OLES during the pre-disciplinary/investigative phase.

### Disposition

The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.

### Department Corrective Action Plan

The hiring authority late-reported this incident to OPS, who in turn immediately notified the OLES. The hiring authority has counseled staff to ensure timely notification to OPS in the future. All officers and investigators have been reminded to audio record all interviews and to properly give *Beheler* Admonishments. As noted by OPS and the OLES, there was insufficient evidence to substantiate the allegation. Nevertheless, the deficiencies in the investigation have been discussed with the Investigator to prevent a recurrence.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Other	FINAL No Change
04/30/2016	2016-00554MC	1. Criminal Act	1. Not Referred		

### Incident Summary

On April 30, 2016, a psychiatric technician allegedly failed to provide adequate water to a client and verbally abused the client. Additionally, unidentified staff allegedly used racial epithets in the client's vicinity.

### Overall Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Sufficient

Overall, the department complied with the policies and procedures governing the investigative process.

### Disposition

An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/29/2016	2016-00631MA	1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty	1. Sustained 2. Sustained 3. Sustained 4. Sustained	Dismissal	No Change

### Incident Summary

On January 29, 2016, a food service worker allegedly encouraged a client to expose his genitals to another employee. The food service worker, a psychiatric technician, and a psychiatric technician assistant allegedly witnessed the client grab at the crotch and buttocks of the other employee and failed to report the incident.

### Overall Assessment

**Procedural Rating:** Sufficient

**Substantive Rating:** Sufficient

Although the department did not consult with the OLES regarding the investigation and investigative findings and the investigative report contained administrative and criminal findings, they complied with policies and procedures in all other respects.

### Disposition

The hiring authority sustained the allegations against the food service worker and dismissed him. The hiring authority also sustained the allegations against the psychiatric technician and the psychiatric technician assistant and rejected both on probation. The OLES was not consulted.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
06/05/2016	2016-00712MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change

### Incident Summary

On June 5, 2016, a client alleged a psychiatric technician threw her onto the floor and dragged her by the hair and clothes, making it difficult for her to breathe.

### Overall Assessment

**Procedural Rating:** Insufficient

**Substantive Rating:** Insufficient

The department did not comply with policies and procedures governing the pre-disciplinary process. The OPS did not confer with the OLES upon case initiation and did not provide the OLES with a draft investigative report. The investigator did not provide one of the subjects with an admonition of legal rights prior to the interview. The final report contained irrelevant and legally inadmissible information. One of the subject interviews did not contain sufficient detail to adequately assess the witnesses' ability to perceive the alleged incident.

### Pre-Disciplinary Assessment

1. Was a department attorney assigned to assist with the case development? • No  
A department attorney was not assigned to the case.

2. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OPS did not confer with the OLES upon case initiation.
3. Did the department appropriately determine the deadline for taking disciplinary action (statute of limitation date)? • No  
The department did not assess the deadline for taking disciplinary action.
4. Were all of the interviews thorough and appropriately conducted? • No  
The interview of the medical expert contained irrelevant and legally inadmissible information. It is unclear in one of the subject interviews whether that subject actually observed the alleged incident. Without that information, that subject's opinion that no abuse occurred carries little weight.
5. Upon completion of the investigation, was a draft copy of the investigative report forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No  
The OPS did not provide the OLES with a copy of the draft investigative report.
6. Was the final investigative report thorough and appropriately drafted? • No  
The final report contained irrelevant and potentially prejudicial information.
7. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The investigation was initiated and completed without consultation with the OLES.
8. Was the investigation thorough and appropriately conducted? • No  
Some of the investigatory interviews contained irrelevant and legally inadmissible information, while other interviews did not contain fundamental facts. One of the subjects was not provided with an admonition of her legal rights prior to interview.

#### Disposition

The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.

#### Department Corrective Action Plan

The deficiencies have been noted and will be addressed with the assigned investigator and the OPS commander.

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL No Penalty Imposed	FINAL No Change
06/08/2016	2016-00724MA	1. Inexcusable neglect of duty	1. Not Sustained		

#### Incident Summary

On June 8, 2016, a client alleged she had been repeatedly beaten by a psychiatric technician over an unknown period of time.

#### Overall Assessment

**Procedural Rating:** Insufficient  
**Substantive Rating:** Sufficient

The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The responding the OPS officer did not audio record interviews. Neither the OPS nor the investigator interviewed a percipient witness identified by the subject. The OPS did not provide the OLES with a draft investigative report.

#### Pre-Disciplinary Assessment

1. Was the incident properly documented? • No  
The responding officer did not audio record any of the interviews.

2. Did the hiring authority timely notify the department's legal office of the incident? • No  
The hiring authority did not notify the legal office of the incident.
3. Was a department attorney assigned to assist with the case development? • No  
A department attorney was not assigned to the case.
4. Did the department appropriately determine the deadline for taking disciplinary action (statute of limitation date)? • No  
The department did not address the statute of limitations with the OLES.
5. Upon completion of the investigation, was a draft copy of the investigative report forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No  
The investigator did not provide the OLES with a draft copy of the report.
6. Did OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The OPS did not provide the OLES with a draft report.
7. Was the investigation thorough and appropriately conducted? • No  
A percipient witness identified by the subject was not interviewed.

### **Disposition**

The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.

### **Department Corrective Action Plan**

The deficiencies have been noted and will be addressed with the assigned investigator and the OPS commander.

# Appendix C

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## Discipline phase cases

The OLES assesses every discipline phase case for both procedural and substantive sufficiency:

- Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion.
- Substantive sufficiency assesses the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

**Appendix C**  
**Discipline Phase Cases**

INCIDENT	OLES CASE #	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/08/2016	2016-00584MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change
<b>Incident Summary</b> On January 8, 2016, an officer allegedly failed to report he struck a patient with his baton during an altercation.					
<b>Overall Assessment</b> The investigation was completed by the OLES and submitted to the hiring authority for disposition.					
<b>Disposition</b> The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the determination.					
<b>Disciplinary Assessment</b> The department's disciplinary process sufficiently complied with policies and procedures. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient  <b>Substantive Rating:</b> Sufficient</p>					

INCIDENT	OLES CASE #	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL	FINAL
01/05/2016	2016-00585MA	1. Inexcusable neglect of duty	1. Not Sustained	No Penalty Imposed	No Change
<b>Incident Summary</b> On January 5, 2016, several officers allegedly engaged in a room extraction of patient and failed to video record the incident.					
<b>Overall Assessment</b> The investigation was completed by the OLES and submitted to the hiring authority for disposition.					
<b>Disposition</b> The hiring authority determined there was insufficient evidence to sustain the allegation against the officers. The OLES concurred in the determination.					
<b>Disciplinary Assessment</b> The department's disciplinary process sufficiently complied with policies and procedures. <p style="text-align: right;"><b>Procedural Rating:</b> Sufficient  <b>Substantive Rating:</b> Sufficient</p>					

# Appendix D

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## **Combined pre-disciplinary and discipline phase cases**

On the following pages are cases that the OLES monitored in both their pre-disciplinary phase (OLEs monitored the department's investigation) as well as the discipline phase. Each phase was rated separately.

Investigations conducted by the departments are rated for procedural and substantive sufficiency:

- Procedural sufficiency is assessing the notifications to the OLES, consultations with the OLES and investigation activities for timeliness, among other things.
- Substantive sufficiency is assessing the quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

Discipline is rated for procedural and substantive sufficiency:

- Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion.
- Substantive sufficiency assesses the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

**Appendix D  
Combined Cases**

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Training	FINAL No Change
01/08/2016	2016-00040MA	1. Inexcusable neglect of duty	1. Sustained		
<b>Incident Summary</b> It was alleged on January 8, 2016, that a psychiatric technician had her head down and appeared to be sleeping while engaged in client care. The client was under a behavioral plan for a medical condition which required constant visual supervision.					
<b>Overall Assessment</b> Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.			<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient		
<b>Disposition</b> The hiring authority sustained the allegation of the psychiatric technician failing to follow the individual supervision plan and imposed counseling and training. The OLES concurred.					
<b>Disciplinary Assessment</b> Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.			<b>Procedural Rating:</b> Sufficient <b>Substantive Rating:</b> Sufficient		

INCIDENT	OLES CASE	ALLEGATIONS	FINDINGS	PENALTY	
				INITIAL Salary Reduction	FINAL No Change
05/27/2013	2016-00434MA	1. Inexcusable neglect of duty 2. Discourteous treatment 3. Willful disobedience 4. Other failure of good behavior	1. Sustained 2. Sustained 3. Sustained 4. Sustained		
<b>Incident Summary</b> On May 27, 2013, a psychiatric technician allegedly posted videos of patients on a social media website.					
<b>Overall Assessment</b> The Office of Protective Services failed to comply with the department's policies and procedures governing the investigative process of notifications and consultations with the OLES. The department did not notify the OLES of the incident.			<b>Procedural Rating:</b> Insufficient <b>Substantive Rating:</b> Sufficient		
<b>Pre-Disciplinary Assessment</b> 1. Did the hiring authority timely notify the OLES of the incident? • No The hiring authority did not notify the OLES of the incident.  2. Did the hiring authority adequately consult with the OLES regarding the incident? • No					

The hiring authority did not consult with the OLES.

3. Was a department attorney assigned to assist with the case development? • No  
The OLES was not advised if a department attorney was assigned to assist with the case development.
4. Did the OPS adequately confer with the OLES upon case initiation and prior to finalizing the investigative plan? • No  
The OLES was not notified of this incident timely, therefore, the investigation was complete before the OLES was able to provide monitoring.
5. Did the OPS cooperate with and provide continued real-time consultation with the OLES? • No  
The OPS did not provide the OLES an opportunity to provide real-time consultation.
6. Did the hiring authority cooperate with and provide continual real-time consultation with the OLES throughout the pre-disciplinary/investigative phase? • No  
The OLES was not notified of the incident until the investigation was complete.

### Disposition

The hiring authority sustained the allegations and imposed a five percent salary reduction for six months. The OLES did not concur in the penalty imposed.

### Disciplinary Assessment

**Procedural Rating:** Sufficient  
**Substantive Rating:** Insufficient

The hiring authority substantially complied with the process requirements of the disciplinary process. The OLES was not provided with a draft disciplinary action for review and the disciplinary action was served one day before the deadline for taking action was to expire. Also, the hiring authority selected a penalty that the OLES did not believe was appropriate for the misconduct.

### Disciplinary Assessment Questions

1. Was a department attorney assigned to this case during the disciplinary phase? • No  
The OLES was not notified that a department attorney was assigned. However, a department attorney did participate in the disciplinary phase.
2. Did the hiring authority who participated in the disciplinary conference select the appropriate penalty? • No  
The hiring authority selected a penalty that the OLES did not believe was appropriate.
3. Did the department attorney or discipline officer provide the OLES with a copy of the draft disciplinary action and consult with the OLES? • No  
A copy of the draft disciplinary action was not provided to the OLES for review.

### Department Corrective Action Plan

DPS did not recognize this as an OLES-reportable event, thus appropriate consult actions/notifications did not occur. The department will provide in-service training to staff on all OLES-reportable incidents including those incidents which are under the category of "Any incident of significant interest to the public." With respect to the disciplinary assessment, there were extenuating circumstances. The incident was discovered during the course of another investigation and the discovery date was near the expiration of the statute of limitations date. As such, a disposition conference was held and the adverse action served the following day. Time constraints did not afford submission of the draft adverse action to the OLES before taking disciplinary action. There also was not time to elevate the disagreement in disciplinary decision to an executive review committee. The department executives will conduct a post review of the case and disciplinary decisions to identify potential process changes for future cases.

# Appendix E

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## Monitored issues

**Appendix E  
Monitored Issues**

INCIDENT DATE 12/19/2015	OLES CASE NUMBER 2016-00007MI	CASE TYPE Misconduct
<p><b>Incident Summary</b></p> <p>On December 19, 2015, it was discovered that a set of keys belonging to the Department of Police Services were missing. Allegedly, the officer who lost the keys notified a supervisor; however, the supervisor took no action. Several weeks later, the officer requested a new set of keys, and at that time the supervisor who got the request took appropriate action by notifying his supervisor and initiating a report of lost state property. The lost keys did not provide access to the secured facility or the Department of Police Services building, however, they were not recovered.</p>		
<p><b>Overall Assessment</b></p> <p>The department's response was satisfactory in all critical aspects.</p>		<p><b>Rating:</b> Sufficient</p>
<p><b>Disposition</b></p> <p>The OLES discovered the circumstances of this case on the daily incident log generated by the facility. The OLES requested documentation from the facility to fully review this incident. The police report received indicated that the report was "closed, information only, forward to records." The OLES discovered a number of potential policies that were not followed in this case, including a requirement that an employee fully and promptly report lost state property and a policy that required a supervisor to take appropriate action when conduct that could result in discipline was discovered. The OLES submitted a memorandum to the department requesting a review of the possible policy violations. The department reviewed this matter and provided training to the law enforcement supervisors in the relevant policies.</p>		

INCIDENT DATE 12/29/2015	OLES CASE NUMBER 2016-00013MI	CASE TYPE Sexual Assault
<p><b>Incident Summary</b></p> <p>On December 29, 2015, a patient alleged she engaged in sex with a male patient in exchange for a soda, but also stated she was forced to have sex. The patient complained of vaginal pain. The hospital police officers and investigators responded to the incident and conducted a brief investigation. However, the patient was minimally cooperative with them. The case was then closed due to insufficient evidence.</p>		
<p><b>Overall Assessment</b></p> <p>Although the department responded appropriately to the concerns raised by the OLES by conducting a thorough investigation into this matter. However, the department failed to notify the OLES of the investigation; therefore, the OLES did not have an opportunity to provide contemporaneous oversight of the investigation.</p>		<p><b>Rating:</b> Sufficient</p>
<p><b>Disposition</b></p> <p>The OLES was notified of this incident. Upon review of the documents received, including the audio recording of the statements received, a number of concerns were raised. The statements from the patient and witnesses did disclose a potential suspect which was not pursued, the interview with the patient was inadequate and not done in a confidential setting, and the sexual assault exam was not properly explained to the patient who suffers from mental incapacity. The OLES requested the department to further investigate this matter. The department responded by re-opening the investigation and assigned an investigator with specialized skills and training in sexual assault investigations.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
08/08/2015	2016-00071MI	Use of Force
<b>Incident Summary</b> <p>On August 8, 2015, three hospital police officers were dispatched to provide assistance to staff that believed a patient was in possession of contraband. The officers indicated that during their involvement with the patient, he became hostile and posed a threat to their safety and ignored repeated orders to submit to the application of mechanical restraints. Two officers determined it was necessary to use physical force, pepper spray, and batons during the incident. All three officers incurred injury, as did the patient, during the incident.</p>		
<b>Overall Assessment</b>		<b>Rating:</b> Sufficient
<p>The department appropriately responded the concerns raised by the OLES. The department has put in place a plan to ensure proper training for investigators and sworn supervisors. The department is also considering a review of the use-of-force process to accurately reflect the needs of the department.</p>		
<b>Disposition</b> <p>The OLES received a referral from Disability Rights California to review this matter. The OLES requested a number of documents from the department to conduct an independent review of the incident. While conducting the independent review, a number of concerns came to light. Although the OLES believed the initial use of force was within departmental policy, concerns about the proper training of investigators in interviewing witness, report writing, and understanding Government Code section 3300-3311 (Public Safety Officers Procedural Bill of Rights Act) were raised. Other concerns also raised were the roles and responsibilities of the use-of-force committee and ensuring sworn supervisors were trained in application of Government Code section 3300-3311.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
02/03/2016	2016-00154MI	Professional Board
<b>Incident Summary</b> <p>On February 3, 2016, a client was observed scratching her groin area from outside her clothes. When a doctor attempted to examine the client, she refused to be examined. Allegedly, the doctor then asked a psychiatric technician to conduct a pelvic exam while he waited outside the bedroom. Based on the examination by the psychiatric technician, the doctor ruled out sexual abuse.</p>		
<b>Overall Assessment</b>		<b>Rating:</b> Sufficient
<p>The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OLES regarding the incident.</p>		
<b>Disposition</b> <p>After a thorough review of the policies and procedures, OLES recommended the facility open an investigation to determine if the employees operated outside of the scope of their licensures. The facility concurred in the recommendation and opened an administrative investigation, which the OLES is monitoring.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
02/23/2016	2016-00255MI	Head/Neck
<b>Incident Summary</b> <p>On February 23, 2016, a clinical social worker received an anonymous note underneath her door which indicated that a patient had been assaulted the night before. The clinical social worker advised a supervisor that she received the note; however, she threw the note away. A search was conducted by an officer; however the note was not located.</p>		
<b>Overall Assessment</b>		<b>Rating:</b> Sufficient
<p>The department's response was satisfactory in all critical aspects.</p>		
<b>Disposition</b> <p>The OLES discovered the circumstances of this case on the daily incident log generated by the facility. The OLES requested documentation from the facility to fully review this incident. Although an investigation was conducted into the patient assault, it was discovered a policy did not exist for proper retention of potential evidence for non-sworn employees and the issue was not covered in employee training. The OLES requested the department to further review this matter to determine if a policy and training should be implemented. The department agreed to do so.</p>		

INCIDENT DATE	OLES CASE NUMBER	CASE TYPE
03/10/2016	2016-00313MI	Misconduct
<b>Incident Summary</b> <p>On March 10, 2016, a patient alleged several officers failed to assume their recreation area (yard) assignments which resulted in patients being unable to go to the recreation area.</p>		
<b>Overall Assessment</b>		<b>Rating:</b> Sufficient
<p>The department was given a memorandum of recommendations and was receptive to the recommendations.</p>		
<b>Disposition</b> <p>The OLES conducted an inquiry into the patient complaint and recommended the department review policies and procedures governing mandatory post coverage, yard hours, and documentation and communication between unit staff and officers specific to yard participation. Further, the OLES recommended changing policies and procedures as appropriate to balance the needs of the facility while providing patients with an opportunity to attend yard during scheduled times.</p>		

# Appendix F

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## Statutes

## California Welfare and Institutions Code 4023.6 et seq.

**4023.6.** (a) The Office of Law Enforcement Support within the California Health and Human Services Agency shall investigate both of the following:

(1) Any incident at a developmental center or state hospital that involves developmental center or state hospital law enforcement personnel and that meets the criteria in Section 4023 or 4427.5, or alleges serious misconduct by law enforcement personnel.

(2) Any incident at a developmental center or state hospital that the Chief of the Office of Law Enforcement Support, the Secretary of the California Health and Human Services Agency, or the Undersecretary of the California Health and Human Services Agency directs the office to investigate.

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

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

(2) Before adopting policies and procedures related to fulfilling the requirements of this section related to the State Department of State Hospitals, the Office of Law Enforcement Support shall consult with the executive director of the protection and advocacy agency established by Section 4901, or his or her designee, and other advocates, including persons with mental health disabilities, former state hospital residents, and their family members.

**4023.7.** (a) The Office of Law Enforcement Support shall be responsible for contemporaneous oversight of investigations that (1) are conducted by the State Department of State Hospitals and involve an incident that meets the criteria of Section 4023, and (2) are conducted by the State Department of Developmental Services and involve an incident that meets the criteria of Section 4427.5.

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

**4023.8.** (a) (1) Commencing October 1, 2016, the Office of Law Enforcement Support shall issue regular reports, no less than semiannually, to the Governor, the appropriate policy and budget committees of the Legislature, and the Joint Legislative Budget Committee, summarizing the investigations it conducted pursuant to Section 4023.6 and its oversight of investigations pursuant to Section 4023.7. Reports encompassing data from January through June, inclusive, shall be made on October 1 of each year, and reports encompassing data from July to December, inclusive, shall be made on March 1 of each year.

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

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

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

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

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

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

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

(G) The number of reports made to an individual's licensing board, including, but not limited to, the Medical Board of California, the Board of Registered Nursing, the Board of Vocational Nursing and

Psychiatric Technicians of the State of California, or the California State Board of Pharmacy, in cases involving serious or criminal misconduct by the individual.

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

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

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

(4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise made available to the public upon their release to the Governor and the Legislature.

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

## **California Welfare and Institutions Code 4427.5**

**4427.5.** (a)(1) A developmental center shall immediately report the following incidents involving a resident to the local law enforcement agency having jurisdiction over the city or county in which the developmental center is located, regardless of whether the Office of Protective Services has investigated the facts and circumstances relating to the incident:

(A) A death.

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

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

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

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

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

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

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

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

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

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

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

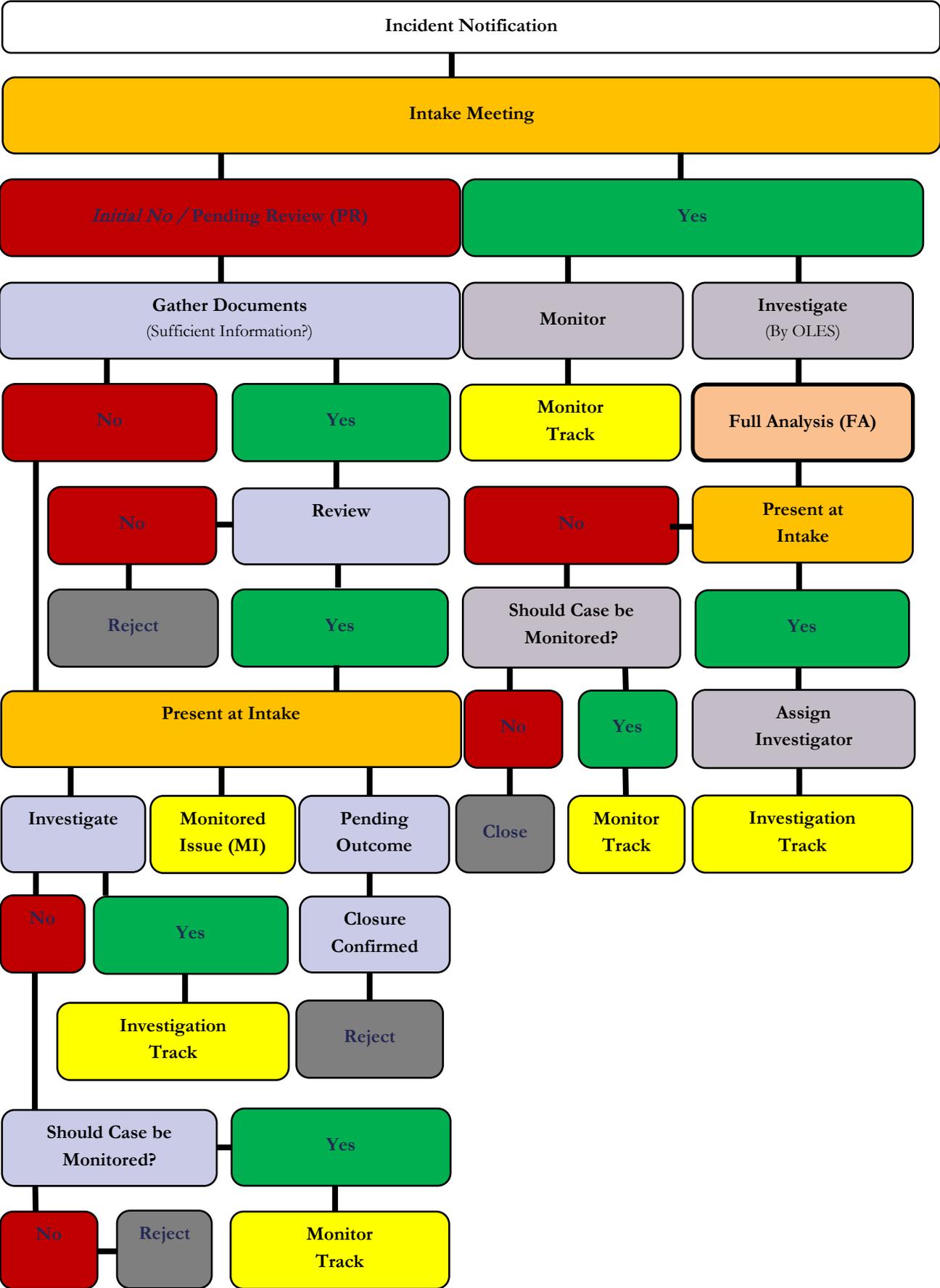
(C) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in Section 15610.63, in which a staff member is implicated.

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

# Appendix G

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## OLES intake flowchart



# Appendix H

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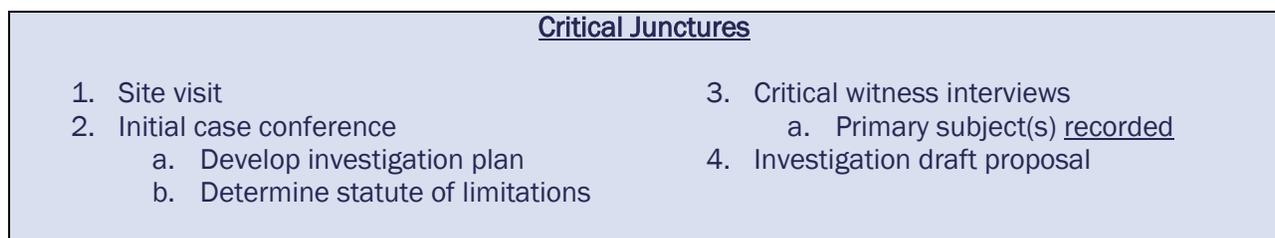
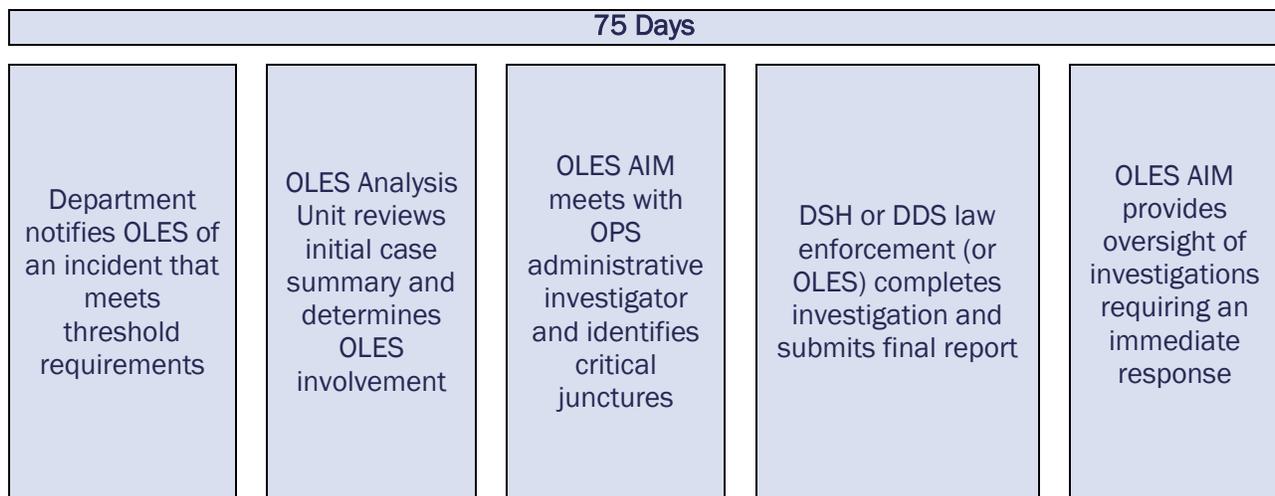
Guidelines for the OLES processes

## Appendix H Guidelines for the OLES processes

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

If, instead, an incident is investigated by DSH or DDS but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH or DDS investigator and the department attorney, if one is designated,<sup>22</sup> throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 75 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 75-day recommendation is followed. However, complex cases can take more time.

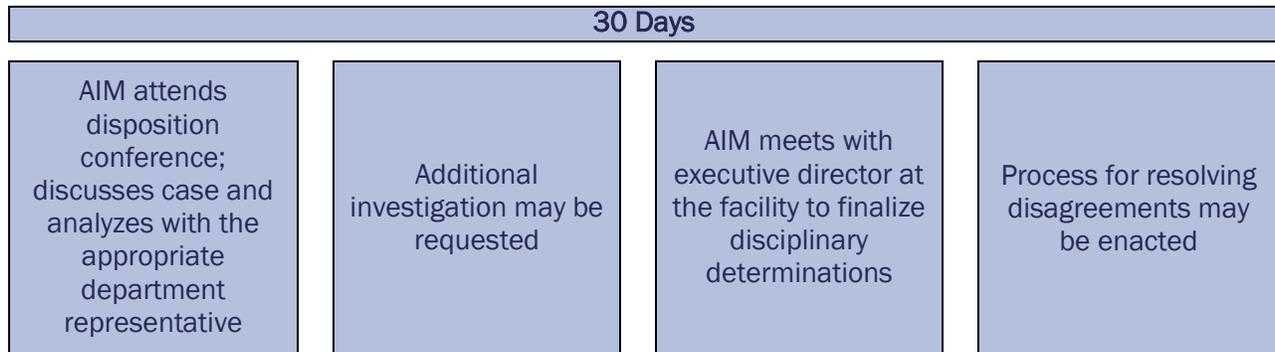
### Administrative Investigation Process THRESHOLD INCIDENTS



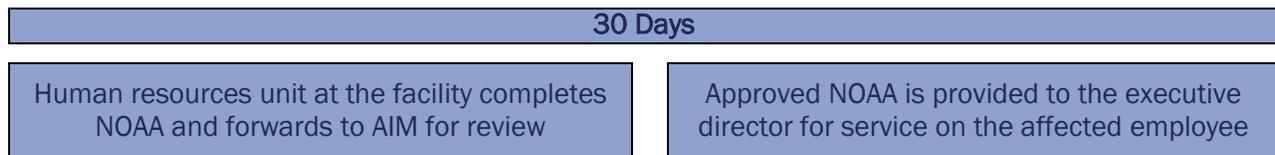
It is recommended that within 30 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code 4023.8, subdivision (a)(2) (C), (D), and (E), the hiring

<sup>22</sup> The best practice is to have an employment law attorney from the department involved from the outset to guide investigators, assist with interviews and gathering of evidence, and to give advice and counsel to the facility management (also known as the hiring authority) where the employee who is the subject of the incident works. Neither DSH nor DDS had the resources in the six-month period to dedicate to this best practice.

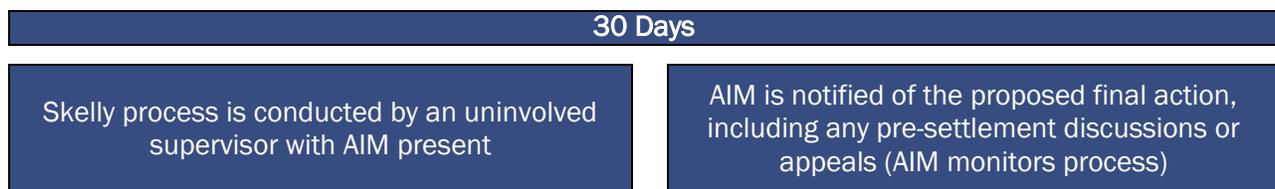
authority shall consult with the AIM attorney on the discipline decision, including 1) the allegations for which the employee should be exonerated, the allegations for which the evidence is insufficient and the allegations should not be sustained, or the allegations that should be sustained; and 2) the appropriate discipline for sustained allegations, if any. If either the AIM attorney or the hiring authority believes the other party's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.



Once a final determination is reached regarding the appropriate allegations and discipline in a case, it is recommended that a Notice of Adverse Action (NOAA) be finalized and served upon the employee within 30 days.



State employees subject to discipline have a due process right to have the matter reviewed in a Skelly hearing by an uninvolved supervisor who, in turn, makes a recommendation to the hiring authority, i.e. whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee.<sup>23</sup> It is recommended that the Skelly due process meeting be completed within 30 days.



State employees who receive discipline have a right to challenge the decision by filing an appeal with the State Personnel Board (SPB), which is an independent state agency. OLES continues monitoring through this appeal process. During an appeal, a case can be concluded by settlement (a mutual agreement between the department(s) and the employee), a unilateral action by one party withdrawing the appeal or disciplinary action, or an SPB decision after a contested hearing. In cases

<sup>23</sup> Skelly v. State Personnel Board, 15 Cal. 3d 194 (1975)

where the SPB decision is subsequently appealed to a Superior Court, the OLES continues to monitor the case until final resolution.

### Conclusion

Department counsel notifies AIM of any SPB hearing dates as soon as known (AIM present at all hearings)

Department counsel notifies and consults with AIM prior to any changes to a disciplinary action

AIM notes quality of prosecution and final disposition