Office of Law Enforcement Support

Semiannual Report

January 1, 2018–June 30, 2018

Independent review and assessment of law enforcement and employee misconduct at the California state hospitals and developmental centers

Promoting a safe, secure and therapeutic environment

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

Contents

Introduction

As the new Chief, I am pleased to present this fifth report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency. This report details the oversight and monitoring conducted at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). This report covers the period from January 1, 2018, through June 30, 2018.

The OLES provides real-time oversight and monitoring of the DSH and DDS employee discipline process, policies and procedures, and law enforcement programs throughout their nine facilities. The OLES also conducts criminal and administrative investigations of DSH and DDS police personnel. Additionally, the OLES provides technical support and investigative assistance to DSH and DDS upon request. All OLES activities are focused on helping to ensure safe and secure environments for patients, residents, staff, and visitors at DSH and DDS facilities so care and treatment of the mentally ill and developmentally disabled can be optimized.

With this report, the OLES begins its third year of oversight and monitoring. Combined, both departments reported 81 fewer incidents as of June 30, 2018, compared to the prior reporting period. At DSH, reported incidents declined from 503 to 426 as of June 30, 2018, compared to the prior reporting period ending on December 31, 2017. DSH has a current population of 6109, compared to last year, at 6086. At DDS, the total reported incident count dropped from 208 to 204 as of June 30, 2018, compared to the prior reporting period ending on December 31, 2017. DDS has a current population of 505 compared to last year at 645.

This report also provides the status, as of June 30, 2018, of 16 recommendations made by the OLES which the departments continue to address to ensure best practices in law enforcement, employee discipline processes, and the tracking and management analysis of employee misconduct cases.

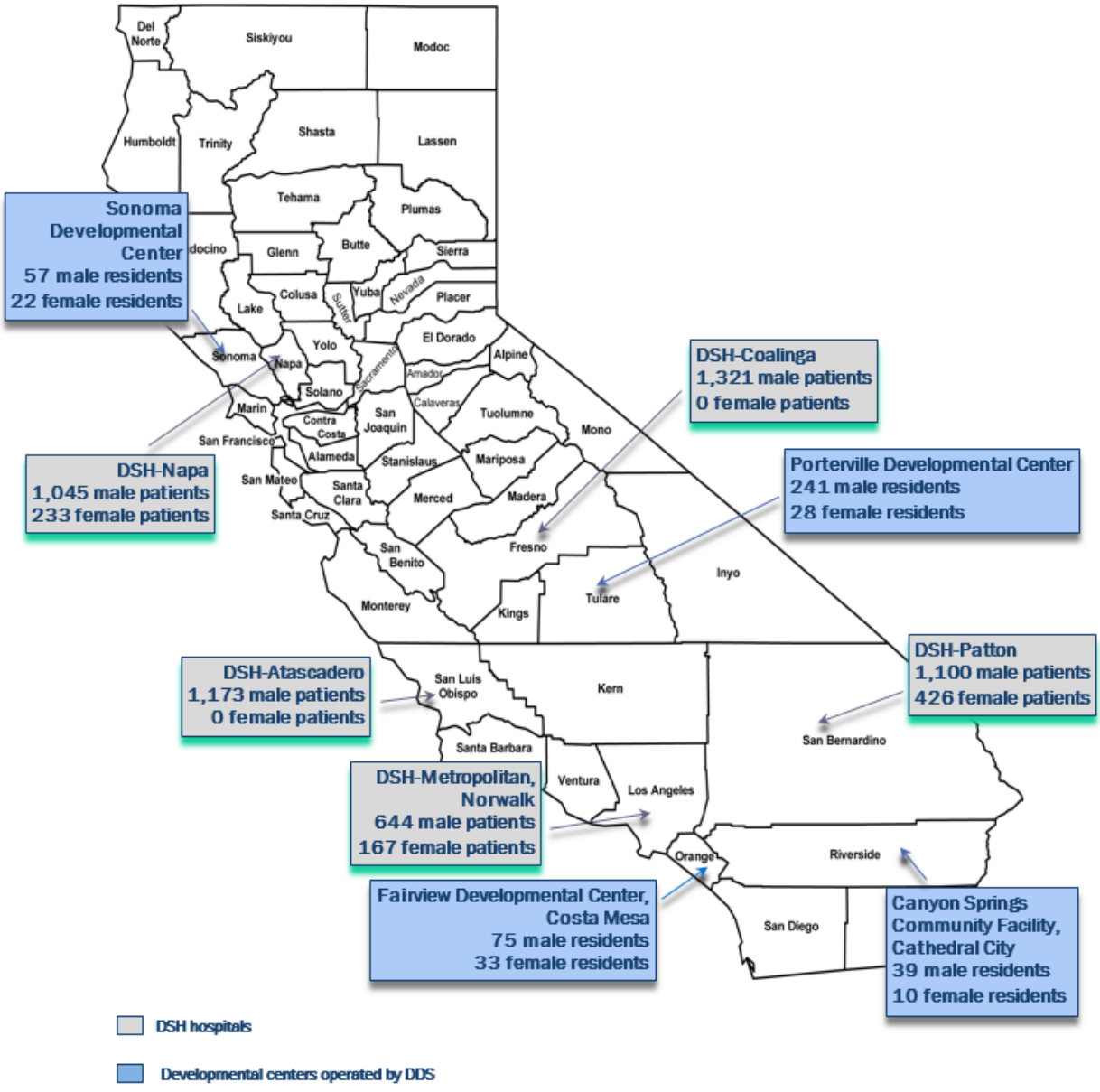
The OLES also remains grateful for the ongoing support and assistance of our stakeholders, including Disability Rights California and the Association of Regional Center Agencies, as well as DSH and DDS management and personnel.

As always, the OLES welcomes comments and questions. Please visit the OLES website at www.oles.ca.gov.

Geoff Britton
Chief, Office of Law Enforcement Support

Facilities

The five DSH and four DDS facilities where the OLES conducted investigations and provided contemporaneous oversight (monitoring) during the current reporting period are shown below.



Note: Population numbers as of June 30, 2018, were provided by the departments.

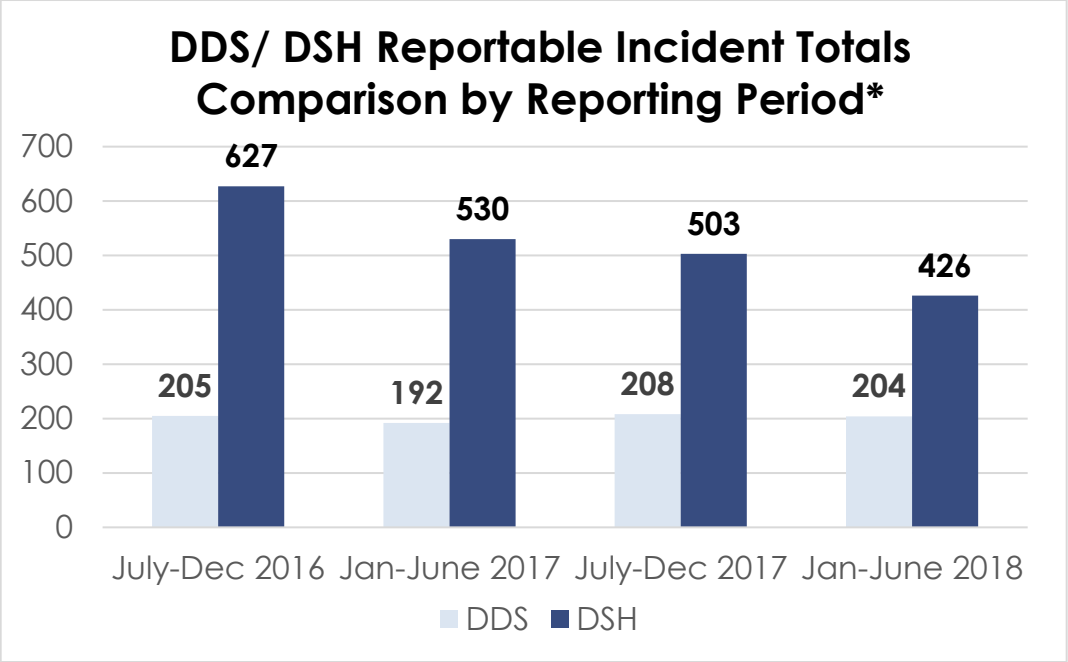
DSH and DDS Facility Population Chart

Facility	Number of Male Residents/Patients	Number of Female Residents/Patients
DSH-Atascadero	1,173	0
DSH-Coalinga	1,321	0
DSH-Metropolitan	644	167
DSH-Napa	1,045	233
DSH-Patton	1,100	426
Fairview	75	33
Porterville	241	28
Sonoma	57	22
Canyon Springs	39	10

Executive Summary

From January 1, 2018, through June 30, 2018, the Office of Law Enforcement Support (OLES) received and processed 630 reportable incidents[1] at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents and patients, resident and patient deaths and other occurrences, per Welfare and Institutions Code, Sections 4023, 4023.6 and 4427.5.

As shown in the adjacent chart, the OLES received 426 incident reports from DSH and 204 from DDS for a total of 630 reports in the current period. This is the lowest number of incident reports in a six-month period since the OLES began oversight operations on January 1, 2016. The overall decline in reportable incidents statewide from 711 to 630 is an 11.4 percent decrease from the previous reporting period of July 1 through December 31, 2017. Of these 630 incidents, the number meeting OLES criteria for investigation, monitoring, and/or research into a systemic issue, decreased from 204 in the previous reporting period to 189 in the current reporting period, a decrease of 7.4 percent.



* Historical numbers are unadjusted and are provided as they were previously published.

In the current reporting period, January 1 through June 30, 2018, DSH had 426 reportable incidents, reflecting a decline of 77 incidents or 15.3 percent from the previous six-month period of July through December of 2017. Of these 426 DSH

[1] Reportable incidents are pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix F).

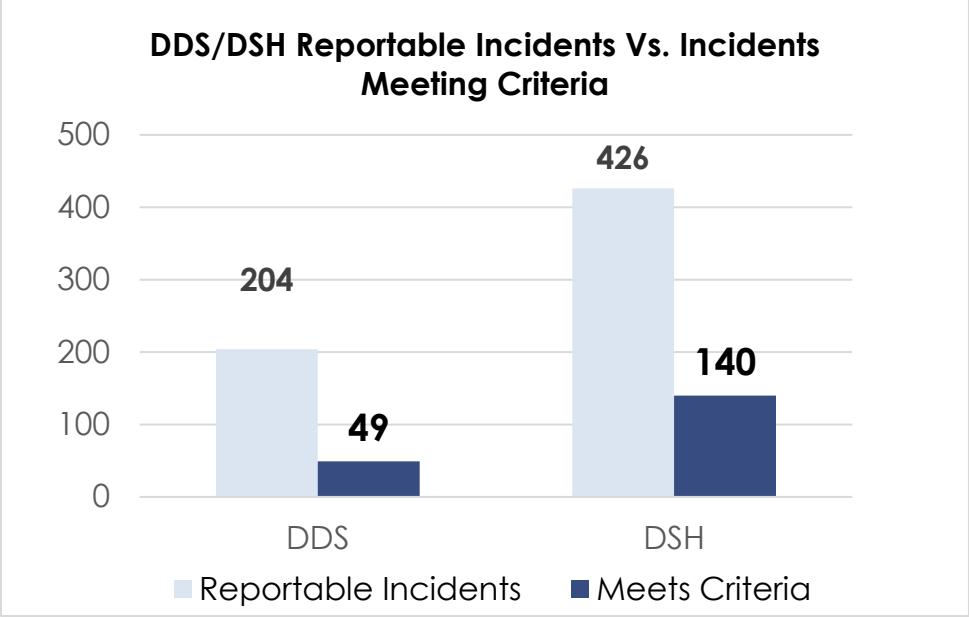
reportable incidents, 32.8 percent, or 140 incidents met the criteria for OLES investigation, monitoring, and/or led to OLES research into a systemic departmental issue.

DDS had 204 reportable incidents in the current reporting period from January 1 through June 30, 2018. This is a decline of four reportable incidents or 1.9 percent from the previous reporting period of July 1 through December 31, 2017. Of these 204 reportable incidents, 49 incidents or 24 percent met the criteria for OLES investigation, monitoring, and/or led to OLES research into a systemic departmental issue.[2]

Types of Incidents - Reportable Incidents vs. Incidents Meeting Criteria

The OLES defines "reportable incidents" as any incident reportable to the OLES by the DSH and DDS as defined in the Welfare and Institutions Code Sections 4023, 4023.6, and 4427.5.

An incident "meeting criteria" is an incident that the OLES Intake Unit has reviewed and considered through the Intake process and determined meets the OLES criteria for investigation and/or monitoring, or consideration for research as a potential departmental systemic issue.



Outside Jurisdiction

This reporting period the OLES has added the category of "outside jurisdiction" to incidents of Sexual Assault. These incidents were previously included in the total count for the category but are now separated into the category of outside

[2] The OLES chief determines whether an issue in DSH or DDS appears to be systemic and, if so, directs OLES staff to research the matter. The OLES labels such matters "monitored issues" and reports on their status in a separate section of each Legislative report.

jurisdiction. The purpose of adding this category of outside jurisdiction is to allow the OLES to define and separate incidents that are alleged to have occurred before or outside of state care. You will see these new category denoted with an "OJ" at the end of the category Sexual Assault.

DSH – Most Frequent Incidents

The single largest number of alleged incidents reported by DSH during the January 1 through June 30, 2018 reporting period was in the category of sexual assault. There were 132 reports of alleged sexual assault, which accounted for 31.2 percent of all reported DSH incidents. This marked a 14.8 percent increase from the 115 sexual assault reports received in the July through December 2017 reporting period. Of the 132 reports of alleged sexual assault, 33 of those reported were from the category of outside jurisdiction.

DSH - Most Frequent Incidents January 1 through June 30, 2018

Incident Categories	Previous Period July 1 through December 31, 2017	Current Period January 1 through June 30, 2018	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Sexual Assault	115	132*	+14.8%	25
Abuse	108	84	-22.2%	63
Broken Bone	66	58	-12.1%	7
Head/Neck Injury	52	36	-30.8%	2
Misconduct	48	29	-39.6%	25

*For the current reporting period, the OLES has added a new category called "Sexual Assault OJ," Outside Jurisdiction. During this reporting period, there were 33 reports of alleged sexual assault outside jurisdiction. For this reporting period only, the OLES has added these 33 reports to the "Sexual Assault" category for purposes of calculating percent change only, as there is no data from the last reporting period to compare in the category of "Sexual Assault Outside Jurisdiction." In future reports, any reports of alleged sexual assault outside jurisdiction will be calculated separately from the "Sexual Assault" category.

Allegations of patient abuse comprised the second largest category of incidents reported at DSH in the current reporting period, with a total of 84 reported incidents. This is a decrease of 22.2 percent from the 108 alleged abuse reports from the previous reporting period.

The OLES revised the reporting policy on broken bone incidents in 2016 to include broken bones of all causes, not just those of unknown origin or cause. This resulted in a significant increase in broken bone reports in the ensuing reporting periods. For the current reporting period, incidents of broken bones are the third most frequently reported incident. Reports of broken bones dropped from 66 reportable incidents in the previous reporting period to 58 in the current reporting period, a decrease of

12.1 percent.

Reports of head/neck injuries at DSH were the fourth most frequently reported category in this reporting period. Reportable head/neck injuries dropped during this reporting period to 36 reportable incidents from 52 in the previous reporting period, a decrease in reportable head/neck injuries of 30.8 percent.

Reportable incidents of misconduct at DSH decreased to 29 during this reporting period, a decrease of 39.6 percent. In the previous reporting period, there were 48 reportable incidents of misconduct at DSH.

DDS - Most Frequent Incidents

As shown in the chart below, allegations of abuse at DDS that did not involve sexual assault comprised the top incident category in the current reporting period. The 115 reports of alleged abuse marked a 9.5 percent increase from the 105 abuse allegations reported in the previous reporting period of July 1 through December 31, 2017.

DDS - Most Frequent Incidents January 1 through June 30, 2018

Incident Categories	Previous Period July 1 through December 31, 2017	Current Period January 1 through June 30, 2018	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	105	115	9.5%	40
Sexual Assault	16	25	56.3%	1
Head/Neck	21	20	-4.8%	0
Broken Bone	16	10	-37.5%	1
AWOL	7	7	0%	0

Allegations of sexual assault ranked second as the most frequent incident reported by DDS to the OLES with 25 incidents reported. This was a 56.3 percent increase from the previous reporting period of 16 incidents.

The third most reported incident in the current reporting period was in the category of head/neck injury. Twenty head/neck injury reports were made by DDS in this reporting period, down 4.8 percent from the 21 reports received by the OLES in the previous reporting period. The DDS, whose population includes residents with developmental disabilities, is required to report to the OLES all head and neck injuries if they required treatment beyond first aid. This is because such injuries can cause lasting health impairment or lead to death and may be indicative of assault, battery or neglect.

Reports of broken bones dropped by 37.5 percent during this reporting period, from 16 in the previous reporting period to 10 in the current reporting period.

DDS had seven reports of clients being AWOL.[3] This was the same number as reported in the previous reporting period.

Deaths at DSH and DDS

Deaths of DSH patients totaled 34, an increase of 21.4% from the last reporting period. Napa State Hospital had the largest number of deaths reported with 11, eight of which were due to cardiac/respiratory issues, two to sepsis, and one to cancer.

Deaths of DDS residents in the current reporting period were 14, a decrease of 22.2% from the previous reporting period. The majority of the deaths at DDS involved residents of the Fairview Developmental Center with a total of eight deaths; six due to cardiac/respiratory issues and two due to sepsis.

Results of OLES investigations

Per statute,[4] an OLES investigation commences after the OLES is 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.[5]

Appendix A of this report provides information on 29 OLES investigations. Two of the investigations involved incidents that occurred in 2015, one in 2016, 14 in 2017, and 12 investigations focused on incidents in 2018. Eight of the closed OLES investigations determined there was insufficient evidence to support the allegations, and summaries of the investigatory findings were provided to the department. Ten completed investigations were submitted to the hiring authorities at the facilities for disposition, and the OLES will monitor the disposition process. The Office of Law Enforcement Support conducted inquiries into 10 incidents and determined there was insufficient evidence that a crime was committed. The matters were closed without referral to a district attorney's office. A summary of the findings were provided to the department.

Results of OLES monitored cases

In this report's Appendices B, C, and D, the OLES provides information on 180 monitored incident cases that, by June 30, 2018, had reached completion. Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct. Eighty-two percent, or 148 of the 180 cases, were at DSH. The OLES found that 67 monitored cases at the two departments, combined, were insufficient either procedurally, substantively or both.

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[3] AWOL – A patient is "AWOL" when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in staff intervention to recover the patient.
[4] Welfare and Institutions Code Section 4023, 4023.6, 4427.5. (See Appendix F).
[5] An OLES investigation also could start when ordered by the California Health and Human Services Secretary, Undersecretary or the OLES chief.

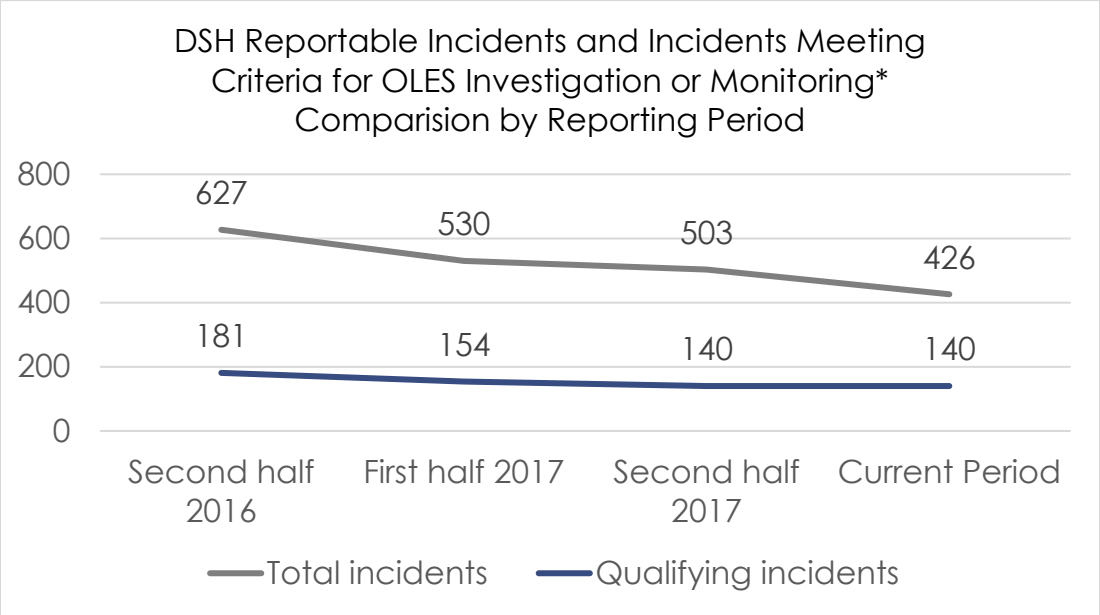
Procedural sufficiency assesses the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency assesses the quality, adequacy and thoroughness of the investigative interviews and reports. During the January 1 through June 30, 2018 period, 37 monitored administrative cases at DSH and DDS had sustained allegations. Another four criminal investigations conducted by DSH and DDS law enforcement in the period resulted in referrals to prosecuting agencies.

DSH Incidents

Every OLES case is initiated by a report of an incident or allegation. Reports are received by the OLES on a 24/7 basis. During the January 1 through June 30, 2018 reporting period, the majority of incident reports came from the facilities.

Fewer incidents during this reporting period

Overall, the number of DSH incidents reported to the OLES from January 1 through June 30, 2018, decreased 15.3 percent, from 503 in the previous reporting period of July 1 through December 31, 2017, to 426 in the current reporting period. Declines were seen in 10 of the 21 incident categories, including incidents involving allegations of sexual assault, abuse, attempted suicide, misconduct, head/neck injury, and neglect.



* Numbers are unadjusted and are provided as they were previously published. They include the three psychiatric programs where mental health care was provided by DSH until July 1, 2017.

Most Frequent DSH Incidents Reported This Period

During the current reporting period, 140 of 426 reportable incidents at DSH met criteria for OLES investigation and/or monitoring or led to OLES research into a potential systemic issue. This was the same number that met criteria in the previous reporting period. Five categories of reported incidents accounted for 80.8 percent of all reportable incidents from DSH. These categories are sexual assault, abuse, broken bones, head/neck injuries and death. There were 344 reportable incidents in these categories. These same five categories accounted for 108 incidents or 77.1 percent of all DSH reportable incidents that met the criteria for the OLES to investigate and/or monitor.

As previously identified, allegations of sexual assault topped all other reportable incidents at DSH in the current reporting period. A total of 132[6] sexual assault allegations accounted for 30.9 percent of all incidents reported. This was an increase of 14.8 percent from the last reporting period of 115 allegations of sexual assault. Of the 132 reports, 25 qualified for investigation and/or monitoring, or consideration of a potential systemic issue. This is an increase of 25 percent from 20 qualifying reports in the prior reporting period.

Abuse allegations that did not involve sexual assault were the second most frequently reported incident at DSH in the current period, totaling 84 and accounting for 19.7 percent of all incidents reported. This was a decrease of 24 reported incidents, or a 22.2 percent decrease from the last reporting period. The number of allegations of abuse that met criteria for investigation and/or monitoring, or consideration of a potential systemic issue in this period also decreased by 18.2 percent, from 77 in the last reporting period, to 63 in the current reporting period.

Note that while "abuse" was how certain incidents were described when they were reported to the OLES, the determination of whether each incident met the threshold for the OLES's purposes of investigation and/or monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.[7]

On the next page is a chart of all reported incidents at DSH during the current reporting period of January 1 through June 30, 2018 and the two prior reporting periods.

[6] During this reporting period, there were 33 reports of alleged sexual assault outside jurisdiction. For the first time, the OLES has separated the "Outside Jurisdiction" reports of sexual assaults to improve overall reporting and presentation of allegations of sexual assaults that occur within the DSH facilities. This means that of the 132 "Sexual Assault" category reported in this SAR period, 99 were alleged to have occurred within a DSH facility. In future reports, all alleged sexual assaults for outside jurisdiction will be calculated separately from the "Sexual Assault" category.

[7] Welfare and Institutions Code Section 15610.63, Physical Abuse (See Appendix F).

DSH Reportable Incidents by Reporting Period

Department of State Hospitals Comparison of Reportable Incidents by Reporting Period*

Incident Categories	Prior Period January 1, 2017 (Reported)	Prior Period January 1, 2017 (Meets Criteria)	Prior Period July 1, 2017 – Dec 31, 2017 (Reported)	Prior Period July 1, 2017 – Dec 31, 2017 (Meets Criteria)	Current Period January 1, 2018 - June 30, 2018 (Reported)	Current Period January 1, 2018 - June 30, 2018 (Meets Criteria)
Sexual Assault	147	24	115	20	132	25
Abuse	121	79	108	77	85	63
Broken Bone	45	4	66	6	58	7
Head/Neck Injury	49	1	52	1	36	2
Death	24	11	28	8	34	11
Sexual Assault O/J**	-	-	-	-	33	0
Misconduct	33	15	48	18	29	25
Neglect	34	14	20	7	16	5
AWOL	14	1	18	1	10	0
Significant Other***	29	4	31	2	10	0
Child Pornography	19	0	7	0	6	0
Attempted Suicide	8	1	3	0	5	0
Attack on Staff	3	0	4	0	3	0
Genital Injury	2	0	1	0	1	1
Burn	2	0	2	0	1	0
Non-Resident Assault	0	0	0	0	1	1
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Totals	530	154	503	140	426	140

* Numbers in these columns are unadjusted and are provided as they were previously published.

* Numbers in these columns are unadjusted and are provided as they were previously published. They include the three psychiatric programs where mental health care was provided by DSH until July 1, 2017.
**For current and future reporting periods, the OLES has added a category called "Outside Jurisdiction" (OJ). These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DSH.
***Any incident of significant interest, e.g., serious crimes committed by a patient; unusual facility events that have the potential to involve patients such as several kitchen personnel fainting without perceptible cause; major patient-on-patient fights resulting in no broken bones and no head/neck injuries but which require first aid treatment; inappropriate visitor-patient behavior that results in the discovery of contraband.

Change From Prior Period July 1 – Dec 31, 2017

Incident Categories	Reportable Incidents	Incidents Meeting Criteria
Sexual Assault	14.8%	25.0%
Abuse	-21.2%	-18.2%
Broken Bone	-12.1%	16.6%
Head/Neck Injury	-30.7%	100.0%
Death	21.4%	37.5%
Sexual Assault O/J**	-	-
Misconduct	-39.6%	38.9%
Neglect	-20.0%	-28.6%
AWOL	-44.4%	-100.0%
Significant Other***	-67.7%	-100.0%
Child Pornography	-14.3%	0.0%
Attempted Suicide	66.7%	0.0%
Attack on Staff	-25.0%	0.0%
Genital Injury	0.0%	100.0%
Burn	-50.0%	0.0%
Non-Resident Assault	100.0%	100.0%
Pregnancy	0.0%	0.0%
Riot	0.0%	0.0%
Totals	-15.3%	0.0%

* Numbers in these columns are unadjusted and are provided as they were previously published. They include the three psychiatric programs where mental health care was provided by DSH until July 1, 2017.
**For current and future reporting periods, the OLES has added a category called "Outside Jurisdiction" (OJ). These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DSH.
***Any incident of significant interest, e.g., serious crimes committed by a patient; unusual facility events that have the potential to involve patients such as several kitchen personnel fainting without perceptible cause; major patient-on-patient

fights resulting in no broken bones and no head/neck injuries but which require first aid treatment; inappropriate visitor-patient behavior that results in the discovery of contraband.

DSH Reportable Incidents by Facility This Reporting Period

Department of State Hospitals Summary of Reportable Incidents by Facility January 1 - June 30, 2018

Incident Categories	ASH	COALINGA	METRO	NAPA	PATTON	TOTALS
Sexual Assault	19	17	24	19	20	99
Sexual Assault O/J*	23	0	3	2	5	33
Abuse	9	11	31	8	25	83
Broken Bone	4	20	21	7	6	58
Head/Neck Injury	9	3	13	3	8	36
Misconduct	4	12	12	0	1	29
Significant Other**	0	3	3	1	3	9
Death	3	5	10	11	5	34
Neglect	5	3	4	1	3	15
AWOL	0	0	6	1	3	10
Child Pornography	0	6	0	0	0	6
Attack on Staff	3	0	0	0	0	3
Attempted Suicide	0	1	1	1	2	5
Burn	1	0	0	0	0	1
Genital Injury	0	0	0	1	0	1
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Non-Resident Assault	0	0	0	0	1	1
Totals	80	81	128	55	82	426

*For current and future reporting periods, the OLES has added a category called "Outside Jurisdiction" (OJ). These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DSH.
**Any incident of significant interest, e.g., serious crimes committed by a patient; unusual facility events that have the potential to involve patients such as several kitchen personnel fainting without perceptible cause; major patient-on-patient fights resulting in no broken bones and no head/neck injuries but which require first aid treatment; inappropriate visitor-patient behavior that results in the discovery of contraband.

Distribution of DSH incidents

With 426 incidents reported from January through June 30, 2018, DSH accounted for 67.6 percent of the reportable incidents to the OLES in this period. With 6109 patients

department-wide, this equates to .069 incidents per patient.

The Metropolitan State Hospital (MSH) had the highest number of reportable incidents in this period with 128 reports, an increase from the previous reporting period where MSH had 106 reportable incidents. With a population of 811, the 128 incidents translated to a rate of .16 incidents per patient at MSH during this period, which is an increase from the rate of .13 incidents per patient in the previous reporting period with the same population of 811.

Coalinga State Hospital (CSH) had a significant decrease of 33.1 percent in reportable incidents, from 121 in the last reporting period to 81 in the current reporting period, despite an increase of 27 in the patient population in this reporting period.

Napa State Hospital (NSH) also had a decrease in reportable incidents of 30.4 percent, from 79 in the previous reporting period to 55 in the current reporting period, despite an increase of 18 in the patient population in this reporting period. Patton State Hospital (PSH) had a decrease of reportable incidents of 28.1 percent from the previous reporting period from 114 to 82, with a patient population decrease of 14 patients.

Atascadero State Hospital (ASH) had a decrease of 3.6 percent in reportable incidents, from 83 in the previous reporting period to 80 reportable incidents in the current reporting period.

DSH Sexual Assault Allegations

Reports of alleged sexual assault were the largest single incident category received by the OLES for the reporting period at DSH. The 132 alleged sexual assault incidents reported from January 1 through June 30, 2018, accounted for 31 percent of all DSH incident reports. Of these, only 25 of 132 reported incidents of alleged sexual assault, or 19 percent, met the OLES criteria for investigation, monitoring and/or research into systemic department issues.

Atascadero State Hospital (ASH) had the highest number of sexual assault reports with 42. Twenty-three reports were in the new category of sexual assault outside jurisdiction, and 19 in the sexual assault category, for 31.8 percent of all alleged sexual assault incidents in this reporting period.

When excluding the new category of outside jurisdiction, MSH had the highest number of alleged sexual assault reports at 24, plus three alleged sexual assaults outside jurisdiction, for a total of 27.

The largest segment of alleged sexual assaults, 37.1 percent or 49 of 132 reported incidents involved allegations of patients assaulting other patients.

The second largest segment of alleged sexual assaults, 44 reported incidents or 33.3

percent, was defined by the OLES as "Outside Jurisdiction/Unknown" because allegations made by patients did not implicate DSH employees or contractors. This category included allegations that implicated family, friends or others in incidents that occurred when patients were not in a DSH facility.

Reports of non-law enforcement hospital employees allegedly sexually assaulting patients accounted for 28.7 percent of all the reports, while law enforcement personnel were alleged to be involved in one incident department-wide during the reporting period. All reports of alleged sexual assaults that the OLES received during the reporting period are shown in the chart below. It is important to note that the OLES takes every allegation seriously and closely reviews every case.

DSH - Sexual Assault Allegations Reported January 1 through June 30, 2018

Facility	Patient on Patient Incidents	Non-Law Enforcement Staff on Patient Incidents	Law Enforcement on Patient Incidents	OJ/Unknown Person on Patient Incidents*	Totals
Atascadero	8	9	0	25	42
Coalinga	10	7	0	0	17
Metropolitan	7	10	0	10	27
Napa	13	5	1	6	25
Patton	11	7	0	3	21
Totals	49	38	1	44	132

*Sexual Assault "Outside Jurisdiction" (OJ) is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH or outside the jurisdiction of the state hospital. Sexual Assault "Unknown" is a patient allegation of sexual assault at DSH when the patient is unsure if another person is involved.

DSH patient deaths

There were 34 patient deaths reported to the OLES at DSH facilities during the current reporting period. This number is up 21.4 percent from the 28 deaths reported in the prior reporting period, July 1 through December 31, 2017. Patient age at the time of death ranged from 47 years to 86 years old. Of the 34 deaths, 31 were male patients and three were female.

DSH - Patient Deaths Reported January 1 through June 30, 2018

Facility	Cardiac/ Respiratory	Cancer	*Renal/Liver*	Cerebral Issue	Sepsis	Other*	Totals
Atascadero	1	1	1	0	0	0	3
Coalinga	2	2	0	0	0	1	5
Metropolitan	3	3	0	1	2	1	10
Napa	8	1	0	0	2	0	11
Patton	1	2	1	1	0	0	5
Totals	15	9	2	2	4	2	34

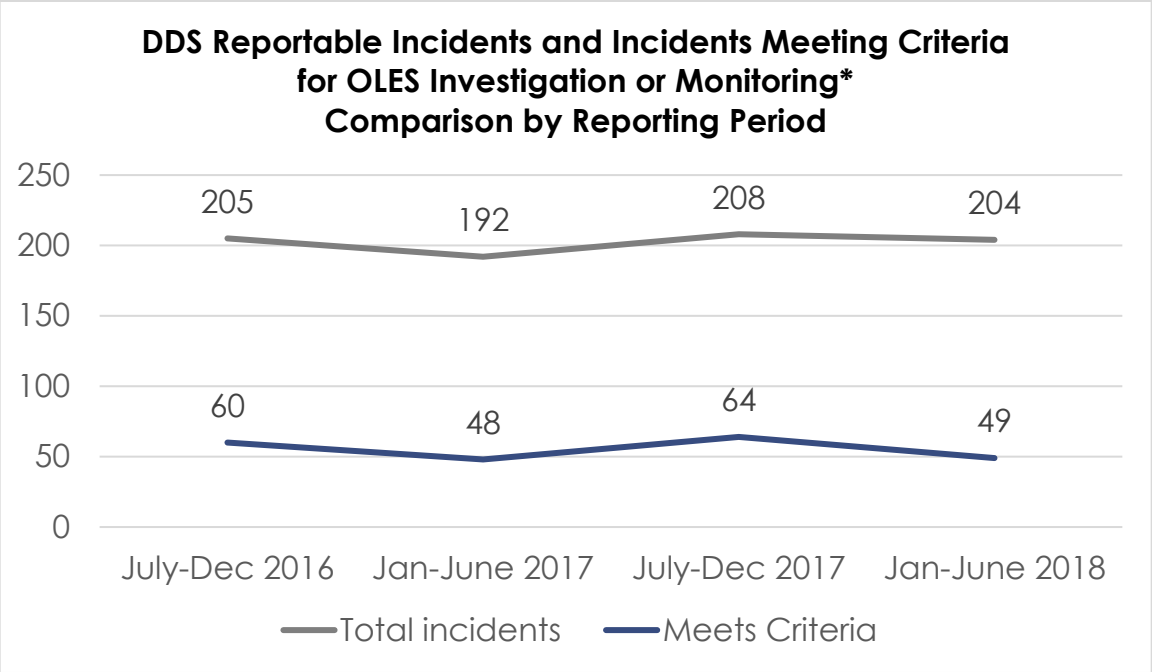
*Other deaths are those pending determination

Approximately 71 percent (24) of the DSH deaths were classified as "expected" due to underlying health conditions, such as cancer and kidney disease. Ten deaths were classified as "unexpected," and each of these deaths received two levels of review within DSH, per department policy. The OLES also reviewed the deaths and monitored the departmental investigations into the unexpected deaths at DSH.

DDS Incidents

Slight decrease in reported DDS incidents this period

Overall, the number of DDS incidents reported in the current reporting period decreased by 1.9 percent, from 208 in the previous reporting period of July 1 through December 31, 2017, to 204 in the current reporting period. During the January 1 through June 30, 2018 reporting period, the majority of incident reports came from the developmental centers.



Of the 204 reportable DDS incidents in the current reporting period of January 1 through June 30, 2018, 24 percent or 49 incidents, met the criteria for OLES investigation or monitoring or led to OLES research into a systemic departmental issue. As the graph shows, the number of reportable incidents dropped slightly, and the number of reportable incidents meeting criteria decreased significantly from 64 in the previous reporting period to 49 in the current reporting period. This is a decrease of 23.4 percent or 15 incidents meeting criteria in this reporting period.

Most frequent DDS Incidents Reported This period

Alleged abuse was the most frequent DDS incident reported in the current reporting period. The 115 abuse allegations from January 1 through June 30, 2018, accounted for 56.3 percent of all DDS incidents reported. The 115 reportable incidents of abuse are an increase of 10 incidents or 9.5 percent over the prior reporting period. While "abuse" was how certain incidents were described when reported to the OLES, the determination of whether each incident met the threshold for the OLES's purposes of investigation and/or monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section

15610.63.[8]

Reports of alleged sexual assault were second in number to abuse, with 25 reported. This is an increase of 64 percent from the previous reporting period where there were 16 reported. Of the 25 reportable incidents, one incident or .04 percent met criteria for investigation or monitoring. This is a change from the last reporting period where reports of head/neck injuries were second in number to abuse and reports of sexual assault ranked fourth in number of incidents reported by DDS.

Reports of head/neck injuries at DDS constituted the third most frequently reported incident by DDS. The OLES requires notification of all head/neck injuries that require treatment beyond first aid because such injuries can cause lasting health impairment or lead to death and may be indicative of assault, battery or neglect. There were 20 reports of head/neck injuries at DDS in the current reporting period, which was a decrease of 1 incident or 4.8 percent from the previous reporting period. None of the 20 reportable incidents for head/neck injury met the OLES criteria for further action.

Deaths at DDS were the fourth most frequently reported incident category. The department reported 14 deaths in the current reporting period, which is a decrease from the previous reporting period where there were 18 deaths at DDS. Overall, for this reporting period, deaths at DDS decreased 22.2 percent from the previous reporting period of July 1 through December 31, 2017.

The chart on the next page shows DDS Reportable Incidents by Reporting Period over three reporting periods starting January 1, 2017, through the current reporting period ending June 30, 2018.

[8] Welfare and Institutions Code Section 15610.63, Physical Abuse (See Appendix F).

DDS Reportable Incidents by Reporting Period

Department of Developmental Services Comparison of Reportable Incidents by Reporting Period

Incident Categories	Prior Period January 1, 2017 - June 30, 2017 (Reported)	Prior Period January 1, 2017 - June 30, 2017 (Meets Criteria)	Prior Period July 1, 2017 – December 31, 2017 (Reported)	Prior Period July 1, 2017 – December 31, 2017 (Meets Criteria)	Current Period January 1, 2018 - June 30, 2018 (Reported)	Current Period January 1, 2018 - June 30, 2018 (Meets Criteria)
Abuse	76	30	105	47	115	40
Sexual Assault	22	7	16	2	25	1
Head/Neck Injury	26	1	21	1	20	0
Death	17	3	18	4	14	2
Broken Bone	23	3	16	3	10	2
Neglect	6	2	15	6	6	1
AWOL	3	1	7	0	5	0
Significant Other*	5	1	6	1	4	1
Genital Injury	11	0	3	0	2	0
Misconduct**	2	0	0	0	2	2
Burn	0	0	1	0	1	0
Attack on Staff	0	0	0	0	0	0
Attempted Suicide	1	0	0	0	0	0
Child Pornography	0	0	0	0	0	0
Non-Resident Assault	0	0	0	0	0	0
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Sexual Assault O/J***	-	-	-	-	0	0
Totals	192	48	208	64	204	49

* Any incident of significant interest, e.g., serious crimes committed by a resident; unusual facility events that have the potential to involve residents; major resident-on-resident fights resulting in no broken bones and no head/neck injuries, but which require first aid treatment; inappropriate visitor-resident behavior that results in the

discovery of contraband.
** Starting in 2017, all reports made to licensing boards about employee misconduct were captured in the Additional Mandated Data section on page 39 of this report.
*** For current and future reporting periods, the OLES has added a category called "Outside Jurisdiction" (OJ). These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DDS.

Change From Prior Period July 1 – Dec 31, 2017

Incident Categories	Reportable Incidents	Incidents Meeting Criteria
Abuse	9.5%	-14.9%
Sexual Assault	56.3%	-50.0%
Head/Neck Injury	-4.8%	-100.0%
Death	-22.2%	-50.0%
Broken Bone	-37.5%	-33.3%
Neglect	-60.0%	-83.3%
AWOL	-28.6%	0.0%
Significant Other*	33.3%	0.0%
Genital Injury	33.3%	0.0%
Misconduct**	100.0%	100.0%
Burn	0.0%	0.0%
Attack on Staff	0	0
Attempted Suicide	0	0
Child Pornography	0	0
Non-Resident Assault	0	0
Pregnancy	0	0
Riot	0	0
Sexual Assault O/J***	0	0
Totals	-1.9%	-23.4%

* Any incident of significant interest, e.g., serious crimes committed by a resident; unusual facility events that have the potential to involve residents; major resident-on-resident fights resulting in no broken bones and no head/neck injuries, but which require first aid treatment; inappropriate visitor-resident behavior that results in the discovery of contraband.
** Starting in 2017, all reports made to licensing boards about employee misconduct were captured in the Additional Mandated Data section on page 39 of this report.
*** For current and future reporting periods, the OLES has added a category called "Outside Jurisdiction" (OJ). These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DDS.

DDS Reportable Incidents by Facility This Reporting Period

Department of Developmental Services Summary of Reportable Incidents by Facility January 1 through June 30, 2018

Incident Categories	Canyon Springs	Fairview	Porterville	Sonoma	Totals
Sexual Assault	14	4	7	0	25
Sexual Assault O/J*	0	0	0	0	0
Abuse	41	34	37	3	115
Broken Bone	0	1	6	3	10
Head/Neck Injury	0	5	10	5	20
Misconduct	0	1	1	0	2
Significant Other**	1	1	2	0	4
Death	0	8	1	5	14
Neglect	0	4	0	2	6
AWOL	0	1	3	1	5
Child Pornography	0	0	0	0	0
Attack on Staff	0	0	0	0	0
Attempted Suicide	0	0	0	0	0
Burn	1	0	0	0	1
Genital Injury	0	0	0	2	2
Pregnancy	0	0	0	0	0
Riot	0	0	0	0	0
Non-Resident Assault	0	0	0	0	0
Totals	57	59	67	21	204

* For current and future reporting periods, the OLES has added a category called "Outside Jurisdiction" (OJ). These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DDS.
** Any incident of significant interest, e.g., serious crimes committed by a resident; unusual facility events that have the potential to involve residents; major resident-on-resident fights resulting in no broken bones and no head/neck injuries, but which require first aid treatment; inappropriate visitor-resident behavior that results in the discovery of contraband.

Most frequent DDS incidents reported this period

Five categories of reportable incidents accounted for 175 or 85.8 percent of all 204 reported incidents from DDS. These categories are abuse, sexual assault, head/neck injuries, broken bone, and AWOL. These same five categories accounted for 43 incidents or 87.8 percent of all DDS reportable incidents that met the criteria for the OLES to investigate and/or monitor or research for potential systemic departmental issues.

Distribution of DDS Incidents

The 204 DDS incidents reported January 1 through June 30, 2018, accounted for 32.4

percent of all 630 reports to the OLES in this reporting period. With 505 residents department-wide, this equates to .40 incidents per resident.

Porterville Developmental Center (PDC), which has 269 residents, had 67 reportable incidents from January 1 through June 30, 2018. This is an increase of two incidents or 3.1 percent from the 65 incidents reported in the previous reporting period. This equates to .25 incidents per resident at the PDC facility. This is a decrease from the previous reporting period where there were 65 reportable incidents, 280 residents, and .6 incidents per resident.

Other significant changes during this reporting period were at the Canyon Springs Developmental Center (CSDC) where reportable incidents increased from 39 to 57 in this reporting period, an increase of 46.2 percent. Sonoma Developmental Center (SDC) had a decrease in reportable incidents from 40 to 21 in this reporting period, a decrease of 47.5 percent in this reporting period.

DDS Sexual Assault Allegations

The OLES received 25 incident reports alleging sexual assault at DDS in the current reporting period, up from 16 in the previous reporting period, for an increase of 56.3 percent. Of these 25 reportable incidents, 14 were from (CSDC), seven from (PDC), and four from Fairview Developmental Center (FDC). Reportable incidents of alleged sexual assault accounted for 12.3 percent of all reportable incidents from DDS. Sixteen of the reported sexual assault incidents, or 64 percent were alleged to be by non-law enforcement staff. Nine allegations of sexual assault reported to the OLES, or 36 percent, were reports of resident on resident assault.

DDS - Sexual Assault Incidents Reported January 1 through June 30, 2018

Facility	*Resident on Resident Incidents*	*Non-Law Enforcement Staff on Resident Incidents*	*Law Enforcement on Resident Incidents*	*OJ/Unknown * on Resident Incidents*	*Total*
Canyon Springs	0	14	0	0	14
Fairview	2	2	0	0	4
Porterville	7	0	0	0	7
Sonoma	0	0	0	0	0
Totals	9	16	0	0	25

*Sexual assault "Outside Jurisdiction" (OJ) is a resident report of an alleged sexual assault that occurred before the resident was in the care of the DDS or outside the jurisdiction of the state facility. Sexual assault "Unknown" is a resident allegation of sexual assault at DDS when the resident is unsure if another person is involved.

DDS resident deaths

The DDS reported 14 deaths during this reporting period. Eight deaths were

reported by FDC, five by SDC, and one by PDC. Of the 14 deaths reported, 11 were due to cardiac or respiratory issues, two from sepsis, and one is pending determination. The ages of the deceased residents ranged from 22 to 101 years old and included nine males and five females. Of the 14 deaths, 11 or 78.6 percent were classified as "expected" and four were "unexpected."

DDS - Resident Deaths Reported January 1 through June 30, 2018

Facility	*Cardiac/ Respiratory*	*Cancer*	*Renal/Liver*	Cerebral Issue	Sepsis	Other	Totals
Canyon Springs	0	0	0	0	0	0	0
Fairview	6	0	0	0	2	0	8
Porterville	1	0	0	0	0	0	1
Sonoma	4	0	0	0	0	1	5
Totals	11	0	0	0	2	1	14

*Other deaths are those pending determination.

Notification of Incidents

Different types of incidents require different kinds of notification to the OLES. Based on legislative mandates 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 are 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 and the receipt of a detailed report no later than the close of the first business day following the discovery of the reportable incident. "Priority 2" threshold incidents require notification within one day and the receipt of a detailed report within two days. Priority 1 and 2 threshold incidents are shown in the tables below.

Priority 1 Threshold Incidents

PRIORITY 1 NOTIFICATIONS- 2-HOUR NOTIFICATION
• Any death of a resident or patient • Any allegation of sexual assault of a resident or patient • An assault with a deadly weapon or an assault with force likely to produce great bodily injury to a resident or patient • Any report of physical abuse of a resident or patient implicating a staff member • Any injury to the genitals of a resident or patient when the cause of injury is undetermined • A broken bone of a resident or patient • Any use of deadly force by staff

Priority 2 Threshold Incidents

PRIORITY 2 NOTIFICATIONS- 1-DAY NOTIFICATION
• A pregnancy involving a resident or patient • Any injury to the head or neck of a resident or patient requiring treatment beyond first aid • Any burns of a resident or patient, regardless of whether the cause is known • Any incident of significant interest to the public including, but not limited to, "AWOL," suicide attempt requiring treatment beyond first aid, commission of serious crimes by a resident or patient, patient or resident arrest, riot and any incident which may potentially draw media attention • Any allegations of peace officer misconduct, whether on-duty or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties • Any staff action or inaction that resulted in, or reasonably could have resulted in, a resident or patient death

Timeliness of notifications this period

In the current reporting period of January 1 through June 30, 2018, DSH and DDS timely reporting of incidents to the OLES statewide was 92.9 percent. This is a slight decrease in timely reporting of incidents statewide from the previous reporting period where the timely reporting was 96.2 percent. Of 630 reportable incidents statewide, 585 were reported timely, 45 reportable incidents or 7.1 percent were not.

The DSH had 426 reportable incidents department-wide. Of these, 386 or 90.6 percent were reported timely, compared to 94.0 percent in the previous reporting period. 40 incidents, or 9.3 percent were not reported timely. Coalinga State Hospital had the highest percentage of timely notifications at 93 percent during this reporting period. Napa State Hospital had the lowest percentage of timely notifications with 87 percent of all reportable incidents.

The DDS had 204 reportable incidents department-wide. Of these, 199 or 97.5 percent were reported timely compared to 96.2 percent in the previous reporting period. Five incidents or 2.5 percent were not reported timely. Fairview Developmental Center reported 100% of their 59 reportable incidents timely. All other DDS facilities had high percentages of notification compliance ranging from 95 to 98 percent.

DSH - Timely Notifications January 1 through June 30, 2018

Rank	DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Coalinga	1321	81	75	93%
2	Metropolitan	811	128	116	91%
3	Patton	1526	82	75	91%
4	Atascadero	1,173	80	72	90%
5	Napa	1,278	55	48	87%
	Totals	6109	426	386	91%

* The department provided population numbers as of June 30, 2018.

DDS - Timely Notifications January 1 through June 30, 2018

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Fairview	108	59	59	100%
2	Canyon Springs	49	57	56	98%
3	Porterville	269	67	65	97%
4	Sonoma	79	21	20	95%

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
	Totals	505	204	199	98%

* The department provided population numbers as of June 30, 2018.

Intake

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

In previous Semi-Annual Reports (SAR), the OLES referred to incident reports where no case was opened as "Rejected." This terminology did not accurately reflect the review or determination made by the OLES. For current and future SARs, the OLES will call these incident reports "Reviewed, Case Closed" or RCC.

For the January 1 through June 2018 reporting period, 405 of the total 630 DSH and DDS incidents the OLES received were reviewed, but no case was opened. These RCC incidents did not meet the criteria for the OLES to undertake an investigation and/or monitoring. This amounted to 64.3 percent of all the incidents that were reviewed by the OLES.

The DSH accounted for 250 of the 405 incidents that were RCC, or 61.7 percent of the total RCC incidents in the current reporting period. Sexual assault allegations were the single largest DSH category where reported incidents did not meet the OLES criteria; therefore, the majority of these cases, 107 out of 132, were RCC.

The DDS component of the total 405 incidents that were RCC during the six-month period totaled 155. This amounted to 38.3 percent of all incidents that were RCC. Abuse allegations accounted for 75 of the 155 DDS incidents that were RCC.

Every incident that is deemed RCC by the OLES receives a pending review – an extra step to ensure that incidents that initially appear to not fit the criteria[9] for OLES involvement are being properly categorized. When allegations are unclear and additional information is needed to finalize an initial Intake decision, it can cause a significant delay. 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 resident was located. This requires more time for the OLES to get the recordings from the facility for review. Once the additional material/information is obtained and evaluated by the OLES, the decision to initially

[9] Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix F).

deem an incident as not meeting the OLES criteria is reviewed again and may be reversed.

The charts below show the outcome of all incidents received by the OLES in the January 1 through June 30, 2018, reporting period.

DSH Disposition of Cases

OLES Disposition Categories	July 1- Dec. 31, 2017 Number	Percentage of Reported Incidents	January 1 – June 30, 2018 Number	Percentage of Reported Incidents
Reviewed, Case Closed (RCC)	334	66.4%	250	58%
Monitored, Criminal	102	20.3%	101	24%
Outside Jurisdiction*	29	5.8%	36	8%
OLES Investigations, Administrative	7	1.4%	17	4%
OLES Investigations, Criminal	13	2.6%	12	3%
Monitored, Administrative	18	3.6%	10	2%
Totals	503	100%	426	100%

*The OLES did not use Outside Jurisdiction as a category in 2017. Outside Jurisdiction includes incidents that may have occurred while the resident or patient was not housed within DSH or DDS.

DDS Disposition of Cases

OLES Disposition Categories	July 1- Dec. 31, 2017 Number	Percentage of Reported Incidents	January 1 – June 30, 2018 Number	Percentage of Reported Incidents
Reviewed, Case Closed (RCC)	144	69.2%	155	76%
Monitored, Criminal	57	27.4%	42	21%
Monitored, Administrative	7	3.4%	4	2%
OLES Investigations, Administrative	0	0%	2	.05%
OLES Investigations, Criminal	0	0%	1	.05%
Outside Jurisdiction*	0	0%	0	0%

OLES Disposition Categories	July 1- Dec. 31, 2017 Number	Percentage of Reported Incidents	January 1 – June 30, 2018 Number	Percentage of Reported Incidents
Totals	208	100%	204	100%

*The OLES did not use Outside Jurisdiction as a category in 2017. Outside Jurisdiction includes incidents that may have occurred while the resident or patient was not housed within DSH or DDS.

Investigations and Monitoring

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 through Skelly hearings, State Personnel Board proceedings and lawsuits.

OLES investigations

During the January 1 through June 30, 2018 reporting period, the OLES completed 29 investigations. Ten investigations were criminal cases and 19 were administrative and all were at DSH.

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. During the first half of 2018, the OLES did not refer any criminal investigations to a prosecuting agency. All completed OLES investigations into administrative wrongdoing/misconduct are forwarded to facility management for review. In the January through June 2018 reporting period, 10 administrative cases were referred to management for possible discipline of state employees, and nine administrative cases were closed for lack of evidence. 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 warranted.

The chart on the next page shows the results of all the completed OLES investigations in the reporting period. These investigations are in Appendix A.

DSH Only - Results of Completed OLES Investigations

Type of Investigation	Total completed January 1 – June 30, 2018	Referred to prosecuting agency	Referred to facility management	Closed without referral*
Administrative	19	0	10	9
Criminal	10	0	0	10
Totals	29	0	10	19

* The OLES provided the department with findings of all criminal and administrative investigations where it was determined there was insufficient evidence that allegations were true.

OLES-monitored departmental investigations

In this report, the OLES provides information on the 180 monitored cases at the two departments that, by June 30, 2018, had reached resolution. Of these cases, 84 or 46.7 percent of the total, involved allegations of administrative misconduct by departmental staff, such as failing to maintain one-on-one supervision, as required, for a patient. The results are summarized in the chart below, and synopses of the cases are in Appendices B, C, and D.

Results of Completed Monitored Cases at DSH and DDS

Type of Case/Result	DSH	DDS	Totals
Criminal/Not Referred	77	15	92
Criminal/Referred to Prosecuting Agency	4	0	4
Total Criminal	81	15	96
Administrative/Without Sustained Allegations	42	5	47
Administrative/With Sustained Allegations	25	12	37
Total Administrative	67	17	84
Grand Totals	148	32	180

The OLES provides assessments of the completed monitored cases. At DSH, 39 of the departmental investigations, also known as pre-discipline phase cases, were deemed procedurally insufficient by the OLES during the first six months of 2018. Three were substantively insufficient. Procedural sufficiency assesses the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency assesses the quality, adequacy, and thoroughness of the investigative interviews and reports.

The most prevalent deficiency continues to be delays in completing investigations. According to DSH, the Chief of Law Enforcement and the facility police chiefs are continuing to work with investigative staff to reduce the case completion timeframes. During the previous reporting period, July 1 through December 2017, 38 percent of the DSH reports were not completed within required timeframes. During the current reporting period, January 1 through June 30, 2018, 24 percent or 34 of 140 monitored investigations and reports were not completed within the 120-day required report completion timeframe. The DSH continues its efforts to reduce the

report delinquency rates by recruiting facility investigators and working with the OLES to identify specific cases which may require additional investigative time due to the complexity of an incident or allegation.

At DDS, 11 of the departmental investigations, also known as pre-discipline phase cases, were assessed as procedurally insufficient by the OLES. There were no substantive insufficiencies.

Monitoring the discipline phase

When an administrative investigation, either 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 hiring authority decides whether to sustain any allegations against the employee. This decision is based upon the evidence presented. If there is a preponderance of evidence showing the allegations are factual, the hiring authority can sustain the allegations. If one or more allegations are sustained, the hiring authority must impose appropriate discipline.

Appendices C and D provide assessments of 20 discipline phase cases monitored by the OLES that reached resolution during the reporting period. Twelve of these 20 cases were at DSH and eight were at DDS. 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.

At DSH, 11 of the discipline phase cases were deemed procedurally insufficient by the OLES, and one was deemed substantively insufficient. At DDS, six discipline cases were assessed as procedurally insufficient. All were substantively sufficient.

Update on the discipline phase

As reported in the prior reporting period, DSH presented the OLES with a draft disciplinary policy and matrix, which incorporated the OLES' recommendations. DSH implemented the discipline tool in April 2018.

The OLES recommended that DDS adopt the DSH disciplinary policy and matrix or develop a similar policy. DDS implemented a disciplinary policy, which is substantially similar to the DSH policy, in January 2018.

Both policies establish department-wide disciplinary processes, which provide guidance to hiring authorities and allows for the application of fair and consistent

disciplinary and penalty determinations. Additionally, both departments' policies incorporated the OLES recommendations to establish benchmarks and timelines to guide the timeliness of investigative and disciplinary processes.
The OLES will continue to monitor and report on the efficacy of the timelines as well as of the other disciplinary tools.

Perspective on departments imposing discipline

The OLES recommended in October 2017, that departments develop timeliness standards for the service of disciplinary actions. The OLES recommended a standard of 60 days from the date the hiring authority makes a determination to impose discipline to the date the hiring authority serves the employee with the disciplinary action.

In this reporting period, both departments have implemented policies which incorporate the OLES' 60-day recommendation for the time in which to serve a disciplinary action after the decision is made to impose discipline.

In the previous reporting period, the average length of time to serve an action at DSH ranged from 13 to 322 calendar days with an average length of time to serve disciplinary actions of 168 calendar days. The average length of time to serve an action at DDS ranged from 75 to 400 calendar days with an average length of time to serve disciplinary actions of 178 calendar days.

In this reporting period, the OLES reviewed 36 disciplinary actions. The departments served 17 disciplinary actions: 14 at DSH and three at DDS. Nineteen cases are pending service of disciplinary actions: 17 at DSH and two at DDS.

DSH served 14 disciplinary actions on employees between 17 and 520 days after the hiring authority made disciplinary determinations. The average length of time to serve an action decreased from the reporting period's average of 168 days to 119 days. DSH failed to meet its own policy requiring service of the disciplinary action within 60 days from the hiring authority's decision in 10 of the 14 disciplinary actions served this reporting period.

The remaining 17 cases at DSH have been pending service of disciplinary actions for up to 298 days. The most significant delays of 298 days are two Metropolitan State Hospital (MSH) cases. The first case involved a psychiatric technician assistant who allegedly fell asleep while assigned to provide constant observation of a patient, who then injured herself. A senior psychiatric technician allegedly failed to document the incident and was dishonest during an investigative interview. The hiring authority sustained the allegations on September 5, 2017, and on December 27, 2017, the hiring authority determined dismissal was the proper penalty for both employees. The disciplinary actions are still pending service.

The second case from MSH that has been pending service of the disciplinary action for 298 days involved a psychiatric technician who failed to properly monitor,

supervise, and account for all patients, allowing a patient an opportunity to leave hospital grounds. The patient broke his foot while climbing a hospital fence. The hiring authority sustained the allegations on September 5, 2017, and on December 27, 2017, the hiring authority determined a salary reduction was the proper penalty. The disciplinary action is still pending service.

DDS served three disciplinary actions on employees between 187 and 752 days after the hiring authority made disciplinary determinations. The average length of time to serve an action increased from last reporting period's average of 178 days to 409 days. DDS failed to meet its own policy requiring service of the disciplinary action within 60 days from the hiring authority's decision in all disciplinary actions served this reporting period.

The remaining two cases at DDS have been pending service of disciplinary actions for up to 278 days. One of the cases is from Sonoma Developmental Center and involved a senior psychiatric technician who allegedly failed to monitor and account for a missing resident. The resident was left unattended for approximately 40 minutes. The hiring authority made disciplinary and penalty determinations on February 22, 2018. The disciplinary action is still pending service.

The three pending cases at DSH and DDS, mentioned above, are serious cases, and delays of service of the disciplinary actions are unacceptable. One of the principles of effective discipline is that discipline should be imposed in a relatively timely manner; otherwise, its effectiveness is diminished. Additionally, employees often appeal disciplinary actions and evidence, and witness memories become stale or unavailable with the passage of time.

The OLES will continue to monitor and report on the departments' efforts to process disciplinary actions in a timely manner and in compliance with their new policies.

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 current reporting period came directly from DSH and DDS and are presented in the following tables.

DSH Mandated Data – Adverse Actions Against Employees

DSH Facilities	Formal administrative investigations/actions completed*	Adverse action taken (Formal investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/ retired pending adverse action****
Atascadero	22	15	6	1	1
Coalinga	51	13	20	18	0
Metropolitan	69	4	63	2	0
Napa	41	9	30	2	1
Patton	49	0	44	5	2
Totals	232	41	163	28	4

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

** Adverse action taken refers to a Notice of Adverse Action being served to an employee after a formal or informal investigation was completed. Direct adverse action taken refers to a Notice of Adverse Action being served to an employee without the completion of a formal investigation. These numbers include rejecting employees during their probation periods.

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

**** Resigned or retired pending adverse action refers to employees who resigned or retired prior to being served with an adverse action. Note that DSH does not report these instances as completed formal investigations.

DDS Mandated Data – Adverse Actions Against Employees

DDS Facilities	Administrative investigations completed*	Adverse action taken**	No adverse action taken***	Resigned/retired pending adverse action****
Canyon Springs	2	0	2	0
Fairview	6	4	2	0
Porterville	5	4	0	1
Sonoma	7	2	5	0
Totals	20	10	9	1

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

** Adverse action taken refers to a Notice of Adverse Action being served to an employee after a formal or informal investigation (Direct Action) was completed. Direct adverse action taken refers to a Notice of Adverse Action being served to an employee without the completion of a formal investigation. These numbers include rejecting employees during their probation periods.

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

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

DSH Mandated Data – Criminal Cases Against Employees*

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	0	0	0	0
Coalinga	4	4	0	0
Metropolitan	47	4	43	2
Napa	0	0	0	0
Patton	10	8	2	7
Totals	61	16	45	9

* 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 prosecuting agencies are criminal cases where the investigations were completed and were then referred to an outside prosecuting entity.

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

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

DDS Mandated Data – Criminal Cases Against Employees*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Canyon Springs	50	0	50	0
Fairview	5	0	5	0
Porterville	5	0	5	0
Sonoma	0	0	0	0
Totals	60	0	60	0

* 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 prosecuting agencies are criminal cases where the investigations were completed and were then referred to an outside prosecuting entity.

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

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

DSH Mandated Data – Patient Criminal Cases*

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	166	98	68	86
Coalinga	328	120	208	27
Metropolitan	622	45	577	8
Napa	576	27	549	9
Patton	260	155	105	133
Totals	1952	445	1507	263

* Patient criminal cases include criminal investigations involving patients. Numbers are for investigations that were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

** Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to outside prosecuting entities.

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

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

DDS Mandated Data – Resident Criminal Cases*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not Referred***	Rejected by prosecuting agencies****
Canyon Springs	0	0	0	0
Fairview	0	0	0	0
Porterville	10	6	4	1
Sonoma	0	0	0	0
Totals	10	6	4	1

* Resident criminal cases include criminal investigations involving residents. Numbers are for investigations that were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

** Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to outside prosecuting entities.

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

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

DSH Mandated Data – Reports of Employee Misconduct to Licensing Boards*

DSH Facilities	Registered Nursing	Vocational Nursing	Medical Board	Public Health
Atascadero	5	11	0	0
Coalinga	1	1	0	0
Metropolitan	0	0	0	0
Napa	0	0	0	0
Patton	0	0	0	0
Totals	6	12	0	0

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

DDS Mandated Data – Reports of Employee Misconduct to Licensing Boards*

DDS Facilities	Registered Nursing	Vocational Nursing	Medical Board	Pharmacy	Public Health
Canyon Springs	0	0	0	0	11
Fairview	0	0	0	0	19
Porterville	0	0	0	0	33
Sonoma	0	0	0	0	0
Totals	0	0	0	0	63

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

Monitored Issues

In the course of its oversight duties, the OLES may observe issues that reveal potential patterns, shortcomings, or systemic issues at the facilities. In these situations, the Chief of the OLES instructs OLES staff to research and document the issues. These issues are then brought to the attention of the departments. In most instances, the OLES requests corrective plans.

From January 1 through June 30, 2018, the departments resolved four monitored issues. Three were at DSH and one was at DDS. The departments were assessed by the OLES as "sufficient" in how they addressed the issues. Both completed monitored issues are in Appendix E. New monitored issues and updates on long-running monitored issues are provided below.

New Monitored Issues

Child Pornography at Coalinga State Hospital

As mentioned in the July 1 through December 31, 2017 SAR, the OLES focused on what appeared to be a spike in reports of patients in possession of child pornography at Coalinga State Hospital (CSH). From January 1 through June 30, 2017, there were 19 reports of patients found in possession of child pornography within the hospital. In the early months of SAR period July 1 through December 31, 2017, another four incidents of child pornography were reported by CSH as part of the mandated reporting set up by the OLES.

CSH opened in 2005 and houses sexually violent predators, which currently make up 71 percent of the 1321 patients. CSH is a self-contained psychiatric hospital constructed with a secure perimeter. The California Department of Corrections and Rehabilitation provides perimeter security as well as transportation of patients to outside medical services and court proceedings.

CSH has experienced an ongoing problem with patients gaining access to and storing child pornography for the last 10 years. Contraband can enter the facility through the patient visiting program, the mail room, and staff circumventing hospital precautions and smuggling contraband into the facility. A catalyst that likely started the storage and distribution of electronic contraband started when CSH authorized Administrative Directive (AD) 654 in November 2006. This directive allowed patients to possess laptop computers and other gaming systems that were capable of accessing and storing electronic media outside the filters and reach of the hospital's digital network. As an unintended consequence, per a memorandum dated February 29, 2007, authored by the "Patient Computer Technology Committee," the program authorized in AD 654 was discontinued after seven months due to the "high rate of policy violations" including "widespread distribution of pornographic material." The memorandum placed a moratorium on patients purchasing new computers but allowed patients to keep electronic devices

approved under AD 654.

The OLES analyzed criminal reports and complaints where CSH patients and staff were arrested for possession of child pornography, some of which made statewide news. Examples include a patient and staff member being arrested in November 2016, for possession of child pornography. Eight patients and one staff member were arrested for possession of child pornography in February 2017.

OLES Investigators visited CSH in August and September 2017 to interview staff and study the problem of patient possession of child pornography CSH. During these visits, the OLES learned CSH Law Enforcement staff have submitted 44 cases to the Fresno County District Attorney's Office, and 18 patients pleaded guilty to 22 charges related to the possession of child pornography. OLES identified several policy and procedural issues and began to work with the DSH to eradicate, investigate and prevent possession of electronic contraband of all types at the hospital.

Eradication

In January 2018, DSH implemented California Code of Regulations, Title 9, Section 4350. The amendments provided clarity on what electronic devices were permitted within the state hospitals and accounted for technological advances that had occurred which allowed patients to have more storage capacity and ways to access the Internet. DSH designed a three-phase process to remove the contraband devices from the facility.

- In the first phase, CSH worked with the Fresno County District Attorney's Office to create an amnesty program that would allow patients to turn over electronic devices.
- The second phase of the program included a voluntary turn-in. This allowed patients to turn in their items that violated Section 4350 with the understanding that the electronic devices would be searched with the patient's consent and mailed out of the facility.
- In the third phase, the Department of Police Services and facility staff conducted a thorough search of the hospital. In this phase, there was a comprehensive search of the facility and any items found that were not compliant with Section 4350 were confiscated.

Prevention

With the elimination of personal laptops, CSH now provides patients with access to over 72 state-owned computers, so patients can continue to conduct their treatment work as well as perform any legal work necessary for their cases. OLES worked closely with DSH to ensure the state-owned computers cannot become storage and distribution points for illegal material. The CSH instituted the following prevention measures:

- Computers reboot every day between 2300 and 2400 hours.
- On reboot, computers are imaged to a default state, and all changes are discarded.

- The main hard drive is blocked from patient logins; patients cannot see this drive and cannot tamper with the hard drive.
- In the Patient Computer Lab, the patients are only allowed to have the state USB drive mounted to the computer on a single E:\ drive. There is a service that runs in the background preventing additional drives mounting to any other letter drives.
- USB ports are blocked except for two in the back of the workstation which are assigned for the keyboard and mouse, and a single USB in front to plug in the patient's state-issued USB Drive.
- Patients cannot write to the local drive; the patients can only save to the state-issued USB devices, and those devices are turned in when a patient leaves the Patient Lab.

In addition to the above, all state computers accessible by patients are overwritten with new images quarterly and new administrator passwords installed.

In addition to these steps, DSH continues the following:

- DSH works with the California Department of Corrections and Rehabilitation to assist with interdiction of contraband into the facility with enhanced sally port searches for electronic storage media and mobile phones.
- DSH conducts multiple K-9 searches inside the facility, including random searches at a frequency of more than one a day, with at least one K-9 specially trained in the detection of mobile phones.
- DSH has informed the OLES they will be implementing a standardized search schedule to locate any rogue hotspots within the facility that would provide an avenue for patients to access the internet.
- DSH now conducts unannounced unit wide searches.
- DSH now conducts nightly off unit common area searches.

Investigation

DSH has increased their Office of Special Investigations investigation unit capacity to one investigator, one sergeant, and two hospital police officers, assigned to the child pornography investigation unit. This is a significant improvement from the first OLES Investigator visit in August 2017, when they had one sergeant assigned to child pornography investigations in addition to one sergeant handling regular supervisory responsibilities.

As of June 15, 2018, DSH reported two additional patients have also been arrested for possession of child pornography. As of June 15, 2018, there were eight child pornography cases at the Fresno County District Attorney's Office pending criminal filing. Eight search warrants have also been served in child pornography investigations during this reporting period.

The OLES is pleased to report that since August 2017, the DSH has made significant improvements in a short period of time to eradicate, investigate, and prevent the

possession of illegal, electronic contraband at Coalinga State Hospital. The OLES commits to continually monitor and work collaboratively with DSH to ensure all measures and precautions are implemented to improve the safety and security of the patients and the communities we serve.

Updated Monitored Issues

As part of its oversight duties, the OLES continued to monitor issues it had identified at the facilities in previous reporting periods. From January 1 through June 30, 2018, the departments resolved four monitored issues; three were at DSH and one was at DDS. The OLES assessed the departments as "sufficient" in how they addressed these matters. These four completed monitored issues are in Appendix E. One new monitored issue and updates on remaining monitored issues are provided below.

Update on Previous Monitored Issues

Duty to cooperate at DSH

In the course of monitoring investigations in the previous reporting period, the OLES identified an issue of DSH employees refusing to cooperate with investigators. The OLES discovered that there is no statewide, written policy concerning the service of notices for interviews. Some investigators simply call or email the employee; others serve a formal notice. The OLES recommended DSH develop a statewide, written policy mandating the use of formal interview notices with standardized language. As of June 30, 2018, the department had not yet drafted a proposed policy or proposed interview notices.

The OLES identified a concern during the prior reporting period that the Office of Protective Services (OPS) had a poor relationship with the medical staff at Patton State Hospital (PSH). The issue centered around the cooperation of medical staff during investigations. The OLES recommended the executive director provide training to the medical staff focused on understanding the investigative process and their need to participate in investigations. The OLES also recommended the PSH executive director work toward improving the relationship between OPS and medical staff.

PSH's executive director, the DSH chief of law enforcement, and the facility police chief have met with the medical staff and provided investigative training to them. A component of that training was an explanation of the investigative process as well as discussing concerns and answering questions from individual medical staff members. The facility police chief is available to the medical staff to discuss their concerns on an ongoing basis. There are also future plans for the DSH chief of law enforcement to have additional discussions related to investigations with PSH medical staff and other employee classifications.

Lack of Patient Separation Policy at DSH
In the course of an investigation during the July 1 through December 2017 reporting

period, the OLES discovered a lack of specific, written policy at Metropolitan State Hospital governing the relocation and separation of patients after they have been in a physical altercation. In the specific case, one patient committed a battery on another patient. Both resided in the same unit as roommates at the facility and continued to do so after the incident, which resulted in a second battery the next day. During the second battery, the aggressor patient choked the victim patient to the point of unconsciousness.

The DSH does not have a written statewide policy to prevent these repeat incidents. The existing practice of giving the clinical treatment team the discretion to decide whether to move or separate patients involved in altercations puts patients at risk of harm and victimization. The OLES previously recommended DSH develop statewide written policy and procedures regarding separation of patients who are involved in altercations. In response to the OLES recommendation, DSH formed a work group comprised of executive directors and the Chief of the Office of Protective Services. As of June 30, 2018, the department had not yet drafted a proposed policy.

Deficiencies in Use of Force reporting at DSH
In the course of monitoring use-of-force incidents, during previous reporting periods, the OLES identified several issues related to policy and reporting of use-of-force incidents and made comprehensive recommendations to DSH in the last reporting period. These observations included officers failing to interview or identify all relevant witnesses, failing to obtain reports from all participants in the incident, and failing to describe the circumstances leading to the officers' use-of-force. Most reports provided insufficient detail as to the officers' actions before, during, and after the incidents. There were also incidents involving allegations of excessive force that were not sufficiently investigated and not included in the required executive committee reviews. The frequency and pervasiveness of these reporting deficiencies indicate there is inadequate supervisory review.

The OLES received a comprehensive response from DSH on the use-of-force recommendations. The department agrees with the following OLES recommendations:

- Executive Committee Review (ECR) for all use-of-force incidents
- Limit ECR attendance to reviewers only
- Require supervisor supplemental report
- Set review timeline
- All patients subjected to use-of-force should receive a medical assessment

The DSH has advised the OLES of a new use-of-force review process, to include new comprehensive forms designed to capture significant supervisor and managerial review to improve the entire documentation process. The on-scene supervisor's actions and observations will be incorporated into each use-of-force incident with the new review process and forms.

The DSH has committed to engage their supervisory staff at a more thorough and

higher level with this improvement in use-of-force review and reporting. The OLES will continue to work with the DSH to monitor the implementation of the new use-of-force review process and evaluate all remaining OLES use-of-force recommendations.

Personal electronic devices at work
In the semi-annual report covering January 1 through June 2017, the OLES recommended that DSH draft and implement a statewide policy prohibiting DSH staff from having and using personal electronic devices at their workstations and while screening staff and visitors. In response to the OLES recommendation, DSH developed a draft policy on the use personal electronic devices at the facilities. The draft policy was provided to the OLES to evaluate and provide input. The OLES recommended that the department adds to its policy a prohibition against cell phone possession while working at certain posts, such as while monitoring a patient on a one-to-one basis. The OLES also recommended a provision in the policy requiring staff to turn off WiFi and hot spot capabilities on their phones while on facility grounds. As of June 30, 2018, the department had made the recommended changes, but the policy was still in draft stage. The OLES will continue to monitor this issue until the policy is fully implemented.

DSH Patient Pregnancies
In the semi-annual report covering January 1 through June 2017, the OLES made several recommendations to DSH with the goal of minimizing patient pregnancies. The OLES also made a recommendation on how best to manage patients who become pregnant while residing in a state hospital or if they are pregnant when they are admitted to a DSH facility. In response to the OLES recommendations, the DSH drafted two policies titled "Child Placement" and "Patient Sexuality."

The first policy titled "Child Placement" allows the pregnant patient to decide where and with whom her infant will be placed after birth. This policy has been fully implemented. The second policy titled "Patient Sexuality" spells out what must be considered when determining patient placement in co-ed living quarters at DSH facilities. This policy is still in draft form. The OLES will continue to monitor this issue until the "Patient Sexuality" policy is fully implemented.

DSH Extraction Policy and Training
In the semi-annual report covering January 1 through June 2017, the OLES identified a systemic issue concerning room and area extractions of patients. The OLES discovered that DSH law enforcement might not be evaluating the circumstances of events to determine if exigency exists or if calculated intervention would be a better and safer option to remove a patient from an area. DSH did not have a policy or procedure outlining how DSH officers are to conduct a calculated intervention. Therefore, the OLES recommended that DSH develop a draft policy on room and area extractions, as well as a mandatory training program. In response to the recommendation, DSH drafted a policy and proposed training plan that OLES has approved. As of June 30, 2018, DSH was working on purchasing the necessary

equipment and scheduling training. Once the training is completed, DSH will implement the policy. The OLES will continue to monitor and report in subsequent semi-annual reports on DSH's progress.

OLES Recommendations-DSH

As required by statute[10], the OLES, in March 2015 provided the Legislature with a report that described the challenges faced by DSH and DDS law enforcement and the OLES recommendations. Additionally, in the OLES reports to the Legislature released previously, the OLES updated the recommendations for best practices in law enforcement and employee discipline that the OLES made to the departments. Below are the 11 recommendations at DSH and their June 30, 2018, status as provided verbatim by DSH.

DSH law enforcement organizational structure

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
A Legislation should be drafted and enacted to consolidate all DSH law enforcement under the department's chief of law enforcement. This would upgrade the chief from consultant to supervising manager, speed up standardization and centralize the fragmented law enforcement authority at DSH	Not yet implemented. Legislation has not been enacted to effect this change. DSH implemented Policy Directive 8000 – DSH Law Enforcement Reporting Structure in December 1, 2015, which clarifies under the existing statute the structure, authority and responsibilities of the DSH Chief of Law Enforcement, Office of Protective Services, and roles and reporting relationships of DSH law enforcement personnel.	Partially Implemented. DSH implemented Policy Directive 8000- DSH Law Enforcement Reporting Structure in December 1, 2015, which clarifies under the existing statute the structure, authority and responsibilities of the DSH Chief of Law Enforcement, Office of Protective Services, and roles and reporting relationships of DSH law enforcement personnel. SB1495 was introduced by the Senate Committee on Health on February 28, 2018, and if passed will further clarify DSH's Law Enforcement Reporting Structure.

DSH law enforcement policies and procedures

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
B By December 1, 2016, DSH	Implemented. The Rapid Containment	Developed and implemented. A training

[10] Penal Code Section 830.38(c) and Welfare and Institutions Code Section 4023.5(a).

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
should decide on one police baton statewide, excluding specialized and tactical police teams, and begin to phase out the other baton. Standardized tools reduce on-the-job confusion about which tools to use and when to use them and reduces complexity of training.	Baton is issued to all new officers and is continuing to be phased out by DSH-Atascadero and DSH-Napa. DSH is on track to complete the phase out of other batons by June 30, 2019.	plan for the RCB baton which was previously selected. All new Officers attending OPS Academy are issued batons. OPS is in process of securing statewide contract for the baton purchase which will be a 3 year contract. Once the contract is in place, DSH-ASH and DSH-NSH will switch to RCB. DSH is still on track for all Officers to be issued and trained on RCB by June 2019.
C DSH should ensure that all equipment needed for law enforcement personnel is available to staff so they can follow policy/ procedure that calls for the use of the equipment.	In progress. OPS purchased audio recording equipment and it has been deployed at the facilities. Training and full implementation is anticipated by January 30, 2018. The project was delayed by technical and contractual challenges.	Implemented. Audio recording policy was fully implemented on March 1, 2018. This includes all training and equipment procurement.

DSH standardized training

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
D By December 31, 2016, DSH should compile and submit to the OLES standardized lesson plans for continued professional training of law enforcement personnel. Standardized lesson plans help ensure consistency in ongoing training of DSH law	In progress. DSH had fully implemented the academy portion of the Envisage training software that allows for efficient scheduling of training classes and instructors. DSH was finalizing the software section involving	The Field training program was fully developed within Envisage training software (OPS TRAIN) on March 14, 2018. Due to unexpected delays the implementation of Continuing Professional

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
enforcement personnel at all facilities statewide.	standardized field training of new officers. The software section on standardized lesson plans for Continuing Professional Training was being finalized, anticipated full implementation by May 1, 2018.	Training (CPT) within OPS TRAIN is still ongoing. DSH anticipates full implementation of CPT December 31, 2018
E DSH should include mental health topics in its ongoing professional development training, and mental health professionals should be trainers for new and longstanding law enforcement personnel. The specialized environment at DSH facilities necessitates ongoing professional development training.	The Critical Incident Training (CIT) program had been developed and DSH was providing two separate sessions of this program to existing law enforcement personnel at all facilities. Additional sessions were to be scheduled in 2018 to continue the training. Every DSH officer was expected to have received CIT by July 1, 2018.	Complete. All OPS Officers have received Critical Incident Training (CIT). All future Officers will receive this training in the OPS Academy.
F DSH should centralize law enforcement training records at the department level. Centralized training data can be tracked and analyzed across the department and allows for department-wide budgeting for training.	DSH had been manually tracking training records of its 700-plus law enforcement staff via spreadsheets at the facility level. DSH was in the process of installing and using the Envisage training software to centralize all of its DSH law enforcement training data at headquarters in Sacramento. DSH anticipated full implementation by May 1, 2018.	Complete. As of May 1, 2018 all OPS personnel training records are contained in the Envisage software program (OPS TRAIN). Training will continue to be tracked in this centralized system

DSH standardized assessments of investigations

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
G By December 1, 2016, DSH should implement written, statewide, standardized policy and procedures for assessing investigation reports in a consistent fashion at all facilities and determine management personnel who should be involved in the evaluations. This provides consistent, fair and reasoned assessment of the quality of investigations and strives to equalize how results of investigations are handled across all state facilities.	In progress. DSH had developed Policy Directive 5315, Objective Discipline Process, which incorporated a procedure for the hiring authority to assess investigation reports. DSH presented the draft policy directive to the OLES on May 15, 2017, and on June 15, 2017, the OLES provided feedback. DSH's executive team approved the policy directive in June 2017 and the unions were later noticed and conferred with in November 2017. The policy directive was expected to be implemented by February 28, 2018.	Policy Directive 5318 Objective Discipline Process was approved and implemented effective April 5, 2018. Please note, Policy Directive was renumbered from 5315 to 5318. No content was changed.

DSH standardized discipline process

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
H By December 1, 2016, DSH should implement comprehensive written, statewide policy and procedures involving standardized penalty matrices for all state employees who are found to be involved in misconduct. This helps provide formalized,	In progress. DSH established a workgroup that developed an Objective Discipline tool that was incorporated in Policy Directive 5315, which was approved by the DSH executive team in June 2017. DSH noticed the unions on October	Policy Directive 5318 Objective Discipline Process was approved and implemented effective April 5, 2018. Please note, Policy Directive was renumbered from 5315 to 5318. No content was changed.

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
consistent and fair imposition of discipline penalties across all state facilities.	30, 2017, and held meet and confers with various unions in November 2017. This policy directive was expected to be implemented by January 31, 2018.	

DSH standardized discipline tracking

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
I DSH should implement department-wide policy and procedures for collecting, organizing, centralizing and keeping consistent records of all employee misconduct reports. This ensures consistent and centralized data collection and record-keeping department-wide.	In progress. DSH developed and approved Policy Directive 5316, Discipline Record Keeping, and it was approved by the executive team on June 15, 2017. This policy directive was to be finalized and released at the same time as Policy Directive 5315 referenced in H above. Therefore, it was expected to be implemented by January 31, 2018.	Implemented. Policy Directive 5316 Personnel Actions Record Keeping was approved and implemented April 5, 2018
J DSH should develop a centralized discipline tracking computer system similar to CDCR's to provide secure, efficient, real-time access to ongoing discipline cases and tracks delays and outcomes so they can be analyzed.	Not implemented. DSH continued to explore technological options. Meantime, DSH was tracking disciplinary actions via the processes identified in the as-yet unimplemented Policy Directive 5316.	Alternative Process Implemented. DSH implemented Policy Directive 5316 on April 5, 2018 which included requirements for centralized tracking and analyzing disciplinary actions.
K DSH should establish department-wide policy	In progress. See recommendation I (above) for additional	Implemented. See response under finding I regarding the

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
and procedures for documenting and recording its analysis of trends and patterns of all DSH employee misconduct. This ensures that centralized data collection and records are used as a management tool to identify and address patterns and trends of employee misconduct.	information.	implementation of Policy Directive 5316. DSH is actively documenting, recording, reviewing/analyzing trends and patterns using Excel spreadsheet as established in Policy Directive 5316. Records are maintained in DSH-Sacramento Human Resources.

OLES Recommendations - DDS

Below are the five recommendations at DDS and their June 30, 2018, status as provided verbatim by DDS.

DDS standardized assessments of investigations

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
A By December 1, 2016, DDS should implement written, statewide, standardized policy and procedures for assessing investigation reports in a consistent fashion at all facilities and determine management personnel who should be involved in the evaluations. This provides formalized, consistent, fair and reasoned assessment of the quality of investigations and strives to equalize how results of investigations are handled across all state facilities.	DDS drafted a policy and the OLES was consulted in December 2017. Distribution and implementation of the new DDS policy was expected in January 2018.	DDS developed and implemented policy #322 Review and Disposition of Office of Protective Services Investigative Unit Cases with OLES Oversight

DDS standardized training

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
B DDS should develop and submit to the OLES for approval the standardized curriculum for the 24-hour critical incident training course that DDS established at the DSH-Atascadero academy in the first half of 2016. A standardized curriculum helps ensure standardized training.	DDS developed a crisis intervention behavioral health training course that was submitted to the California Commission on Peace Officers Standards and Training (POST) in 2016 and certified by POST in March 2017. All law enforcement employees were to complete the course, taught by law enforcement managers and DDS mental health professionals, by the fall of 2017. DDS was reviewing the DSH Crisis Intervention Training program to see what, if any, components might be adapted into the DDS POST-approved training.	The authors of the DDS POST approved Crises Intervention Behavioral Health training course, reviewed the Dept. Of State Hospitals (DSH) crises intervention behavioral health training course. The finding was no additional components were applicable to DDS
C DDS should complete and submit to the OLES the policy and procedures for consistent law enforcement field training for newly deployed law enforcement personnel, including objectives, evaluation methods and passing standards, across the department. Consistent training and evaluation in the field, after initial, new-hire training, helps ensure	DDS developed a draft field training manual that was for all new DDS Peace Officer Is. The draft manual was submitted to the OLES for review on December 21, 2017.	DDS Office of Protective Services (OPS) developed a Field Training Officer (FTO) Manual. The FTO manual has been reviewed and approved by OLES. The FTO manual has been implemented at each of the Developmental Centers and Community facility. OPS will submit the FTO manual to POST for review and approval.

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
that initial standardized training of new hires is retained and reinforced.		

DDS standardized discipline process

OLES Recommendation of Best Practice	Status as of December 31, 2017	Status as of June 30, 2018
D By December 1, 2016, DDS should implement a comprehensive written, statewide policy and procedures involving standardized penalty matrices for all state employees assigned to facilities who are found to be involved in misconduct. This provides formalized, consistent and fair imposition of discipline penalties across all state facilities	A draft policy and procedures involving standardized penalty matrices was in draft review. DDS anticipated it would be issued by December 2017.	DDS developed and implemented policy #322 Review and Disposition of Office of Protective Services (OPS) Investigative Unit Cases with OLES Oversight in January 2018
E By December 1, 2016, DDS should establish a written, statewide executive review process to address situations where facility executive directors, labor attorneys and/or OLES disagree about employee discipline decisions. This provides consistent and formalized review process of discipline penalties across all state facilities.	Policy was drafted and circulated and was expected to be issued by December 2017.	DDS developed and implemented policy #322 Review and Disposition of Office of Protective Services (OPS) Investigative Unit Cases with OLES Oversight in January 2018.

Appendix A: OLES Investigations

Investigation Detail	Section Content
Incident Date	08/04/2017
OLES Case Number	2017-00972A
Case Type	Misconduct
Incident Summary	On August 4, 2017, an officer allegedly brandished a handgun during a dispute with his neighbors. The officer was also allegedly dishonest to his supervisor regarding the incident.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter. It was determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	03/23/2017
OLES Case Number	2017-01035A
Case Type	Broken Bone
Incident Summary	On March 23, 2017, an officer allegedly used unnecessary force on a patient who was refusing orders to return to his unit. The officer and patient both sustained injuries and were transported to an outside medical facility for medical attention.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	01/01/2015
OLES Case Number	2017-01238A
Case Type	Misconduct
Incident Summary	In January 2015, an officer allegedly used State training funds for his personal use. In June 2015, the officer was allegedly dishonest when he completed a travel claim form stating the funds had been used for training. In June and July 2017, the officer was allegedly dishonest to his supervisors regarding the misuse of the funds.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES will monitor the disposition process.

Investigation Detail	Section Content
Incident Date	10/30/2017
OLES Case Number	2017-01275A
Case Type	Misconduct
Incident Summary	On October 30, 2017, an officer allegedly falsely claimed to be leaving for military duty to avoid working overtime. A sergeant allegedly failed to prevent and report the misconduct.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	11/01/2017
OLES Case Number	2017-01290A
Case Type	Significant Interest - Other
Incident Summary	On November 1, 2017, a patient alleged staff were causing serious bodily injury or death of patients and that he was force medicated in retaliation for reporting the staff misconduct.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/23/2017
OLES Case Number	2017-01336A
Case Type	Misconduct
Incident Summary	On March 23, 2017, an officer allegedly failed to investigate a use of force incident. The officer allegedly falsified his report regarding the incident and was dishonest during his investigative interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	03/23/2017
OLES Case Number	2017-01337A
Case Type	Misconduct
Incident Summary	On March 23, 2017, an officer allegedly failed to investigate a use of force incident. The officer allegedly falsified his report regarding the incident and was dishonest during his

	investigative interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	03/23/2017
OLES Case Number	2017-01338A
Case Type	Misconduct
Incident Summary	On March 23, 2017, an officer allegedly failed to investigate a use of force incident. The officer allegedly falsified his report regarding the incident and was dishonest during his investigative interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	03/23/2017
OLES Case Number	2017-01339A
Case Type	Misconduct
Incident Summary	On March 23, 2017, an officer allegedly falsified an arrest report following a use of force incident and was dishonest during his investigative interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	11/23/2017
OLES Case Number	2017-01381A
Case Type	Misconduct
Incident Summary	On November 23, 2017, an officer allegedly made a disparaging remark about a deceased patient to the responding county coroner.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	09/19/2015
OLES Case Number	2017-01478A
Case Type	Misconduct
Incident Summary	On September 19, 2015, an officer allegedly failed to thoroughly investigate a crime scene. On December 8,

	2017, the officer allegedly gave false testimony during a court hearing on the underlying crime.
Disposition	The Office of Law Enforcement Support conducted an investigation and forwarded the case to the hiring authority for review and disposition.

Investigation Detail	Section Content
Incident Date	10/22/2017
OLES Case Number	2018-00015C
Case Type	Misconduct
Incident Summary	On October 22, 2017, a detective allegedly submitted a false probable cause declaration to a judge. Two supervisors allegedly allowed detectives to falsify probable cause declarations.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	08/01/2017
OLES Case Number	2018-00030A
Case Type	Misconduct
Incident Summary	In August 2017, an officer allegedly harassed a hospital employee by inquiring into the validity of her disability parking placard. The officer also allegedly discussed the event with one of the employee's family members and threatened legal action against the employee.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	05/07/2017
OLES Case Number	2018-00151A
Case Type	Misconduct
Incident Summary	Between May 7, 2017, and January 6, 2018, an officer allegedly altered three medical notes to give himself additional days off of work.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES

	monitored the disposition process.

Investigation Detail	Section Content
Incident Date	02/14/2018
OLES Case Number	2018-00197C
Case Type	Misconduct
Incident Summary	On February 14, 2018, an officer allegedly used excessive force on a patient while conducting a pat search, injuring the patient's knee.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	01/03/2018
OLES Case Number	2018-00204C
Case Type	Misconduct
Incident Summary	On January 3, 2018, multiple officers allegedly battered a patient causing injury to the patient's head.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	01/01/2016
OLES Case Number	2018-00214A
Case Type	Sexual Assault
Incident Summary	In January 2016, a nurse was allegedly overly familiar with a patient.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	02/27/2018
OLES Case Number	2018-00256C
Case Type	Abuse

Incident Summary	On February 27, 2018, an officer allegedly used excessive force when he punched a patient in the head and face and sprayed him with pepper spray.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/01/2018
OLES Case Number	2018-00261A
Case Type	Misconduct
Incident Summary	On March 1, 2018, it was alleged that a detective was making false statements to gain convictions of staff and patients and was soliciting officers to work for his private security company. A supervisor allegedly failed to report the detective's misconduct. A sergeant allegedly failed to report patient abuse and was misusing state property to search for private information regarding staff.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/01/2018
OLES Case Number	2018-00278C
Case Type	Abuse
Incident Summary	Between 2014 and 2018, a psychiatric technician allegedly abused patients and provoked them to fight. Hospital management allegedly failed to take appropriate action against the psychiatric technician.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	01/14/2018
OLES Case Number	2018-00298C

Case Type	Abuse
Incident Summary	On January 14, 2018, an officer allegedly slammed a patient against a wall, forcibly placed handcuffs on him, and placed him in seclusion.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/12/2018
OLES Case Number	2018-00299C
Case Type	Abuse
Incident Summary	On March 12, 2018, officers allegedly jumped on a patient's back while he was on the ground, ripped a ring off his finger causing injury, and caused him to defecate himself.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/26/2018
OLES Case Number	2018-00343A
Case Type	Misconduct
Incident Summary	On March 26, 2018, it was alleged that a sergeant was unfairly targeting a new officer. It was also alleged that a second sergeant was engaged in criminal activity and management failed to take action.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/23/2018
OLES Case Number	2018-00344A
Case Type	Misconduct
Incident Summary	On March 23, 2018, a sergeant allegedly gave an officer a ballistic shield and instructed the officer to strike a patient

	with the shield.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/24/2018
OLES Case Number	2018-00345A
Case Type	Misconduct
Incident Summary	On March 24, 2018, a sergeant allegedly misused state property and conducted unwarranted stops of visitors.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	04/03/2018
OLES Case Number	2018-00381C
Case Type	Misconduct
Incident Summary	On April 3, 2018, an officer allegedly used excessive force against a patient during a search.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	10/22/2017
OLES Case Number	2018-00402A
Case Type	Misconduct
Incident Summary	On October 22, 2017, a sergeant allegedly fraudulently submitted a probable cause declaration to a judge.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	03/08/2018
OLES Case Number	2018-00455C
Case Type	Misconduct
Incident Summary	On March 8, 2018, officers allegedly struck a patient several times in the head with batons.
Disposition	The Office of Law Enforcement Support 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.

Investigation Detail	Section Content
Incident Date	12/15/2017
OLES Case Number	2018-00468C
Case Type	Misconduct
Incident Summary	In December 2017, a lieutenant allegedly threw a water bottle at a subordinate officer and sexually assaulted him.
Disposition	The Office of Law Enforcement Support 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: 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 B1 – DSH Pre-Disciplinary Cases

Case Table Section	Section Content
Incident Date	06/29/2016
OLES Case Number	2016-0849MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 29, 2016, a psychiatric technician allegedly struck a patient in the face. The patient sustained swelling and bruising to his eye.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative 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 notify the OLES of the incident in a timely manner. The investigation was not completed until 588 days from the date the investigation was initiated.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority failed to notify the OLES by phone of the incident in a timely manner. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on June 29, 2016. The

	administrative investigation was opened on October 18, 2016, after the criminal investigation was completed. The administrative investigation was completed on May 29, 2018, 588 days later.
Department Corrective Action Plan	The Chief/OPS reminded the staff of the priority 1 reporting requirements. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/13/2016
OLES Case Number	2016-0983MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 13, 2016, a unit supervisor allegedly struck a patient after the patient threw an identification card at the unit supervisor. A psychiatric technician then allegedly kicked the same patient in the face for several minutes.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the unit supervisor and the psychiatric technician. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The department failed to timely notify the OLES of the alleged incident, failed to conduct a timely investigation, and did not timely consult with the OLES regarding the sufficiency of the investigation and investigative findings. The incident was assigned for an investigation on August 11, 2016, and was completed 189 days later. The investigative report was completed on September 27, 2017; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings until January 2, 2018, 98 days later.
Pre-Disciplinary	1. Did the Hiring Authority timely notify the Office of Law

Assessment	Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the alleged incident on August 4, 2016, at 0925; however, the OLES was not notified until August 4, 2016, at 1224, approximately three hours later. 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 investigative report was completed on September 27, 2017; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation and investigative findings until January 2, 2018, 98 days later. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The department did not timely notify the OLES of the alleged incident. The investigation was not timely completed. The incident was assigned for an investigation on August 11, 2016, and was completed 189 days later.
Department Corrective Action Plan	OPS provided training to all OPS supervisors on OLES reporting guidelines in January 2017. The command staff provided roll call training to their staff. OPS will provide training to all staff to ensure the consultation with OLES is completed within the investigation process guidelines. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	10/17/2016
OLES Case Number	2016-1364MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained

	2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 17, 2016, a registered nurse and psychiatric technician allegedly used unnecessary force to place a patient on the floor and take her to a seclusion room. Once inside the seclusion room, the registered nurse allegedly placed a sheet over the patient making it difficult to breathe and another staff member allegedly twisted her nipple.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. Level of care staff failed to timely report the allegations to the hospital police. The hiring authority failed to consult with the OLES concerning the sufficiency of the investigation and the investigative findings. The investigation was not completed until 377 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority respond timely to the incident? No. Level of care staff did not timely notify the hospital police of the allegation. Level of care staff became aware of the allegation on October 17, 2016, at 2145; however, hospital police were not notified until October 18, 2016, at 0124. 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. 3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority failed to consult with the OLES concerning the investigative findings. 4. Was the pre-disciplinary/investigative phase

	conducted with due diligence? No. The incident was discovered on October 18, 2016; however, the investigation was not completed until October 30, 2017, 377 days later.
Department Corrective Action Plan	OPS staff have been reminded of the reporting requirements for Priority 1 notifications to the Office of Law Enforcement Support. In the future, the Hiring Authority will consult with OLES as required. In the future, the Hiring Authority will consult with OLES as required. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation and report is going to go beyond the 120-day timeframe. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	11/25/2016
OLES Case Number	2016-1543MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 25, 2016, two psychiatric technicians allegedly assaulted a patient while escorting the patient to his room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to sufficiently comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 497 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 25, 2016; however, the investigation was not completed until April 6, 2018, 497 days later.
Department	The Chief/OPS discussed with the entire investigative staff

Corrective Action Plan	the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/12/2017
OLES Case Number	2017-0047MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 12, 2017, several staff members allegedly struck a patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative 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 concerning the sufficiency of the investigation and investigative findings. The investigation was not completed until 279 days from the date of discovery.
Pre-Disciplinary Assessment	1. 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. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority failed to consult with the OLES concerning the investigative findings. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? The incident was discovered on January 12, 2017;

	however, the investigation was not completed until October 18, 2017, 279 days later.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/21/2017
OLES Case Number	2017-0084MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 21, 2017, a patient died of chronic lung disease while in the care of an outside hospital.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the investigation was not forwarded to the local district attorney's office, nor was an administrative investigation initiated. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/21/2017
OLES Case Number	2017-0085MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 21, 2017, a senior psychiatric technician allegedly twisted a patient's arm during a wall-stabilization procedure, causing injury to the patient. A psychiatric technician allegedly failed to intervene to prevent the alleged abuse.
Disposition	The Office of Protective Services conducted an investigation

	which resulted in inconclusive findings, and referred the case to the district attorney for review. The OLES concurred with the determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/23/2017
OLES Case Number	2017-0365MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 23, 2017, a unit supervisor allegedly choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 218 days from the date of discovery. The hiring authority did not consult with the OLES until March 20, 2018, 175 days after the completion of the investigation.
Pre-Disciplinary Assessment	1. 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 investigation was completed on October 27, 2017; however, the hiring authority did not consult with the OLES until March 20, 2018, 175 days later. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not timely consult with the

	OLES concerning investigative findings and disciplinary determinations. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on March 23, 2017; however, the investigation was not completed until October 27, 2017, 218 days later. The hiring authority did not consult with the OLES regarding investigative findings until March 20, 2018, 175 days after the completion of the investigation.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/30/2017
OLES Case Number	2017-0384MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 30, 2017, a psychiatrist allegedly slapped a patient's leg while the patient was being placed in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 202 days from the date of discovery. Additionally, the hiring authority did not make investigative determinations until 184 days after the

	investigation was completed.
Pre-Disciplinary Assessment	1. 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 investigation was completed on October 18, 2017; however, the hiring authority did not consult with the OLES until March 20, 2018. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not timely consult with the OLES. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on March 30, 2017; however, the investigation was not completed until October 18, 2017, 202 days later. Additionally, the hiring authority did not consult with the OLES regarding investigative findings until March 20, 2018, 184 days after the investigation was completed.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	04/11/2017
OLES Case Number	2017-0439MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On April 11, 2017, a psychiatric technician allegedly grabbed a patient by the collar and forced the patient against a wall several times.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES concerning investigative findings. The investigation was not completed until 191 days from the date of discovery.
Pre-Disciplinary Assessment	1. 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 failed to consult with the OLES regarding the sufficiency of the investigation and the investigative findings. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation or investigative findings. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 12, 2017; however, the investigation was not completed until October 20, 2017, 191 days later.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the

	investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	04/25/2017
OLES Case Number	2017-0495MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 25, 2017, a senior psychiatric technician allegedly aggressively approached a patient and pushed the brim of his hat into the patient's face. It is also alleged the psychiatric technician grabbed and took a fighting stance with the patient. It is further alleged the psychiatric technician failed to properly document the incident.
Disposition	The hiring authority sustained the allegation of failing to properly document the incident and imposed corrective action. The hiring authority determined there was insufficient evidence to sustain the allegations of physical abuse. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 231 days from the date of discovery. The hiring authority did not make investigative findings for 98 days from the date the investigation was completed.
Pre-Disciplinary Assessment	1. 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 timely consult with the OLES regarding the sufficiency of the investigation and investigative findings. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?

	No. The investigation was completed in December 12, 2017; however, the hiring authority did not consult with the OLES concerning investigative findings until March 20, 2018. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on April 25, 2017; however, the investigation was not completed until December 12, 2017, 231 days later.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meetings either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	05/02/2017
OLES Case Number	2017-0528MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 2, 2017, a psychiatric technician allegedly forcefully moved a patient from a restricted medication dispensary.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 210 days from the date of discovery. The hiring authority did not consult with the OLES regarding investigative findings until 112 days after

	the investigation was completed.
Pre-Disciplinary Assessment	1. 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 investigation was completed on November 28, 2017; however, the hiring authority did not consult with OLES until March 20, 2018, 112 days later. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with the OLES regarding investigative findings until 112 days after the investigation was completed. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on May 2, 2017; however, the investigation was not completed until November 28, 2017, 210 days later. The hiring authority did not make disciplinary determinations until 112 days after the investigation was completed.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	05/04/2017
OLES Case Number	2017-0545MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On May 4, 2017, a registered nurse allegedly grabbed and struck a patient.
Disposition	The hiring authority determined that there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 169 days from the date of discovery. The hiring authority did not consult with the OLES regarding investigative findings until 151 days after the investigation was completed.
Pre-Disciplinary Assessment	1. 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 investigation was completed on October 20, 2017; however, the hiring authority did not consult with the OLES regarding investigative findings until March 20, 2018, 151 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on May 4, 2017; however, the investigation was not completed until October 20, 2017, 169 days later. The hiring authority did not consult with the OLES regarding investigative findings until March 20, 2018, 151 days after the investigation was completed.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative

	case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	12/09/2016
OLES Case Number	2017-0616MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On December 9, 2016, a registered nurse allegedly struck a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. However, the registered nurse resigned before the disciplinary action could be imposed. A letter indicating the registered nurse resigned under adverse circumstances was placed in his official personnel file.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The administrative investigation commenced on August 15, 2017; however, the investigation was not completed until April 3, 2018, 231 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The administrative investigation was initiated on August 15, 2017; however, the investigation was not completed until April 3, 2018, 231 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	05/29/2017
OLES Case Number	2017-0627MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 29, 2017, two registered nurses allegedly used excessive force during a containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The responding officer did not identify or interview the staff involved in the incident. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and investigative findings. The investigation was not completed until 169 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The OPS did not identify or attempt to interview all staff involved in the incident. 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 failed to consult with the OLES. 3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with the OLES during the pre-disciplinary phase of the case. 4. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on May 29, 2017; however, the investigation was not completed until November 14, 2017, 169 days later.
Department Corrective Action Plan	Training had been provided to the OPS investigative staff to do their due diligence to identify additional witnesses. If no additional witness found to clearly state no additional

	witness located in the report. In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meetings either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	02/03/2017
OLES Case Number	2017-0682MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final:
Incident Summary	On February 3, 2017, a psychiatric technician allegedly struck a patient in the back of the head and called the patient a derogatory term because the patient would not leave the dining hall during a fire alarm drill. Additionally, the psychiatric technician was allegedly dishonest during his investigatory interview.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on September 19, 2017; however, the findings and penalty conference was not held until January 10, 2018, 113 days later. Furthermore, the hiring authority did not consult with the OLES regarding findings and penalty determinations until March 20, 2018, 69 days after the penalty determination had been made.

Pre-Disciplinary Assessment	1. 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 investigation was completed on September 19, 2017, and the findings and penalty conference was held on January 10, 2018; however, the hiring authority did not consult with the OLES until March 20, 2018. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not provide real-time consultation with OLES concerning the findings and penalty conference. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was completed on September 19, 2017; however, the findings and penalty conference was not held until January 10, 2018, 113 days later. Furthermore, the hiring authority did not consult with the OLES until March 20, 2018, 69 days later.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meetings either in person or via conference call. This procedure will allow for real-time consultation between all parties.

Case Table Section	Section Content
Incident Date	05/25/2017
OLES Case Number	2017-0690MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Not Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On May 25, 2017, a psychiatric technician allegedly falsified documentation regarding a medication administration error. In addition, a senior psychiatric

	technician allegedly failed to timely prepare a medication variance report as a result of the medication error.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation against the psychiatric technician. The hiring authority sustained the allegation against the senior psychiatric technician and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/24/2017
OLES Case Number	2017-0738MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 24, 2017, a patient was found hanging from a sheet in his bedroom. Staff provided emergency life saving measures until paramedics responded. The paramedics pronounced the patient dead and did not transport the patient to an outside hospital.
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 did not open an administrative investigation due to a lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/10/2017
OLES Case Number	2017-0805MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On July 10, 2017, a psychiatric technician intentionally rolled a wheel chair over a patient's foot.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officer failed to provide the two employees who were the subjects of the investigation with their legal rights prior to conducting interviews. The investigation was not completed until 186 days from the date of discovery. The hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation and investigative findings. The investigative report was completed on January 12, 2018; however, the hiring authority did not consult with the OLES until March 20, 2018, 67 days later.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The responding officer failed to provide the subjects of the investigation their legal rights prior to interviewing them. 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 investigation was completed on January12, 2018; however, the hiring authority did not consult with the OLES until March 20, 2018, 67 days later. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 10, 2017; however, the investigation was not completed until January 12, 2018, 186 days later. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings until March 20, 2018, 67 days later.
Department Corrective Action	A reminder regarding the legal rights afforded to subjects of both criminal and administrative investigations will be

Plan	reviewed with hospital police officers on a continual basis. In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	07/11/2017
OLES Case Number	2017-0812MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 11, 2017, a patient alleged that a psychiatric technician "shot" her in the back of the head with a pencil.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The initial officer did not provide the subject employee with his legal rights before obtaining his statement. The incident was not completed until 161 days from the date of discovery. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation or investigative findings until 91 days after the investigation was completed.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The OPS officer did not provide the subject psychiatric technician with his pre-interview legal rights. 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 investigation was completed on December 16, 2017; however, the hiring authority did not consult with the OLES until March 20, 2018, 91 days later. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 11, 2017; however, the investigation was not completed until December 19, 2017, 161 days later.
Department Corrective Action Plan	A reminder regarding the legal rights afforded to subjects of both criminal and administrative investigations will be reviewed with hospital police officers on a continual basis. In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	07/25/2017
OLES Case Number	2017-0874MC
Allegations	1. Criminal Act
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 25, 2017, a patient died from cirrhosis of the liver.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the matter was not referred to the district attorney's office nor was an administrative investigation opened. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	07/25/2017
OLES Case Number	2017-0880MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No change
Incident Summary	On July 25, 2017, two psychiatric technicians allegedly struck a patient multiple times.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 240 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 24, 2017; however, the investigation was not completed until March 21, 2018, 240 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	07/27/2017
OLES Case Number	2017-0885MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 27, 2017, staff members allegedly used excessive

	force on a patient during a floor containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 263 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 27, 2017; however, the investigation was not completed until April 16, 2018, 263 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	12/21/2017
OLES Case Number	2017-0903MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 21, 2017, a registered nurse alleged other staff members agitated and unnecessarily medicated a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content

Incident Date	09/19/2016
OLES Case Number	2017-0956MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 19, 2016, a psychiatric technician allegedly pushed his knees into the back of a patient's knees, put his body weight on the back of the patient's calves as the patient knelt, and allegedly struck the patient several times. After the incident, the senior psychiatric technician, a psychiatric technician, and the patient allegedly entered into a mutual agreement to not seek criminal prosecution against one another regarding the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 140 days from the date the administrative investigation was opened.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The Office of Protective Services opened the administrative investigation on July 19, 2017; however, the investigation was not completed until December 5, 2017, 140 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	08/14/2017
OLES Case Number	2017-0969MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 14, 2017, a senior psychiatric technician allegedly slapped a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative 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 concerning the sufficiency of the investigation and investigative findings until 103 days after the investigation was completed.
Pre-Disciplinary Assessment	1. 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 investigation was completed on December 7, 2017; however, the hiring authority did not consult with the OLES until March 20, 2018, 103 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was completed on December 7, 2017; however, the hiring authority did not consult with the OLES until March 20, 2018, 103 days later
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties.

Case Table Section	Section Content
Incident Date	08/19/2017
OLES Case Number	2017-0990MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 19, 2017, a psychiatric technician allegedly grabbed and twisted a patient's arm and struck the patient on the face and ear.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings.
Pre-Disciplinary Assessment	1. 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.
Department Corrective Action Plan	In the future, the hiring authority will consult with OLES as required.

Case Table Section	Section Content
Incident Date	08/31/2017
OLES Case Number	2017-1045MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 31, 2017, two psychiatric technicians allegedly refused to give food to a patient. The two psychiatric technicians also allegedly bumped the patient's genital area.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Table Section	Section Content
Incident Date	09/06/2017
OLES Case Number	2017-1069MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 6, 2017, a psychiatric technician allegedly failed to properly maintain supervision of a patient, who fell, traumatized a previous head injury, and subsequently died from her injuries.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	09/11/2017
OLES Case Number	2017-1074MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 11, 2017, a patient was found unresponsive in his room. Responding staff provided emergency life saving measures until fire department personnel responded. The patient was transported to an outside hospital where he died of end stage renal disease.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	05/02/2017
OLES Case Number	2017-1096MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	On May 2, 2017, a psychiatric technician allegedly repeatedly struck a patient on the back of the head.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. However, the psychiatric technician had previously been dismissed on an unrelated case; therefore, disciplinary action could not be imposed in this case.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Insufficient The Office of Protective Services failed to comply with the department's policies and procedures governing the pre-disciplinary process. The administrative investigation reflected the investigator's biases and the opinions reached by the investigator were not based on the evidence. The OLES monitor had made recommendations to edit the report, which the investigator refused to make. A second investigation had to be completed because of the insufficiency of the initial investigation.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report was biased and the conclusion reached by the investigator was not based on the evidence. 2. Was the final investigative report thorough and appropriately drafted? No. The final report was biased and the conclusions reached by the investigator were not based on the evidence. The OLES monitor had made recommendations to edit the draft report; however, the investigator refused to follow the recommendations. 3. Was the investigation thorough and appropriately conducted?

	No. The administrative investigation reflected the investigator's biases and the opinions reached by the investigator were not based on the evidence. 4. If the Hiring Authority determined that any of the allegations could not be sustained or that an accurate finding could not be made regarding any allegation was that determination the result of an insufficient or untimely investigation? Yes. A second independent investigation had to be completed by the Office of Protective Services because the initial investigation was determined to be insufficient.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties.

Case Table Section	Section Content
Incident Date	09/14/2017
OLES Case Number	2017-1110MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 14, 2017, a psychiatric technician allegedly choked a patient while attempting to restrain the patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	09/20/2017
OLES Case Number	2017-1118MC
Allegations	1. Criminal Act
Findings	1. Not Referred

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 20, 2017, a physician allegedly used unnecessary force during a genital examination of a patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The hiring authority did not timely notify the OLES of the incident and the investigation was not completed until 160 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not timely notify the OLES of the incident. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on September 21, 2017; however, the investigation was not completed until March 1, 2018, 160 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	09/24/2017
OLES Case Number	2017-1130MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On September 24, 2017, a psychiatric technician allegedly used excessive force while placing a patient against a glass window.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	09/28/2017
OLES Case Number	2017-1155MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On September 28, 2017, three psychiatric technicians allegedly failed to properly supervise a patient during a court appearance. She left the courthouse and traveled by bus to a relative's residence where she cut her neck and wrists with a knife.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the first psychiatric technician and determined dismissal was the proper penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the other two psychiatric technicians. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on December 28, 2017; however, the findings and penalty conference was not completed until April 5, 2018, 97 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on December 28, 2017; however, the findings and penalty conference was not completed until April 5, 2018, 97 days later.
Department Corrective Action Plan	The Hiring Authority is working with Human Resources on a tracking system to ensure timely notification of the findings and penalty conference.

Case Table Section	Section Content
Incident Date	10/02/2017
OLES Case Number	2017-1160MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 2, 2017, two psychiatric technicians allegedly assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 214 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 2, 2017; however, the investigation was not completed until May 4, 2018, 214 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/01/2017
OLES Case Number	2017-1161MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	During January 2017, a psychiatric technician allegedly sold a mobile phone to a patient in exchange for money and sexual favors. On September 29, 2017, the psychiatric technician allegedly propositioned the patient for additional sexual favors.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/04/2017
OLES Case Number	2017-1168MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 4, 2017, health care staff members allegedly forcefully administered medication to a patient, placed a blanket over the patient's head, and let the patient lay in his own urine and feces for an extended period of time.
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. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	10/07/2017
OLES Case Number	2017-1179MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 7, 2017, a psychiatric technician allegedly struck and kicked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative 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 timely notify the OLES of the incident. The investigation was completed on December 26, 2017; however, the hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings until March 20, 2018, 84 days later.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The incident was discovered on October 7, 2017, at 1002; however, the OLES was not notified of the incident until 1329, approximately 3.5 hours later. 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 investigation was completed on December 26, 2017; however, the hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings until March 20, 2018, 84 days later. 3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout

	the pre-disciplinary/investigative phase? No. The hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation and investigative findings. 4. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was completed on December 26, 2017; however, the hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings until March 20, 2018, 84 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting. In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties. The Hiring Authority discussed with the entire staff the importance of meeting the OLES notification time frame criteria.

Case Table Section	Section Content
Incident Date	10/06/2017
OLES Case Number	2017-1180MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 6, 2017, two psychiatric technicians allegedly used excessive force while placing a patient against a wall, causing injuries to the patient's eye, chin, and knee.
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.
Investigative	Procedural Rating: Sufficient

Assessment	Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/12/2017
OLES Case Number	2017-1201MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 12, 2017, two psychiatric technicians allegedly used unnecessary force while placing a patient on the floor, causing pain to the patient's knee.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 188 days from the date of discovery
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 12, 2017; however, the investigation was not completed until April 18, 2018, 188 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	10/17/2017
OLES Case Number	2017-1216MC
Allegations	1. Criminal Act
Findings	1. Not Referred

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 17, 2017, a physician allegedly struck a patient in the kidney during a medical examination.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 149 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 18, 2017; however, the investigation was not completed until March 16, 2018, 149 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	10/17/2017
OLES Case Number	2017-1217MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 17, 2017, a physician allegedly used unnecessary force while examining a patient.
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.
Investigative	Procedural Rating: Insufficient

Assessment	Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 149 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 18, 2018; however, the investigation was not completed until March 16, 2018, 149 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	10/18/2017
OLES Case Number	2017-1221MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 18, 2017, a psychiatric technician and registered nurse allegedly assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The notification of the incident to outside law enforcement was not recorded in the report. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings until 61 days after the investigation was completed.
Pre-Disciplinary Assessment	1. 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 investigation was completed on January 18, 2018; however, the hiring authority did not consult with the OLES until March 20, 2018, 61 days later. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation or investigative findings. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was completed on January 18, 2018; however, the hiring authority did not consult with the OLES until March 20, 2018, 61 days later.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the Incident Review Committee (IRC) meeting either in person or via conference call. This procedure will allow for real-time consultation between all parties.

Case Table Section	Section Content
Incident Date	10/13/2017
OLES Case Number	2017-1227MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained 7. Sustained 8. Sustained

Penalty	Initial: Salary Reduction Final:
Incident Summary	On October 13, 2017, a nurse and a psychiatric technician allegedly failed to conduct a required medical assessment of a patient. A second psychiatric technician also failed to document the alleged failure to assess the patient.
Disposition	The hiring authority sustained the allegations. The hiring authority imposed a 10 percent salary reduction for 15 months on the nurse and first psychiatric technician and issued a counseling memorandum to the second psychiatric technician. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	10/14/2017
OLES Case Number	2017-1230MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Unfounded 2. Unfounded 3. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between October 14, 2017, and October 16, 2017, staff members allegedly left a patient in restraints for approximately 30 hours.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/01/2014
OLES Case Number	2017-1250MC

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between May 2014 and May 2015, a staff member allegedly sexually assaulted a patient two to three times per week.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/23/2017
OLES Case Number	2017-1252MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 23, 2017, a psychiatric technician allegedly coerced a patient to expose her breasts.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	05/25/2017
OLES Case Number	2017-1255MA
Allegations	1. Dishonesty 2. Misuse of state property
Findings	1. Sustained 2. Sustained

Penalty	Initial: Dismissal Final: Dismissal
Incident Summary	On May 25, 2017, May 26, 2017, and May 31, 2017, an officer allegedly used a State credit card to purchase gasoline for his personal vehicle. On May 30, 2017, and May 31, 2017, the officer was allegedly dishonest to his supervisor about his use of the credit card. On September 18, 2017, the officer allegedly was dishonest during his investigative interview.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. However, the officer resigned before the disciplinary action was served. A letter indicating the officer resigned under adverse circumstances was placed in his official personnel file. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	
Incident Date	11/19/2016
OLES Case Number	2017-1256MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 19, 2016, a registered nurse allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to consult with the OLES concerning the investigation. The administrative investigation was not initiated until 219 days after the criminal investigation was closed.
Pre-Disciplinary Assessment	1. 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 OLES

	regarding the sufficiency of the investigation or investigative findings. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with the OLES regarding the pre-disciplinary phase of the case. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on November 19, 2016, and was first investigated as a criminal investigation. The case was referred to the district attorney's office for a probable cause review and rejected for filing on March 14, 2017. The administrative investigation was not opened until October 19, 2017, 219 days later.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. The Chief/OPS discussed with the investigator the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame.

Case Table Section	Section Content
Incident Date	10/25/2017
OLES Case Number	2017-1260MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 25, 2017, a psychiatric technician allegedly slapped a patient's hand.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and

	procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/27/2017
OLES Case Number	2017-1270MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 27, 2017, staff members allegedly sexually assaulted a patient.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/26/2017
OLES Case Number	2017-1279MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 26, 2017, a psychiatric technician allegedly struck a patient with a shoe.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 134 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 31, 2017;

	however, the investigation was not completed until March 14, 2018, 134 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor in the investigation report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	02/01/2017
OLES Case Number	2017-1291MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between February 1, 2017, and August 23, 2017, a psychiatric technician allegedly engaged in an overly familiar relationship with a patient.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. However, the psychiatric technician resigned before disciplinary action could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	11/02/2017
OLES Case Number	2017-1293MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On November 2, 2017, a psychiatric technician allegedly kicked a patient in the head.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/03/2017
OLES Case Number	2017-1310MA 1
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 3, 2017, a physical therapist allegedly grabbed and twisted a patient's neck
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	11/12/2017
OLES Case Number	2017-1322MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 12, 2017, a psychiatric technician allegedly struck a patient on the head and upper body after the patient pushed the psychiatric technician's finger away.
Disposition	The Office of Protective Services conducted an investigation and referred the case to the district attorney's office for review. The OLES concurred. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	01/01/2017
OLES Case Number	2017-1327MC
Allegations	1. Criminal Act
Findings	1. Not Refered
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	During 2017, a psychiatric technician allegedly engaged in a sexual relationship with a patient.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The department failed to notify the OLES and there is no indication that outside law enforcement was notified. Several incidents were included in one special incident report even though the incidents were unrelated, involving different staff members and patients and alleging different types of misconduct.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not notify the OLES of the incident. 2. Was the incident properly documented? No. Several unrelated incidents involving different patients, staff, and different types of alleged misconduct were reported in one special incident report. 3. Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames required by law? No. There is no record that outside law enforcement

	was timely notified of the allegations.
Department Corrective Action Plan	OPS provided training to all OPS supervisors on OLES reporting guidelines. The command staff provided roll call training to their staff. Additional training will be provided to the staff on appropriate documentation for the Special Incident Report (SIR). In conjunction with the training the staff will also receive a summary of discussion. OPS will provide training to all OPS supervisors on incidents that require to be reported to outside law enforcement.

Case Table Section	Section Content
Incident Date	05/01/2017
OLES Case Number	2017-1346MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between May 1, 2017, and May 31, 2017, a registered nurse allegedly struck a patient in the stomach.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/16/2017
OLES Case Number	2017-1350MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 16, 2017, healthcare staff members allegedly broke a patient's toes.
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.
Investigative	Procedural Rating: Sufficient

Assessment	Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/17/2017
OLES Case Number	2017-1351MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 17, 2017, a psychiatric technician allegedly grabbed and pushed a patient's hand away when the patient reached for an item during a room search.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/19/2017
OLES Case Number	2017-1357MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 19, 2017, a psychiatric technician allegedly used unnecessary force on a patient during a floor containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative 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 concerning the

	sufficiency of the investigation and investigative findings.
Pre-Disciplinary Assessment	1. 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 regarding the sufficiency of the investigation and the investigative findings. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. Also, as of April 2018, a new procedure has been implemented where OLES is present during the IRC meetings either in person or via conference call. This procedure will allow for real-time consultation between all parties.

Case Table Section	Section Content
Incident Date	11/23/2017
OLES Case Number	2017-1364MC
Allegations	1. Behavior that results in death
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 23, 2017, a patient began to choke while eating dinner. Responding staff initiated emergency life-saving measures, which continued as the patient was transported to the urgent care room, where he was later pronounced dead.
Disposition	The Office of Protective Services completed the required investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/18/2017
OLES Case Number	2017-1378MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 18, 2017, a unit supervisor allegedly used excessive force while placing a patient on the floor.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/09/2017
OLES Case Number	2017-1382MC
Allegations	1. Criminal Act
Findings	1. Unsubstantiated
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 9, 2017, a psychiatric technician allegedly engaged in an inappropriate relationship with a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/21/2017
OLES Case Number	2017-1389MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 21, 2017, a psychiatric technician and a senior psychiatric technician allegedly improperly carried and placed a patient into a seclusion room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/01/2017
OLES Case Number	2017-1390MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 1, 2017, a psychiatric technician allegedly was overly familiar with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	09/01/2015
OLES Case Number	2017-1391MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between September 1, 2015, and September 30, 2015, a psychiatric technician allegedly was overly familiar with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred

	with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	12/01/2017
OLES Case Number	2017-1396MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 1, 2017, a psychiatric technician allegedly struck a patient in the face.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/13/2017
OLES Case Number	2017-1400MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On February 13, 2017, a registered nurse allegedly failed to properly assess a patient complaining of stroke-like symptoms.
Disposition	The department conducted an investigation into this matter; however, during the course of the investigation a program director prematurely issued the registered nurse a letter of instruction, which precluded the hiring authority from taking disciplinary action.
Investigative	Procedural Rating: Insufficient

Assessment	Substantive Rating: Sufficient The hiring authority failed to comply with the department's policies and procedures governing the pre-disciplinary process. The program director improperly issued a letter of instruction to the employee during the investigation, which precluded the hiring authority from pursuing any disciplinary action against the employee.
Pre-Disciplinary Assessment	1. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. A program director improperly issued a letter of instruction to the employee during the investigation, which precluded the hiring authority from pursuing any disciplinary action against the employee.
Department Corrective Action Plan	The Employee Relations Department gave instruction if an investigation through OSI is possible to occur, do not provide counseling although it is acceptable to provide training.

Case Table Section	Section Content
Incident Date	12/04/2017
OLES Case Number	2017-1401MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 4, 2017, four staff members allegedly twisted a patient's arm.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/06/2017
OLES Case Number	2017-1413MC
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 6, 2017, a psychiatric technician allegedly shook, hit, and slapped a patient in order to awaken the patient.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/07/2017
OLES Case Number	2017-1417MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 7, 2017, a patient, who was being constantly monitored, lost consciousness. Emergency life-saving measures were initiated. He was transported to an outside hospital where he died of respiratory failure.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The Office of Protective Services did not open an administrative investigation due to a lack of evidence of staff misconduct. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/23/2017
OLES Case Number	2017-1421MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On November 23, 2017, a patient alleged she had been raped by a registered nurse and inappropriately touched by a psychiatric technician.
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. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/06/2017
OLES Case Number	2017-1423MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 6, 2017, a licensed clinical social worker allegedly sexually assaulted a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/01/2007
OLES Case Number	2017-1432MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between January 1, 2007, and December 31, 2010, a senior

	psychiatric technician and a psychiatric technician assistant allegedly forced a patient into a laundry room for coerced sexual activity with the senior psychiatric technician.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/23/2017
OLES Case Number	2017-1435MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between November 23, 2017, and November 28, 2017, a psychiatric technician allegedly engaged in sexual acts with three patients and made personal telephone calls to them.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department substantially complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/11/2017
OLES Case Number	2017-1443MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On December 11, 2017, a unit supervisor and a psychiatric technician allegedly grabbed and forced a patient face down on a bed, causing the patient's dentures to dislodge and affect the patient's breathing. One of the staff members also allegedly pressed a knee into the patient's back.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/13/2017
OLES Case Number	2017-1444MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 13, 2017, a psychiatric technician allegedly posted a story on a social media website indicating the psychiatric technician had sexually assaulted a patient.
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. An administrative investigation was not opened because of insufficient evidence. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/13/2017
OLES Case Number	2017-1446MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On December 13, 2017, a psychiatric technician allegedly repeatedly struck a patient during a floor containment procedure.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigative report was not provided to the OLES before being delivered to the district attorney's office.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The investigative report was not provided to OLES for review before it was forwarded to the prosecuting agency. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. OPS did not provide the OLES with a draft of the criminal report prior to it being forwarded to the district attorney's office.
Department Corrective Action Plan	In the future a copy of the approved investigative report will be provided to OLES prior to providing to the District Attorney‘s office.

Case Table Section	Section Content
Incident Date	07/01/2017
OLES Case Number	2017-1455MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 1, 2017, a nurse allegedly failed to respond appropriately after a patient complained of chest pains.
Disposition	The hiring authority sustained allegations against the nurse; however, no disciplinary action was taken because the nurse resigned before completion of the investigation. A letter indicating the nurse resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	12/17/2017
OLES Case Number	2017-1465MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 17, 2017, a psychiatric technician allegedly slapped a patient.
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 did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/18/2017
OLES Case Number	2017-1467MC
Allegations	1. Behavior that results in death
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 18, 2017, after vomiting, and exhibiting

	slurred speech, a patient was transported to an outside hospital for further treatment. The patient suffered cardiac arrest while en route to the hospital. Paramedics initiated life-saving measures. The outside hospital confirmed the patient had an advanced health directive, refusing any life-saving measures. Life-saving efforts ceased, and the patient died at the outside hospital. The cause of death was cardiac arrest and lung cancer.
Disposition	The Office of Protective Services conducted the required death investigation which confirmed no crime or policy violation contributed to the patient's death. The OLES concurred with the determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/18/2017
OLES Case Number	2017-1468MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 18, 2017, a psychiatric technician allegedly struck a patient while the patient was in bed restraints.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/18/2017
OLES Case Number	2017-1469MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On December 18, 2017, staff members allegedly pushed and struck a patient.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/20/2017
OLES Case Number	2017-1488MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 20, 2017, a facility maintenance staff member allegedly sexually assaulted a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/24/2017
OLES Case Number	2017-1500MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 24, 2017, two psychiatric technicians allegedly grabbed and shoved a patient, while two other psychiatric technicians observed and failed to report the incident.
Disposition	The hiring authority determined that the investigation

	conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	12/30/2017
OLES Case Number	2018-0003MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 30, 2017, a nurse allegedly struck a patient after the patient had become agitated while waiting for his shower.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/29/2017
OLES Case Number	2018-0004MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 29, 2017, a staff member allegedly grabbed a patient's genitals, while two other staff members were assigned to monitor the patient.
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.
Investigative	Procedural Rating: Sufficient

Assessment	Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/05/2018
OLES Case Number	2018-0042MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 5, 2018, a physician allegedly used excessive force during a patient's eye examination.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/01/2015
OLES Case Number	2018-0044MA
Allegations	1. Misuse of state property 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final:
Incident Summary	In January 2015, an officer allegedly used State training funds for his personal use. In June 2015, the officer was allegedly dishonesty when he completed a travel claim form stating the funds had been used for training. In June and July 2017, the officer was allegedly dishonest to his supervisors regarding the misuse of the funds.
Disposition	The hiring authority sustained the allegations and dismissed the officer. The OLES concurred with the hiring authority's determination.

Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	01/08/2018
OLES Case Number	2018-0046MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 8, 2018, a psychiatric technician allegedly grabbed and twisted a patient's arm.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 138 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 10, 2018; however, the investigation was not completed until June 7, 2018, 138 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/10/2018
OLES Case Number	2018-0052MC
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 10, 2018, a staff member allegedly kicked a patient.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/10/2018
OLES Case Number	2018-0053MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 10, 2018, a patient was treated for severe genital bruising. An investigation was initiated to investigate the cause of the bruising.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/10/2018
OLES Case Number	2018-0054MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On January 10, 2018, a psychiatric technician allegedly closed a bathroom door on a patient's foot.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/20/2017
OLES Case Number	2018-0061MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 20, 2017, a registered nurse allegedly pushed a blind patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/13/2018
OLES Case Number	2018-0071MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 13, 2018, a staff member allegedly struck a patient in the eye.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/15/2018
OLES Case Number	2018-0075MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 15, 2018, a registered nurse allegedly struck a restrained patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	01/17/2018
OLES Case Number	2018-0088MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 17, 2018, staff members allegedly used excessive force to restrain and forcefully medicate a patient.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	01/14/2018
OLES Case Number	2018-0089MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 14, 2018, three psychiatric technicians allegedly failed to properly maintain supervision of a patient, resulting in the patient being able to cut herself with a screw.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/16/2018
OLES Case Number	2018-0098MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 16, 2018, a psychiatric technician allegedly pushed a patient against a wall.
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 did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	01/24/2018
OLES Case Number	2018-0107MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 24, 2018, a patient became unresponsive and was transported to an outside hospital where he died from cardiac arrest.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/25/2018
OLES Case Number	2018-0108MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 25, 2018, a patient was found unresponsive in his room. Emergency life-saving measures were initiated; however, the patient was declared dead. An autopsy determined the patient died of natural causes attributed to heart disease.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the case was not referred to the district attorney's office. The OLES concurred with the hiring authority's determination. An administrate investigation was not opened. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and

	procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/07/2018
OLES Case Number	2018-0112MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 7, 2018, a psychiatric technician allegedly struck and scratched a patient.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/26/2018
OLES Case Number	2018-0120MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 26, 2018, a psychiatric technician allegedly grabbed a patient by the arm and stabbed her with a knife.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	01/30/2018
OLES Case Number	2018-0123MC
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 30, 2018, three staff members allegedly grabbed a patient, which caused bruising on the patient's arm.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/30/2017
OLES Case Number	2018-0125MA
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 30, 2017, an officer allegedly improperly claimed military leave in order to avoid working overtime.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. Based upon the OLES' recommendations the hiring authority will develop a policy governing military leave for hospital police officers.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/05/2018
OLES Case Number	2018-0149MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 5, 2018, a patient died at an outside hospital

	of heart disease and other chronic medical conditions for which he had been receiving treatment.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the case was not referred to the district attorney's office. The OLES concurred with the hiring authority's determination. An administrative investigation was not opened. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/06/2018
OLES Case Number	2018-0155MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 6, 2018, a social worker allegedly struck a patient multiple times.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/07/2018
OLES Case Number	2018-0158MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 7, 2018, a patient was found unresponsive in his room. Emergency life-saving measures were initiated and he was transported to an outside hospital where he died of cardiac arrest.
Disposition	The hiring authority determined there was no evidence of

	staff misconduct; therefore, the case was not referred to the district attorney's office. An administrative investigation was not opened. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/15/2018
OLES Case Number	2018-0161MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 15, 2018, a psychiatric technician allegedly slapped a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/08/2018
OLES Case Number	2018-0162MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 8, 2018, a patient's conservator alleged the patient may have had sexual contact with a staff member.
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 did not open an administrative investigation due to lack of evidence.

Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/09/2018
OLES Case Number	2018-0170MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final:
Incident Summary	On February 9, 2018, a patient died at an outside hospital from colon cancer.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the case was not referred to the district attorney's office nor was an administrative investigation opened. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/04/2018
OLES Case Number	2018-0184MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 4, 2018, a psychiatric technician allegedly used excessive force to administer medication to a patient.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/13/2018
OLES Case Number	2018-0185MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 13, 2018, four staff members allegedly punched a patient in the mouth, nose, and eyes.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/16/2018
OLES Case Number	2018-0206MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 16, 2018, a senior psychiatric technician allegedly sexually assaulted a patient during a room search.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/21/2018

OLES Case Number	2018-0221MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 21, 2018, during a medical assessment, medical staff discovered a small laceration and bruising in a patient's genital area.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/22/2018
OLES Case Number	2018-0224MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 22, 2018, a patient alleged a psychiatric technician placed one gloved finger in her vagina.
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 also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/21/2018
OLES Case Number	2018-0225MC
Allegations	1. Criminal Act
Findings	1. Not Referred

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 21, 2018, a staff member allegedly struck a patient in the face, breaking the patient's jaw.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority failed to comply with the department's policies and procedures governing the investigative process. The department failed to include the OLES in all of the critical activities related to the case.
Pre-Disciplinary Assessment	1. Did the Hiring Authority adequately consult with OLES regarding the incident? No. The hiring authority did not adequately consult with OLES regarding the incident. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The OPS did not adequately confer with OLES upon case initiation and prior to finalizing the investigative plan. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. OPS did not cooperate with and provide continued real-time consultation with OLES. 4. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The facility failed to properly notify the assigned investigator that this was an OLES monitored case. Therefore, the OLES was not notified of, nor able to monitor investigative activities.
Department Corrective Action Plan	A process has been implemented to track cases that are being monitored by OLES.

Case Table Section	Section Content
Incident Date	02/23/2018
OLES Case Number	2018-0228MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 23, 2018, a psychiatric technician allegedly smothered a patient.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/24/2018
OLES Case Number	2018-0231MA
Allegations	1. Behavior that results in death 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 24, 2018, a patient was found unresponsive in his room when staff attempted to wake him for breakfast. Responding staff initiated emergency life-saving measures; however, the patient was later pronounced dead. The cause of death was myocardial infarction with multiple contributing medical conditions.
Disposition	The hiring authority determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/23/2018
OLES Case Number	2018-0233MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 23, 2018, a unit supervisor allegedly bent a patient's fingers while he choked the patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/27/2018
OLES Case Number	2018-0244MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 27, 2018, a patient alleged that a psychiatric technician had previously sexually assaulted two other patients.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/28/2018
OLES Case Number	2018-0245MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 28, 2018, health care staff discovered a non-responsive patient in his room. Emergency life-saving measures were initiated, but were ceased when staff learned the patient had executed a Do Not Resuscitate order. A doctor pronounced the patient deceased. The death was attributed to cardiopulmonary arrest.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/04/2018
OLES Case Number	2018-0273MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 4, 2018, a psychiatric technician allegedly administered medication intended for a patient to a second patient. As a result, the second patient had to be taken to an outside hospital for treatment.
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 also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	03/06/2018
OLES Case Number	2018-0280MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 6, 2018, a psychiatric technician allegedly struck a patient on the neck and stepped on the patient's toes.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing he investigative process.

Case Table Section	Section Content
Incident Date	03/06/2018
OLES Case Number	2018-0281MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 6, 2018, three health care staff members allegedly repeatedly sexually assaulted a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/01/2018
OLES Case Number	2018-0304MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No change
Incident Summary	Between February 1, 2018, and February 28, 2018, a psychiatric technician allegedly sexually assaulted a patient multiple times.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	09/14/2017
OLES Case Number	2018-0310MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 14, 2017, a psychiatric technician allegedly choked a patient while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	01/19/2018
OLES Case Number	2018-0346MA

Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On January 19, 2018, a registered nurse allegedly failed to make the required notifications regarding a patient's allegation of sexual assault.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the registered nurse and imposed a 5 percent salary reduction for one month. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	03/27/2018
OLES Case Number	2018-0353MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 27, 2018, a patient died while receiving medical treatment for chronic medical conditions at an outside hospital. The death was attributed to cardiopulmonary arrest.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the case was neither referred to the district attorney's office, nor was an administrative investigation initiated. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/04/2018
OLES Case Number	2018-0355MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 4, 2018, a psychiatric technician allegedly administered medication intended for a patient to a second patient. As a result, the second patient had to be taken to an outside hospital for treatment.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	03/29/2018
OLES Case Number	2018-0360MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 29, 2018, a psychiatric technician allegedly kicked a patient.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/20/2018
OLES Case Number	2018-0407MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 20, 2018, a psychiatric technician allegedly struck a patient in the mouth, fracturing the patient's jaw and

	dislodging three of the patient's teeth.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/20/2018
OLES Case Number	2018-0428MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final:
Incident Summary	On April 20, 2018, a psychiatric technician allegedly struck a patient in the mouth, fracturing the patient's jaw and dislodging three of the patient's teeth. It was also alleged the psychiatric technician failed to wear his personal alarm as required by policy.
Disposition	The hiring authority sustained the allegations and dismissed the psychiatric technician. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/04/2018
OLES Case Number	2018-0469MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 4, 2018, a patient died at an outside hospital after receiving treatment for pneumonia. The death was

	attributed to respiratory failure and cardiac arrest.
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 of staff misconduct
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/01/2018
OLES Case Number	2018-0524MA
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	Between February 2018 and April 2018, a psychiatric technician allegedly engaged in an overly familiar relationship with a patient. The psychiatric technician allegedly provided a mobile telephone to the patient, through which the psychiatric technician communicated with the patient and exchanged inappropriate self-photographs. The psychiatric technician also allegedly sent a money order and provided prohibited items to the patient.
Disposition	The hiring authority sustained the allegations against the psychiatric technician and determined dismissal was the appropriate penalty. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Appendix B2 – DDS Pre-Disciplinary Cases

Case Table Section	Section Content
Incident Date	01/04/2017
OLES Case Number	2017-0074MC
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 4, 2017, a psychiatric technician assistant allegedly threw a coffee pod at a resident and touched the resident's hand in a sexually suggestive manner. During an unspecified time period, a psychiatric technician allegedly engaged in a sexual relationship with the resident and brought narcotics into the facility for the resident. Additionally, a second psychiatric technician and the psychiatric technician assistant allegedly showed the resident favoritism.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigative report was not completed until 356 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 19, 2017; however, the investigative report was not completed until January 9, 2018, 356 days later.
Department Corrective Action Plan	The OPS Commander will monitor SIU Investigator caseloads and ensure cases/investigations are being disbursed evenly within the unit. Open communication will

	continue with the SIU Lieutenant, SIU Investigators, OLES Monitors and Investigators, Administration, and stakeholders in order to expedite the completion on investigations and reports.

Case Table Section	Section Content
Incident Date	02/19/2017
OLES Case Number	2017-0293MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 19, 2017, heath care staff allegedly did not report that a resident sustained a right ankle fracture as a result of a fall.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The administrative investigation was initiated on April 18, 2017; however, the investigation was not completed until December 28, 2017, 274 days later. Additionally, the hiring authority received the final investigation on January 18, 2018; however, the findings and penalty conference was not complete until March 14, 2018, 55 days later.
Pre-Disciplinary Assessment	1. 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 received the final investigation on January 18, 2018; however, the findings and penalty conference was not complete until March 14, 2018, 55 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The administrative investigation was initiated on April 18, 2017; however, the investigation was not completed until December 28, 2017, 274 days later.
Department	The FDC case review process was revisited with Governing

Corrective Action Plan	Body and Executive Members, using DDS Policy Memorandum 322, Review/Disposition of Office of Protective Services (OPS) Investigation Unit Cases with Office of Law Enforcement Support (OLES) Oversight, dated January 31, 2018. Modifications to the case review process were made to schedule weekly. OPS/OLES cases to be scheduled for case review, upon Quality Assurances' receipt of completed OPS investigative reports forwarded from the Office of Protective Services. The Director of Quality Assurance/designee will monitor the completed cases posted on the shared drive (with OPS) and will be reviewed based upon the following prioritized criteria: a) OLES monitored cases. b) SIU reports and/or police reports where staff were removed from client care; or reports where findings against staff were substantiated. To close the time gap and to ensure timely investigative interviews are conducted, Investigators have been instructed to make contact with all involved individuals immediately after the investigation has been launched, regardless of the employee's employment status or assigned on duty/off duty status, in order to obtain the necessary information to complete the investigation.

Case Table Section	Section Content
Incident Date	07/16/2017
OLES Case Number	2017-0850MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 16, 2017, two psychiatric technicians allegedly pushed, struck, kicked, and verbally threatened a resident.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/26/2017
OLES Case Number	2017-0891MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On July 26, 2017, a psychiatric technician allegedly failed to properly monitor a resident who was on an enhanced level of supervision, thereby allowing the resident an opportunity to insert an object into his genitals.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. However, the hiring authority issued the psychiatric technician a letter of instruction and ordered additional training for the employee regarding proper monitoring procedures. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The department failed to consult with the OLES during the investigative process.
Pre-Disciplinary Assessment	1. Did the Hiring Authority adequately consult with OLES regarding the incident? No. The hiring authority did not consult with OLES during the investigative process. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. OPS did not confer with OLES during the investigative process. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. OPS did not consult with OLES during critical investigative junctures.
Department Corrective Action Plan	The hiring authority will ensure communication with OPS for any OLES needed consultation. The Executive Director meets with OPS on a daily basis and as needed, has provided instruction to the Acting Commander regarding confer with the OLES monitor to provide updates and status

	reviews on all OLES pending cases. The Executive Director will monitor this communication on a weekly basis and on Fridays the QA office will provide a listing of all pending OPS/OLES cases, to ensure that the time frames outlined in the DDS PM are being met and barriers are being removed to ensure the timely completion of OPS investigations. Investigators are provided an email notifying them when a case is assigned to them and whether it is an OLES monitored case. The OPS Lieutenant will monitor and track compliance.

Case Table Section	Section Content
Incident Date	07/29/2017
OLES Case Number	2017-898MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Unfounded 2. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 29, 2017, a psychiatric technician assistant allegedly failed to report a resident's suicide threat.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services failed to consult with OLES during critical junctures of the investigative process and the hiring authority delayed conducting the findings and penalty conference. The investigation was completed on October 4, 2017; however, the findings and penalty conference was not held until March 21, 2018, 168 calendar days later.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. OPS did not confer with OLES during critical junctures of the investigation. OLES was not informed of a subject interview and was therefore, unable to monitor the interview. 2. Was the pre-disciplinary/investigative phase

	conducted with due diligence? No. The investigation was completed on October 4, 2017; however, the findings and penalty conference was not held until March 21, 2018, 168 calendar days later.
Department Corrective Action Plan	OPS Management revisited and reviewed protocol and guidelines to ensure compliance. OPS staff received additional instruction on the importance of adhering to protocols and to use mechanisms in place to track notifications. The Acting Commander will monitor for compliance in this area, with weekly reviews completed within the OPS department to ensure timely communication with the OLES monitor is made. The FDC case review process was revisited with Governing Body and Executive Members, using DDS policy memorandum 322, review/disposition of the Office of protective Services (OPS) investigation unit cases with Office of Law Enforcement Support (OLES) oversight, dated January 31, 2018. Modifications to the case review process were made to schedule weekly. OPS/OLES cases to be scheduled for case review upon receipt of completed OPS investigative reports received from OPS. The Director of Quality Assurance/designee will monitor completed OPS cases posted on the shared drive (with OPS) and will be reviewed based upon the following prioritized criteria: a) OLES monitored cases b) SIU reports and/or police reports where staff were removed from client care; or reports where the findings against staff were substantiated.

Case Table Section	Section Content
Incident Date	08/30/2017
OLES Case Number	2017-1042MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Unfounded
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On August 30, 2017, a senior psychiatric technician and a teacher allegedly failed to monitor and account for a

	missing resident. The resident was left unattended for approximately 40 minutes.
Disposition	The hiring authority sustained the allegation against the senior psychiatric technician and imposed a 10 percent salary reduction for six months. The hiring authority determined the allegation against the teacher was unfounded. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	09/05/2017
OLES Case Number	2017-1065MA
Allegations	1. Incompetency
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 5, 2017, a psychiatric technician allegedly failed to properly monitor a resident who required a constant level of supervision, thereby providing the resident an opportunity to ingest a zipper.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	09/23/2017
OLES Case Number	2017-1132MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 23, 2017, a resident died from a heart attack while receiving treatment at an outside hospital.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/01/2016
OLES Case Number	2017-1229MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between June 2016 and July 2016, a pre-licensed psychiatric technician allegedly shared personal information with a resident, provided money and gifts to the resident, and had sex with the resident. The pre-licensed psychiatric technician was also allegedly dishonest during the investigation.
Disposition	The hiring authority sustained the allegations against the pre-licensed psychiatric technician. However, the pre-licensed psychiatric technician resigned before completion of the investigation; therefore, no disciplinary action was taken. A letter indicating the pre-licensed psychiatric technician resigned while under investigation was placed in her official personnel file. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	11/03/2017
OLES Case Number	2017-1297MC

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 3, 2017, a psychiatric technician assistant allegedly pushed and grabbed a resident, then took and threw the resident's water bottle when the resident refused to terminate a phone call.
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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 124 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The Office of Protective Services discovered the allegations on November 3, 2017; however, the investigative report was not completed until March 6, 2018, 124 days later.
Department Corrective Action Plan	The OPS Commander will monitor SIU Investigator caseloads and ensure cases/investigations are being disbursed evenly within the unit. Open communication will continue with the SIU Lieutenant, SIU Investigators, OLES Monitors and Investigators, Administration, and stakeholders in order to expedite the completion on investigations and reports.

Case Table Section	Section Content
Incident Date	05/10/2017
OLES Case Number	2017-1330MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between May 10, 2017, and May 14, 2017, a psychiatric technician allegedly hit a resident numerous times.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred

	with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	11/14/2017
OLES Case Number	2017-1334MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 14, 2017, a resident was found unresponsive and emergency life saving measures were initiated. The resident was transported to an outside hospital where she subsequently died of cardiac arrest.
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 did not open an administrative investigation due to lack of evidence of any staff misconduct.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/08/2017
OLES Case Number	2017-1433MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 8, 2017, a registered nurse allegedly shared a resident's confidential medical information with an unauthorized recipient. Additionally, two psychiatric technician assistants allegedly knocked on a resident's

	window in order to intentionally harass the resident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the registered nurse and determined a letter of reprimand was the appropriate penalty. However, the registered nurse resigned prior to the completion of the investigation. A letter indicating the nurse resigned under adverse circumstances was placed in her official personnel file. The hiring authority determined there was insufficient evidence to sustain the allegations against the two psychiatric technician assistants. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	12/13/2017
OLES Case Number	2017-1445MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 13, 2017, two psychiatric technicians allegedly told a resident to retrieve and ingest medication out of her vomit; if she refused, she would not be allowed to take a smoke break.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to provide the OLES with either the draft or final investigative report.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?

	No. The draft report was not provided to the OLES. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services did not provide the OLES with either the draft or final investigative report. 3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not provide the OLES with either a copy of the draft or final investigative report.
Department Corrective Action Plan	The OPS Commander will ensure that OLES be provided with a copy of draft and final investigative reports. The OPS Commander has discussed with the Investigator the importance of providing the draft and final reports. The investigator understands our expectations.

Case Table Section	Section Content
Incident Date	12/20/2017
OLES Case Number	2017-1476MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 20, 2017, a resident died while receiving treatment at an outside hospital. The cause of death was pneumonia with advanced respiratory distress syndrome and respiratory failure.
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 of staff misconduct.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/02/2018
OLES Case Number	2018-0018MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 2, 2018, a resident suffering from osteoporosis was diagnosed with a fractured arm.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/31/2017
OLES Case Number	2018-0057MA
Allegations	1. Inexcusable neglect of duty 2. Other
Findings	1. Unfounded 2. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On December 31, 2017, a psychiatric technician allegedly slapped a resident.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur, but did sustain an added allegation of not properly reporting and documenting the incident, and served the employee with a letter of instruction and ordered additional training. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/06/2018
OLES Case Number	2018-0156MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 6, 2018, a senior psychiatric technician allegedly choked a resident.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to follow policies and procedures governing the investigative process. The Office of Protective Services did not provide the OLES with a draft copy of the investigative report.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The draft copy of the investigative report was not provided to the OLES before it was completed. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The OPS did not provide the draft investigative report to the OLES.
Department Corrective Action Plan	The Office of Protective Services (OPS) admits it failed to submit a draft copy of the investigative report to the OLES monitor. The investigator accepts responsibility for this. The Commander has instructed the investigator to copy him (CC) when the investigator submits the draft investigative report to the OLES monitor as a way of monitoring that this requirement is followed.

Case Table Section	Section Content
Incident Date	02/27/2018
OLES Case Number	2018-0241MC
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 27, 2018, a resident died of cardiovascular disease.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/28/2018
OLES Case Number	2018-0251MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 28, 2018, a psychiatric technician allegedly pushed a resident into a wall.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The OLES was not provided with the draft report before it was forwarded to the hiring authority. The draft report did not accurately reflect the statement of a witness.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The draft report was not provided to the OLES for review before the report was finalized.

	2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The statement of one of the witnesses was not correctly summarized in the report.
Department Corrective Action Plan	A copy of the report was provided to the Executive Director on 03/29/2018, to assist in making staff assignment decisions. Going forward, no monitored report will be provided to the Executive Director until approval of the draft report by the OPS Attorney. OPS asks that any issue with a draft report be discussed with the author and the OLES attorney prior to the report being finalized.

Case Table Section	Section Content
Incident Date	03/11/2018
OLES Case Number	2018-0295MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 11, 2018, a psychiatric technician allegedly slapped a resident and a psychiatric technician assistant allegedly placed her knee on the resident's shoulder and neck.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/14/2018
OLES Case Number	2018-0305MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 14, 2018, a psychiatric technician allegedly pushed a resident to the ground and a second psychiatric technician put her knee on the resident's neck.

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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/01/2018
OLES Case Number	2018-0335MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 1, 2018, a psychiatric technician allegedly forced a resident against a wall, while a second psychiatric technician witnessed the incident and did not intervene. On March 23, 2018, a senior psychiatric technician allegedly used a pressure point technique on the resident's jaw, and the first psychiatric technician allegedly punched the resident's lower back, while a third psychiatric technician held the resident's arm. The senior psychiatric technician and the first psychiatric technician also allegedly choked the resident.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/28/2018
OLES Case Number	2018-0362MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On March 28, 2018, a psychiatric technician allegedly struck a resident, pulled the resident's hair, and forcefully placed the resident on the ground.
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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Appendix C: 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 C1 DSH Discipline Phase Cases

Case Table Section	Section Content
Incident Date	03/29/2016
OLES Case Number	2016-0369MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Suspension Final: Salary Reduction
Incident Summary	On March 29, 2016, four nurses allegedly failed to complete required nursing assessments on a patient in full bed restraints. Two of those nurses were also allegedly dishonest during investigative interviews.
Disposition	The hiring authority sustained allegations against two of the nurses and imposed a seven-working-day suspension on each. The OLES concurred. A third nurse resigned before completion of the investigation; therefore, no disciplinary action was taken. A letter indicating the third nurse resigned under adverse circumstances was placed in his official personnel file. No allegations were sustained against the fourth nurse. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient Pending service of the disciplinary action, one of the two

	remaining nurses voluntarily resigned. A letter indicating the nurse resigned under adverse circumstances was placed in his official personnel file. The hiring authority modified the penalty against the remaining nurse from a seven-working-day suspension to an equivalent penalty of a 5 percent salary reduction for seven months. Following the Skelly hearing, the department entered into a settlement agreement wherein the penalty was reduced to a 5 percent salary reduction for three months due to the nurse's remorse, taking responsibility for his actions, and because of his continued exemplary record after the incident. The nurse waived any right of appeal to the State Personnel Board. The OLES concurred. The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was served 520 days after the decision to take action was made.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The decision to take disciplinary action was made on September 19, 2016; however, the disciplinary action was not served until February 20, 2018, 520 days later.
Department Corrective Action Plan	The department is working on hiring additional staff/discipline analyst to handle the increased workload. A new procedure has been implemented. This procedure consists of written documentation of all consultations and decisions to ensure follow up and due diligence.

Case Table Section	Section Content
Incident Date	04/29/2016
OLES Case Number	2016-0545MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
Incident Summary	On April 29, 2016, a psychiatric technician allegedly gave his personal food to a patient after the food had fallen on the floor.
Disposition	The hiring authority sustained all allegations against the psychiatric technician and imposed a 10 percent salary reduction for six months. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a 10 percent salary reduction for five months. The psychiatric technician agreed to withdraw his appeal. The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was served 323 days after the decision to take action was made.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority decided to take disciplinary action against the psychiatric technician on December 6, 2016; however, the disciplinary action was not served on the psychiatric technician until October 24, 2017, 323 days later.
Department Corrective Action Plan	The department is working on hiring additional staff/discipline analyst to handle the increased workload. A new procedure has been implemented. This procedure consists of written documentation of all consultations and decisions to ensure follow up and due diligence.

Case Table Section	Section Content
Incident Date	05/14/2016
OLES Case Number	2016-0728MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Discourteous treatment 4. Dishonesty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Not Sustained
Penalty	Initial: Suspension Final: No Change
Incident Summary	On May 14, 2016, a nurse was allegedly less than alert while on duty, and confronted the patient who reported the nurse's inattentiveness to a supervising nurse. The supervising nurse allegedly failed to intervene when the first nurse confronted the patient. Additionally, a licensed vocational nurse was allegedly less than alert while assigned to enhanced observation duties over a patient.

	The licensed vocational nurse was also allegedly dishonest during the investigation.
Disposition	The hiring authority sustained the allegations against the first nurse, and imposed a 10 percent salary reduction for six months. The hiring authority also sustained the allegations against the licensed vocational nurse, and imposed a 12-working-day suspension. The OLES concurred with the hiring authority's determinations. The hiring authority determined there was insufficient evidence to sustain the allegation against the supervising nurse. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The licensed vocational nurse filed an appeal with the State Personnel Board. At a settlement conference, the department entered into a settlement agreement with the licensed vocational nurse wherein the dishonesty allegation was removed from the disciplinary action, and the penalty was reduced to a 5-working-day suspension. The licensed vocational nurse agreed to withdraw her appeal. The OLES concurred because the resulting penalty was still significant for the remaining allegation, and had a deterrent effect. The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority determined the penalties for the nurse and the licensed vocational nurse on June 16, 2017; however, the disciplinary action was not served on the licensed vocational nurse until February 6, 2018, 236 days later. Pending drafting of the disciplinary actions, the first nurse transferred to another state agency and was not served the disciplinary action.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority determined the penalties for the nurse, and the licensed vocational nurse on June 16, 2017; however, the disciplinary action was not served on the licensed vocational nurse until February 6, 2018, 236 days later. Pending drafting of the disciplinary actions, the nurse transferred to another state agency.
Department Corrective Action Plan	The Employee Relations Office has been reorganized with an Employee Relations Manager who will oversee the completion of actions. OLES monitored cases will remain a priority.

Case Table Section	Section Content
Incident Date	09/21/2016
OLES Case Number	2016-1550MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Inexcusable neglect of duty 4. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On September 21, 2016, a patient alleged a psychiatric technician would not allow her to use the restroom. The psychiatric technician was also allegedly dishonest during an investigative interview. A registered nurse allegedly failed to report the allegation.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the psychiatric technician and dismissed the employee. The hiring authority also sustained the allegation against a registered nurse and ordered she receive corrective action. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The psychiatric technician filed an appeal with the State Personnel Board. Prior to a State Personnel Board evidentiary hearing the department entered into a settlement agreement with the psychiatric technician wherein the psychiatric technician resigned in lieu of dismissal and agreed to not seek re-employment as a psychiatric technician or in any patient care position. The OLES concurred with the settlement. The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	04/19/2016
OLES Case Number	2017-0407MA
Allegations	1. Unlawful discrimination 2. Unlawful retaliation 3. Dishonesty 4. Other failure of good behavior
Findings	1. Sustained

	2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: No Penalty Imposed
Incident Summary	On April 19, 2016, a law enforcement supervisor allegedly sexually harassed a subordinate peace officer by leaning over a desk to say, "good morning" in an emphatic manner and stared at her breasts. From May 10, 2016, to September 26, 2016, the supervisor allegedly retaliated against the officer after she filed a complaint, by issuing corrective actions and by having her removed from training so the supervisor could attend instead. The supervisor also was allegedly dishonest during the investigatory interview.
Disposition	The hiring authority sustained the allegations and dismissed the supervisor. The OLES concurred with the hiring authority's determinations. The supervisor filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board revoked the supervisor's dismissal. The administrative law judge made a credibility determination, and ruled the evidence was insufficient to counter the supervisor's credible denials of the allegations.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority did not consult with the OLES before making disciplinary determinations. The department also did not provide the OLES with a copy of the disciplinary action for review before serving it on the supervisor.
Disciplinary Assessment Questions	1. Did the Hiring Authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision? No. The hiring authority did not consult with the OLES regarding disciplinary determinations before making a final decision, and serving the disciplinary action on the law enforcement supervisor. 2. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? No. The OLES received a copy of the final disciplinary

	action after it was already served on the law enforcement supervisor. 3. Did SPB's decision uphold all of the factual allegations sustained by the Hiring Authority? No. The State Personnel Board adopted the decision of the administrative law judge who heard the case, and directed the disciplinary action be revoked. 4. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? No. The hiring authority did not consult with the OLES regarding disciplinary determinations until after a final decision was made, and the disciplinary action was already served.
Department Corrective Action Plan	The department's process has improved and the issues identified should not recur.

Case Table Section	Section Content
Incident Date	09/21/2016
OLES Case Number	2017-0442MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Not Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
Incident Summary	On September 21, 2016, two officers allegedly failed to investigate, document, or report a patient fight to a supervisor. The officers were also allegedly dishonest during their investigatory interviews. A third officer allegedly failed to respond to the alarm and provide assistance.
Disposition	The hiring authority sustained neglect of duty allegations against the first two officers, but did not sustain the dishonesty allegations. The first officer retired before the disciplinary determinations were made. A letter indicating the officer retired pending disciplinary action was placed in her official personnel file. The hiring authority imposed a salary reduction of 10 percent for 12 months on the second officer. The hiring authority did not sustain the allegations against the third officer. The OLES concurred with the hiring

	authority's determinations. The second officer filed an appeal with the State Personnel Board. Prior to State Personnel Board proceedings, the department entered into a settlement agreement wherein the penalty was reduced to a 10 percent salary reduction for six months and the officer agreed to withdraw his appeal. The OLES concurred with the settlement.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the disciplinary process. The hiring authority made disciplinary findings on April 18, 2017; however, the action was not served until September 15, 2017, 150 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority made disciplinary findings on April 18, 2017; however, the action was not served until September 15, 2017, 150 days later.
Department Corrective Action Plan	The hiring authority will provide continual consultation with OLES as needed during the disciplinary phase and serving of the adverse action. Also, a tracking system has been implemented to ensure adverse actions are served within a timely manner.

Case Table Section	Section Content
Incident Date	02/17/2017
OLES Case Number	2017-0613MA
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On February 17, 2017, a psychiatric technician allegedly engaged in a long-term overly familiar relationship with a patient.
Disposition	The hiring authority sustained the allegations against the psychiatric technician and determined dismissal was the appropriate penalty. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient Although the disciplinary action was served, the psychiatric

	technician resigned before the dismissal took effect. The psychiatric technician did not file an appeal with the State Personnel Board. The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was not served until 213 days after the hiring authority made penalty determinations.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. On June 6, 2017, the hiring authority sustained allegations against the psychiatric technician, and determined dismissal was the appropriate penalty; however, the disciplinary action was not served on the psychiatric technician until January 5, 2018, 213 days later.
Department Corrective Action Plan	The department is working on hiring additional staff/discipline analyst to handle the increased work load.

Case Table Section	Section Content
Incident Date	12/26/2016
OLES Case Number	2017-0811MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On December 26, 2016, a psychiatric technician allegedly intentionally gave the wrong medication to a patient and then intimidated a nurse from reporting the incident.
Disposition	The hiring authority sustained the allegations and dismissed the psychiatric technician. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The psychiatric technician filed an appeal with the State Personnel Board. However, pursuant to a settlement agreement the psychiatric technician technician agreed to resign in lieu of dismissal and withdrew her appeal. The psychiatric technician also agreed that should she ever attempt to apply for future employment with the department, a copy of the settlement agreement must be

	attached to any application, and failure to do so would be a breach of the settlement agreement, and grounds for dismissal. The department agreed to the settlement agreement because it ultimately ensured the psychiatric technician would no longer work for the department. The OLES concurred. Overall, the department complied with policies and procedures governing the disciplinary process.

Appendix C2 – DDS Discipline Phase Cases

Case Table Section	Section Content
Incident Date	04/10/2016
OLES Case Number	2016-0420MA
Allegations	1. Incompetency 2. Incompetency 2. Discourteous treatment
Findings	1. Unfounded 2. Sustained 3. Unfounded
Penalty	Initial: Suspension Final: Letter of Reprimand
Incident Summary	On April 10, 2016, two psychiatric technicians allegedly were negligent when they failed to properly monitor a resident who was on a direct observation level of supervision during the evening shift. The resident swallowed a mobile phone battery. A third psychiatric technician allegedly threatened to choke the resident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the psychiatric technician who supervised the resident during the evening shift 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.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient On May 17, 2016, the hiring authority determined the appropriate penalty was a two-working-day suspension without pay. On May 23, 2018, the penalty determination was revisited by the hiring authority and the original penalty was reduced to a letter of reprimand. The modification was based on the fact that the employee was on disability leave and not returning to full employment status. The original penalty would not become effective. However, the letter of reprimand did have an effective date and documented the misconduct. The OLES concurred. The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was not served in a timely manner. The initial findings and penalty conference was held on May 17, 2016; however, the disciplinary action was not served until June 8, 2018, 752 days later.

Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? The penalty determination was made on May 17, 2016; however, the disciplinary action was not served until June 8, 2018, 752 days later.
Department Corrective Action Plan	The Hiring Authority will engage in continuous consultation with all entities of the disciplinary action and resolution process to ensure timeline guidelines related to disciplinary action and resolution phases are met. Consultation will include ongoing review with needed parties within the review process through resolution.

Case Table Section	Section Content
Incident Date	04/27/2016
OLES Case Number	2016-0523MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On April 27, 2016, a senior psychiatric technician allegedly left a resident, who was on one-to-one supervision status unattended, to care for another resident. While unsupervised, the resident engaged in self-injurious behavior by attempting to ingest his socks.
Disposition	The hiring authority sustained the allegation and imposed a salary reduction of 5 percent for six months. The OLES concurred in the determination.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The senior psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the senior psychiatric technician wherein the penalty was reduced to a 5 percent salary reduction for three months. The senior psychiatric technician agreed to withdraw her appeal. The OLES concurred. The hiring authority failed to comply with policies and procedures governing the disciplinary process. The date of the initial disposition meeting was September 20, 2016; however, the disciplinary action was not served until November 8, 2017, 404 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department?

	No. The date of the initial disposition meeting was September 20, 2016; however, the disciplinary action was not served until November 8, 2017, 404 days later.
Department Corrective Action Plan	As for the adverse actions (AA's) being delayed for any reason, the Executive Director will determine what barriers are occurring and identify an action plan to address the barrier. The Executive Director will continue to track the timeliness of these AA's at the bi-monthly meeting. If there are barriers identified outside of SDC's control, the ED will elevate the barrier to DDS for resolution.

Case Table Section	Section Content
Incident Date	07/27/2016
OLES Case Number	2016-0941MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On July 27, 2016, a senior psychiatric technician allegedly failed to make required notifications after hearing a resident's arm make a popping sound while the resident was being moved. The resident was later diagnosed with a fractured arm.
Disposition	The hiring authority sustained the allegation against the senior psychiatric technician and imposed a 5 percent salary reduction for 12 months. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The psychiatric technician did not file an appeal with the State Personnel Board. The department complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	08/27/2016
OLES Case Number	2016-01106MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: Training
Incident Summary	On August 27, 2016, a psychiatric technician allegedly failed to adequately maintain enhanced supervision of a resident, which resulted in the resident's escape from the facility.

Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 5 percent salary reduction for twelve months. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority did not timely conclude the disciplinary determinations. The hiring authority decided to provide training in lieu of discipline 367 days after the original decision to impose discipline.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The initial findings and penalty conference occurred on January 3, 2017, wherein the hiring authority determined dismissal was the appropriate penalty. On May 31, 2017, the penalty was reduced to a 5 percent salary reduction for 12 months. On January 5, 2018, the hiring authority made a decision to impose training instead of disciplinary action, 367 days after the initial findings and penalty conference.
Department Corrective Action Plan	All pending adverse actions (AA's) will be reviewed at the bi-monthly SDC labor meeting which includes the Executive Director, Clinical Director, Administrative Services Director, Human Resources Director, and the Labor Relations Analyst.

Case Table Section	Section Content
Incident Date	02/07/2017
OLES Case Number	2017-0160MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Suspension Final: Letter of Reprimand
Incident Summary	On February 7, 2017, a resident alleged a psychiatric technician threatened to hit her.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 30-working-day suspension. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient On April 18, 2017, the hiring authority determined the appropriate penalty was a 30-working-day suspension. On

	July 5, 2017, the penalty determination was revisited by the hiring authority and the original penalty was determined to be appropriate. On December 5, 2017, the penalty was reduced to a 5 percent salary reduction for six months, after a department attorney provided input. The department again reduced the penalty after a Skelly hearing to a letter of reprimand. The reduction in penalty was based on input from the Skelly Officer who felt the mitigating evidence presented by the employee during the hearing warranted a penalty reduction. However, the OLES was not included in the Skelly hearing, and was therefore unable to independently evaluate the reasonableness of the penalty reduction. The psychiatric technician did not file an appeal with the State Personnel Board. The department failed to comply with policies and procedures governing the disciplinary process. The department did not provide OLES with a draft of the disciplinary action, failed to inform OLES of the Skelly hearing, and failed to serve the disciplinary action in a timely manner. The initial findings and penalty conference was held on April 18, 2017; however, the disciplinary action was not served until February 1, 2018, 289 days later.
Disciplinary Assessment Questions	1. Did the department attorney or human resources personnel provide to the Hiring Authority and OLES written confirmation of penalty discussion? No. The department attorney did not provide the OLES written confirmation of the penalty discussion. 2. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? No. The department attorney did not provide the OLES with a copy of the draft disciplinary action. 3. If there was a Skelly hearing, was it conducted properly? No. The OLES was not notified of the Skelly hearing. 4. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?

	No. The hiring authority failed to inform OLES of the Skelly hearing. 5. Was the disciplinary phase conducted with due diligence by the department? No. The initial findings and penalty conference was held on April 18, 2017; however, the disciplinary action was not served until February 1, 2018, 289 days later.
Department Corrective Action Plan	To prevent reoccurrence the Hiring Authority will follow DDS policy memorandum 322, emphasizing timeline guidelines related to disciplinary action and resolution phases. OPS/OLES cases will be scheduled for case review, upon receipt of completed OPS investigative reports forwarded to the Quality Assurance Department from the Office of Protective Services. Upcoming Skelly Training, scheduled in July 2018, will include components of policy memorandum 322, specific to the role and notification of the OLES – Attorney Investigation Monitor (AIM), when Skelly Hearings are scheduled for cases monitored by the OLES-AIM. The Hiring Authority meets with OPS on a daily basis, and as needed, to provide updates and status reviews on all OLES-monitored cases pending. OLES status reviews will be monitored on a weekly basis during the General Event Reviews and weekly comprehensive compliance updates. The Director of Quality Assurance/designee will monitor the completed cases posted on the shared drive (with OPS) and will review OPS completed investigative reports ensuring required timeframes are met.

Case Table Section	Section Content
Incident Date	04/02/2017
OLES Case Number	2017-0397MA
Allegations	1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
Incident Summary	On April 2, 2017, two psychiatric technicians allegedly failed to properly supervise residents who had engaged in sexual activity. One of the residents lacked the legal

	capacity to consent. Additionally, the psychiatric technicians allegedly falsified medical rounds documents.
Disposition	The hiring authority determined that one of the psychiatric technicians falsified documents and failed to adequately supervise the residents and imposed a salary reduction of 5 percent for 12 months. The hiring authority determined the second psychiatric technician failed to properly complete documentation and likewise failed to adequately supervise the residents and imposed a salary reduction of 5 percent for 12 months.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The first psychiatric technician filed an appeal with the State Personnel Board. At a State Personnel Board settlement conference the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a 5 percent salary reduction for nine months. The psychiatric technician withdrew his appeal. The second psychiatric technician resigned before disciplinary action could be imposed. The department did not comply with policies and procedures governing the disciplinary process. The department did not provide the OLES with written confirmation of penalty discussions. Neither disciplinary action was served within 60 days of the date the decision was made to impose discipline.
Disciplinary Assessment Questions	1. Did the department attorney or human resources personnel provide to the Hiring Authority and OLES written confirmation of penalty discussion? No. The department did not provide the OLES with written confirmation of penalty discussions. 2. Was the disciplinary phase conducted with due diligence by the department? No. The decision to impose discipline was made on June 28, 2017. The disciplinary actions were served on September 11 and 20, 2017; 75 and 84 days later respectively.
Department Corrective Action Plan	On January 31, 2018 the Department of Developmental Services developed and implemented Policy Memorandum 322: "Review/Disposition of Office of Protective Services Investigation Unit cases with Office of Law Enforcement Support Oversight" outlining the facilities

	expectation. This process was implemented at Canyon Springs to remain in compliance with future obligations of required notifications to OLES. On January 31, 2018 the Department of Developmental Services developed and implemented Policy Memorandum 322: "Review/Disposition of Office of Protective Services Investigation Unit cases with Office of Law Enforcement Support Oversight" outlining the facilities expectation. This policy was implemented and the facility will ensure adverse are served as outlined in this policy.

Case Table Section	Section Content
Incident Date	10/03/2016
OLES Case Number	2017-0615MA
Allegations	1. Dishonesty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On October 3, 2016, a psychiatric technician allegedly handled a resident in an aggressive manner while at an outside hospital and was allegedly dishonest during the investigatory interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations, and dismissed the employee. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The employee filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board upheld the dismissal. The department failed to sufficiently comply with policies and procedures governing the disciplinary process. Penalty determinations were made on June 13, 2017; however, the disciplinary action was not served until September 29, 2017, 108 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. Penalty determinations were made on June 13, 2017; however, the disciplinary action was not served until September 29, 2017, 108 days later.
Department Corrective Action	To prevent reoccurrence the FDC case review process was reviewed with Governing Body and Executive Committee

Plan	members, and other case review team members, using DDS policy memorandum 322, Review/Disposition of Office of Protective Services (OPS) Investigations Unit Cases with Office of Law Policy memorandum 322 has a case finalization process.

Case Table Section	Section Content
Incident Date	02/18/2016
OLES Case Number	2017-0729MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On February 18, 2016, a psychiatric technician assistant allegedly kicked a resident in the leg. A second psychiatric technician assistant allegedly was uncooperative during the investigation.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the first psychiatric technician assistant and issued a letter of reprimand to the second psychiatric technician assistant. The OLES concurred with the hiring authority's determinations.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Both psychiatric technicians resigned prior to the disciplinary actions being served. Letters indicating they resigned under unfavorable circumstances were placed in their official personnel files. Overall, the hiring authority complied with policies and procedures governing the disciplinary process.

Appendix D: 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 DSH Combined Cases

Case Table Section	Section Content
Incident Date	06/29/2017
OLES Case Number	2017-00766MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Letter of Reprimand Final: No Change
Incident Summary	On June 29, 2017, a hospital communications operator allegedly posted inappropriate comments about a patient on social media.
Disposition	The hiring authority sustained the allegations against the communications operator and issued a letter of reprimand. The OLES concurred with the hiring authority's determination. The communications operator did not file an appeal with the State Personnel Board.

Investigative 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 timely consult with the OLES regarding the sufficiency of the investigation and the investigative findings until 51 days after the investigative report was completed.
Pre-Disciplinary Assessment	1. 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 investigative report was completed on October 10, 2017; however, the hiring authority did not attempt to conduct the findings and penalty conference until November 29, 2017, 51 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The findings conference was not conducted until 51 days after the investigative report was completed.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The Hiring Authority will conduct training with all staff who act on behalf of their absence to ensure the consultation with OLES is completed within the investigation process guidelines. The Employee Relations Office has been reorganized with an Employee Relations Manager who will oversee the completion of actions. OLES monitored cases will remain a priority.

Case Table Section	Section Content
Incident Date	06/29/2017
OLES Case Number	2017-00952MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On June 29, 2017, an officer allegedly failed to report that a

	hospital operator posted disparaging remarks about a patient on social media. The officer also allegedly added an inappropriate comment about the patient in response to the operator's post.
Disposition	The hiring authority sustained the allegations against the officer and issued a letter of instruction. The OLES did not concur and recommended a formal letter of reprimand because the officer is held to a higher standard as a peace officer, is relied upon to report alleged misconduct, and is expected to refrain from making disparaging remarks about patients. However, the difference did not warrant seeking a higher level of review.
Investigative 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 timely consult with the OLES regarding the sufficiency of the investigation, and investigative findings until 50 days after the investigative report was completed.
Pre-Disciplinary Assessment	1. 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 investigative report was completed on October 11, 2017; however, the hiring authority did not attempt to conduct the findings conference until November 29, 2017, 50 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The findings conference was conducted 50 days after the investigative report was completed.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority did not timely consult with the OLES regarding penalty determinations. The hiring authority also issued corrective action to the officer when disciplinary action should have been imposed.
Disciplinary Assessment	1. Did the Hiring Authority who participated in the disciplinary conference select the appropriate

Questions	penalty? No. The hiring authority issued corrective action instead of taking disciplinary action against the officer. As a peace officer, the officer is held to a higher standard and the officer's disparaging comment should have been considered more seriously. 2. Was the disciplinary phase conducted with due diligence by the department? No. Although the investigative report was completed on October 11, 2017, the hiring authority did not attempt to conduct the penalty conference until November 29, 2017, 50 days later.
Department Corrective Action Plan	The Employee Relations Office has been reorganized with an Employee Relations Manager who will oversee the completion of actions. OLES monitored cases will remain a priority.

Case Table Section	Section Content
Incident Date	02/25/2016
OLES Case Number	2017-00994MA
Allegations	1. Misuse of state property 2. Inexcusable neglect of duty 3. Other
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On February 25, 2016, a lieutenant allegedly consumed alcohol while on duty. Between August 4, 2014, and January 23, 2017, the lieutenant allegedly used a department computer to write a book for personal gain and directed subordinate employees to misuse state time to read his book. A sergeant and two officers allegedly failed to report the lieutenant's misconduct.
Disposition	The hiring authority sustained the allegations and dismissed the lieutenant, imposed a six-month demotion to officer on the sergeant, and issued letters of reprimand to the two officers. The OLES concurred with the hiring authority's determinations. The lieutenant retired before the disciplinary action took effect. Following a Skelly hearing for the sergeant, the department entered into a settlement

	agreement wherein the sergeant accepted a letter of reprimand and in exchange, agreed not to file an appeal with the State Personnel Board. The OLES concurred with the settlement as the sergeant expressed remorse and the misconduct was not likely to recur.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the disciplinary process. The hiring authority made disciplinary findings on October 25, 2017; however, the actions were not served until January 22, 2018, 89 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority conducted the disciplinary findings conference on October 25, 2017, but the department did not serve the disciplinary actions until January 22, 2018, 89 days later.
Department Corrective Action Plan	In the future the department personnel will provide real-time consultation and will request an extension from the Office of Law Enforcement Support when additional time is needed to complete.

Case Table Section	Section Content
Incident Date	06/07/2017
OLES Case Number	2017-01513MA
Allegations	1. Absence without leave 2. Dishonesty 3. Discourteous treatment
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On June 7, 2017, an officer allegedly left hospital grounds before being cleared to leave and was dishonest and discourteous to a supervisor regarding the incident. On September 27, 2017, the officer was allegedly dishonest during the investigative interview.

Disposition	The hiring authority sustained the allegations and dismissed the officer. At the pre-hearing settlement conference, the department entered into a settlement agreement wherein the officer resigned in lieu of dismissal and agreed never to seek employment with the department in the future. The OLES concurred with the settlement because the ultimate goal of ensuring the officer did not work for the department was achieved.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The OLES was not included in the Skelly hearing.
Disciplinary Assessment Questions	1. If there was a Skelly hearing, was it conducted properly? No. The OLES was not included in the Skelly hearing.
Department Corrective Action Plan	The department has made changes in the process of OLES monitored Skelly hearing. The department now includes the OLES monitor in the calendar invite to the Skelly hearing and writes in the subject line of the calendar invite "OLES monitored" to give the notetaker a reminder that the OLES monitor should be in attendance.

Appendix E: Monitored Issues

Appendix E1 DSH Monitored Issues

Case Table Section	Section Content
Incident Date	01/10/2017
OLES Case Number	2017-00446MI
Case Type	OPS Law Enforcement
Incident Summary	On January 10, 2017, the OLES issued a memorandum to the Department of State Hospitals (DSH) recommending that hospital police record investigatory interviews, except in cases where the recording would make a patient anxious, uncomfortable, or result in a patient's refusal to participate in the interview.
Disposition	In response to the OLES memorandum, DSH implemented a recording system on March 1, 2018. Internal policies and procedures were updated to incorporate the OLES recommendations requiring the recording of most investigatory interviews by hospital police. The OLES will continue to monitor the department's adherence to its recording policies.
Overall Assessment	Rating: Sufficient The department appropriately responded to the concerns by the OLES. The department's updated policies make the recording of all interviews by HPOs mandatory unless the recording would make the patient anxious, uncomfortable, or result in the patient's refusal to participate in the interview.

Case Table Section	Section Content
Incident Date	03/17/2017
OLES Case Number	2017-00644MI
Case Type	Sexual Assault
Incident Summary	During an investigation involving a patient allegation of sexual abuse against staff, the OLES identified a systemic issue involving Department of State Hospital employees who are accused of physical or sexual abuse of patients. Department policy allowed clinical staff to decide whether an employee who was accused of patient abuse could be reinstated to a patient-care position without consultation with facility law enforcement and before facility law enforcement completed an investigation of the abuse allegation.
Disposition	The department appropriately responded to the concerns raised by the OLES. The department prepared a statewide

	policy standardizing the recommendations made by OLES. Clinical staff now consult with facility law enforcement when determining if an accused staff member can be returned to patient care, even if the law enforcement investigation has not yet concluded.
Overall Assessment	Rating: Sufficient The department appropriately responded to the concerns raised by the OLES. The department prepared a statewide policy standardizing the recommendations made by OLES.

Case Table Section	Section Content
Incident Date	01/14/2018
OLES Case Number	2018-00072MI
Case Type	Significant Interest - Other
Incident Summary	On January 14, 2018, patients at Coalinga State Hospital were placed on administrative lockdown after threatening to damage the facility, start fires, and create disorder. The threats stemmed from the department making the decision to confiscate the patients' electronic equipment to stop the use of of child pornography. The OLES responded to the facility to monitor the lockdown.
Disposition	The lockdown was successfully completed. Multiple department law enforcement personnel from various facilities responded and assisted in restoring and maintaining order. A confiscation process ensued at the facility, with the cooperation and assistance of the Fresno County District Attorney's Office, which subsequently led to the seizure of large amounts of child pornography images. On February 14, 2018, the department ended the lockdown.
Overall Assessment	Rating: Sufficient The department responded to and acted in an appropriate fashion during the course of this incident. During the OLES monitoring process, staff was observed interacting with patients in a professional manner.

Appendix E2 DDS Monitored Issues

Case Table Section	Section Content
Incident Date	03/27/2017
OLES Case Number	2017-00449MI
Case Type	Significant Interest - Other
Incident Summary	On March 27, 2017, a review was completed of two investigations involving medical care received by residents.

	The first matter involved a resident who appeared to have expired from natural causes; however, toxicology results could not rule out a possible drug overdose as the cause of death. The second matter involved a resident who was sent to an outside hospital for treatment of a large, cancerous growth on the resident's head. Upon assessment of the growth, hospital personnel had concerns about the treatment received by the resident at the DDS facility.
Disposition	The OLES reviewed the investigations in both matters and recommended that the department establish an independent medical review panel staffed with medical experts having no relational ties to the facilities where the cases arose. This medical review panel would eliminate a conflict of interest and provide a higher level of legitimacy to investigations that deal with the standard of medical care.
Overall Assessment	Rating: Sufficient The department appropriately responded to the concerns raised by the OLES. Because the department is currently downsizing, it is not practicable to establish a full medical review panel to review medical standard of care cases. However, the department is currently placing one of the facility Medical Directors in its headquarters office. This Medical Director will independently review DDS cases, when requested, and provide a higher level of objectivity and legitimacy to investigations where the medical standard of care is in issue.

Appendix F: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

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

Developmental Services and involve an incident that meets the criteria of Section 4427.5.

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

(3) The reports required by paragraph (1) shall be in a form that does not identify the agency employees involved in the alleged misconduct.
(4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise made available to the public upon their release to the Governor and the Legislature.

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

California Welfare and Institutions Code 4427.5

4427.5.

(a) (1) A developmental center shall immediately report the following incidents involving a resident to the local law enforcement agency having jurisdiction over the city or county in which the developmental center is located, regardless of whether the Office of Protective Services has investigated the facts and circumstances relating to the incident:
(A) A death.
(B) A sexual assault, as defined in Section 15610.63.
(C) An assault with a deadly weapon, as described in Section 245 of the Penal Code, by a nonresident of the developmental center.
(D) An assault with force likely to produce great bodily injury, as described in Section 245 of the Penal Code.
(E) An injury to the genitals when the cause of the injury is undetermined.
(F) A broken bone, when the cause of the break is undetermined.
(2) If the incident is reported to the law enforcement agency by telephone, a written report of the incident shall also be submitted to the agency, within two working days.
(3) The reporting requirements of this subdivision are in addition to, and do not substitute for, the reporting requirements of mandated reporters, and any other reporting and investigative duties of the developmental center and the department as required by law.
(4) Nothing in this subdivision shall be interpreted to prevent the developmental center from reporting any other criminal act constituting a danger to the health or safety of the residents of the developmental center to the local law enforcement agency.

(b) (1) The department shall report to the agency described in subdivision (i) of Section 4900 any of the following incidents involving a resident of a developmental center:
(A) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
(B) Any allegation of sexual assault, as defined in Section 15610.63, in which the alleged perpetrator is a developmental center or department employee or contractor.

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

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

California Welfare and Institutions Code 4023

4023

(a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of Section 4900 the following incidents involving a resident of a state mental hospital:

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

(2) Any allegation of sexual assault, as defined in Section 15610.63, in which the alleged perpetrator is an employee or contractor of a state mental hospital or of the Department of Corrections and Rehabilitation.

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

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

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

(a) Assault, as defined in Section 240 of the Penal Code.

(b) Battery, as defined in Section 242 of the Penal Code.

(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.

(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.

(e) Sexual assault, that means any of the following:

(1) Sexual battery, as defined in Section 243.4 of the Penal Code.

(2) Rape, as defined in Section 261 of the Penal Code.

(3) Rape in concert, as described in Section 264.1 of the Penal Code.

(4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code.

(6) Sodomy, as defined in Section 286 of the Penal Code.

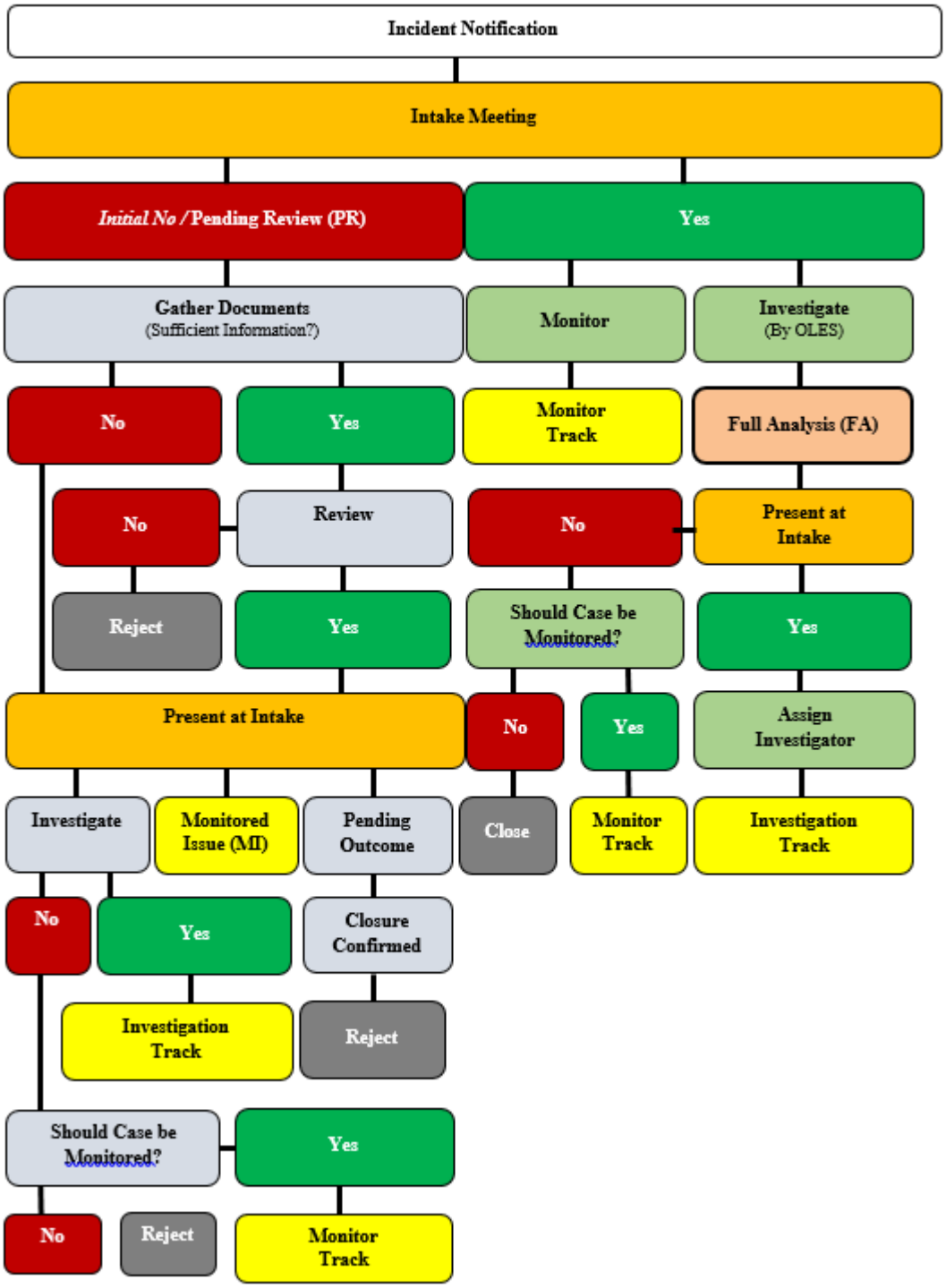
(7) Oral copulation, as defined in Section 288a of the Penal Code.

(8) Sexual penetration, as defined in Section 289 of the Penal Code.

(9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.

(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
(1) For punishment.
(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
(3) For any purpose not authorized by the physician and surgeon.

Appendix G: OLES Intake Flow Chart



Outline Description

1. OLES receives a notification of an incident and discusses the incident during an intake meeting
2. The disposition of the incident case may be assigned to any of the following:
    a. Initial No/Pending Review
    b. OLES Monitored Case

c. OLES Investigation Case

3. If the disposition is "Initial No/Pending Review", the case is reviewed for sufficient information and is represented at an intake meeting. From there, the case may be investigated, become a monitored issue, be monitored, be investigated or be rejected.

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 an OLES investigator. 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,[11] throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

1. Department notifies OLES of an incident that meets threshold requirements
2. OLES Analysis Unit reviews initial case summary and determines OLES involvement
3. OLES AIM meets with OPS administrative investigator and identifies critical junctures
4. DSH or DDS law enforcement (or OLES) completes investigation and submits final report
5. OLES AIM provides oversight of investigations requiring an immediate response

Critical Junctures

1. Site visit
2. Initial case conference
    a. Develop investigation plan
    b. Determine statute of limitations
3. Critical witness interviews
    a. Primary subject(s) recorded
4. Investigation draft proposal

[11] 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.

It is recommended that within 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority 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.

45 Days

1. AIM attends disposition conference; discusses case and analyzes with the appropriate department representative
2. Additional investigation may be requested
3. AIM meets with executive director at the facility to finalize disciplinary determinations
4. Process for resolving disagreements may be enacted

Once a final determination is reached regarding the appropriate allegations and discipline in a case, it is recommended that a Notice of Adverse Action (NOAA) be finalized and served upon the employee within 60 days.

60 Days

1. Human resources unit at the facility completes NOAA and forwards to AIM for review
2. Approved NOAA is provided to the executive director for service on the affected employee

State employees subject to discipline have a due process right to have the matter reviewed in a Skelly hearing by an uninvolved supervisor who, in turn, makes a recommendation to the hiring authority, i.e. whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee[12]. It is recommended that the Skelly due process meeting be completed within 30 days.

30 Days

1. Skelly process is conducted by an uninvolved supervisor with AIM present
2. AIM is notified of the proposed final action, including any pre-settlement discussions or appeals (AIM monitors process).

State employees who receive discipline have a right to challenge the decision by

[12] Skelly v. State Personnel Board, 15 Cal. 3d 194 (1975)

filing an appeal with the State Personnel Board (SPB), which is an independent state agency. OLES continues monitoring through this appeal process. During an appeal, a case can be concluded by settlement (a mutual agreement between the department(s) and the employee), a unilateral action by one party withdrawing the appeal or disciplinary action, or an SPB decision after a contested hearing. In cases where the SPB decision is subsequently appealed to a Superior Court, the OLES continues to monitor the case until final resolution.

Conclusion

1. Department counsel notifies AIM of any SPB hearing dates as soon as known (AIM present at all hearings).
2. Department counsel notifies and consults with AIM prior to any changes to disciplinary action
3. AIM notes quality of prosecution and final disposition