Office of Law Enforcement Support

Semiannual Report

January 1, 2020–June 30, 2020

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

Promoting a safe, secure and therapeutic environment

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

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Introduction

As the coronavirus disease 2019 (COVID-19) pandemic spread, we saw devastating effects on the economy, healthcare systems and communities. As is the case with many disasters, vulnerable populations can be disproportionately affected by COVID-19. Among those vulnerable populations include the patients housed in the California state hospitals operated by the Department of State Hospitals (DSH).

In response to COVID-19, DSH took special measures to protect the health, safety and welfare of patients and employees while ensuring continuity of care. These measures include, but are not limited to, widespread testing for both patients and employees, the establishment of patient isolation units for patients who tested positive, admission observation units for new admissions and patients returning from outside medical facilities, updating plans for infection control and limiting in-person hospital visits.

During these unprecedented times, providing safe, high-quality patient care and services is essential to ensuring positive patient outcomes. The Office of Law Enforcement Support (OLES) recognizes the individual actions of DSH staff, law enforcement and management who play a vital role in protecting patients from COVID-19. As we navigate through these challenging times, it is critical that we continue to respond with compassion, commitment and urgency. The OLES is grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DSH management and personnel.

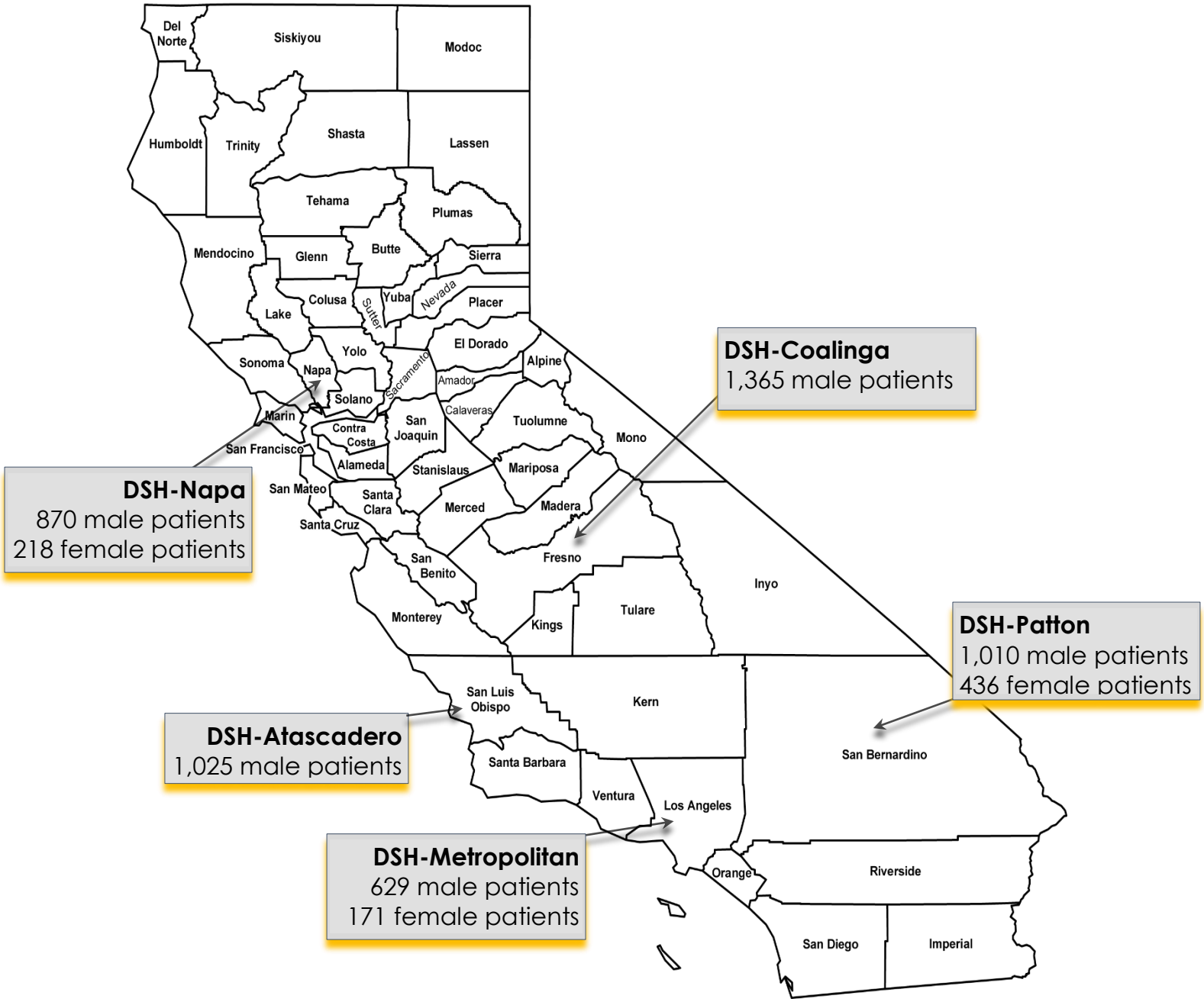
I am pleased to present the ninth semiannual report by OLES in the California Health and Human Services Agency. Beginning with this report, the OLES will publish separate reports for the DSH and Department of Developmental Services. This report details OLES' oversight and monitoring of the DSH from January 1 through June 30, 2020.

We welcome comments and questions. Please visit the OLES website at https://www.oles.ca.gov/.

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers as of June 30, 2020, were provided by the department.

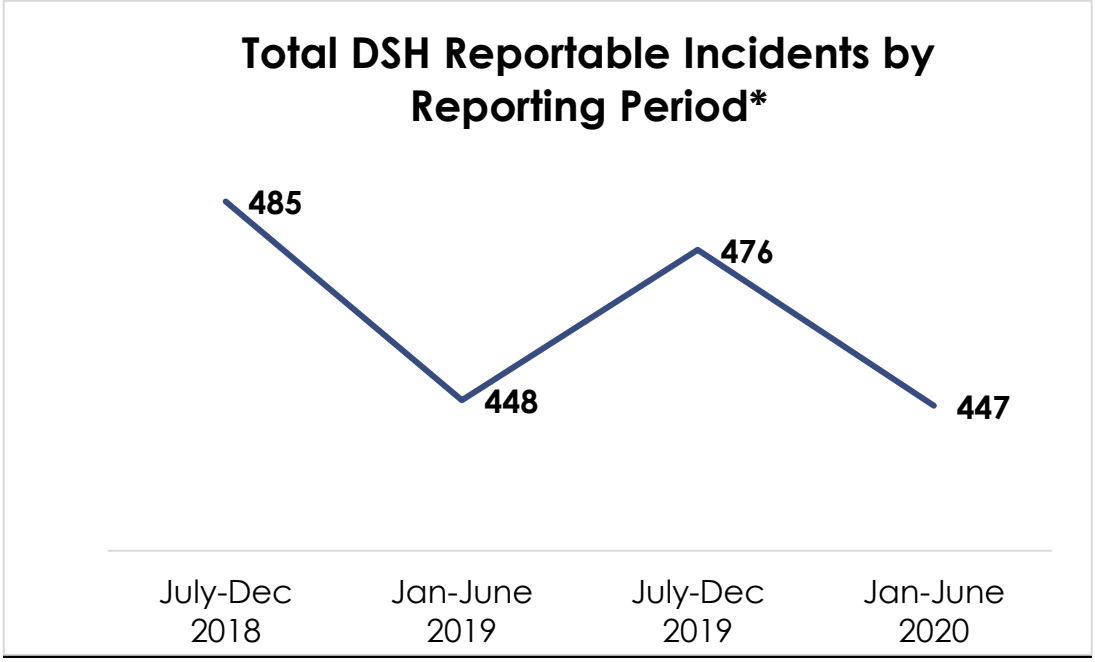


DSH Facility Population Table

Facility	Number of Male Patients	Number of Female Patients	Total
DSH-Atascadero	1,025	0	1,025
DSH-Coalinga	1,365	0	1,365
DSH-Metropolitan	629	171	800
DSH-Napa	870	218	1,088
DSH-Patton	1,010	436	1,446
Total	4,899	825	5,724

Executive Summary

During the reporting period of January 1, 2020 through June 30, 2020, the Office of Law Enforcement Support (OLES) received and processed 447 reportable incidents[1] from the California Department of State Hospitals (DSH). Reportable incidents include alleged misconduct by state employees, serious offenses between patients, patient deaths and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is a decrease of 29 incident reports compared to the prior reporting period which had 476 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



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

Incident Types Meeting OLES Criteria

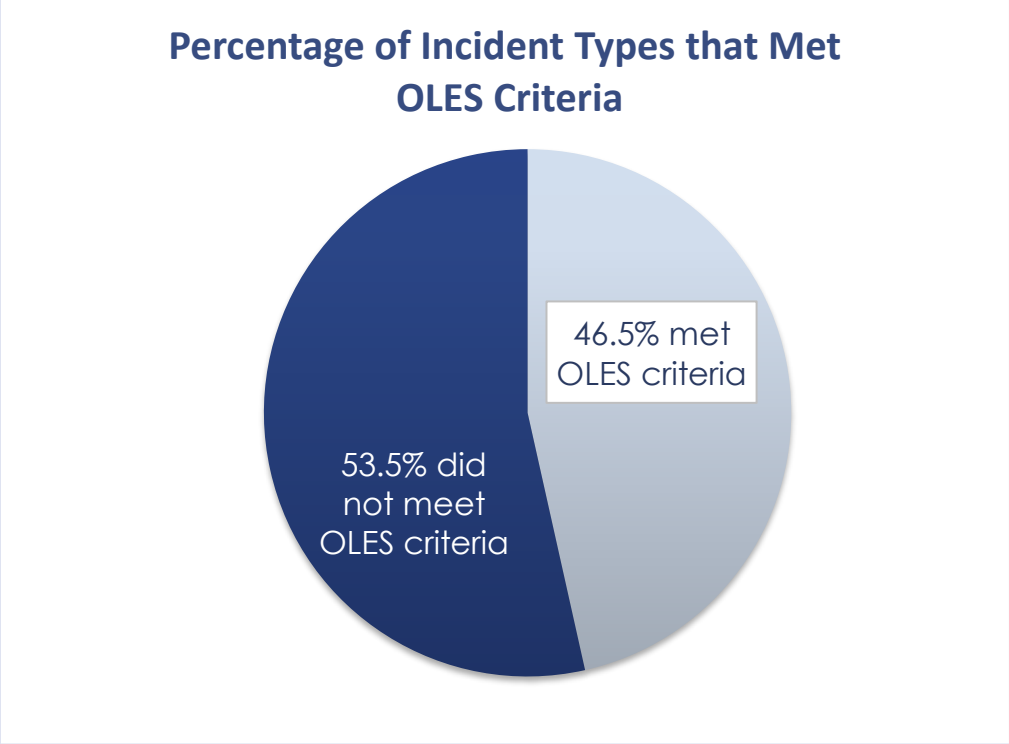
The DSH reports to OLES any incidents and associated reportable incident types[2] listed in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. During this reporting period, the OLES amended its reporting guidelines to allow

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

[2] The OLES defines an incident as an event in which allegations or occurrences meeting the OLES criteria may arise from or have taken place. Allegations or occurrences from incidents such as allegations of sexual assault or physical abuse, or an occurrence of a broken bone are referred to as incident types.

for more accurate and relevant data collection. The OLES differentiated incidents of broken bone and genital injury in which the cause is undetermined. The broken bone and genital injury incident types are separated into incident types of known origin and incident types of unknown origin. In addition, OLES further analyzed allegations against peace officers for reportable incident types within each incident. For example, an allegation of abuse by a peace officer is reported under the abuse incident type and also the misconduct incident type. The OLES also introduced the significant interest-over-familiarity incident type, an incident type used for conduct between a staff member and a patient that extends beyond authorized treatment or is contrary to the treatment plan and treatment success of the patient. Collecting data and ensuring quality, quantitative and qualitative data are critical to OLES' effective oversight and monitoring. This more specific data enables OLES to better identify trends and outliers, make comparisons and extract insights that can improve patient outcomes.

An incident type "meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 447 reported incidents, the OLES identified 40 incidents with two or more incident types. The DSH reported a total of 493 incident types during this reporting period. Two hundred and twenty-nine, or 46.5% of the 493 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported by DSH include: abuse, sexual assault, head or neck injury, death, sexual assault-outside jurisdiction, broken bone of unknown origin and broken bone of known origin. Allegations of abuse represented the single largest number of alleged incidents reported by DSH during this reporting period. The OLES received 93 reports of alleged abuse, which accounted for 18.9 percent of all reported incident types by DSH. The DSH reported 86 incident types of sexual assault, making sexual assault the second largest category of incident types. Reports of broken bone remain a frequently reported incident type. Reports of broken bone decreased by 22.1 percent. During this reporting period, DSH reported 33 broken bone incident types of unknown origin and 27 broken bone incident types of known origin. There were 44 reports of the head or neck injury incident type. Reports of patient deaths increased by 100% to 38 patient deaths. Reports of head or neck injuries increased by 91.3% to 44 reports of head or neck injuries. Reports of sexual assault decreased by 15.7 percent. The number of sexual assault-outside jurisdiction incident types decreased by 5.7 percent.

Patient Deaths

The number of patient deaths increased by 100%, from 19 deaths to 38 deaths during this reporting period. Twenty of the reported death incident types met the OLES criteria for investigation or monitoring. Nineteen of the 38 patient deaths were expected due to existing medical conditions. Nineteen patient deaths were classified as "unexpected" and received two levels of review by DSH, per department policy. The OLES reviewed each unexpected death and monitored the cases that met OLES criteria. Thirteen of the 19 "unexpected" deaths were due to cardiac or respiratory issues, one was due to sepsis, one was due to sequelae of Huntington's disease and four are pending determination for the cause.

Coalinga State Hospital (CSH) and Patton State Hospital (PSH), reported the largest number of patient deaths with twelve patient deaths from each facility. At CSH, seven patient deaths were due to cardiac or respiratory issues, two to renal or liver issues, two to sepsis, and one patient death is pending determination. At PSH, eight patient deaths were due to cardiac or respiratory issues, three to COVID-19 and one death remains pending determination for the cause. While the final cause of death for three patients was attributed to respiratory failure due to COVID-19, two of the patients also had a diagnosis of cancer.

Patient Arrests

The OLES works collaboratively with DSH to ensure patients receive the best

possible treatment and care at the local jurisdiction holding facility. The OLES also reviews each circumstance to safeguard patient rights and make certain there is strict compliance to the laws of arrest. The purpose of OLES oversight of patient arrests is twofold:

- To ensure continuity of patient treatment and care through an agreement or an understanding between the state facility and the local jurisdiction holding facility.
- To determine the circumstances of the arrest, and if there is no arrest warrant filed by a district attorney, that the arrest meets or exceeds the best practices standard for probable cause arrest.

During this reporting period, DSH reported 16 patient arrests, 11 fewer arrests than in the prior reporting period. The patients were arrested for violations of the following statutes:

Statute	Description
Health and Safety Code section 11379	transport of controlled substances
Penal Code section 69	resisting an executive officer with threat or violence
Penal Code section 242	battery
Penal Code section 243(c)	battery on a peace officer
Penal Code section 243(d)	battery causing serious bodily injury
Penal Code section 245(a)(1)	assault with a deadly weapon
Penal Code section 245(a)(4)	assault with force likely to cause great bodily injury
Penal Code section 311.11(b)	possession of child pornography
Penal Code section 368(b)(1) and (2)	elder abuse resulting in great bodily injury
Penal Code section 422	threat to kill or cause great bodily injury
Penal Code section 664/187(a)	attempted murder
Penal Code section 4573.6	possession of controlled substances

Results of Completed OLES Investigations on DSH Law Enforcement

Per statute[3], an OLES investigation is initiated after OLES is notified of an allegation that a DSH law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents. As of June 30, 2020, DSH had approximately 729 sworn staff members.

Appendix A provides information on the 34 OLES investigations that were

[3] Welfare and Institutions Code Section 4023, 4023.6, 4427.5. (See Appendix F).

completed during this reporting period. These investigations involved allegations against at least 43 sworn staff members, which is approximately 5.9 percent of DSH sworn staff. Some allegations did not specify the number of officers involved. Six investigations involved alleged incidents that occurred in 2020. Twenty-five investigations involved an alleged incident that occurred in 2019. Two investigations involved alleged incidents that occurred in 2018. One investigation involved an alleged incident that occurred in 2017.

The OLES submitted 11 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process. The OLES conducted inquiries into 12 criminal allegations and determined there was insufficient evidence that a crime was committed. The cases were closed without referral to a district attorney's office. A summary of the review and decision was provided to the departments. In the remaining administrative investigations, the OLES determined that the allegation did not meet OLES criteria and the matter was closed. The OLES provided a summary of the review and decision to the department.

Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct. In Appendices B, C, and D of this report, OLES provides information on 89 monitored administrative cases and 56 monitored criminal cases that, by June 30, 2020, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These monitored cases included allegations against psychiatric technicians, psychiatric technician assistants, officers, registered nurses, unit supervisors and several other types of staff members.

Nineteen pre-disciplinary administrative cases had sustained allegations and six criminal investigations resulted in referrals to prosecuting agencies.

The OLES monitored 138 pre-disciplinary phase cases, 131 of the pre-disciplinary phase cases are listed in Appendix B and seven are in Appendix D. Nineteen of 138 pre-disciplinary phase cases were rated as procedurally insufficient only. Three cases were rated both procedurally and substantively insufficient. The DSH's failure to complete investigations within the 120-day required timeframe remains the most frequent procedural deficiency observed in pre-disciplinary phase cases.

The OLES monitored the disciplinary action, *Skelly* hearings, settlements and State Personnel Board proceedings in fourteen administrative cases, seven are listed in Appendix C and seven are in Appendix D. Four cases were rated as procedurally insufficient only. Three cases were rated both procedurally and

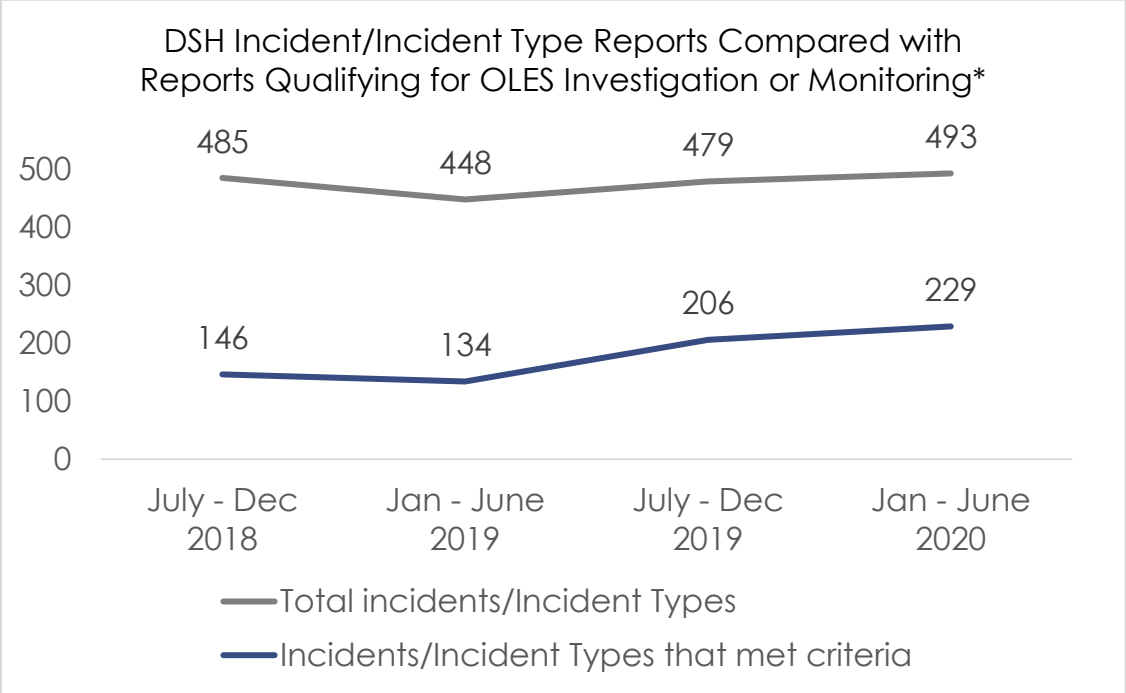
substantively insufficient. Five of these cases were procedurally insufficient due to delayed service of the disciplinary action.

Incidents and Incident Types

Every OLES case is initiated by a report of an incident or allegation. The OLES receives reports 24 hours a day, seven days a week. During this reporting period, the majority of incident reports came from the facilities.

Increase in Reported Incident Types

The number of DSH incidents reported to OLES from January 1 through June 30, 2020, decreased 6.1 percent, from 476 during the prior reporting period to 447 in this reporting period. From the 447 reported incidents, the OLES identified 493 incident types, as 40 of the incidents featured two or more incident types. Two hundred and twenty-nine of the 493 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic issue.



* Numbers are unadjusted and are provided as they were previously published. Beginning in the July through December 31, 2019 reporting period, the OLES switched from evaluating incidents to evaluating incident types for meeting OLES criteria.

Most Frequent Incident Types Reported

The most frequent incident types reported were abuse, sexual assault, head or neck injury, death, broken bone of unknown origin, broken bone of known origin and sexual assault-outside jurisdiction. These incident types accounted for 354 or

71.8 percent of all incident types reported by DSH. Of the 354 incident types, 186 met criteria for OLES to investigate or monitor. This is 81.2% of the 229 incident types that met criteria.

Allegations of abuse or sexual assault remain the two most frequently reported incident types at DSH. In this reporting period, allegations of abuse accounted for 18.9 percent of all incident types reported. Of the 93 allegations of abuse reported in this period, 85 allegations qualified for investigation, monitoring or consideration of a potential systemic issue. This is an increase of 13.3 percent or 10 qualifying reports from the prior reporting period, which had 75 incident types of abuse that met OLES criteria.

Sexual assault allegations were the second most frequently reported incident type at DSH in this reporting period, totaling 86 incident types and accounting for 17.4 percent of all incident types reported. This was a decrease of 16 reported incident types compared to the total in the prior reporting period. The number of allegations of sexual assault that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period increased by 26.5 percent, from 34 during the prior reporting period, to 43 in this reporting period.

Reports of head or neck injuries increased 91.3 percent compared to the prior reporting period. Twenty head or neck injuries resulted from a physical altercation between patients. Nineteen head or neck injuries resulted from a self-injury by the patient, an unwitnessed or witnessed fall or the patient losing balance. Three head or neck injuries involved tooth falling out or chipping without any signs of physical altercation or other injuries. One head or neck injury involved an unknown suspect and another occurred while the patient was playing a sport.

The following table provides the most frequently reported incident types reported by DSH and the percent change from the previous reporting period.

Most Frequent Incident Types January 1 through June 30, 2020

Incident Type Category	Prior Period Incident Type Total - July 1 through December 30, 2019	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Abuse	79	93	+17.7%	85
Sexual Assault	102	86	-15.7%	43

Incident Type Category	Prior Period Incident Type Total - July 1 through December 30, 2019	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Head/Neck Injury	23	44	+91.3%	8
Death	19	38	+100%	20
Sexual Assault-OJ*	35	33	-5.7%	0
Broken Bone**	77	-	-22.1%	-
Broken Bone (Unknown Origin)	-	33	-	29
Broken Bone (Known Origin)	-	27	-	1

*All reports of alleged sexual assault-outside jurisdiction (OJ) are calculated separately from the "Sexual Assault" category.
**Beginning with the January 1 through June 30, 2020 reporting period, the OLES separated the broken bone incident type into two incident types: broken bone of known origin and broken bone of unknown origin.

Incident Types by Reporting Period

The following table compares the total count of reported incident types during this reporting period to the total count from the two prior reporting periods.

Incident Categories	Prior Period January 1- June 30, 2019 (Reported) *	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Prior Period July 1- December 31, 2019 (Reported)*	Prior Period July 1 - December 31, 2019 (Meets Criteria)*	Current Period January 1 - June 30, 2020 (Reported)	Current Period January 1 - June 30, 2020 (Meets Criteria)
Abuse	80	66	79	75	93	85
Broken Bone	71	6	77	26	-	-
Broken Bone (Known Origin)	-	-	-	-	27	1
Broken Bone (Unknown	-	-	-	-	33	29

Incident Categories	Prior Period January 1- June 30, 2019 (Reported) *	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Prior Period July 1- December 31, 2019 (Reported)*	Prior Period July 1 - December 31, 2019 (Meets Criteria)*	Current Period January 1 - June 30, 2020 (Reported)	Current Period January 1 - June 30, 2020 (Meets Criteria)
Origin)						
Burn	3	0	3	0	3	0
Death	27	5	19	5	38	20
Genital Injury	1	0	2	0	-	-
Genital Injury (Known Origin)	-	-	-	-	3	1
Genital Injury (Unknown Origin)	-	-	-	-	2	1
Head/Neck Injury	40	0	23	2	44	8
Misconduct**	21	12	41	38	30	21
Neglect	21	14	19	19	18	11
Non-patient assault/GBI on Patient	0	0	1	1	0	0
Patient on Patient Assault/GBI	9	0	15	0	24	0
Pregnancy	1	0	0	0	0	0
Sexual Assault	96	27	102	34	86	43
Sexual Assault-OJ***	32	0	35	0	33	0
Significant Interest- Attack on Staff****	2	0	10	0	13	0
Significant Interest- Attempted Suicide	4	0	1	0	5	0
Significant Interest-	8	1	9	2	6	0

Incident Categories	Prior Period January 1- June 30, 2019 (Reported) *	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Prior Period July 1- December 31, 2019 (Reported)*	Prior Period July 1 - December 31, 2019 (Meets Criteria)*	Current Period January 1 - June 30, 2020 (Reported)	Current Period January 1 - June 30, 2020 (Meets Criteria)
AWOL						
Significant Interest-Child Pornography	2	0	3	0	1	0
Significant Interest-Other***	6	3	13	1	9	1
Significant Interest-Over-Familiarity	-	-	-	-	9	8
Significant Interest-Patient Arrest	24	0	27	0	16	0
Significant Interest-Riot	0	0	0	0	0	0
Total	448	134	479	209	493	229

*Numbers in this column are unadjusted and provided as they were previously published.
**Beginning in the January 1, 2020, through June 30, 2020, reporting period, the OLES identified applicable incident types within each incident involving peace officer misconduct. For example, an allegation of abuse by a peace officer is recorded as one incident type for abuse and one incident type for misconduct.
***These incidents occurred outside the jurisdiction of DSH.
****The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department reported to OLES and therefore does not reflect all attacks on staff that may have occurred.
*****Any other incident of significant interest, e.g., civilian arrest for providing contraband to a patient; and the smuggling of drugs into a State hospital.

Incident Types by Facility

The following table provides the total incident types by facility. One misconduct incident type was reported from the DSH OPS academy and is not included in the table below.

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Abuse	4	16	31	9	33	93
Broken Bone (Known Origin)	6	7	6	2	6	27
Broken Bone (Unknown Origin)	2	13	8	2	8	33
Burn	1	1	1	0	0	3
Death	1	12	6	7	12	38
Genital Injury (Known Origin)	0	0	3	0	0	3
Genital Injury (Unknown Origin)	0	0	2	0	0	2
Head/Neck Injury	7	6	18	7	6	44
Misconduct*	5	14	5	1	4	29
Neglect	6	3	5	2	2	18
Non-Patient on Patient Assault/GBI	0	0	0	0	0	0
Patient on Patient Assault/GBI	7	6	1	7	3	24
Pregnancy	0	0	0	0	0	0
Sexual Assault	16	22	24	9	15	86
Sexual Assault-OJ**	16	0	7	4	6	33
Significant Interest- Attack on Staff***	8	0	3	1	1	13
Significant Interest- Attempted Suicide	0	1	3	0	1	5
Significant Interest-AWOL	0	0	3	0	3	6
Significant Interest-Child Pornography	0	1	0	0	0	1
Significant Interest-	1	3	0	5	0	9

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Other**						
Significant Interest-Over-Familiarity	5	2	0	0	2	9
Significant Interest-Patient Arrest	2	6	3	1	4	16
Significant Interest-Riot	0	0	0	0	0	0
Total	87	113	129	57	106	492

*Beginning in the January 1, 2020, through June 30, 2020, reporting period, the OLES identified applicable incident types within each incident involving peace officer misconduct. For example, an allegation of abuse by a peace officer is recorded as one incident type for abuse and one incident type for misconduct.
**These incidents occurred outside the jurisdiction of DSH.
***The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department has reported to OLES and therefore does not reflect all attacks on staff that may have occurred.
****Any other incident of significant interest, e.g., civilian arrest for providing contraband to a patient; and the smuggling of drugs into a State hospital.

Distribution of Incident Types

With 5,724 patients department-wide, this equates to 0.086 incident types per patient when excluding the incident type reported by the OPS Academy. The following table provides the population counts of DSH facilities for reference.

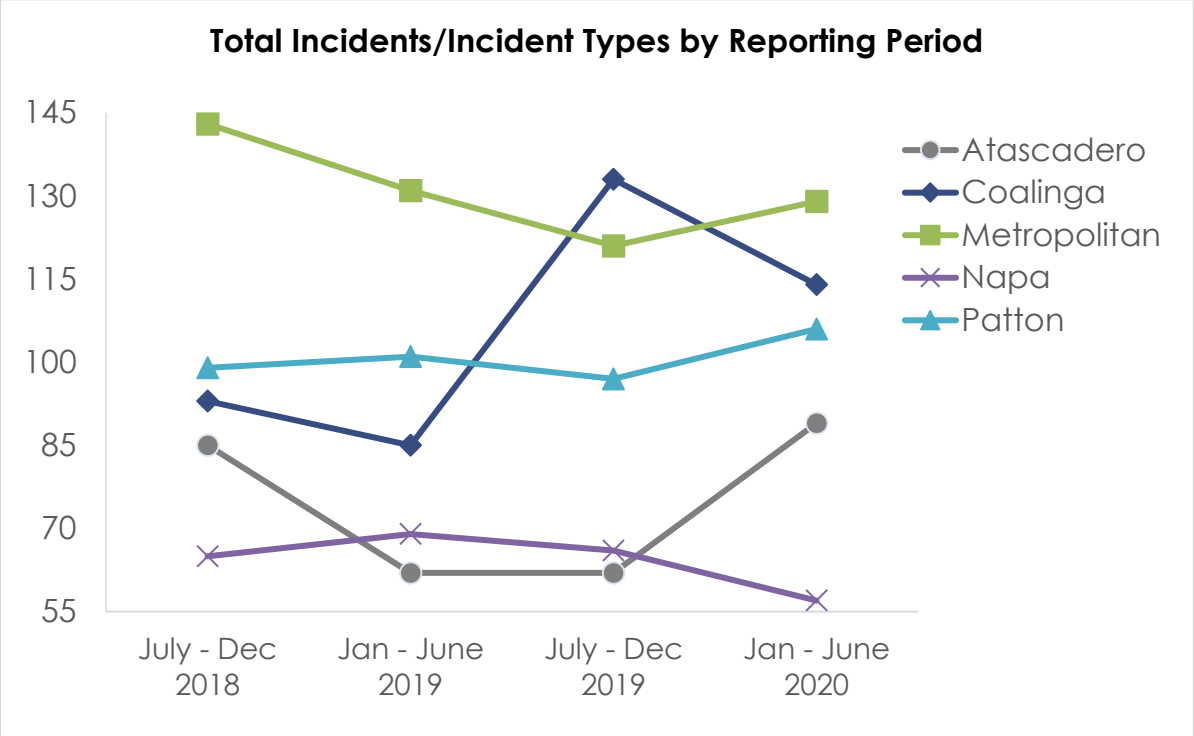
DSH Population and Total Incident Types

DSH Facility	Number of Patients*	Total Incident Types	Ratio of Incident Types to Population
Atascadero	1,025	87	0.085
Coalinga	1,365	113	0.083
Metropolitan	800	129	0.161
Napa	1,088	57	0.052
Patton	1,446	106	0.073
Total	5,724	492	0.086

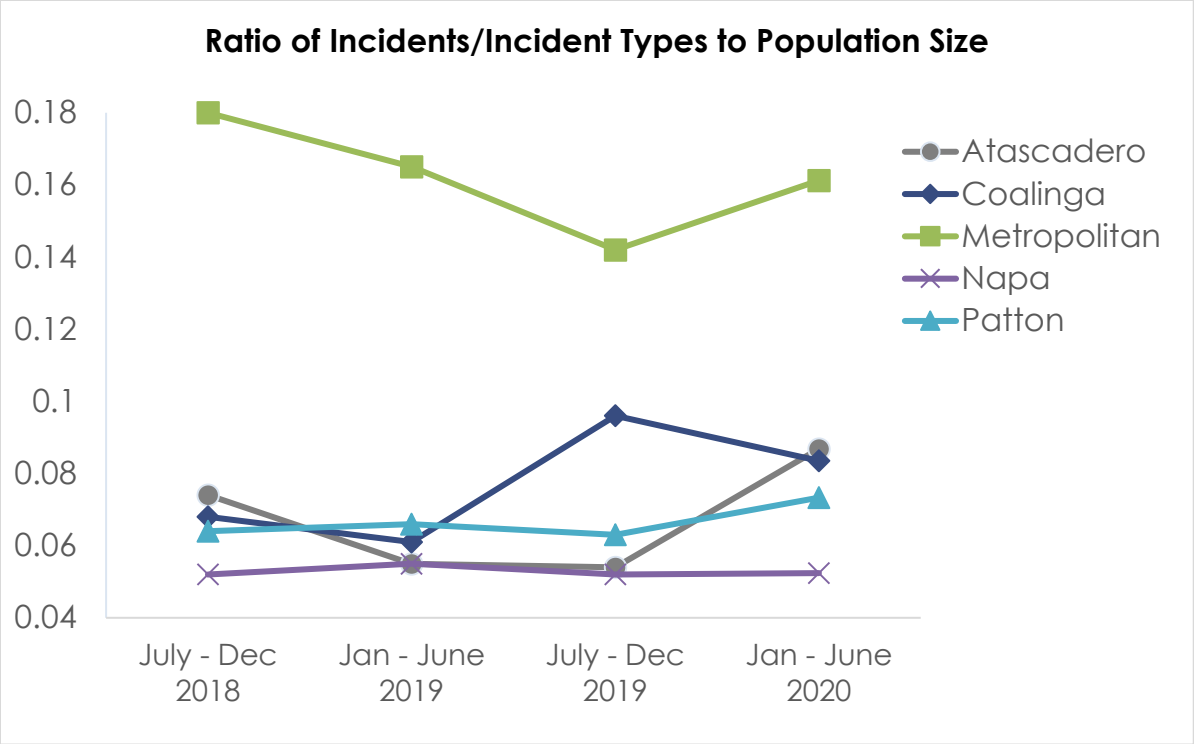
* The department provided population numbers as of June 30, 2020.

With the exception of the July 1, 2019 through December 31, 2019, reporting period, Metropolitan State Hospital (MSH) consistently reports the highest number of incident types. The Atascadero State Hospital (ASH) and Napa State Hospital (NSH) report the fewest incident types. There is little variation in the

number of incident types reported by PSH in this reporting period and the prior three reporting periods. The following charts depict the total number of incidents or incident types for this reporting period and the prior three reporting periods as well as the ratio of incidents or incident types compared to the population size of each facility.



Despite having the smallest patient population, MSH consistently reports the highest number of incident types compared to the population size as shown in the chart on the following page.



Sexual Assault Allegations

Sexual assault was the second most frequently reported incident type from January 1 through June 30, 2020. The 86 alleged sexual assault incident types reported in this reporting period accounted for 17.4 percent of all reported incident types from DSH. Forty-three of the 86 reported incident types of alleged sexual assault, or 50.0 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 33 reported incident types under the sexual assault-OJ category, none of which met OLES criteria for investigation or monitoring.

MSH reported the highest number of incident types under the sexual assault incident type category. MSH reported 24 incident types, or 27.9 percent of all alleged sexual assault incident types reported during this reporting period. CSH reported 22 incident types under the sexual assault category, the second highest number of sexual assault incident type reports.

ASH consistently reports the highest number of alleged sexual assault-OJ incident types. In this reporting period, ASH reported 16 out of the 33 reported incident types under the alleged sexual assault-OJ. This category includes allegations that implicated family, friends, or others in incidents that occurred when patients were not in a DSH facility.

When excluding the sexual assault-OJ incident type, allegations of sexual assault

involving a patient assaulting other patient(s) were the most frequently reported, with a total of 38 incident types, or 44.2 percent of the alleged sexual assault incident types. The second most frequent type of alleged sexual assault involved non-law enforcement staff on a patient, with 34 incident types or 39.5 percent of the 86 alleged sexual assault incident types. The third most frequent allegation involved an unknown assailant on a patient, with 11 incident types or 12.8 percent of the alleged sexual assault incident types. Allegations involving an unknown assailant include allegations made by patients that did not implicate DSH employees or contractors. DSH reported three allegations of sexual assault on a patient by law enforcement personnel during this reporting period. All DSH reports of alleged sexual assaults received by OLES during the reporting period are shown in the following table.

Sexual Assault Allegations Reported January 1 through June 30, 2020

Facility	Patient on Patient	Non-Law Enforcement Staff on Patient	Law Enforcement on Patient	Unknown Person on Patient	OJ*	Totals
Atascadero	5	8	2	1	16	32
Coalinga	14	7	1	0	0	22
Metropolitan	11	5	0	8	7	31
Napa	4	4	0	1	4	13
Patton	4	10	0	1	6	21
Totals	38	34	3	11	33	119

**Sexual Assault-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.

Patient Deaths

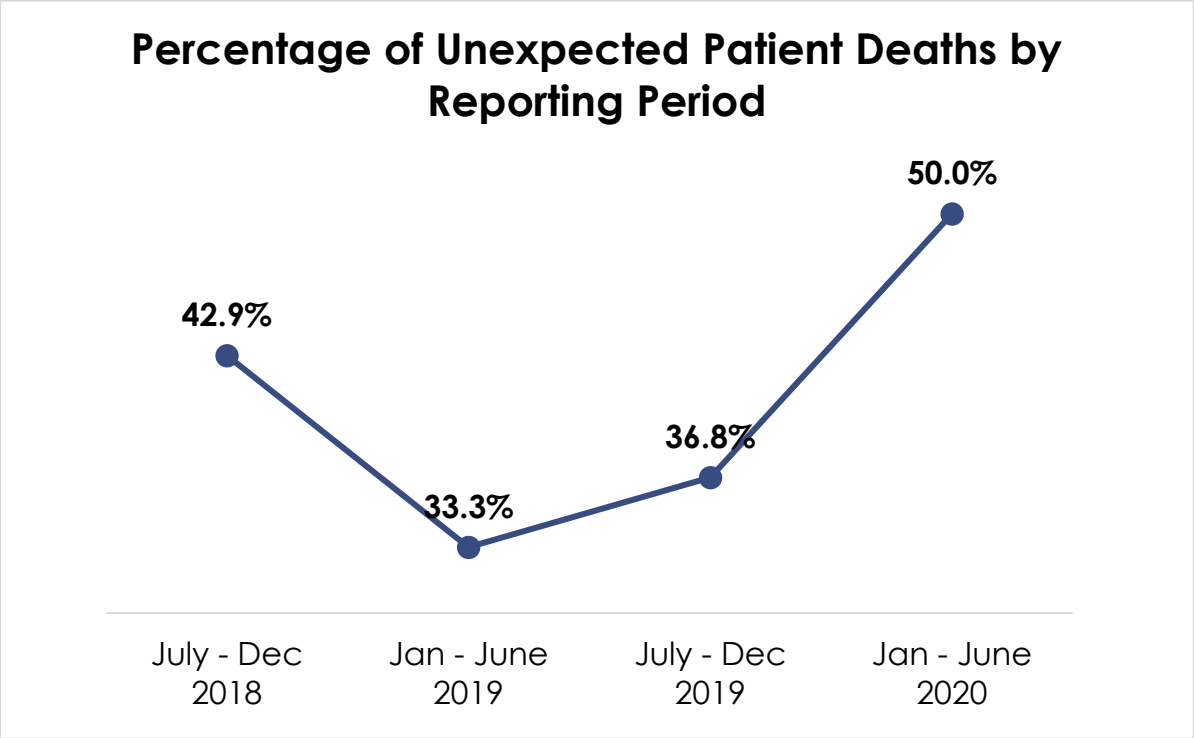
There were 38 patient deaths reported to OLES from DSH facilities during this reporting period. This number increased 100 percent from the 19 patient deaths reported in the prior reporting period of July 1 through December 31, 2019. Of the 38 patient deaths, 36 were male patients and two were female. The patient age at the time of death ranged from 31 years to 93 years old. The following table provides the total number of patient deaths in each age group.

Patient Deaths by Age Group

Age Group (years)	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
25-34	0	0	0	0	1	1
35-44	0	1	1	0	2	4
45-54	0	1	2	0	0	3
55-64	0	2	1	2	5	10
65-74	1	3	0	5	2	11

Age Group (years)	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
75-84	0	4	1	0	0	5
85 and over	0	1	1	0	2	4
Total	1	12	6	7	12	38

Fifty percent or 19 of the patient deaths were classified as "expected" due to underlying health conditions, such as cancer and kidney disease. Nineteen deaths were classified as "unexpected". In addition to the significant increase in patient deaths, the percentage of unexpected patient deaths also increased compared to the percentage in the prior reporting period. The following chart depicts the percentage of unexpected patient deaths in this reporting period and the three prior reporting periods.



Each unexpected patient death receives two levels of review within DSH, per department policy. The OLES reviewed each unexpected death and monitored the cases that met OLES criteria. In 20 of the 38 patient deaths, the OLES monitored the departmental investigations. The final determination for the cause of death of reported patient deaths are provided in the following table.

Cause of Patient Deaths

Facility	Cancer	Cardiac/ Respiratory	Renal/Liver	Sepsis	COVID-19	Other	Totals
Atascadero	0	1	0	0	0	0	1
Coalinga	0	7	2	2	0	1	12
Metropolitan	0	2	0	1	0	3	6
Napa	3	3	0	1	0	0	7
Patton	0	8	0	0	3	1	12
Totals	3	21	2	4	3	5	38

Cardiac or respiratory issues were responsible for 55.3% of the reported patient deaths. Five patient deaths were listed with the cause as "other" for the following reasons. One patient death from CSH is pending determination for the cause. Two patient deaths from MSH are pending determination for the cause; the other patient death is ascribed to sequelae of Huntington's disease. One patient death from PSH is pending determination for the cause.

Reports of Patients Absent without Leave

In this reporting period, MSH and PSH each reported three incident types under the significant interest-absent without leave (AWOL) category. At MSH a non-forensic patient, with permission to be out with family, fled his father's vehicle upon returning to the facility's front gate. Officers detained the patient 15 minutes later and returned the patient to his unit without further incident. Another non-forensic patient walked away from staff during a visit to an outside hospital, but was located unharmed within 90 minutes. The third non-forensic patient ran away from staff when she was about to be taken to a medical appointment. Hospital police located the patient a quarter of a mile away from her housing unit. Hospital police detained and transported the patient back to her unit without further incident.

At PSH, a patient picked a lock and exited his unit into an unauthorized ramp area that led to the second floor of another unit. Staff located the patient and returned him to his unit. Another PSH patient climbed over the courtyard fence of his unit, proceeded to climb over the outer fence of another unit and ran down a roadway inside the secure treatment area. Staff immediately activated their alarms and officers returned the patient to his unit. The third patient climbed a perimeter fence in an attempt to escape the facility, but was quickly taken back into custody by officers while still inside the secure treatment area. In all incidents, the patients did not require treatment beyond first aid.

Notification of Incident Types

Different incident types require different kinds of notification to OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq., and agreements between OLES and the departments, certain serious incident types are required to be reported to OLES within two hours of their discovery. Notification of these "Priority One" incident types 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 within 24 hours of the time and date of discovery of the reportable incident. "Priority Two" threshold incidents require notification within 24 hours of the time and date of discovery. Priority One and Two threshold incident types are shown in the tables below.

Priority One Notifications – Two Hour Notification

Incident	Description
ADW	An assault with a deadly weapon (ADW) against a patient by a non-patient.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a patient.
Broken Bone (U)	A broken bone of a patient when the cause of the break is undetermined.
Deadly force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a patient.
Genital Injury (U)	An injury to the genitals of a patient when the cause of injury is undetermined.
Physical Abuse	Any report of physical abuse of a patient implicating staff.
Sexual Assault	Any allegation of sexual assault of a patient.

Priority Two Notifications – 24 Hour Notification

Incident	Description
Broken Bone (K)	A broken bone of a patient when the cause of the break is known by staff.
Burns	Any burns of a patient. This does not include sunburns or mouth burns caused by consuming hot food or liquid unless blistering occurs.
Genital Injury (K)	An injury to the genitals of a patient when the cause of injury is known by staff.
Head/Neck Injury	Any injury to the head or neck of a patient requiring treatment beyond first-aid that is not caused by staff or

Incident	Description
	law enforcement. Or any tooth injuries, including but not limited to, a chipped, cracked, broken, loosened or displaced tooth that resulted from a forceful impact, regardless of treatment.
Neglect	Any staff action or inaction that resulted in, or reasonably could have resulted in a patient death, or injury requiring treatment beyond first-aid.
Patient Arrest	Any arrest of a patient.
Peace Officer Misconduct	Any allegations of peace officer misconduct, whether on or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties.
Pregnancy	A patient pregnancy.
Significant Interest	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 patient(s) or staff, child pornography, riot (as defined for OLES reporting purposes), over-familiarity between staff and patients or any incident which may potentially draw media attention.

Timeliness of Notifications

In this reporting period, DSH timely reporting of incidents to OLES decreased to 90.7 percent compared to the prior reporting period where the timely reporting was 92.6 percent.

Seven of the 447 incidents were excluded from DSH's total incident count when calculating timeliness. These seven incidents were incidents involving a patient attack on staff or were incidents reported directly to OLES by a patient, family member of a patient or by a separate DSH facility. Of the 440 incidents evaluated for timeliness, 399 were reported timely and 41 incidents with reportable incident types were not. Two of the 41 untimely incidents were unreported and were discovered by OLES when reviewing the DSH facility daily incident logs.

MSH had the highest percentage of timely notifications at 96.6 percent during this reporting period. CSH had the lowest percentage of timely notifications at 84.5 percent. When compared to the prior reporting period, MSH and PSH increased in the percentage of timely reports. ASH, CSH AND NSH had a lower percentage of timely notifications this reporting period compared to the prior reporting period.

The DSH OPS Academy reported one incident to OLES, which was timely. The

following table provides the percentage of timely notifications to OLES for each facility. The table does not include the report from the OPS Academy.

Rank	DSH Facility	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Metropolitan	119	115	96.6%
2	Atascadero	73	67	91.8%
3	Patton	98	89	90.8%
4	Coalinga	97	82	84.5%
5	Napa	52	45	86.5%
	Total	439	398	90.7%

Intake

All incidents received by 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 warrant an internal affairs investigation by OLES. If the allegations are against other DSH 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 OLES is independently assessing whether an allegation meets its criteria, OLES requires the departments to broadly report misconduct allegations.

For incidents that initially do not appear to fit the criteria[4] for OLES involvement, the OLES categorizes the incident under the "Pending Review" category and conducts an extra step to ensure the incident is properly categorized. When allegations are unclear and additional information is needed to finalize an initial intake decision, OLES may review video files or digital recordings of a particular hallway, day room, or staff area where a patient was located. Once OLES obtains and evaluates the additional materials or information, the decision to initially deem an incident as not meeting OLES criteria is reviewed again and may be reversed.

For the January 1 through June 30, 2020, reporting period, 201 of the total 485 cases opened for DSH incidents that occurred within DSH's jurisdiction or 41.4 percent were assigned a pending review. The OLES opened cases for 33 incidents that may have occurred while the patient was not housed within a DSH facility and assigned those cases a pending review. The OLES opened 14 administrative investigations and 11 criminal investigations. The OLES opened 151 monitored criminal cases and 75 monitored administrative cases.

The table on the following page provides the case assignments for incidents received by OLES during reporting period. Please note that the table on the following page separates out the outside jurisdiction cases from the Pending Review cases.

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

Cases Opened in the Current Reporting Period

OLES Case Assignments	January 1 – June 30, 2020	Percentage of Opened Cases
Pending Review	201	41.4%
Monitored, Criminal	151	31.1%
Monitored, Administrative	75	15.5%
Outside Jurisdiction*	33	6.8%
OLES Investigations, Criminal	11	2.3%
OLES Investigations, Administrative	14	2.9%
Totals	485	100%

*Outside Jurisdiction includes incidents that may have occurred while the patient was not housed within a DSH facility.

Completed Investigations and Monitored Cases

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 law enforcement personnel. These investigations can involve criminal or administrative wrongdoing, or both.
- Monitor investigations conducted by DSH 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.
- Review and assess the appropriateness of disciplinary actions resulting from a case involving an investigation and report the degree to which OLES and the hiring authority agree on the disciplinary actions, including settlements.
- Monitor that the agreed-upon disciplinary actions are imposed and not inappropriately modified. Note that this can include monitoring adverse actions against employees all the way through Skelly hearings, State Personnel Board proceedings and lawsuits.

OLES Investigations

During this reporting period, OLES completed 34 investigations. Twelve investigations were criminal cases and 22 were administrative.

If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, OLES submits the investigation to the appropriate prosecuting agency. In this reporting period, the OLES did not refer any criminal investigations to a prosecuting agency. All completed OLES investigations into administrative wrongdoing or misconduct are forwarded to facility management for review. In this reporting period, 11 administrative cases were referred to management for possible discipline of state employees. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted. The following table shows the results of all the completed OLES investigations in this reporting period. These investigations are summarized in Appendix A.

Results of Completed OLES Investigations

Type of Investigation	Total completed January 1-June 30, 2020	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	22	N/A	11	11
Criminal	12	0	N/A	12
Total	34	0	11	23

The OLES provided the department with summaries of the reviews and decisions of all administrative and criminal investigations in which the OLES determined there was insufficient evidence that allegations were true.

OLES Monitored Cases

In this report, OLES provides information on 145 completed monitored cases. By the end of the reporting period, 56 monitored criminal cases had either been referred or not referred to a prosecuting agency. Six out of 56 criminal cases were referred to a prosecuting agency.

There were 89 completed monitored administrative cases. Eighty-two monitored administrative cases had allegations that were sustained or not sustained during this reporting period. Seven of the monitored administrative cases had sustained allegations that OLES reported on in the prior reporting period. Results of OLES monitored cases are provided in the table below.

Type of Case/Result	DSH
Criminal-Referred to Prosecuting Agency	6
Criminal-Not Referred	50
Total Criminal	56
Administrative-With Sustained Allegations	19
Administrative- With Sustained Allegations Reported in the Prior Reporting Period	7
Administrative-Without Sustained Allegations	63
Total Administrative	89
Grand Total	145

Pre-Disciplinary Phase Cases

Of the 138 pre-disciplinary phase cases provided in Appendix B and D, the OLES rated 22 cases procedurally insufficient and three cases substantively insufficient. The following table provides the type of case and the corresponding

number of cases rated procedurally or substantively insufficient.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	2	1
Criminal/Not Referred	4	0
Administrative/With Sustained Allegations	6	2
Administrative/Without Sustained Allegations	10	0
Total	22	3

Significant procedural deficiencies found in insufficient cases and their potential consequences include, but are not limited to following:

Procedural Deficiencies found in Insufficient Cases

Procedural Deficiency	Potential Consequence
Failure to complete investigations within 120 days	As investigations age, memories may fade, witnesses may become unavailable, patients may be discharged or transferred.
Failure to notify OLES of suspect interview	This prevents OLES from providing contemporaneous oversight of the interview.
Failure to notify OLES of incident within required timeframe	This prevents OLES from properly processing and classifying or assigning the case. Many reporting requirements are required by statute.
Failure to consult with OLES regarding sufficiency of investigation and investigative findings in a timely manner	This consult should take place within 45 days. This may prevent the case from being processed in a timely manner.
Level of care staff did not report incident in a timely manner	This delays department's initial response and delays notification to OLES.
Failure to interview suspect prior to drafting investigative report.	This may result in an incomplete and inadequate investigation. The suspect may have provided a relevant explanation. It is important to provide the employee an opportunity to admit or deny the misconduct or provide otherwise relevant information.

Procedural Deficiency	Potential Consequence
Failure to audio record suspect or victim interview	This limits the department to have to rely upon notes and may affect the accuracy of investigative reports.
Failure to identify and interview witnesses	This increases the likelihood of missing or erroneous information.
Failure to consult with OLES regarding the sufficiency of the investigation and the investigative findings in a timely manner	This consult should take place within 45 days. This may prevent the case from being processed in a timely manner

The DSH's failure to complete investigations within the 120-day required timeframe remains the most frequent procedural deficiency observed in pre-disciplinary phase cases. After excluding the nine investigations in which OLES conducted the investigation, of the 138 pre-disciplinary phase cases, there were eight pre-disciplinary phase cases in which DSH conducted the investigation, or 6.2 percent that were not completed within the required timeframe. Of the untimely cases, the longest duration of an investigation was 300 days and the shortest duration was 143 days. The median duration for cases that did not meet the 120-day timeframe was 189 days. The CSH and MSH each had two investigations that were not completed within the required 120-day timeframe. The remaining four untimely investigations were completed at ASH.

Substantive Deficiencies found in Insufficient Cases

Substantive Deficiency	Potential Consequence
Failure to provide required legal admonition prior to taking a statement	This may compromise the integrity of the statement and render a statement inadmissible in court. In some cases, it may violate union contracts or the Public Safety Officer Bill of Rights.
Failure to interview suspect or subject prior to drafting investigative report	This may result in an incomplete and inadequate investigation. The suspect may provide a relevant explanation. It is important to provide the employee an opportunity to admit or deny the misconduct or provide otherwise relevant information.
Failure to add and sustain an appropriate allegation	This may prevent the appropriate penalty from being imposed.

Corrective action plans for procedural and substantive deficiencies in pre-disciplinary phase cases are provided in Appendix B and D.

Disciplinary Phase Cases

The OLES monitored the disciplinary action, *Skelly* hearings, settlements and State Personnel Board proceedings in fourteen administrative cases. Four cases were rated as procedurally insufficient. Three cases were rated both procedurally and substantively insufficient. Five of these cases were procedurally insufficient due to delayed service of the disciplinary action. These five disciplinary actions were served between 87 and 182 days after a disciplinary determination was made. When compared to last year's average, the average length of time to serve an action in procedurally insufficient cases decreased from 132.5 days to 110 days. In response to the insufficient rating, DSH stated the department will implement a tracking system to ensure all disciplinary actions are served within a timely manner and train staff.

The three cases were rated as substantively insufficient due to the following reasons:

- The penalty imposed was not consistent with the department's disciplinary matrix and was not significant enough to deter future misconduct.
- The hiring authority did not add and sustain an appropriate allegation of dishonesty. Due to this, the hiring authority did not impose the appropriate penalty of dismissal.
- Following the Skelly hearing, the hiring authority changed the findings and modified the penalty from a dismissal to a letter of reprimand without adequately consulting with the OLES.

For the first case, the department disagreed with OLES' assessment and did not provide a corrective action plan. In the remaining two substantively insufficient cases, DSH stated the department will provide continual consultation with OLES regarding the appropriate penalty imposed. Details regarding the monitoring of these seven cases are in Appendix C and D of this report.

Additional Mandated Data

In accordance with Welfare and Institutions Code section 4023.8, the OLES publishes data in its semiannual report about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where patients are the perpetrators. All the mandated data for this reporting period came directly from DSH and are presented in the following tables.

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	35	6	17	11	1
Coalinga	43	4	25	14	0
Metropolitan	60	7	47	5	1
Napa	49	14	16	14	5
Patton	57	1	47	7	2
Totals	244	32	152	51	9

* 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.

Criminal Cases against Employees

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	0	0	0	0
Coalinga	0	0	0	0
Metropolitan	35	1	34	0
Napa	15	0	15	0
Patton	7	5	2	3
Totals	57	6	51	3

* 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.

Patient Criminal Cases

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	181	141	40	96
Coalinga	341	61	280	40
Metropolitan	512	16	496	2
Napa	238	13	225	1
Patton	430	223	207	204
Totals	1702	454	1248	343

* 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.

Reports of Employee Misconduct to Licensing Boards

DSH Facilities	Registered Nursing	Vocational Nursing/Psych Tech	Medical Board	Public Health	CA Board of Psychologist
Atascadero	0	1	6	0	0
Coalinga	0	0	1	0	0
Metropolitan	0	0	1	0	0
Napa	0	2	2	0	1
Patton	0	0	2	0	0
Totals	0	3	12	0	1

*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, OLES may observe issues that reveal potential patterns, shortcomings, or systemic issues at the facilities. In these situations, the Chief of OLES instructs OLES staff to research and document the issues. These issues are then brought to the attention of the departments. In most instances, OLES requests corrective plans. In this reporting period, the OLES reopened a monitored issue on the enforcement of the employee return to patient care policy and opened a new monitored issue on escape prevention and key control. Updates on long-running monitored issues are provided below.

Enforcement of Employee Return to Patient Care Policy

As previously published in the semiannual report covering the period of January 1, 2018 through June 30, 2018, the OLES identified a systemic issue involving DSH employees who were 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.

DSH drafted PD 3101 in response to OLES concerns regarding the lack of consultation with OPS in circumstances where an employee is returned to patient care despite the employee being the subject of a pending, open criminal investigation for allegations of physical abuse or sexual abuse of a patient. In September 2017, the OLES reviewed and agreed with the proposed draft of PD 3101. At the time, the department appropriately responded to the concerns and recommendations raised by OLES.

However, the OLES learned that DSH has not implemented the policy. The number of the policy changed from PD 3101 to PD 9500. The department is consulting with internal stakeholders and the Standards Compliance Directors to complete the policy.

Escape Prevention and Key Control at CSH

On April 7, 2020, the OLES initiated a monitored issue in response to a patient escaping through unsecured receiving and release (R&R) doors, gates or locks at CSH. The attempted escape was possible due to lack of supervision and communication by hospital police officers and lack of adequate control or accountability measures in issuing and inventorying keys.

The OLES recommended CSH implement the following 14 recommendations:

Receiving and Release Area

- Add signage in the R&R area prohibiting employees from propping doors open or other methods of circumventing security systems. CSH should reflect this prohibition in policy.
- Instruct field sergeants to make daily rounds of the R&R area, filling out a logbook indicating they have toured the area and found no security deficiencies and that all doors are operational and secured. CSH policy should include this as a required task for security personnel.
- The communications center should not be able to control a door they cannot visually see via camera. Install a camera that enables the communication center to monitor the door or assign control of the door to someone who can monitor the door.
- Develop post orders regarding handling escorts.
- Develop post orders for the Support Services Lieutenant (Lt.). Post orders should include that the Support Services Lt. is responsible for ensuring the Field Sergeants sign daily the logbook showing they have made their rounds of the R&R area and ensured there are no security deficiencies and that all doors are operational and secure.
- Vehicle sally port gates should never be open at the same time or left open.
- When the automatic feature of a vehicle sally port door is not functioning, staff must immediately close the gate manually after a person/vehicle passes through it. The appropriate post orders should reflect this requirement.
- Footage from video cameras at CSH should be DVR-recorded.

Key Control

- Repair or replace the key boxes in such a manner their security features function appropriately (this includes regular software updates).
- Assign a HPO or supervisor to monitor key activity at the beginning, during and end of each shift to ensure keys are turned to the lock position and the key boxes are properly secured.
- Allow OPS access to the key computer system so an inventory of each box can be completed on each shift. Have policy in place to address next steps when a key is missing. (Lockdown, secure a given area etc.).
- Provide ongoing training to all staff regarding key control.
- All key box areas must be under DVR-video surveillance.
- Develop policy where officers are responsible for key inventory and security. The locksmiths should only be responsible for functioning keys and ensuring the lock box operates properly.

Per a memorandum from DSH in April 2020, DSH accomplished six out of the

eight recommendations for the receiving and release area. The two remaining recommendations that need to be addressed for the receiving and release area include ensuring that the communications center is able to monitor all doors that the center controls and ensuring footage from video cameras is DVR-recorded. The DSH is in the process of addressing the remaining eight recommendations for the R&R area and key control. The OLES will continue to monitor the department's progress.

Underutilization of Blue Team/IAPro

In March 2015, the OLES provided the Legislature with a report that described the challenges faced by law enforcement at DSH along with recommendations to address these challenges. One of the recommendations was for the departments to use an early intervention (EI) system to monitor incidents for selected performance indicators such as use of force and patient complaints. The intent was for the departments to use data to proactively identify potential performance problems with staff. The DSH selected the IAPro/Blue Team software for its EI system. BlueTeam is the interface of IAPro that allows officers and supervisors to input and manage incidents such as use of force, field-level discipline, complaints and vehicle accidents. The software also allows these incidents to be routed through the chain-of-command with review and approval at each step.

The OLES semiannual report covering the period of January 1 through June 30, 2016 recommended DSH OPS Chief review monthly reports from the system to ensure employees with the identified behavior or activities received prompt management attention. The OLES also recommended using the employee trends pinpointed in the system to review whether training was adequate or needed to be updated or supplemented. During the semiannual reporting period of July 1 through December 31, 2016, the DSH reported that DSH completed staff training at all facilities and that staff would begin using Blue Team/IAPro on December 31, 2016. DSH facilities were to enter incident data into the system and DSH-HQ would track eight incident-types: Use of Force, Patient Complaints, Citizens Complaints, Citizens Complaints¬ Other, Vehicle Accidents, Administrative Investigation, Censurable Incident Report, and Merit Salary Advance Denial. DSH-HQ would generate monthly reports to send to the DSH Police Chief at each facility for review.

On July 25, 2017, OLES initiated a Monitored Issue (Case 2017-00878-1-MI) to assess DSH's implementation and usage of the Blue Team/IA Pro program at DSH. On January 24, 2018, the OLES received the year-end totals for IAPro from four of the five facilities. The OLES did not receive the totals from CSH until February 26, 2018.

The number of incidents inputted by the facilities are provided below:

DSH Facility	January 1- June 30, 2017	July 1 - December 31, 2017
ASH	12	11
CSH	41	51
MSH	12	24
NSH	3	6
PSH	4	7
Total	72	99

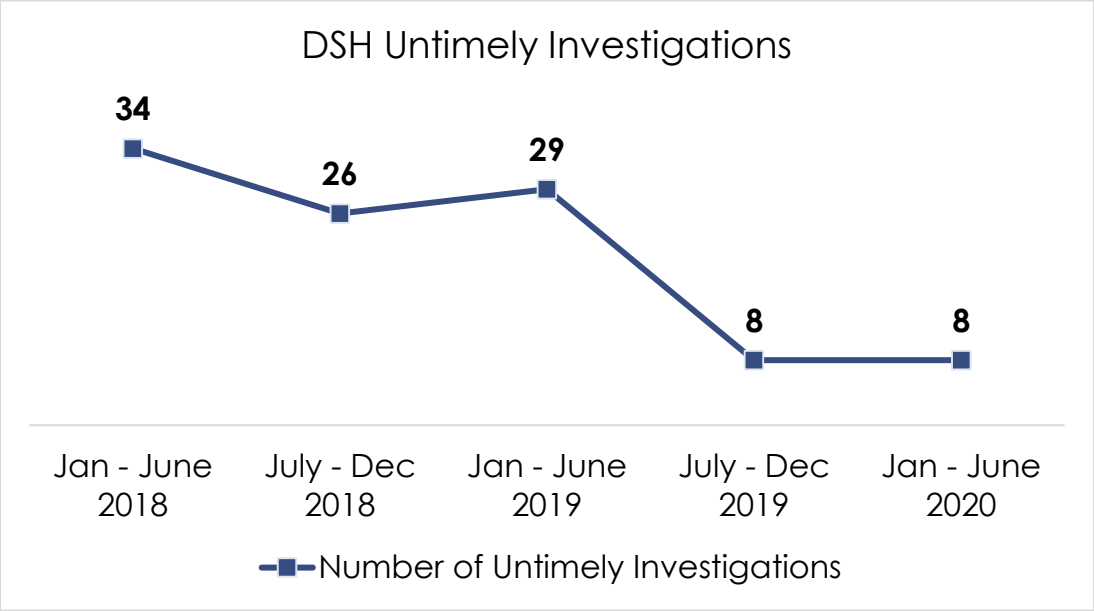
The OLES completed a comprehensive review of the data to determine whether the monthly reports submitted to the DSH Police Chiefs accurately reflected the number of reportable incidents, and to identify any potential systemic issues. The OLES determined IAPro did not accurately reflect the number of incidents that met the criteria as a reportable incident to both Blue Team and OLES. Also, some reportable use of force incidents were discovered in DSH'S Records Management System, but they were not in IAPro. The facilities did not accurately record facility case numbers in Blue Team; they used partial facility case numbers or case numbers previously used in an unrelated incident. Some monthly IA Pro reports DSH-HQ generated and sent to DSH Police Chiefs did not contain any incidents, which appeared to be the result of late reporting. There appeared to be a lack of responsibility to ensure monthly reports submitted with no reportable incidents are questioned and updated if appropriate. DSH-HQ did not contact the DSH Police Chiefs to question the accuracy of zero incidents before the monthly report was generated, and the DSH Police Chiefs did not question the accuracy of the monthly report they received.

On March 12, 2018, the interim OLES Chief, DSH OPS Chief and their respective staff discussed OLES' findings. The DSH OPS Chief advised additional training was scheduled to refresh staff knowledge of reporting requirements. The DSH OPS Chief was granted 60 days to address the issues. Discussions between OLES and DSH revealed additional training to refresh staff knowledge of reporting requirements and utilizing Blue Team appropriately did not occur. The DSH is in the process of providing administrator training and training for field users. The OLES continues to monitor this issue and is working with DSH.

Untimely Investigations at PSH

Since March 2018, OLES reported that delays in completing investigations were the most prevalent procedural deficiency for pre-disciplinary phase cases at DSH facilities. To address this deficiency, DSH added additional staff to the investigative teams at several facilities and extended the required investigative timeframe from 75 days to 120 days. Furthermore, DSH implemented additional review and monitoring processes. The chart below shows the overall declining

trend for untimely investigations for OLES monitored cases.



OLES previously reported that PSH historically had a disproportionately high number of untimely monitored investigations. In response, PSH implemented several remedial measures, including but not limited to, a visual tracking system, additional supervisory review and assignment of a liaison for contact between the hospital police department and the Office of Protective Services. Since implementing these changes, PSH significantly reduced the number of untimely investigations. As shown in the following table, PSH had no untimely investigations in this reporting period.

Reporting Period	# of PSH Untimely Investigations	Total DSH Untimely Investigations	Percent of Untimely Investigations from PSH	PSH Range for Untimely Investigations (days)
January-June 2018	19	34	55.9%	134-588
July-December 2018	20	26	76.9%	131-358
January-June 2019	17	29	58.6%	132-674
July-December 2019	6	8	75.0%	149-484
January-June 2020	0	8	0%	N/A

The OLES continues to monitor PSH's progress on this issue.

Lack of Patient Separation Policy at DSH

In the course of an investigation during the July 1, 2017, through December 31, 2017, reporting period, OLES discovered a lack of specific, written policy at MSH 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 did not have a written department-wide policy to prevent these repeat incidents. The practice of giving the clinical treatment team the discretion to decide whether to move or separate patients involved in altercations put patients at risk of harm and victimization. The OLES recommended DSH develop department-wide written policy and procedures regarding separation of patients who are involved in altercations. In response to the OLES recommendation, DSH drafted PD 8008 Patient Transfer, a policy directive which requires the review of a patient's housing to determine the most appropriate housing placement following an assaultive incident. Policy 8008 Patient Transfer is fully implemented. The DSH appropriately responded to the concerns and recommendations raised by OLES.

Personal Electronic Devices at Work

In the semiannual report covering January 1 through June 30, 2017, OLES recommended that DSH draft and implement a department-wide 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 of personal electronic devices at the facilities. PD 1102, Use of Personally Owned Electronic Devices at DSH Hospitals, is fully implemented. The OLES will continue to monitor the department's adherence to its policy.

DSH Patient Pregnancies

In the semiannual report covering January 1 through June 30, 2017, OLES made several recommendations to DSH to minimize patient pregnancies. The OLES also made a recommendation on how to best manage patients who become pregnant while residing in a state hospital or if they are pregnant when they are admitted to a DSH facility.

The OLES' recommendations included the following:

- Establish a statewide policy requiring that every pregnancy be reported to facility law enforcement.
- Establish a statewide policy requiring that every pregnancy be investigated by law enforcement. Complete investigations should determine, among other things, whether there was any staff misconduct, whether threats, force or bribes were used for sex, whether the patients could understand the nature or condition of the act and thereby legally give consent and whether patients were disabled or medicated such that they could not legally give consent.
- Coordinate with county Child and Family Services for placement of newborns.
- Establish a statewide policy that ensures that patients with demonstrated sexual aggression and sexually harmful behavior are not in DSH coed units.

In response to the OLES recommendations, the DSH drafted two policies titled "Child Placement" and "Patient Sexuality." The first policy titled PD 3108 Child Placement allows the pregnant patient to decide where and with whom her infant will be placed after birth. PD 3108 was fully implemented. The second policy titled "Patient Sexuality" identifies what must be considered when determining patient placement in co-ed living quarters. DSH renamed "Patient Sexuality" to *PD 3106 – Patient Sexual Behavior and Health*. The DSH has not yet implemented this policy.

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. The 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 OPS Policy Directive 338 Area Extraction and proposed a training plan. On December 31, 2018, DSH completed the purchase of extraction equipment and developed a training program for facility trainers. Facility trainers trained law enforcement staff in both the OPS Extraction Policy and Extraction Techniques. ASH, NSH and PSH completed the initial training. The CSH and MSH are in the process of training their law enforcement staff. Mandatory annual training for ASH and PSH is paused at this time due to COVID-19.

Child Pornography at Coalinga State Hospital

As reported 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 made up 68.9 percent of the 1365 patients as of June 30, 2020. The 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 a problem with patients gaining access to and storing child pornography. 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 DSH 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.

Outcome

The OLES staff toured CSH and met with officials and can report that DSH attempts to eradicate, investigate and prevent patient possession of child pornography are working. As a result of the three phase January 2018 sweep and search for contraband, a significant amount of illegal and contraband materials was seized and stored in secure containers onsite at CSH. The OLES entered into an agreement with CSH that monthly reports will be provided to the OLES on the progress of processing and adjudicating all illegal and contraband materials seized during the January 2018 implementation of the three phase eradication plan. Materials discovered from processing this seized material are reported to the OLES on a monthly basis to reflect the progress being made for closure of the three phase plan.

DSH continues to report newly discovered "post sweep" contraband to the OLES, which is then documented in the appropriate SAR, according to the reported timeframe. The OLES continues to monitor and work collaboratively with DSH to increase compliance with the DSH regulations on contraband to improve the safety and security for all patients.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2020.

Case Detail	Description
Incident Date	03/08/2019
OLES Case Number	2019-00250-1A
Case Type	Investigative
Incident Type	1. Significant Interest - AWOL
Incident Summary	On March 8, 2019, officers allegedly failed to properly secure doors and gates, allowing a patient to leave the secured treatment area.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there were systemic issues which allowed the incident to occur. The case was closed and a summary of the review and decision was provided to the department. The systemic issues will be addressed in a monitored issue.

Case Detail	Description
Incident Date	07/31/2019
OLES Case Number	2019-00775-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On July 31, 2019, an officer allegedly used state resources to upload a derogatory video to an internet site which compromised officer safety.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	07/18/2019
OLES Case Number	2019-00808-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between July 1, 2019, and July 31, 2019, an officer

	allegedly sexually harassed, threatened, and physically harmed a hospital communications operator.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	07/18/2019
OLES Case Number	2019-00808-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between July 1, 2019, and July 31, 2019, an officer allegedly sexually harassed, threatened, and physically harmed a hospital communications operator.
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.

Case Detail	Description
Incident Date	08/25/2019
OLES Case Number	2019-00877-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On August 25, 2019, an officer accidentally discharged his firearm while attempting to place the firearm on a nightstand inside a residence.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	07/05/2019
OLES Case Number	2019-00895-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On July 5, 2019, a psychiatric technician and several officers allegedly used excessive and unnecessary force

	on a patient, thereby injuring the patient. Another officer allegedly pulled down the patient's pants during the incident.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	09/09/2019
OLES Case Number	2019-00956-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On September 9, 2019, an officer reported that several items of department issued police equipment were stolen from their personal vehicle.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	09/21/2019
OLES Case Number	2019-01059-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On September 21, 2019, two officers allegedly engaged in unprofessional conduct.
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.

Case Detail	Description
Incident Date	01/01/2017
OLES Case Number	2019-01094-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between January 1, 2017 and January 31, 2018, a hospital police officer allegedly had illegally sold high capacity rifle magazines and received unauthorized

	secondary employment compensation.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	10/11/2019
OLES Case Number	2019-01125-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 11, 2019, officers and other staff members allegedly used excessive force on a handcuffed patient.
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.

Case Detail	Description
Incident Date	10/17/2019
OLES Case Number	2019-01158-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 17, 2019, an officer allegedly negligently discharged a firearm during scheduled weapons qualification.
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.

Case Detail	Description
Incident Date	10/25/2018
OLES Case Number	2019-01179-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 25, 2018, a sergeant allegedly made false entries in an official record and was dishonest during an investigative interview.
Disposition	The Office of Law Enforcement Support completed an

	inquiry into alleged allegations and found insufficient evidence to warrant an investigation.

Case Detail	Description
Incident Date	10/21/2019
OLES Case Number	2019-01181-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 21, 2019, an officer allegedly inappropriately touched and made inappropriate comments while searching a patient.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	10/30/2019
OLES Case Number	2019-01220-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 30, 2019, an officer allegedly inappropriately touched an academy cadet while she was sleeping.
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.

Case Detail	Description
Incident Date	11/12/2019
OLES Case Number	2019-01250-1A
Case Type	Investigative
Incident Type	1. Misconduct 2. Misconduct
Incident Summary	On November 12, 2019, an officer allegedly left their personal vehicle running while unattended and the vehicle which contained department-issued equipment was stolen. The hospital police officer subsequently provided confidential information regarding another hospital employee to a family member.

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.

Case Detail	Description
Incident Date	10/27/2019
OLES Case Number	2019-01262-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 27 and 30, 2019 an officer allegedly drove a department patrol vehicle while under the influence of alcohol.
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.

Case Detail	Description
Incident Date	01/01/2019
OLES Case Number	2019-01285-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	During 2019 and 2020, an officer allegedly repeatedly harassed another employee and trespassed into the employee's home.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	11/26/2019
OLES Case Number	2019-01311-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On November, 26, 2019, a patient's mother alleged the patient had been abused by an officer and staff members.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	12/05/2019
OLES Case Number	2019-01342-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On December 5, 2019, an officer allegedly left his personal vehicle unlocked and unattended causing the vehicle to be stolen with several items of department issued police equipment inside.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that serious misconduct occurred and the matter was closed. However, the case was referred to the department for additional review.

Case Detail	Description
Incident Date	12/18/2019
OLES Case Number	2019-01392-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On December 18, 2019, an officer allegedly fell asleep while assigned to monitor two patients at an outside hospital.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition.

Case Detail	Description
Incident Date	10/25/2018
OLES Case Number	2019-01396-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 25, 2018, an officer allegedly falsified entries in an official record and was allegedly dishonest on January 9, 2019, during an investigative interview.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	12/19/2019
OLES Case Number	2019-01402-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On December 19, 2019, officers and other staff members allegedly assaulted a patient.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	12/18/2019
OLES Case Number	2019-01430-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On December 18, 2019, a patient alleged that staff members, including a hospital police officer, had been bringing methamphetamine into the hospital.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	12/30/2019
OLES Case Number	2019-01433-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On December 30, 2019, an officer allegedly expressed suicide ideation.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	01/01/2019
OLES Case Number	2020-00052-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	During 2019, two sergeants allegedly engaged in an inappropriate relationship while on-duty.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	10/24/2019
OLES Case Number	2020-00093-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 24, 2019, a law enforcement supervisor allegedly disclosed inaccurate and confidential information in a memorandum.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	01/27/2020
OLES Case Number	2020-00098-1C
Case Type	Investigative
Incident Type	1. Sexual Assault
Incident Summary	On January 27, 2020, several officers allegedly sexually assaulted a patient.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	01/28/2020
OLES Case Number	2020-00111-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	On January 28, 2020, several hospital staff members and officers allegedly dropped a patient during an escort to a seclusion room, causing injury to the patient's ankle.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	01/01/2019
OLES Case Number	2020-00127-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between January 1, 2019, and December 31, 2019, a sergeant allegedly committed time sheet fraud by engaging in fundraising activities during working hours.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	12/20/2019
OLES Case Number	2020-00149-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On December 20, 2019, five officers allegedly assaulted and violated the civil rights of a person attempting to make a video recording on state hospital property.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	02/12/2020
OLES Case Number	2020-00150-1C
Case Type	Investigative
Incident Type	1. Sexual Assault
Incident Summary	On February 12, 2020, an officer allegedly inappropriately touched a restrained patient.
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 review and decision was provided to the department.

Case Detail	Description
Incident Date	03/03/2020
OLES Case Number	2020-00235-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On March 3, 2020, an officer allegedly lost a set of facility keys and failed to report the matter in an expeditious manner.
Disposition	After a thorough review and analysis of the documentation received, no further action is required and the case has been closed. A disposition memorandum has been provided to the department.

Case Detail	Description
Incident Date	02/08/2020
OLES Case Number	2020-00250-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between February 8, 2020, and March 10, 2020, an officer cadet allegedly threatened and made inappropriate comments regarding staff and other officer cadets.
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.

Case Detail	Description
Incident Date	03/16/2020
OLES Case Number	2020-00270-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	On March 16, 2020, an officer allegedly used excessive and unnecessary force on a patient.
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 review and decision was provided to the department.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2020, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. The OLES monitored each departmental investigations for both procedural and substantive sufficiency.

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

Criminal-Referred to Prosecuting Agency

Case Detail	Description
Incident Date	07/07/2018
OLES Case Number	2019-00149-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Referred 2. Referred 3. Referred
Incident Summary	On July 7, 2018, a psychiatric technician assistant allegedly assisted a patient in escaping a forensic conditional release program. Between July 7, 2018, and November 26, 2018, the psychiatric technician assistant allegedly engaged in sexual relations with the patient and prevented the patient from receiving psychiatric and medical care. Between December 4, 2018, and August 11, 2019, the psychiatric technician assistant allegedly sent money to the patient after the patient returned to the hospital.
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 opened

	an administrative investigation, which the OLES monitored.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator did not adequately prepare for the investigation when he failed to verify the psychiatric technician's home address prior to executing a search warrant. The investigator did not appropriately conduct the psychiatric technician's interview when he failed to provide the appropriate legal admonition prior to obtaining her statement. The draft and final investigative reports contained statements by the psychiatric technician that were obtained in violation of her constitutional rights.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator failed to verify the psychiatric technician's current home address prior to executing a search warrant. 2. Were all of the interviews thorough and appropriately conducted? No. The investigator failed to provide the appropriate legal admonitions prior to conducting an interview of the psychiatric technician. 3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report included a summary of the psychiatric technician's interview containing statements obtained in violation of her constitutional rights. 4. Was the final investigative report thorough and appropriately drafted? No. The final investigative report included a summary of

	the psychiatric technician's interview containing statements obtained in violation of her constitutional rights.
Department Corrective Action Plan	In the interest of safety for all parties involved, OPS will diligently verify the employee/suspect address/location to be searched 48 hours prior to executing a search warrant. OPS will use best industry standards e.g. surveillance, pulling and verifying all available records, etc. to accomplish this. Refresher training will be provided to all of the OPS sworn staff to ensure the proper admonishment is being used. This will avoid any potential for violation of their constitutional rights.

Case Detail	Description
Incident Date	09/16/2019
OLES Case Number	2019-01014-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On September 16, 2019, a psychiatric technician allegedly forcibly grabbed and bruised a patient's arm.
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 will open an administrative investigation, which the OLES will monitor.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/25/2019
OLES Case Number	2019-01106-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Referred

Incident Summary	On September 25, 2019, a senior psychiatric technician allegedly inappropriately grabbed a patient's genitals.
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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/10/2019
OLES Case Number	2019-01244-1C
Case Type	Monitored
Incident Types	1. Non-Patient Assault/GBI
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	On November 10, 2019, a psychiatric technician allegedly choked a patient, rendering him unconscious, allowing a second patient to commit a sexual assault on the unconscious patient.
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 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 Detail	Description
Incident Date	01/28/2020
OLES Case Number	2020-00095-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On January 28, 2020, a staff member allegedly grabbed and forced a patient to the floor.
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 incident was discovered on January 28, 2020; however, the investigation was not completed until June 19, 2020, 143 days later.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report required additional clarification and contained irrelevant information. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The OPS failed to notify OLES regarding the scheduling of the victim interview. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 28, 2020; however, the investigation was not completed unit June 19, 2020, 143 days later.
Department	Ensure OLES and legal are consulted prior to the

Corrective Action Plan	finalization and issuance of the disciplinary action. Training on the requirements of an agreement of all stake holders that the draft is supported by relevant facts supported within the investigation. The OPS Chief/OSI discussed with the entire investigative staff the importance of meeting the OLES completion/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. In addition, the policy procedure manual for the facility was updated to reflect the investigation will be initially turned in 30 days prior to the due date to ensure all timelines are met.

Case Detail	Description
Incident Date	01/29/2020
OLES Case Number	2020-00118-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On January 29, 2020, a psychiatric technician allegedly neglected to assess a patient's blood sugar and allegedly falsified documents indicating she conducted an assessment.
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 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.

Criminal-Not Referred

Case Detail	Description
Incident Date	08/01/2013
OLES Case Number	2018-00747-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between August 2013 and October 2014, a program assistant allegedly engaged in sexual activity 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 investigation took 300 days to complete.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The department discovered the alleged misconduct on July 19, 2018; however, the final investigative report was not completed until June 18, 2020. Excluding all days where laboratory test results were pending, the actual investigation took 300 days to complete. The first-assigned detective was assigned on July 24, 2018, but did not begin her investigation until November 5, 2018.
Department Corrective Action Plan	The Chief/OPS will ensure all investigative phases are conducted in a timely manner. Chief/OPS will meet on a weekly basis to discuss active cases.

Case Detail	Description
Incident Date	08/13/2019
OLES Case Number	2019-00838-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 13, 2019, a psychiatric technician allegedly forced a patient into a wall, struck the patient's rib area three times and twisted 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. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/02/2019
OLES Case Number	2019-00901-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 2, 2019, a staff member allegedly 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 complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/03/2019
OLES Case Number	2019-00925-2C
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 3, 2019, a psychiatric technician and multiple patients allegedly restrained and sexually assaulted another 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 Detail	Description
Incident Date	09/16/2019
OLES Case Number	2019-00995-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 16, 2019, a psychiatric technician allegedly forcibly opened a patient's mouth, and forcibly administered medication to 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 Detail	Description
Incident Date	09/15/2019
OLES Case Number	2019-01016-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 15, 2019, a nurse allegedly ignored a patient when the patient reported he did not feel well, and was experiencing pain after taking medication.
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 Detail	Description
Incident Date	09/18/2019
OLES Case Number	2019-01019-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 18, 2019, a nursing coordinator, a unit supervisor and three psychiatric technicians allegedly dragged a patient into a room, stomped on the patient's head, and bruised the patient's ribs. The nursing coordinator also allegedly used profanity towards 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 sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/21/2019
OLES Case Number	2019-01032-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 21, 2019, a psychiatric technician allegedly teased a patient by telling the patient he had been sexually assaulted by another 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 Detail	Description
Incident Date	09/23/2019
OLES Case Number	2019-01036-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 23, 2019, a psychiatric technician allegedly pushed 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 Detail	Description
Incident Date	09/25/2019
OLES Case Number	2019-01041-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 25, 2019, a registered nurse allegedly injured an unconscious patient while conducting a sternum rub before initiating CPR.
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 Detail	Description
Incident Date	09/28/2019
OLES Case Number	2019-01055-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 28, 2019, a senior psychiatric technician allegedly slammed a patient against a wall, bruising the patient's arm, and dragged the patient into a room.
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 Detail	Description
Incident Date	10/01/2019
OLES Case Number	2019-01080-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On October 1, 2019, a psychiatric technician allegedly repeatedly 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 Detail	Description
Incident Date	10/05/2019
OLES Case Number	2019-01103-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On October 5, 2019, a psychiatric technician allegedly grabbed and pushed 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 Detail	Description
Incident Date	10/08/2019
OLES Case Number	2019-01107-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On October 8, 2019, a senior psychiatric technician allegedly inappropriately touched a patient during a full-body search for contraband.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	10/01/2019
OLES Case Number	2019-01130-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	During August 2019, a psychiatric technician allegedly attempted to break a patient's arm.
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 Detail	Description
Incident Date	09/25/2019
OLES Case Number	2019-01173-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 25, 2019, a psychiatric technician allegedly forced a patient's head against a wall.
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 complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	10/27/2019
OLES Case Number	2019-01214-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On October 27, 2019, two psychiatric technicians allegedly inappropriately brushed up against a patient's breasts.

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 Detail	Description
Incident Date	07/01/2019
OLES Case Number	2019-01215-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between July 1, 2019 and November 30, 2019, a psychiatric technician assistant allegedly took a patient's journal and read it out loud on the unit, bumped into the patient and asked her if she would go into the bathroom and have sex with the men on the unit.
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 Detail	Description
Incident Date	11/04/2019
OLES Case Number	2019-01226-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 4, 2019, an unidentified person allegedly sexually assaulted a patient while he slept in his room.
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. 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 143 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 5, 2019; however, the investigation was not completed until March 27, 2020, 143 days later.
Department Corrective Action Plan	OPS has now established a procedure that includes the OLES Case Request for Extension forms be sent via Watchdox to the OLES general mailbox and the form and Watchdox confirmation email be included with the case file. The Detective Unit Sergeant, Investigators and Office Professional staff will receive training on the new procedure.

Case Detail	Description
Incident Date	08/01/2019
OLES Case Number	2019-01252-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between August 1, 2019, and November 30, 2019, a psychiatric technician 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 the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/18/2019
OLES Case Number	2019-01264-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 18, 2019, staff members allegedly forcibly pulled a patient's underpants upwards from the back, pushed and forced him on the bed, choked and administered him two injections.
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 Detail	Description
Incident Date	09/19/2019
OLES Case Number	2019-01265-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On or about September 19, 2019, a support staff assistant allegedly grabbed and pushed 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 Special Investigations opened an administrative investigation, which the OLES did not monitor because the department did not inform the OLES about that investigation being opened.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process when it failed to notify the OLES that it opened an administrative investigation, thus preventing the OLES from monitoring that investigation.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services did not notify the OLES that it opened an administrative investigation, thus preventing the OLES from monitoring the investigation.
Department Corrective Action Plan	The supervising special investigator will continue to ensure investigators meet and discuss with the AIM's regarding the status of their case being monitoring. When the supervising investigator is notified the case is being monitored on the criminal side; however, not administratively, the Supervising Investigator will reach out to the assigned AIM to confirm and make a note in the case file.

Case Detail	Description
Incident Date	11/24/2019
OLES Case Number	2019-01293-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 24, 2019, a psychiatric technician allegedly 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 this determination. The Office of Special Investigations opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/26/2019
OLES Case Number	2019-01312-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On November 26, 2019, a unit supervisor, and a psychiatric technician allegedly grabbed a patient's arms while escorting him to the seclusion room. A second psychiatric technician allegedly refused to give a urinal to 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	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	11/27/2019
OLES Case Number	2019-01316-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 27, 2019, a psychiatric technician assistant allegedly struck 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 Detail	Description
Incident Date	11/28/2019
OLES Case Number	2019-01327-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 28, 2019, a psychiatric technician allegedly had sex 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 also opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	11/25/2019
OLES Case Number	2019-01331-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 25, 2019, a psychiatric technician and other staff members allegedly assaulted a patient. On December 2, 2019, the psychiatric technician allegedly grabbed the patient's neck in an attempt to place the patient into 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 Detail	Description
Incident Date	12/19/2019
OLES Case Number	2019-01397-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 19, 2019, a psychiatric technician 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 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 Detail	Description
Incident Date	12/20/2019
OLES Case Number	2019-01398-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 20, 2019, a psychiatric technician 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 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 Detail	Description
Incident Date	12/18/2019
OLES Case Number	2019-01430-2C
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 18, 2019, a patient reported that several staff members, including one officer, were allegedly bringing narcotics into the facility.
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 Detail	Description
Incident Date	01/06/2020
OLES Case Number	2020-00027-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 6, 2020, an unidentified person allegedly entered a patient's room and raped 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 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 Detail	Description
Incident Date	01/09/2020
OLES Case Number	2020-00028-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 9, 2020, a patient was sent to an outside hospital, for treatment of flu-like symptoms, where he died later that same day from flu and pneumonia.
Disposition	No staff misconduct was identified during the investigation. It was determined the patient died from flu and pneumonia, therefore the case was not referred to the district attorney's office for review.

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

Case Detail	Description
Incident Date	01/11/2020
OLES Case Number	2020-00033-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 11, 2020, a staff member allegedly grabbed and bruised a patient's breast, and dislocated the patient's shoulder.
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 Detail	Description
Incident Date	01/16/2020
OLES Case Number	2020-00059-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 16, 2020, a nurse allegedly incorrectly inserted an intravenous line into a patient, causing pain and swelling to the patient's hand. The nurse also allegedly forcefully removed the patient's bandages.
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 Detail	Description
Incident Date	01/15/2020
OLES Case Number	2020-00062-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 15, 2020, a staff member allegedly broke a patient's wrist. Additionally, a registered nurse allegedly pulled the patient's hair while the patient was using the phone.
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 Detail	Description
Incident Date	01/22/2020
OLES Case Number	2020-00073-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 21, 2020, a patient was transported to an outside hospital for treatment of abdominal pain. The patient died at the hospital on January 22, 2020.
Disposition	No staff misconduct was identified during the

	investigation. It was determined the patient died from ischemic bowel disease; therefore, the case was not referred to the district attorney's office for review.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/04/2019
OLES Case Number	2020-00074-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	On September 4, 2019, a psychiatric technician assigned to enhanced observation of a patient allegedly failed to maintain continuous observation of that patient. That patient allegedly assaulted a second patient. On January 18, 2020, a second psychiatric technician assigned to enhanced observation over a third patient allegedly failed to maintain continuous observation of the third patient. The third patient allegedly assaulted the second 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 Detail	Description
Incident Date	01/17/2020
OLES Case Number	2020-00076-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 17, 2020, a patient alleged that a psychiatric technician allegedly had previously caused another patient's death.
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 had already opened an administrative investigation regarding the patient's death prior to the discovery of any abuse allegations. The administrative investigation was suspended pending the completion of the criminal investigations. The OLES accepted the administrative investigation for monitoring.
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 timely notify the OLES of the alleged abuse.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on January 17, 2020, but did not notify the OLES until January 29, 2020, 12 days later.
Department Corrective Action Plan	The Chief/OPS conducted training with the Sergeants/Command staff on the OLES's reporting guidelines.

Case Detail	Description
Incident Date	01/21/2020
OLES Case Number	2020-00087-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 21, 2020, a psychiatric technician allegedly pushed a patient. Additionally, a unit supervisor allegedly grabbed and 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 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 Detail	Description
Incident Date	01/28/2020
OLES Case Number	2020-00097-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 28, 2020, a registered nurse allegedly struck 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 Detail	Description
Incident Date	02/10/2020
OLES Case Number	2020-00146-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 10, 2020, a psychiatric technician allegedly grabbed and injured 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 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 Detail	Description
Incident Date	01/11/2020
OLES Case Number	2020-00147-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 11, 2020, a psychiatric technician allegedly pulled a patient's hair.
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 Detail	Description
Incident Date	02/13/2020
OLES Case Number	2020-00153-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 13, 2020, an unidentified person allegedly raped 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 Detail	Description
Incident Date	02/24/2020
OLES Case Number	2020-00194-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 24, 2020, staff found a 44 year-old patient unresponsive and initiated emergency life-saving measures; however, the patient was declared dead. An autopsy determined the cause death was an underlying disease.
Disposition	The case was not referred to the district attorney's office because 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 sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/10/2020
OLES Case Number	2020-00253-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Attempted Suicide
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 10, 2020, staff members issued a shaving razor to a patient and allegedly failed to collect and account for the razor. The patient disassembled the razor, and used the blades in an attempt to commit suicide by cutting his forearm.
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 sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/30/2020
OLES Case Number	2020-00311-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 30, 2020, staff found a 93 year old patient unresponsive and initiated emergency life-saving measures; however, the patient was declared dead. An autopsy determined the immediate cause of death was atherosclerotic cardiovascular disease.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the matter was not referred to the district attorney's office. 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 Detail	Description
Incident Date	01/01/2020
OLES Case Number	2020-00345-1C
Case Type	Monitored
Incident Types	1. Sexual Assault 2. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On or about January 1, 2020, a psychiatric technician allegedly pinched two patients on the chest.
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 department 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 Detail	Description
Incident Date	11/01/2019
OLES Case Number	2020-00367-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	In November 2019, a staff member allegedly allowed three non-staff members into a facility where they 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 also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	05/28/2020
OLES Case Number	2020-00550-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 28, 2020, a staff member 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 sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/30/2020
OLES Case Number	2020-00554-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 30, 2020, a staff member 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 sufficiently complied with policies and procedures governing the investigative process.

Administrative-With Sustained Allegations

Case Detail	Description
Incident Date	08/13/2018
OLES Case Number	2018-00858-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Other failure of good behavior 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Sustained 4. Not Sustained 5. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On August 13, 2018, a nurse and three psychiatric technicians allegedly deliberately injected a patient with a higher than prescribed dose of anti-psychotic emergency medication.
Disposition	The hiring authority sustained allegations against the nurse and two of the psychiatric technicians for violating policies regarding administration of medications. Corrective action and training had already been issued to these three employees soon after the incident; therefore, the hiring authority determined no further action should be taken. The hiring authority did not sustain any allegations against the third psychiatric technician. 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 210 days after the

	administrative investigation was opened.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. An administrative investigation was opened on May 1, 2019; however, the investigative report was not completed until November 27, 2019, 210 days later.
Department Corrective Action Plan	The Chief/OPS will ensure all investigative phases are conducted in a timely manner. Chief/OPS will meet on a weekly basis to discuss active cases.

Case Detail	Description
Incident Date	05/07/2019
OLES Case Number	2019-00469-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Training **Final:** No Change
Incident Summary	On May 7, 2019, a senior psychiatric technician and two psychiatric technicians allegedly refused to let a patient use the restroom as they attempted a contraband search, causing the patient to urinate on himself.
Disposition	The hiring authority sustained an allegation against the senior psychiatric technician for failing to ensure the patient was adequately searched before being placed in seclusion and ordered re-training for the senior psychiatric technician on that policy. No allegations were sustained against any of the staff members for abuse of the patient. 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 Detail	Description
Incident Date	07/05/2019
OLES Case Number	2019-00657-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Disciplinary Phase Pending
Incident Summary	On July 5, 2019, a psychiatric technician allegedly pushed a patient to the floor, causing an injury to the patient's head. The psychiatric technician allegedly failed to document the incident or inform the shift leader about the incident. A registered nurse allegedly failed to initiate head injury protocol after becoming aware of the head injury.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the psychiatric technician for failure to document the incident and imposed a 10 percent salary reduction for 12 months. The hiring authority determined there was sufficient evidence to sustain the allegation against the registered nurse for failure to initiate head injury protocols and imposed a 10 percent salary reduction for 12 months. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/12/2019
OLES Case Number	2019-00985-1A
Case Type	Monitored
Incident Types	1. Neglect
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:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On September 12, 2019, two nurses and a senior psychiatric technician allegedly failed to provide medical attention to a patient who complained of pain.
Disposition	The hiring authority sustained the allegations against the first nurse and determined a salary reduction of 10 percent for 12 months was the appropriate penalty, but determined there was insufficient evidence to sustain the allegations against the senior psychiatric technician and the second nurse. 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 not completed until 232 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 September 12, 2019; however, the investigation was not completed until April 30, 2020, 232 days later.
Department Corrective Action Plan	The Supervising Special Investigator I discussed/retrain the entire investigative staff on the importance of meeting the OLES completion/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. If needed, the Supervising Special

	Investigator will assign two Retired Annuitant Investigators to more complex cases.

Case Detail	Description
Incident Date	01/01/2019
OLES Case Number	2019-01175-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Suspension **Final:** Disciplinary Phase Pending
Incident Summary	In 2019, a senior psychologist supervisor and four psychiatric technicians were allegedly aware of an overly familiar relationship between a former psychiatric technician assistant and a patient and failed to report the misconduct. The senior psychologist supervisor allegedly was overly familiar with the same patient when she provided clothing and other items to the patient without the approval of the hiring authority and failed to wait a year from the patient's discharge before involving herself with the patient in any personal capacity. It was also alleged that the senior psychologist supervisor was less than truthful during her investigative interview.
Disposition	The hiring authority determined the senior psychologist supervisor violated policy when she purchased clothing and other items for the patient and gave the patient those items on the day of his discharge without obtaining permission from the hiring authority. The hiring authority determined the senior psychologist supervisor likewise violated policy when she failed, in spite of significant evidence, to report the former psychiatric technician assistant for being overly familiar with the patient. Further, it was determined the senior psychologist supervisor was less than truthful during her investigative interview. The hiring authority determined

	a 14-day suspension was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the four psychiatric technicians. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/22/2019
OLES Case Number	2019-01194-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	On October 22, 2019, a senior psychiatric technician allegedly failed to report an assault involving two patients.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued the senior psychiatric technician a letter of instruction. 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 Detail	Description
Incident Date	10/30/2019
OLES Case Number	2019-01220-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Disciplinary Phase Pending
Incident Summary	On October 30, 2019, an officer allegedly

	inappropriately touched an academy cadet while she was sleeping.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. 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 Detail	Description
Incident Date	11/14/2019
OLES Case Number	2019-01272-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On November 14, 2019, a psychiatric technician assigned to provide direct observation of a patient, allegedly slapped the patient in the face after the patient spat on her. The psychiatric technician then allegedly left the patient unattended for several minutes. On an unspecified date, a second psychiatric technician allegedly elbowed the same patient in the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the physical abuse allegation against the first psychiatric technician; however found sufficient evidence to sustain the allegation for leaving the patient unattended. The hiring authority issued the psychiatric technician a letter of instruction. The hiring authority determined there was insufficient evidence to sustain the physical abuse allegation against the second psychiatric technician. 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 responding officer failed to conduct a thorough investigation when he failed to identify and interview percipient witnesses.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not record the interview with the patient. The officer did not attempt to identify and interview the witnesses who were present when the psychiatric technician allegedly admitted to hitting the patient.
Department Corrective Action Plan	The responding officers shall be reminded to record all interviews that are potentially Office of Law Enforcement Support monitored investigations as well as all interviews. The officers will be reminded to provide the legally required admonishment prior to taking a statement from Level of Care staff when it's applicable. This can be accomplished during In-service briefing training.

Case Detail	Description
Incident Date	12/08/2019
OLES Case Number	2019-01349-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	On December 8, 2019, a psychiatrist allegedly failed to properly return a set of controlled keys prior to leaving a secured area of the hospital.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a letter of reprimand. 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 Detail	Description
Incident Date	12/11/2019
OLES Case Number	2019-01371-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment 3. Dishonesty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Disciplinary Phase Pending
Incident Summary	On December 11, 2019, a registered nurse allegedly failed to medically assess a patient complaining of stomach pain. On December 11, 2019, a second registered nurse was allegedly discourteous to the first registered nurse. On January 14, 2020, the second registered nurse was allegedly dishonest during her investigative interview.
Disposition	The hiring authority sustained the allegation against the first registered nurse and determined a salary reduction of 5 percent for six months was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the second registered nurse. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigator did not properly identify and interview the second registered nurse as a subject before making recommended findings against her in the draft investigative report. Also, the investigation was not completed until 175 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?

	No. The draft report included inappropriate proposed findings against the second registered nurse who was not previously named as a subject of the investigation and who had not been questioned about an allegation that she was discourteous to the first registered nurse and possibly dishonest during her first investigative interview. 2. Was the investigation thorough and appropriately conducted? No. The investigator did not interview the second registered nurse as a potential subject before making recommended findings in the draft investigative report that she was discourteous to the first registered nurse and possibly dishonest during her first investigative interview. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on December 11, 2019; however, the investigation was not completed until June 3, 2020, 175 days later.
Department Corrective Action Plan	The Supervising Special Investigator will ensure Investigators meet and discuss with the AIM when a staff member's involvement status changes as a result of facts brought forth through active investigation. The staff's involvement will be finalized before a draft is submitted to the AIM for review. The Supervising Special Investigator will closely monitor cases. If needed, the Supervising Special Investigator will assign two Retired Annuitant Investigators to more complex cases.

Case Detail	Description
Incident Date	12/18/2019
OLES Case Number	2019-01392-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction

Incident Summary	On December 18, 2019, an officer was allegedly asleep while assigned to monitor two patients at an outside hospital.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 10 percent for 24 months was the appropriate penalty. The OLES concurred with the hiring authority's determination. At the pre-hearing settlement conference, the department entered into a settlement agreement whereby the penalty was reduced to a salary reduction of 10 percent for 12 months.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/08/2020
OLES Case Number	2020-00250-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Discourteous treatment
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Disciplinary Phase Pending
Incident Summary	Between February 8, 2020, and March 10, 2020, an officer allegedly made threatening and racist remarks during the training academy. On March 25, 2020, the officer was allegedly dishonest during the investigative 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:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	03/16/2019
OLES Case Number	2019-00282-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 16, 2019, a psychiatric technician allegedly grabbed a patient's wrist, causing pain to 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:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/10/2019
OLES Case Number	2019-00475-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 10, 2019, a psychiatric technician allegedly sexually 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/17/2019
OLES Case Number	2019-00493-2A
Case Type	Monitored
Incident Types	1. Abuse
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 Penalty Imposed
Incident Summary	On May 17, 2019, a psychiatric technician allegedly slammed a patient's head into the wall and twisted the patient's arm while stabilizing the patient against the wall.
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 Detail	Description
Incident Date	06/08/2019
OLES Case Number	2019-00566-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 8, 2019, a psychiatric technician allegedly struck a patient in the head with a coffee mug after the patient allegedly attacked the psychiatric technician.
Disposition	The hiring authority found 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 Detail	Description
Incident Date	06/17/2019
OLES Case Number	2019-00596-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 17, 2019, two unit supervisors, three psychiatric technicians, and other staff members allegedly assaulted a patient in retaliation because the patient had made a staff complaint.
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 Detail	Description
Incident Date	06/24/2019
OLES Case Number	2019-00641-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Unfounded 3. Not Sustained 4. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	On June 24, 2019, two nurses allegedly failed to properly assist a patient after the patient complained of eye pain, and dizziness.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against one nurse, and determined the investigation conclusively proved that the other nurse did not engage in any misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/20/2019
OLES Case Number	2019-00718-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On July 20, 2019, a senior psychiatric technician allegedly grabbed and pulled a patient, injuring the 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 investigative report was sent to the hiring authority on October 23, 2019; however, the consultation did not occur until January 3, 2020, 73 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 investigation report was sent to the hiring authority on October 23, 2019; however, the consultation did not occur until January 3, 2020, 73 days later.
Department Corrective Action Plan	An internal tracking system and improved communication has been implemented between the hiring authority and OLES regarding the sufficiency of the investigation and the investigative findings. This tracking system will assist in ensuring the OLES recommended time frames are being met.

Case Detail	Description
Incident Date	07/22/2019
OLES Case Number	2019-00726-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On July 22, 2019, a unit supervisor allegedly spat on and struck 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:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/29/2019
OLES Case Number	2019-00752-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On July 29, 2019, a registered nurse allegedly refused to loosen restraints which a patient complained were too

	tight.
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 Detail	Description
Incident Date	08/14/2019
OLES Case Number	2019-00826-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 14, 2019, a staff member 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	08/20/2019
OLES Case Number	2019-00861-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 20, 2019, three psychiatric technicians allegedly used unnecessary force when placing a patient 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. Level of care staff failed to timely notify the Office of Protective Services of the allegation. The Office of Protective Services failed to timely notify the OLES of the incident. The responding officer failed to audio record the interview of the patient and failed to determine when the patient first made the allegation of abuse, which is critical to the statute of limitations analysis.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services was notified of the allegation on August 22, 2019, at 2028 hours; however, did not notify the OLES until August 23, 2019, at 0329 hours, approximately seven hours later. 2. Did the department adequately respond to the incident? No. The responding officer neither audio recorded the patient's interview nor establish when the patient first made the allegation of abuse. This information is critical in determining the time period in which administrative or criminal action must be commenced.
Department Corrective Action Plan	The Officers and Watch Commanders shall be informed of the importance of promptly informing OLES within the stated guidelines for priority one and two incidents. The responding Officers shall be informed to record all potential OLES monitored investigations. This can be accomplished during an In-service training briefing. The officers will be reminded to ascertain essential information during their interviews which can be critical to the statute of limitations pertaining to Administrative and Criminal investigations.

Case Detail	Description
Incident Date	08/27/2019
OLES Case Number	2019-00878-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 11, 2019, a psychiatric technician allegedly grabbed a patient while two other psychiatric technicians kicked 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	08/27/2019
OLES Case Number	2019-00890-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 27, 2019, A psychiatric technician who was assigned to provide constant observation of a patient allegedly failed to notice and intervene when the patient fell and injured her knee.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's recommendation.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officer failed to record significant interviews

	and did not provide the psychiatric technician with the legally required admonition prior to taking his statement.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The responding officer failed to record interviews and failed to provide the psychiatric technician with the legally required admonishment prior to taking the psychiatric technician's statement.
Department Corrective Action Plan	The responding officers shall be reminded to record all interviews that are potentially Office of Law Enforcement Support monitored investigations as well as all interviews. The officers will be reminded to provide the legally required admonishment prior to taking a statement from Level of Care staff when it's applicable. This can be accomplished during In-service briefing training.

Case Detail	Description
Incident Date	08/29/2019
OLES Case Number	2019-00906-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between August 29, 2019, and August 30, 2019, a registered nurse and psychiatric technician allegedly failed to prevent a patient, who required constant monitoring, from placing items in a body cavity.
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 Detail	Description
Incident Date	09/03/2019
OLES Case Number	2019-00915-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 3, 2019, a psychiatric technician allegedly spat on 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 did not comply with policies and procedures governing the pre-disciplinary process. The investigator did not notify the OLES monitor about the psychiatric technician's interview; therefore, the monitor was unable to attend the interview and provide real-time feedback.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not notify the OLES monitor about the psychiatric technician's interview; therefore, the monitor was not afforded the opportunity to attend the interview, and provide input or contemporaneous monitoring.
Department Corrective Action Plan	The Supervising Special Investigator I, will continue to work with the investigator regarding the expectations regarding OLES monitored cases to ensure there is real-time consultation with the OLES monitor.

Case Detail	Description
Incident Date	09/09/2019
OLES Case Number	2019-00952-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 9, 2019, a psychiatric technician 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/12/2019
OLES Case Number	2019-00968-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 12, 2019, a psychiatric technician allegedly restrained a patient and placed his forearm against the patient's throat.
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 responding officer failed to provide the psychiatric technician with the legally required admonition before obtaining the psychiatric technician's statement.

Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer failed to provide the psychiatric technician with the legally required admonition prior to taking the psychiatric technician's statement.
Department Corrective Action Plan	The officers will be reminded to provide the legally required admonishment prior to taking a statement from Level of Care staff when it's applicable. This can be accomplished during In-service briefing training.

Case Detail	Description
Incident Date	09/14/2019
OLES Case Number	2019-00982-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 14, 2019, a 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/14/2019
OLES Case Number	2019-00984-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 14, 2019, a staff member allegedly struck 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 Detail	Description
Incident Date	09/16/2019
OLES Case Number	2019-00995-2A
Case Type	Monitored
Incident Types	1. Abuse
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 Penalty Imposed
Incident Summary	On September 16, 2019, a psychiatric technician allegedly forcibly opened a patient's mouth, and forcibly administered medication to 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:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/08/2019
OLES Case Number	2019-01004-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 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

Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 8 and 9, 2019, a senior psychiatric technician, four psychiatric technicians, and a nurse allegedly neglected a patient when they left him wearing urine soaked clothing and laying in soiled bedding for approximately nine hours.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. 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 176 days from the date of discovery, and the hiring authority did not consult with OLES prior to making the investigative findings.
Pre-Disciplinary Assessment	1. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with OLES prior to making the investigative findings. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on September 17, 2019; however, the investigation was not completed until March 11, 2020, 176 days later.
Department Corrective Action Plan	The OPS chief discussed with the entire investigative staff the importance of meeting the OLES completion/ 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.

Case Detail	Description
Incident Date	08/22/2019
OLES Case Number	2019-01006-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 22, 2019, the first patient allegedly moved a mop over a second patient's foot, and struck the second patient's ankle while the first patient was mopping the bathroom floors. A senior psychiatric technician allegedly laughed, and failed to do anything after being notified of the incident. On August 23, 2019, a unit supervisor, allegedly threatened to move the second patient off the unit if he kept harassing the first 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:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/16/2019
OLES Case Number	2019-01014-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 16, 2019, a psychiatric technician allegedly forcibly grabbed and bruised a patient's arm.
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 Detail	Description
Incident Date	09/18/2019
OLES Case Number	2019-01019-2A
Case Type	Monitored
Incident Types	1. Abuse
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:** Other
Incident Summary	On September 18, 2019, a psychiatric technician allegedly dragged a patient, stomped on the patient's head and bruised the patient's ribs.
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 Detail	Description
Incident Date	09/24/2019
OLES Case Number	2019-01033-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 24, 2019, a senior radiologist allegedly touched a patient's breasts while administering an x-ray.
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 the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/25/2019
OLES Case Number	2019-01041-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 25, 2019, a registered nurse allegedly injured an unconscious patient while conducting a sternum rub before initiating CPR.
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 Detail	Description
Incident Date	09/21/2019
OLES Case Number	2019-01059-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment 2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Discourteous treatment 5. Other failure of good behavior
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 21, 2019, two officers allegedly engaged in unprofessional conduct.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. 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 pre-disciplinary process.

Case Detail	Description
Incident Date	10/01/2019
OLES Case Number	2019-01064-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 1, 2019, a staff member was allegedly having sexual contact with a patient in exchange for drugs.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/29/2019
OLES Case Number	2019-01065-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	On September 29, 2019, a psychiatric technician allegedly attempted to kiss and have sex with a patient. A registered nurse allegedly witnessed the incident and failed to intervene.
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 Detail	Description
Incident Date	10/03/2019
OLES Case Number	2019-01082-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 3, 2019, two psychiatric technicians allegedly pushed 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 Detail	Description
Incident Date	10/11/2019
OLES Case Number	2019-01125-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 11, 2019, officers and other staff members

	allegedly used excessive force on a restrained patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. 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 Detail	Description
Incident Date	10/14/2019
OLES Case Number	2019-01133-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 14, 2019, a psychiatric technician allegedly struck and used an unauthorized control hold on 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 responding officer failed to provide both the complaining patient and the psychiatric technician with the legally required admonitions before obtaining their statements. The officer failed to record the psychiatric technician's statement.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The responding officer failed to provide the patient and the psychiatric technician with the legally required admonition before obtaining their statements. The officer also failed to record the psychiatric technician's statement.
Department	The responding officers shall be reminded to record all

Corrective Action Plan	interviews that are potentially Office of Law Enforcement Support monitored investigations as well as all interviews. The officers will be reminded to provide the legally required admonishment prior to taking a statement from Level of Care staff when it's applicable. This can be accomplished during In-service briefing training.

Case Detail	Description
Incident Date	10/15/2019
OLES Case Number	2019-01148-1A
Case Type	Monitored
Incident Types	1. Neglect 2. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 15, 2019, a registered nurse and a psychiatric technician allegedly failed to properly monitor a violent patient who subsequently assaulted another patient. The registered nurse and psychiatric technician also allegedly failed to report 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/17/2018
OLES Case Number	2019-01155-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 17, 2019, a patient alleged she had been raped by an unidentified staff member approximately a

	year prior.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/30/2019
OLES Case Number	2019-01242-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 30, 2019, a psychiatric technician allegedly pulled down a patient's pants and underwear while the patient slept.
Disposition	The hiring authority determined that the investigation conclusively proved 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 Detail	Description
Incident Date	11/10/2019
OLES Case Number	2019-01244-2A
Case Type	Monitored
Incident Types	1. Non-Patient Assault/GBI
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 10, 2019, a psychiatric technician allegedly choked a patient, rendering him unconscious,

	allowing a second patient to commit a sexual assault on the unconscious patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation of abuse. 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 Detail	Description
Incident Date	11/20/2019
OLES Case Number	2019-01276-1A
Case Type	Monitored
Incident Types	1. Neglect 2. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 20, 2019, a staff member failed to lock a cabinet containing compact discs. Two patients obtained a disc from the cabinet and used the disc to cut their arms.
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 Detail	Description
Incident Date	11/21/2019
OLES Case Number	2019-01281-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	On November 21, 2019, a registered nurse allegedly 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/01/2019
OLES Case Number	2019-01282-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between November 1 and November 30, 2019, a psychiatric technician allegedly pushed his knee onto a patient's leg, causing the patient to lose her balance. On November 19, 2019, the same psychiatric technician allegedly grabbed the same patient's shoulders.
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 initial responding officer failed to audio record significant interviews. The officer did not provide the psychiatric technician with the required legal admonition before taking the psychiatric technician's statement. The interviews conducted by the officer were cursory and lacked important details.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not record the interviews

	of the patient or psychiatric technician. Further, the officer did not provide the psychiatric technician with the required legal admonition before taking the psychiatric technician's statement. Additionally, the interviews were cursory and lacked important details.
Department Corrective Action Plan	The responding officers shall be reminded to record all interviews that are potentially Office of Law Enforcement Support monitored investigations as well as all interviews. The officers will be reminded to provide the legally required admonishment prior to taking a statement from Level of Care staff when it's applicable. This can be accomplished during In-service briefing training.

Case Detail	Description
Incident Date	11/24/2019
OLES Case Number	2019-01293-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 24, 2019, a psychiatric technician allegedly struck a patient in the chest.
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 Detail	Description
Incident Date	11/22/2019
OLES Case Number	2019-01300-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed

	Final: No Penalty Imposed
Incident Summary	On November 22, 2019, a staff member allegedly sexually 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	12/02/2019
OLES Case Number	2019-01332-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 2, 2019, a psychiatric technician allegedly struck a patient and forced the patient into a seclusion room where the patient was forcibly medicated.
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 Detail	Description
Incident Date	12/10/2019
OLES Case Number	2019-01363-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	On December 10, 2019, a senior psychiatric technician allegedly put his foot on the back of a patient's head while administering medication.
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 Detail	Description
Incident Date	12/16/2019
OLES Case Number	2019-01385-1A
Case Type	Monitored
Incident Types	1. Significant Interest - AWOL
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 16, 2019, staff members allegedly failed to properly supervise a patient while at an outside hospital.
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 Detail	Description
Incident Date	12/16/2019
OLES Case Number	2019-01387-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
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 December 16, 2019, a unit supervisor alleged a psychiatric technician was overly familiar with a patient. On December 18, 2019, another psychiatric technician also alleged the same psychiatric technician was overly familiar with the same 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:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	12/17/2019
OLES Case Number	2019-01388-1A
Case Type	Monitored
Incident Types	1. Significant Interest - AWOL
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 17, 2019, staff members allegedly failed to properly supervise a patient while at an outside hospital.
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 Detail	Description
Incident Date	12/26/2019
OLES Case Number	2019-01413-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 26, 2019, a registered nurse allegedly inappropriately touched a patient. Additionally, several staff members allegedly assaulted the 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 Detail	Description
Incident Date	12/27/2019
OLES Case Number	2019-01420-1A
Case Type	Monitored
Incident Types	1. Broken Bone
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 27, 2019, a staff member allegedly failed to properly treat a patient's injury.
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 Detail	Description
Incident Date	01/07/2020
OLES Case Number	2020-00021-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	On January 7, 2020, a psychiatric technician allegedly inappropriately touched 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 Detail	Description
Incident Date	01/10/2020
OLES Case Number	2020-00030-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 10, 2020, a patient was found unresponsive and was transported to an outside hospital where he was declared deceased. An autopsy determined the patient died from acute myocardial infarction.
Disposition	The Office of Protective Services completed the required post-death 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 pre-disciplinary process.

Case Detail	Description
Incident Date	01/13/2020
OLES Case Number	2020-00045-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	On January 13, 2020, a unit supervisor allegedly encouraged a group of patients to assault another patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. 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 Detail	Description
Incident Date	01/09/2020
OLES Case Number	2020-00050-1A
Case Type	Monitored
Incident Types	1. Abuse
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 Penalty Imposed
Incident Summary	On January 9, 2020, a custodian allegedly choked a patient and a psychiatric technician allegedly failed to report 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/16/2020
OLES Case Number	2020-00054-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	On January 16, 2020, a staff member allegedly struck a patient in the face with an ice pack while the patient was restrained.
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 initial responding officer did not provide the six potential staff subjects with the legally required admonishment before he obtained their statements.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The responding officer did not provide the six potential staff subjects the legally required admonishment before he obtained each of their statements.
Department Corrective Action Plan	The officer in this case has been reminded/retrained on the importance of providing the legally required admonishment prior to taking any statement from any potential subject of an investigation when it's applicable. All officers and investigators will be reminded of the importance of providing the legally regarded admonishments prior to taking any statement from a potential subject. This will be accomplished during In-service briefing training.

Case Detail	Description
Incident Date	01/24/2020
OLES Case Number	2020-00085-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 21, 2020, a patient went to an outside hospital for treatment. On January 24, 2020, the patient died at the outside hospital. An autopsy determined the

	cause of death was pneumonia and other underlying health 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:** 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.
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 April 7, 2020; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation, and the investigative findings until June 17, 2020, 72 days later.
Department Corrective Action Plan	This was an oversight by the Executive Director due to the COVID-19 pandemic. More attention will be placed on thoroughly reviewing all OLES cases in the future for timely submission of review forms to the AIM.

Case Detail	Description
Incident Date	01/24/2020
OLES Case Number	2020-00100-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 24, 2020, a staff member allegedly forced a patient to the floor, then kicked and spat on the 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 Detail	Description
Incident Date	01/28/2020
OLES Case Number	2020-00104-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 28, 2020, a registered nurse allegedly inappropriately touched a patient while applying a condom catheter on the 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 Detail	Description
Incident Date	02/02/2020
OLES Case Number	2020-00115-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 2, 2020, a patient's relative alleged that staff members were sexually assaulting the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	02/13/2020
OLES Case Number	2020-00179-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 13, 2020, a staff member 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/22/2020
OLES Case Number	2020-00186-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 22, 2020, a patient was found unresponsive and emergency life saving measures were initiated. He was taken to the urgent care room where he was pronounced dead. An autopsy determined the cause of death was lung and cardiac failure.
Disposition	The Office of Protective Services completed the required post-death 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 pre-disciplinary process.

Case Detail	Description
Incident Date	02/24/2020
OLES Case Number	2020-00193-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 24, 2020, a psychiatric technician allegedly forcibly grabbed a patient's arm.
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 Detail	Description
Incident Date	03/08/2020
OLES Case Number	2020-00240-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 8, 2020, a psychiatric technician allegedly injured a patient's arm.
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 Detail	Description
Incident Date	01/01/2020
OLES Case Number	2020-00345-2A
Case Type	Monitored
Incident Types	1. Sexual Assault 2. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On or about January 1, 2020, a psychiatric technician allegedly pinched two patients and made an inappropriate comment to a third 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/21/2020
OLES Case Number	2020-00540-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 21, 2020, a nurse allegedly allowed a restrained patient to remain in food-soiled clothing for approximately one hour.
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.

Appendix C: Discipline Phase Cases

When an administrative investigation, either by the department or by OLES, is completed, an investigation report with facts about the allegations is sent to the hiring authority. 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.

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

- Procedural sufficiency includes, among other things, whether 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. Both departments have implemented policies that incorporate OLES' recommendation to serve a disciplinary action within 60 days after a decision is made to impose discipline.

- Substantive sufficiency includes 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.

Procedurally and Substantively Insufficient Cases

Case Detail	Description
Incident Date	11/12/2017
OLES Case Number	2018-00591-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 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:** Dismissal **Final:** Letter of Reprimand
Incident Summary	On November 12, 2017, a senior psychiatric technician allegedly struck a patient several times. A nurse and a psychiatric technician allegedly witnessed the incident, failed to report the abuse, and were dishonest during the investigation. The senior psychiatric technician then allegedly deleted an electronic record of the incident completed by the nurse. The senior psychiatric technician also allegedly forwarded a patient's medical records to the senior psychiatric technician's personal email address.
Disposition	The hiring authority sustained allegations against the senior psychiatric technician, the nurse, and the pre-licensed psychiatric technician, and determined dismissal was the appropriate penalty for all three employees. The OLES concurred. After the senior psychiatric technician's Skelly hearing, the hiring authority decided to only sustain security and electronic mail violations regarding confidential information. The other allegations were withdrawn. The hiring authority reduced the original penalty of dismissal to a letter of reprimand. The OLES was not consulted with, and would not have concurred with the changed findings, and modified penalty, because no information was presented at the Skelly hearing to warrant the modification. The basis for the original penalty of dismissal remained unchanged. The department and the senior psychiatric technician entered into a settlement agreement regarding the modified disposition, and the senior psychiatric technician agreed to not file an appeal with the State Personnel Board. Based on the changed disposition of the senior psychiatric technician's case, the hiring authority withdrew the pending disciplinary actions against the pre-licensed psychiatric technician, and the nurse. The

	OLES concurred.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was served 157 days after the decision to take action was made. Following the Skelly hearing, the hiring authority changed the findings and modified the penalty without adequately consulting with the OLES. The disciplinary officer failed to provide the draft amended disciplinary action to the OLES.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? No. Although the original draft disciplinary action was appropriately provided, the OLES was not provided with the draft amended disciplinary action after the findings and penalty were modified. 2. Was the penalty upheld by the department after a Skelly hearing? No. After the Skelly hearing, the hiring authority reduced the penalty from a dismissal to a letter of reprimand. 3. Did the hiring authority consult with OLES and the department attorney (if applicable) before modifying the penalty or agreeing to a settlement? No. The hiring authority only notified the OLES of his decision to change the findings and modify the penalty against the senior psychiatric technician. The hiring authority did not consult with the OLES prior to making those final determinations. 4. If the penalty was modified by department action or a settlement agreement, did OLES concur with the modification? No. The OLES did not agree with the modified penalty. The modified penalty was unreasonable because no

	new information was presented by the senior psychiatric technician which warranted the modification. 5. Did the department attorney or discipline officer 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 discipline officer did not provide the draft amended disciplinary action to the OLES for review before serving the document. 6. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority confirmed findings and disciplinary determinations on May 20, 2019; however, the disciplinary action was not served until October 23, 2019, 157 days later.
Department Corrective Action Plan	In the future the Employee Relations Office will ensure that the OLES monitor is provided a copy of any amended draft NOAAs. In the future, the Employee Relations Office will make more of an effort to ensure consultation with the monitor before a final decision is made. The hiring authority has implemented a tracking mechanism to prevent missed timelines in future monitored cases.

Procedurally Insufficient Cases

Case Detail	Description
Incident Date	01/14/2019
OLES Case Number	2019-00128-1A
Case Type	Monitored
Incident Types	1. Neglect
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

Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Not Sustained 6. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Instruction
Incident Summary	On January 14, 2019, a pharmacist allegedly mislabeled a patient's prescribed medicated cream. From January 14, 2019, until January 21, 2019, five psychiatric technicians then allegedly provided the mislabeled cream to the patient, failing to identify it was the wrong cream. On January 20, 2019, a nurse, and a unit supervisor allegedly failed to comply with medication variance policy after they were notified of the mislabeled cream.
Disposition	The hiring authority sustained allegations against the pharmacist, and imposed a 5 percent salary reduction for six months. The hiring authority also sustained an allegation against the unit supervisor and one of the psychiatric technicians for failing to comply with medication variance policy, and also sustained an allegation against that same psychiatric technician for failing to properly complete the controlled medication log. The hiring authority issued letters of expectation to the unit supervisor and the psychiatric technician. The OLES concurred with the hiring authority's findings, and penalty determinations. The hiring authority did not sustain any allegations against the nurse, and the remaining four psychiatric technicians. The OLES concurred. After the Skelly hearing, the hiring authority modified the penalty to a letter of instruction because the pharmacist accepted responsibility, expressed remorse, and had received training to prevent future mistakes. The OLES concurred with the modification.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was served 182 days after the decision to take action was made, and the disciplinary officer failed to notify the OLES of the Skelly hearing.

Disciplinary Assessment Questions	1. Did the department attorney or discipline officer 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 discipline officer failed to notify the OLES of the Skelly hearing. As a result, the OLES was unable to monitor the proceedings. 2. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority decided to take action against the pharmacist on August 23, 2019; however, the disciplinary action was not served until February 20, 2020, 182 days later.
Department Corrective Action Plan	The OLES monitor was not included in the Skelly hearing as an oversight by the Employee Relations Office. The department has made changes in the process of scheduling Skelly hearings to ensure all parties, including the OLES monitor, are notified prior to the Skelly hearing, Calendar invites will also be sent to all parties to document the notifications.

Case Detail	Description
Incident Date	02/22/2019
OLES Case Number	2019-00201-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On February 22, 2019, a psychiatric technician allegedly raped a patient. The psychiatric technician also allegedly failed to properly document the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the rape allegation; however, found there was sufficient evidence to sustain the allegation the psychiatric technician failed to properly

	document the incident. The hiring authority imposed a 5 percent salary reduction for six months. The OLES concurred with the hiring authority's determinations. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceeding, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a 5 percent salary reduction for three months and the psychiatric technician agreed to withdraw his appeal. The OLES concurred with the settlement.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary officer failed to provide OLES with the written confirmation of penalty discussions, and with a draft copy of the disciplinary action before it was served. Additionally, the department took 159 days to prepare and serve the disciplinary action.
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 human resources personnel failed to provide OLES with written confirmation of penalty discussions. 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 failed to provide OLES with a copy of the draft disciplinary action prior to it being served. 3. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority determinations were made on June 13, 2019; however, the action was not served until November 18, 2019, 159 days later.
Department	The penalty consultation with the AIM was held on June

Corrective Action Plan	13, 2019. The justification of corrective and/or disciplinary action was completed and signed by the Executive Director on the same day. A copy was not sent to the AIM, in the future Human Resources will forward a copy for the AIM's records. On or about October 4, 2019, the Discipline Officer submitted the draft of the Notice of Adverse Action (NOAA) to the assigned attorney. The Legal Department is responsible for providing the AIM a copy of the draft. Human Resources will continue to coordinate with our Legal Department to submit drafts of the NOAA. The Legal Department will confirm submission with the OLES AIM and notify Human Resources. Pursuant to Government Code Section 19574, the statute of limitations to take adverse action against an employee is three years. However, Human Resources has made, and will continue to make, every effort to issue adverse actions in an expeditious manner, using the resources available, to ensure compliance with OLES recommended time frames.

Case Detail	Description
Incident Date	06/26/2019
OLES Case Number	2019-00632-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Dishonesty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	On June 26, 2019, a food service technician allegedly kissed 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. The employee filed an appeal with the state Personnel Board. Prior to the State Board proceedings, the department entered into a settlement agreement with the employee wherein the employee resigned from his position and waived any back pay. The employee agreed to withdraw his appeal. The OLES

	concurred.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The Disposition was determined on November 25, 2019; however, the disciplinary action was not served until February 20, 2019, 87 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The final penalty determinations were made by the hiring authority on November 25, 2019; however, the disciplinary action was not served until February 20, 2020, 87 days later.
Department Corrective Action Plan	A tracking system has been created to ensure all disciplinary actions are served within a timely manner. The Hiring Authority will ensure continued compliance with the Office of Law Enforcement Support investigative process guidelines to include that disciplinary actions are being served within the guidelines through training.

Procedurally and Substantively Sufficient Cases

Case Detail	Description
Incident Date	08/20/2017
OLES Case Number	2018-00797-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	On August 20, 2017, a psychiatric technician allegedly grabbed a patient's wrist and punched the patient's palm.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. The employee filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the

	department entered into a settlement agreement with the employee wherein the employee resigned in lieu of dismissal and waived any back pay. The employee agreed to withdraw her appeal. The OLES concurred.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	04/01/2019
OLES Case Number	2019-00395-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	On April 1, 2019, a psychiatric technician allegedly gave a patient, with a known tendency to injure himself, three sharpened pencils. The supervising registered nurse allegedly approved the psychiatric technician's decision. The patient stabbed himself shortly thereafter and subsequently died due to sepsis from complications of bowel resection surgery due to the self-inflicted wound.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty for both employees. The OLES concurred with the hiring authority's determinations. The supervising registered nurse did not file and appeal and resigned in lieu of dismissal. 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 psychiatric technician resigned in lieu of dismissal. The psychiatric technician agreed to withdraw her appeal. The OLES concurred because the settlement was reasonable.
Disciplinary	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	04/22/2019
OLES Case Number	2019-00401-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 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
Findings	1. Sustained 2. Sustained 3. Not Sustained 4. Sustained 5. Not Sustained 6. Not Sustained 7. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On April 22, 2019, an officer allegedly brought a firearm onto hospital grounds and negligently discharged the firearm, causing damage to state property. A lieutenant and two sergeants allegedly failed to collect evidence, properly document the incident, and ensure the officer properly documented the incident.
Disposition	The hiring authority dismissed the officer, a retired annuitant, immediately following the incident. The hiring authority sustained the allegations against the lieutenant and the first sergeant, except that they allegedly failed to document criminal activity, and imposed salary reductions of 5 percent for four months and 5 percent for three months, respectively. The hiring authority sustained the allegation against the second sergeant that he failed to document the incident, but found insufficient evidence to sustain the remaining

	allegations, and issued a letter of instruction. The OLES concurred with the determinations. After the first sergeant's Skelly hearing, the hiring authority entered into a settlement agreement modifying the penalty to a letter of reprimand. The OLES concurred with the settlement based on the factors learned at the Skelly hearing. The lieutenant filed an appeal with the State Personnel Board. Prior to the investigatory hearing, the hiring authority entered into a settlement agreement modifying the penalty to a letter of reprimand because of the unavailability of a staff witness.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently 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, in this reporting period, OLES monitored in both their pre-disciplinary phase as well as the discipline phase. Each phase was rated separately.

Investigations and other activities conducted by the departments during the pre-disciplinary phase are rated for procedural and substantive sufficiency.

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

The disciplinary phase is rated for procedural and substantive sufficiency.

- Procedural sufficiency includes, among other things, whether 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 includes 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.

Procedurally or Substantively Insufficient in Both Phases

Case Detail	Description
Incident Date	03/02/2019
OLES Case Number	2019-00431-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Modified Salary Reduction
Incident Summary	On March 2, 2019, a psychiatric technician allegedly pushed a patient onto his bed, bruising the patient's back.

Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined the appropriate penalty was a dismissal. After a Skelly hearing, where mitigating and other information was presented, the department entered into a settlement agreement wherein the penalty was reduced to a 5 percent salary reduction for eight months and the employee agreed to not file an appeal. 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 administrative investigation was initiated on April 22, 2019; however, the investigation was not completed until December 12, 2019, 202 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The administrative investigation was initiated on April 22, 2019; however, the investigation was not completed until December 12, 2019, 202 days later.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the disciplinary process. The investigator included unsupported conclusions in the draft report. The penalty determination was made on December 27, 2019; however, the disciplinary action was not served on the employee until April 2, 2020, 122 days later.
Disciplinary Assessment Questions	1. Was the draft disciplinary action provided to OLES for review appropriately drafted? No. The draft report contained conclusions that were not supported by relevant facts. 2. Was the disciplinary phase conducted with due diligence by the department? No. The findings determination was made by the hiring

	authority on December 27, 2019; however, the disciplinary action was not served on the employee until April 2, 2020, 122 days later.
Department Corrective Action Plan	The command staff provided roll call training to their staff. The OPS chief discussed with the entire investigative staff the importance of meeting the OLES completion/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 hiring authority will ensure the Office of Law enforcement Support (OLES) and legal are consulted prior to the finalization and issuance of the disciplinary action. Training has been provided and an agreement between all stakeholders, that the draft report contains facts supported by the investigation. A tracking system has been created to ensure all disciplinary actions are served within a timely manner. Training has been provided to staff to ensure continued compliance with the Office of Law Enforcement Support investigative process guidelines.

Case Detail	Description
Incident Date	02/23/2019
OLES Case Number	2019-00567-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior 2. Willful disobedience 3. Willful disobedience 4. Discourteous treatment
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Demotion **Final:** Demotion
Incident Summary	On February 23, 2019, a sergeant allegedly battered his spouse and threatened his child during an off-duty incident.
Disposition	The hiring authority sustained the allegations and determined a salary reduction was the appropriate penalty. The OLES did not concur. The OLES

	recommended that the hiring authority add and sustain an allegation that the sergeant was dishonest during his administrative interview and dismiss the sergeant. However, the OLES' recommendation was not adopted. After a higher level of review, the penalty was increased to a demotion from sergeant to officer. The OLES still did not concur but did not invoke a higher level of review because the increased penalty was significant and more appropriate than a salary reduction. Following a Skelly hearing, the department entered into a settlement agreement whereby the sergeant agreed to a temporary demotion to officer for one year with right to reinstatement to sergeant if he completes counseling and drug and alcohol testing requirements. The OLES concurred with the settlement as it remained a demotion for at least one year with strict conditions required before reinstatement.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process because the hiring authority did not add and sustain an appropriate allegation of dishonesty.
Pre-Disciplinary Assessment	1. Did the hiring authority who participated in the findings conference identify the appropriate subjects and factual allegations for each subject based on the evidence? No. The hiring authority failed to add an additional allegation the officer was dishonest during his interview with the OLES when he denied battering his spouse and threatening his child.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the disciplinary process because the hiring authority did not select the appropriate penalty of dismissal.
Disciplinary Assessment Questions	1. Did the hiring authority who participated in the disciplinary conference select the appropriate penalty?

	No. Because the department did not add and sustain an allegation of dishonesty, it did not impose the appropriate penalty of dismissal.
Department Corrective Action Plan	The hiring authority will provide continual consultation with the Office of Law Enforcement Support and with the input from the Legal department regarding the appropriate penalty imposed.

Procedurally or Substantively Insufficient in the Pre-Disciplinary Phase or Disciplinary Phase

Case Detail	Description
Incident Date	04/19/2019
OLES Case Number	2019-00407-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment 2. Other failure of good behavior
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	On April 19, 2019, an officer allegedly pushed, choked and threatened to kill his girlfriend. The officer also allegedly broke his girlfriend's mobile phone, pulled phone cords out of her wall and prevented his girlfriend from leaving her house.
Disposition	The hiring authority sustained the allegations that the officer pulled phone cords out of his girlfriend's wall and prevented her from leaving her house but not the remaining allegations. The hiring authority determined a letter of reprimand was the appropriate penalty. The OLES did not concur as the misconduct warranted a salary reduction based on the seriousness of the misconduct and the department's own disciplinary matrix.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary	**Procedural Rating:** Insufficient

Assessment	**Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the disciplinary process. The penalty imposed was not consistent with the department's disciplinary matrix and was not significant enough to deter future misconduct.
Disciplinary Assessment Questions	1. Did the hiring authority who participated in the disciplinary conference select the appropriate penalty? No. The penalty should have been a salary reduction based on the department's disciplinary matrix.
Department Corrective Action Plan	The department disagreed with the assessment and did not provide a corrective action plan.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	07/18/2019
OLES Case Number	2019-00808-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment 2. Other failure of good behavior
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	On July 18, 2019, an officer allegedly groped, threatened to physically harm, and swore at, a co-worker.
Disposition	The hiring authority sustained the allegation that the officer swore at a co-worker, but not the remaining allegations and issued a letter of reprimand. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary	**Procedural Rating:** Sufficient

Assessment	**Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	10/17/2019
OLES Case Number	2019-01158-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On October 17, 2019, an investigator allegedly accidentally discharged his duty weapon in the staging area of a firing range causing injuries to two colleagues.
Disposition	The hiring authority sustained the allegation and imposed a salary reduction of 5 percent for 12 months. The OLES concurred with the hiring authority's determination. Following a Skelly hearing, the department entered into a settlement agreement wherein the penalty was reduced to a salary reduction of 5 percent for three months. The OLES concurred with the settlement as the investigator expressed remorse during his Skelly hearing and had completed additional training to ensure the misconduct would not recur.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	11/12/2019
OLES Case Number	2019-01250-2A
Case Type	Monitored
Incident Types	1. Misconduct 2. Misconduct

Allegations	1. Misuse of state property 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Instruction
Incident Summary	On November 12, 2019, a sergeant allegedly left his personal vehicle running and unattended allowing the vehicle to be stolen with department police equipment inside.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 5 percent for six months was the appropriate penalty. The OLES concurred. Following a Skelly hearing, the hiring authority reduced the penalty to a letter of instruction plus reimbursement of the cost of the stolen equipment. Due to the sergeant's expression of remorse and efforts he had made to ensure the misconduct did not recur, the OLES concurred.
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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	03/03/2020
OLES Case Number	2020-00227-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	Beginning approximately October 1, 2020, a psychiatric technician allegedly was involved in an ongoing overly familiar relationship with a patient. Specifically, it is alleged the psychiatric technician provided personal information to the patient and spoke him on the phone, sent letters and explicit photos to the patient, observed

	the patient while he was showering, and spent time alone with the patient during work hours.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. However, the psychiatric technician assistant resigned before discipline could be imposed. A letter indicating the psychiatric technician assistant resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix E: Monitored Issues

Case Details	Description
Incident Date	09/06/2016
OLES Case Number	2016-00844-1MI
Case Type	Monitored Issue
Incident Types	1. Significant Interest - Other
Incident Summary	On September 6, 2016, the OLES issued a memorandum to the Department of State Hospitals (DSH) recommending it develop a policy for use of personal electronic equipment within the state hospitals.
Disposition	In response to the OLES memorandum, DSH developed and implemented a policy on the use of personal electronic equipment within the state hospitals. The OLES will continue to monitor the department's adherence to its policy.

Case Details	Description
Incident Date	09/16/2016
OLES Case Number	2018-00594-1MI
Case Type	Monitored Issue
Incident Types	1. Neglect
Incident Summary	During an investigation the OLES discovered the lack of a specific 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 assaulted another patient. The patients were roommates and remained housed together after the altercation, culminating in a second assault the next day. During the second assault, the aggressor patient choked the victim patient to the point of unconsciousness. The hospital staff handles the separation of patients who are housed on the same unit and have been involved in an altercation as a clinical decision. The department does not have a statewide policy which addresses how to properly evaluate patients' housing needs after an incident involving patients.

Disposition	The department appropriately responded to the concerns raised by the OLES. The department prepared a statewide policy standardizing the recommendations made by OLES which has been fully implemented.

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.

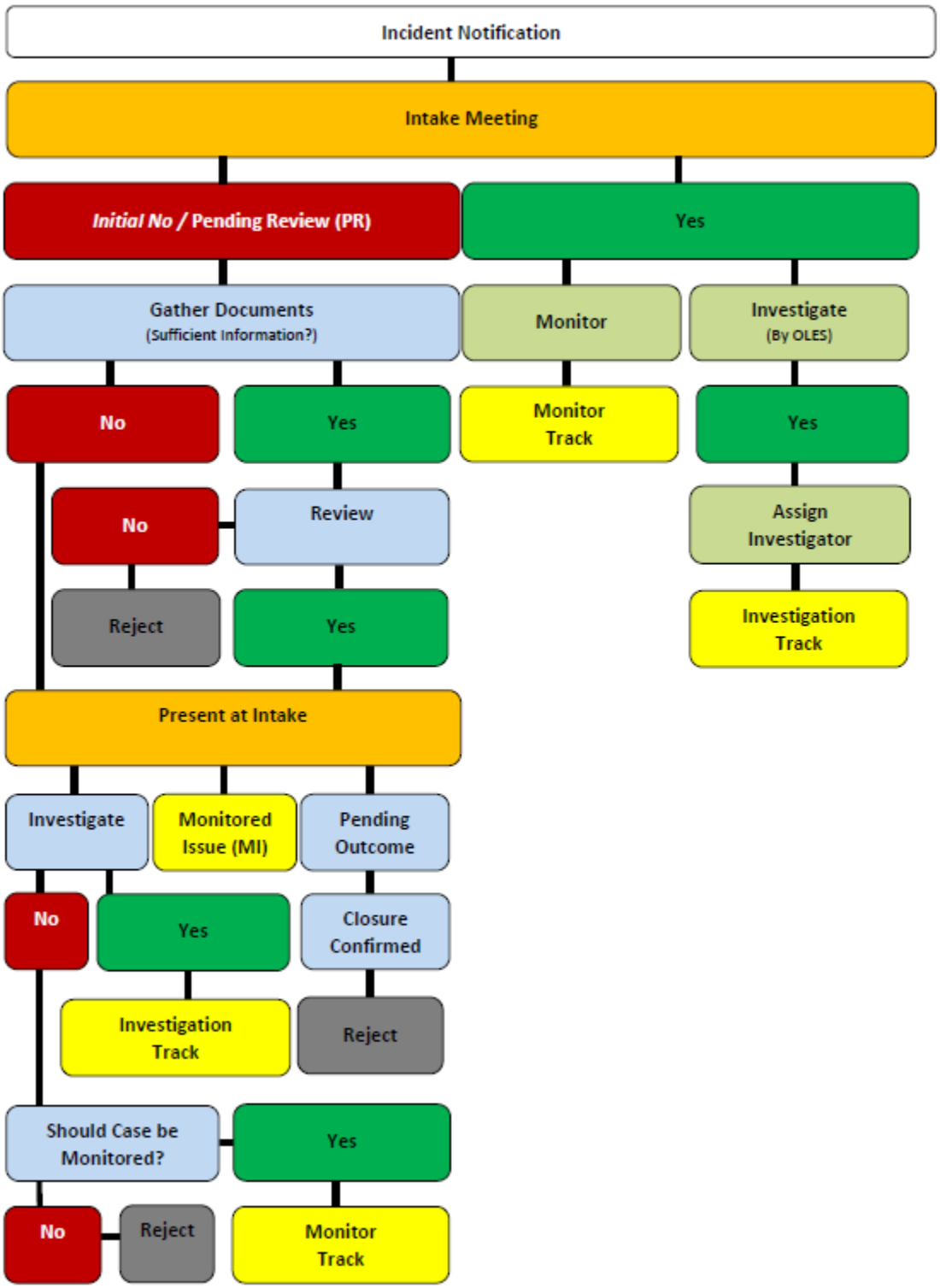
(d) Unreasonable physical constraint, or prolonged or continual deprivation of

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 OLES Processes

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

If, instead, an incident is investigated by DSH but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH investigator and the department attorney, if one is designated[5], 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 OLES reporting criteria.
2. The OLES reviews the incident and makes a case determination.
3. If the case is monitored by OLES, the OLES AIM meets with the OPS administrative investigator and identifies critical junctures.
4. DSH law enforcement completes investigation and submits final report.

Critical Junctures

- Site visit
- Initial case conference
    - Develop investigation plan
    - Determine statute of limitations
- Critical witness interviews
    - Primary subject(s) recorded
- Draft investigation report

It is recommended that within 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report

[5] 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.

and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority must 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 the AIM believes the hiring authority's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.

45 Days

1. The AIM attends the disposition conference, discusses and analyzes the case with the appropriate department representative.
2. Additional investigation may be required.
3. The AIM meets with executive director at the facility to finalize disciplinary determinations.
4. The 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. The department's human resources unit completes the NOAA and provides it to AIM for review.
2. The approved NOAA is provided to the executive director for service to the 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, that is, whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee[6]. It is recommended that the Skelly due process meeting be completed within 30 days.

30 Days

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

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

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

by filing an appeal with the State Personnel Board (SPB), which is an independent state agency. The 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, OLES continues to monitor the case until final resolution.

Conclusion

1. The department attorney notifies AIM of any SPB hearing dates. The AIM monitors all hearings.
2. The department attorney notifies and consults with AIM prior to any settlements or changes to disciplinary action.
3. The AIM notes the quality of prosecution and final disposition.