
Office of Law Enforcement Support

# Semiannual Report

JULY 1, 2022 – DECEMBER 31, 2022

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.

# Contents

# Introduction

I am pleased to present the fourteenth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health & Human Services Agency. This report details OLES's oversight and monitoring of the Department of State Hospitals (DSH) from July 1 through December 31, 2022.

In this report, OLES provides details on 636 reported incidents and the results of completed investigations and monitored cases.

The OLES brings attention to a significant issue with DSH, and a new monitored issue concerning a facility's handling of contraband electronic devices. This contraband led to false bomb threats, and patient evacuations. DSH quickly responded to our concerns and provided the OLES with a plan to eradicate the contraband.

The OLES provides updates on previous monitored issues regarding the department's audio recordings of investigatory interviews, use of force reporting and documentation, utilization of the department's early intervention system and delayed mandated reporting.

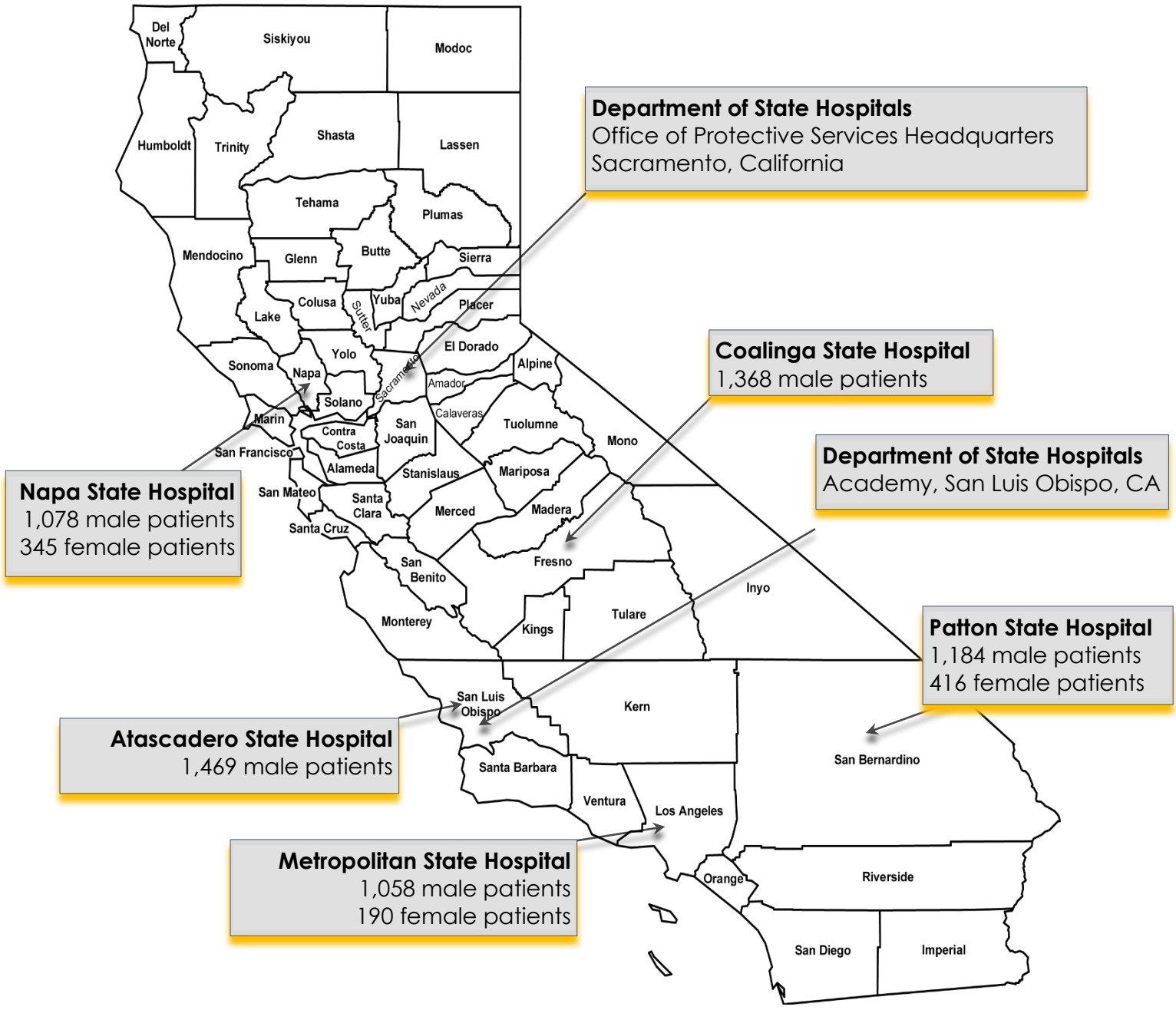
As OLES continues its eighth year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DSH.

We are grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DSH management and personnel. 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 and Population Served

The OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers reflect the total patients served from July 1 through December 31, 2022 and were provided by the department.



**Total Patients Served by Facility**

| DSH Facility | Number of Male Patients | Number of Female Patients | Total |
|---|---|---|---|
| **Atascadero** | 1,469 | 0 | 1,469 |
| **Coalinga** | 1,368 | 0 | 1,368 |
| **Metropolitan** | 1,058 | 190 | 1,248 |
| **Napa** | 1,078 | 345 | 1,423 |
| **Patton** | 1,184 | 416 | 1,600 |
| **Total** | 6,157 | 951 | 7,108 |

**Total Patients Served by Commitment Type**

Patients are committed to a state hospital by a civil court proceeding according to the Welfare and Institutions Code (WIC) or committed by a criminal court proceeding according to the Penal Code (PC). Commitment types are described below.

| Commitment Type | Description |
|---|---|
| **PC 1370 IST** | Felony Incompetent to Stand Trial. Effective January 1, 2019, the maximum term for ISTs was reduced from three years to two years, pursuant to SB 1187. |
| **PC 1026 NGI** | Not Guilty by Reason of Insanity. Maximum commitment is equal to the longest sentence which could have been imposed for the crime; can be extended at two-year intervals. |
| **PC 2962/ 2964a OMD** | Offender with a Mental Disorder. A prisoner who as a result of a severe mental disorder is ordered into treatment by the court as a condition of his parole. Six specific criteria must be met to be certified as an Offender with a Mental Disorder. Can be an Offender with a Mental Disorder for up to three years. |
| **PC 2972 OMD** | Prisoner who was paroled as an Offender with a Mental Disorder and parole has ended. Placed on civil commitment where it must be shown that the individual has a severe mental disorder that is not in remission and that, due to this mental disorder, the individual is a substantial danger to others. One year commitment. Renewable annually. |
| **WIC 6316 MDSO** | Mentally disordered sex offender. |
| **PC 2684 CDCR** | California Department of Corrections and Rehabilitation (CDCR) inmate sent to DSH for psychiatric stabilization with the expectation that they will return to CDCR when they have reached maximum benefit from treatment. |
| **WIC 6602 SVPP** | Sexually violent predator probable cause. A prisoner who has been identified as likely to engage in sexually violent predatory criminal behavior upon release and will remain in custody until the completion of the probable cause. |
| **WIC 6604 SVP** | Sexually violent predator. Civil commitment for prisoners released from prison who meet criteria under the Sexually Violent Predator Act. |
| **WIC 5358 LPS** | Full Conservatorship for Grave Disability. Annual renewal. |

| Commitment Type | Description |
|---|---|
| **WIC 1756 DJJ** | Juvenile offender referred by CDCR Division of Juvenile Justice for treatment |

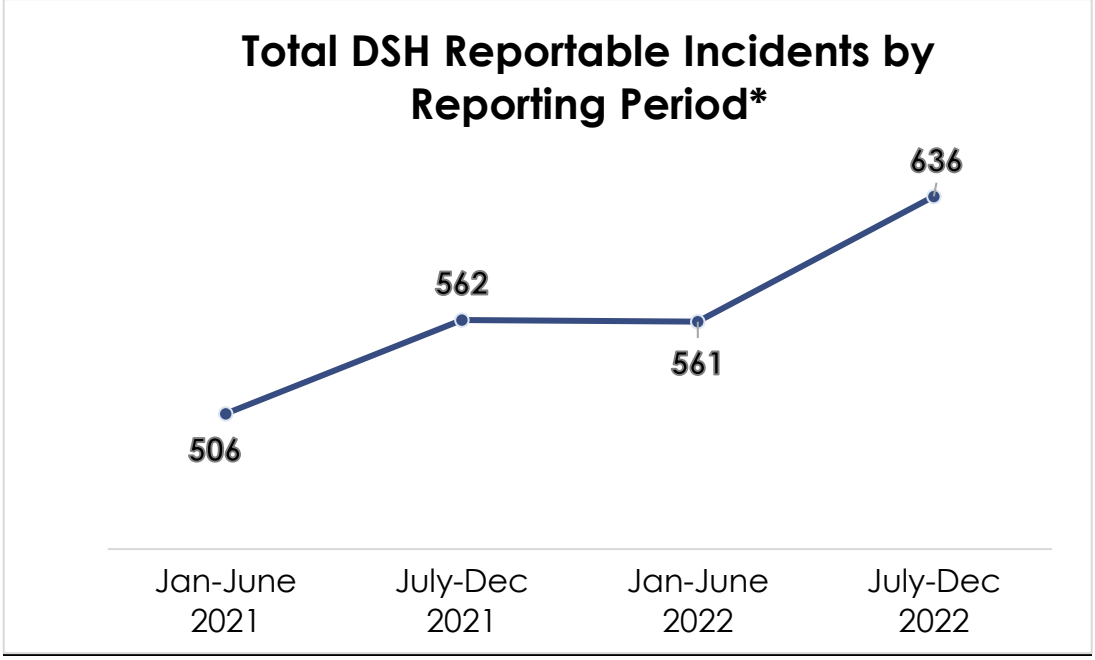
The following table provides the commitment type of patients served during the reporting period.

| Commitment Type | Atascadero | Coalinga | Metropolitan | Napa | Patton |
|---|---|---|---|---|---|
| **PC 1370 IST** | 532 | 0 | 914 | 691 | 527 |
| **PC 1026 NGI** | 223 | <11 | 27 | *** | 529 |
| **PC 2962/2964a OMD** | 430 | 0 | <11 | 0 | *** |
| **PC 2972 OMD** | 111 | *** | <11 | 40 | 193 |
| **WIC 6316 MDSO** | 0 | <11 | 0 | <11 | <11 |
| **PC 2684 CDCR** | 139 | 39 | 0 | 0 | 15 |
| **WIC 6002/6604 SVP** | <11 | 976 | 0 | 0 | <11 |
| **WIC 5358 LPS** | *** | <11 | 300 | 177 | 204 |
| **WIC 1756 DJJ** | 0 | 0 | <11 | 0 | <11 |

*Data is de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

# Executive Summary

During the reporting period of July 1 through December 31, 2022, the Office of Law Enforcement Support (OLES) received and processed 636 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 an increase of 74 incident reports compared to the prior reporting period which had 561 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.

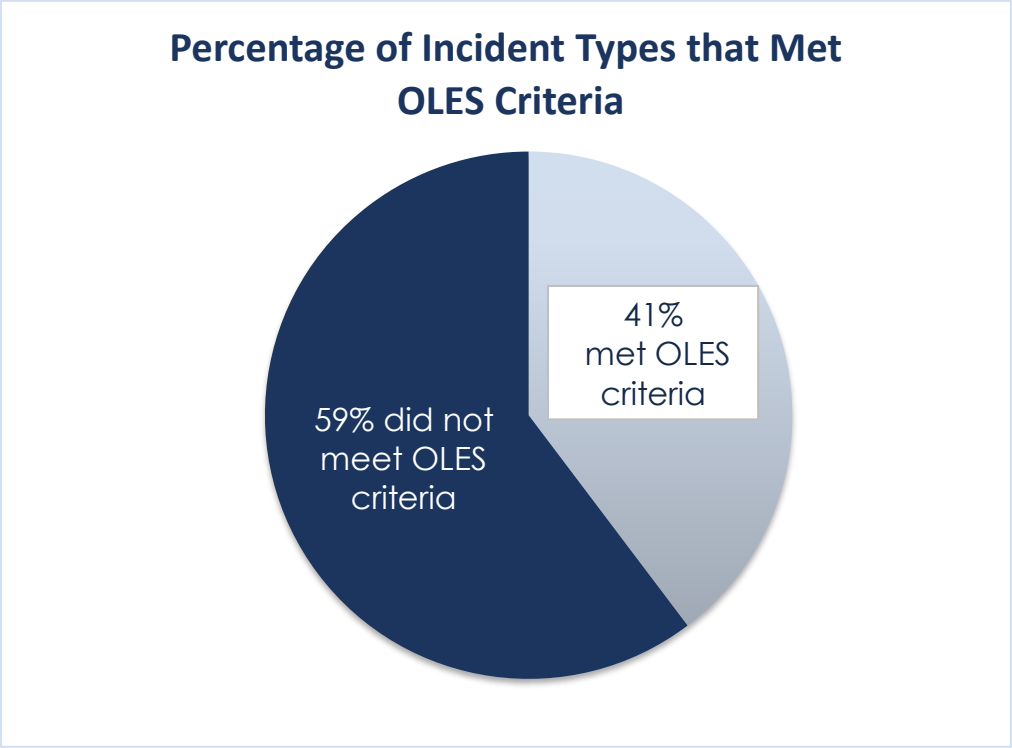
## Incident Types Meeting OLES Criteria

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. An incident type "meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for

[1] Reportable incidents are pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix E) and existing agreements between OLES and the department.

[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.

investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 636 reported incidents, the OLES identified 22 incidents with two or more incident types. The DSH reported a total of 658 incident types during this reporting period. Two hundred and seventy, or 41 percent of the 658 incident types reported by DSH met OLES criteria.




## Most Frequent Incident Types

The most frequent incident types reported by DSH include, allegations of, sexual assault, abuse, use of force by law enforcement, and broken bone injury (unknown origin).

Sexual assault represented the single largest number of incidents. The DSH reported 102 allegations of sexual assault during this reporting period, which is a 10.9 percent increase from the prior reporting period of 92 reports of sexual assaults.

Allegations of patient abuse was the second most reported incident type, with 100 allegations reported, representing a 19 percent increase compared to the 84 reported allegations in the prior reporting period.

Law enforcement use of force was the third most reported incident type. A use of force report documents an operational incident and does not necessarily indicate misconduct or excessive force by an officer. The OLES received 99 reports of use of force, which accounted for 15 percent of all reported incident types by DSH. Four of the 99 use of force reports included an allegation of patient abuse against law enforcement, which are included in the Abuse and Misconduct totals. Use of force by Law Enforcement has been trending down the last three reporting periods from 130, 107

and 99.

For reporting purposes, the OLES reporting guidelines lists the following definition for use of force by staff from the Office of Protective Services (OPS):

*Any OPS staff member within DSH that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject shall be considered a reportable use of force incident regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by subject to the officer or officers.*

The fourth most frequent incident type was Broken Bone (unknown origin), with 53 reports. This is an increase of 43.2 percent, compared to the prior reporting period of 37 reports. The OLES monitored 89 percent of these incidents.

## Patient Deaths

The number of patient deaths increased by 37 percent, from 25 deaths to 37 deaths during this reporting period. Seven of the reported death incident types met the OLES criteria for investigation or monitoring. Twenty-five of the 37 patient deaths were expected due to existing medical conditions. Twelve patient deaths were classified as "unexpected" and received two levels of review by DSH, per department policy.

Napa State Hospital (NSH) and Coalinga State Hospital (CSH) reported the largest number of patient deaths.

## 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 nine patient arrests, one more arrest compared to the prior reporting period. The patients were arrested for violations of the statutes listed in the following table.

| Statute | Description |
|---|---|
| **Penal Code section 69** | resisting an executive officer with threat or violence |
| **Penal Code section 243(d)** | battery causing serious bodily injury |
| **Penal Code section 243(c)(2)** | battery with injury on a Peace Officer |
| **Penal Code section 245(a)(1) assault with a deadly weapon** | assault with a deadly weapon |
| **Penal Code section 245(a)(4)** | assault with force likely to cause great bodily injury |
| **Penal Code section 4576.6** | possession of controlled substance |
| **Penal Code section 203** | Mayhem |
| **Penal Code section 243.4(e)(1)** | sexual battery |
| **Outside Warrant** | assault/battery |

## 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 administrative or criminal misconduct.

Appendix A provides information on the 22 investigations that OLES completed during this reporting period. These investigations involved allegations against at least 25 sworn staff members. As of December 31, 2022, there were approximately 718 DSH sworn staff.

The OLES submitted 13 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process. Administrative investigations were initiated in response to alleged policy violations such as excessive force, dishonesty, discourteous treatment, failure to report misconduct or sleeping on duty. The OLES completed four criminal investigations. The OLES did not refer any criminal cases to a district attorney's office. A summary of the review and decision for each case was provided to the department.

## Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the department and the discipline process for employees involved in misconduct. In Appendices B and C of this report, OLES provides information on 96 monitored administrative cases and 47 monitored criminal cases that, by December 31, 2022, 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.

Thirty-four pre-disciplinary administrative cases had sustained allegations and no

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

criminal investigations resulted in referrals to prosecuting agencies.

The OLES monitored 143 pre-disciplinary phase cases; 127 of the pre-disciplinary phase cases are listed in Appendix B and 16 are in Appendix C. The OLES rated 25 of the 143 pre-disciplinary phase cases insufficient. Frequent deficiencies include delayed investigations, inadequate interviews and delays in conducting the findings and penalty conference.

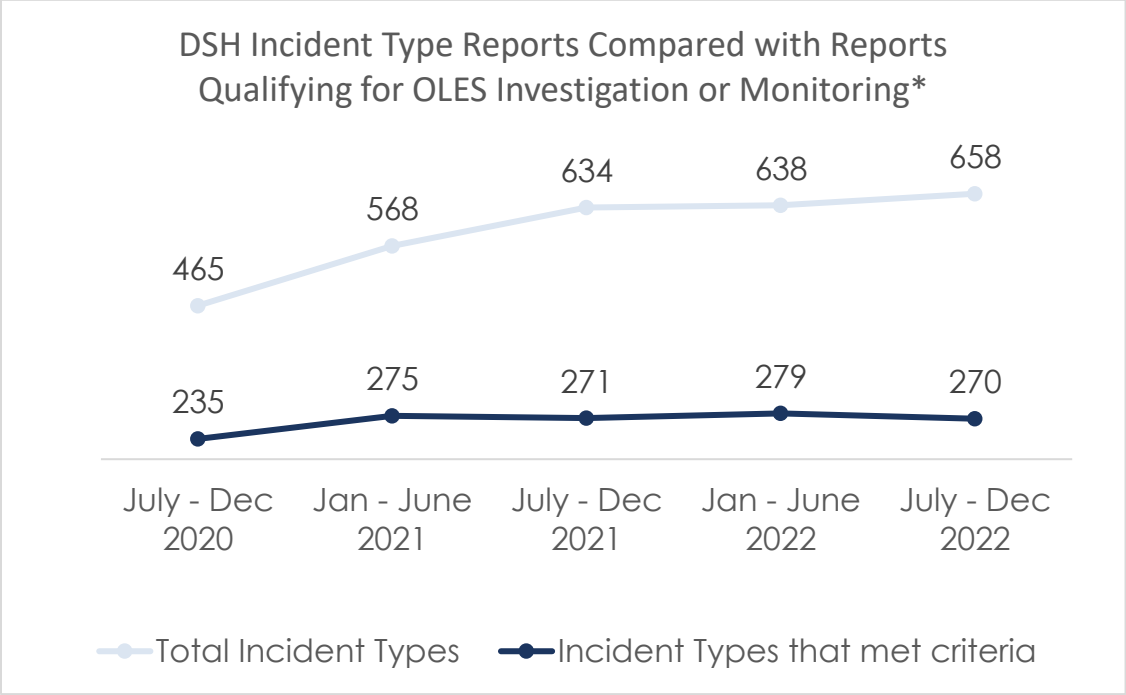
The OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in 16 administrative cases listed in Appendix C. Four of the 16 disciplinary phase cases were rated insufficient due to delays in serving a disciplinary action.

# 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 July 1 through December 31, 2022, increased 13.4 percent, from 561 during the prior reporting period to 636 in this reporting period. From the 636 reported incidents, the OLES identified 658 incident types, as 22 of the incidents featured two or more incident types. Two hundred and seventy-six of the 658 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.

## Most Frequent Incident Types Reported

The most frequent incident types reported were, allegations of sexual assault, allegations of abuse, and use of force by law enforcement. These three incident type categories accounted for 354 or 53.7 percent of all incident types reported by DSH. Of the 354 incident types, 190 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was allegations of sexual assault. The number of sexual assault allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period increased by 10.9 percent, from 92 during the

prior reporting period, to 102 in this reporting period. The 102 reports of sexual assaults accounted for 15.5 percent of the reported incident types.

Allegations of abuse were the second most frequently reported incident type by DSH, with 100 incident types reported. Allegations of abuse accounted for 15.2 percent of all incident types reported. Of the 100 abuse allegations reported in this period, 92 allegations qualified for investigation, monitoring or consideration of a potential systemic issue. This is an increase of 15 percent or 12 more qualifying reports from the prior reporting period, which had 80 incident types of abuse that met OLES criteria.

The DSH's third most frequent report to OLES was use of force by law enforcement. The 99 reports of use of force accounted for 16.8 percent of the reported incident types, and down 7.5 percent from the last period's 107 reports. This is the third full reporting period of OLES requiring the department to report all use of force by law enforcement.

The broken bone (unknown origin) incident type category was the fourth most reported incident type with 53 reports. This is an increase of 43.2 percent from the 37 incident types reported during the last reporting period. This increase is likely attributed to the OLES continued requirement to require staff witnesses for all broken bones before the incident can be categorized as of known origin. The OLES monitored 89 percent of the reported broken bone (unknown origin) incidents.

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 July 1 through December 31, 2022***

| Incident Type Category | Prior Period Incident Type Total January 1 through June 30, 2022 | Current Period Incident Type Total | Percent Change from Previous Period | Current Period Number Meeting OLES Criteria |
|---|---|---|---|---|
| **Sexual Assault** | 92 | 102 | +10.9% | 45 |
| **Abuse** | 84 | 100 | +19.0% | 92 |
| **Use of Force** | 107 | 99* | -7.5% | 4 |
| **Broken Bone Injury (Unknown Origin)** | 37 | 53 | +43.2% | 47 |

*Four use of force reports included allegations of excessive force by law enforcement and are also included in the total count for the abuse incident type category.

## 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 July 1 - December 31, 2021 (Reported)* | Prior Period July 1 - December 31, 2021 (Meets Criteria)* | Prior Period January 1 - June 30, 2022 (Reported)* | Prior Period January 1 - June 30, 2022 (Meets Criteria)* | Current Period July 1 - December 31, 2022 (Reported) | Current Period July 1 - December 31, 2022 (Meets Criteria) |
|---|---|---|---|---|---|---|
| **Abuse** | 85 | 84 | 84 | 80 | 100 | 94 |
| **Broken Bone (Known Origin)** | 12 | 2 | 19 | 3 | 15 | 0 |
| **Broken Bone (Unknown Origin)** | 32 | 31 | 37 | 37 | 53 | 47 |
| **Burn** | 7 | 0 | 7 | 0 | 10 | 1 |
| **Death** | 34 | 11 | 27 | 10 | 37 | 7 |
| **Genital Injury (Known Origin)** | 11 | 1 | 6 | 1 | 6 | 0 |
| **Genital Injury (Unknown Origin)** | 10 | 7 | 9 | 5 | 10 | 6 |
| **Head/Neck Injury** | 47 | 9 | 42 | 5 | 38 | 2 |
| **Misconduct** | 25 | 23 | 41 | 39 | 26 | 26 |
| **Neglect** | 25 | 21 | 34 | 27 | 23 | 15 |
| **Non-patient assault/GBI on Patient** | 1 | 1 | 0 | 0 | 0 | 0 |
| **OPS Use of Force** | 130 | 6 | 107 | 2 | 99 | 4 |
| **Patient on Patient Assault/GBI** | 18 | 2 | 10 | 0 | 17 | 2 |
| **Pregnancy** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Sexual Assault** | 103 | 47 | 92 | 40 | 102 | 45 |
| **Sexual Assault-OJ*** ** | 28 | 0 | 31 | 0 | 42 | 0 |
| **Significant Interest-Attack on Staff**** ** | 12 | 1 | 7 | 0 | 5 | 0 |

| Incident Categories | Prior Period July 1 - December 31, 2021 (Reported)* | Prior Period July 1 - December 31, 2021 (Meets Criteria)* | Prior Period January 1 - June 30, 2022 (Reported)* | Prior Period January 1 - June 30, 2022 (Meets Criteria)* | Current Period July 1 - December 31, 2022 (Reported) | Current Period July 1 - December 31, 2022 (Meets Criteria) |
|---|---|---|---|---|---|---|
| **Significant Interest-Attempted Suicide** | 1 | 1 | 1 | 0 | 0 | 0 |
| **Significant Interest-AWOL** | 4 | 2 | 1 | 0 | 10 | 0 |
| **Significant Interest-Child Pornography** | 1 | 0 | 2 | 0 | 2 | 0 |
| **Significant Interest-Drugs*****| 10 | 5 | 42 | 12 | 38 | 7 |
| **Significant Interest-Other******| 11 | 2 | 12 | 2 | 5 | 4 |
| **Significant Interest-Over-Familiarity** | 15 | 15 | 19 | 16 | 11 | 10 |
| **Significant Interest-Patient Arrest** | 12 | 0 | 8 | 0 | 9 | 0 |
| **Significant Interest-Riot** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 634 | 271 | 638 | 279 | 658 | 270 |

*Numbers in this column are unadjusted and provided as they were previously published.

**Four use of force reports included allegations of excessive force by law enforcement and are also included in the total count for the abuse incident type category.

***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.

*****Beginning in the July 1, 2021, through December 31, 2021, reporting period, the OLES distinguished drug-related allegations and crimes by patients or staff as a separate incident type. These incidents include verified drug offenses by patients and allegations of drug trafficking or smuggling against patients or staff.

******Any other incident of significant interest, e.g., staff arrest by an outside law enforcement agency for driving under the influence, a fire captain failed to implement corrective action after a failed inspect, potentially putting staff and patients at risk, and a patient was mistakenly released, but recovered during transport.

## Distribution of Incident Types

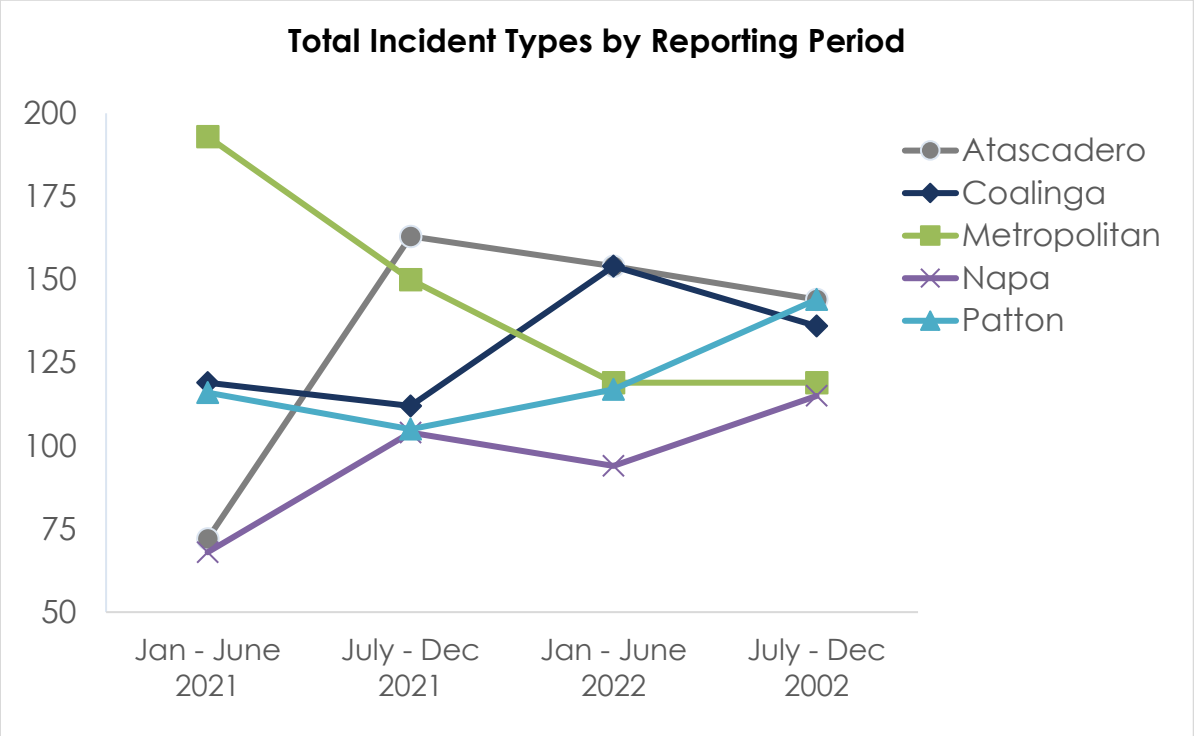
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

***DSH Population and Total Incident Types***

| DSH Facility | Number of Patients Served* | Total Incident Types |
|---|---|---|
| **Atascadero** | 1,469 | 144 |
| **Coalinga** | 1,368 | 136 |
| **Metropolitan** | 1,177 | 119 |
| **Napa** | 1,423 | 115 |
| **Patton** | 1,600 | 144 |
| **Total** | 7,073 | 658 |

*The department provided population numbers as of December 31, 2022.

The following chart depicts the total number of incident types for this reporting period and the prior three reporting periods.




## Sexual Assault Allegations

During this reporting period, sexual assault allegations were the most frequently reported incident type from July 1 through December 31, 2022. The 102 alleged sexual assault incident types reported in this reporting period accounted for 15.5 percent of all

reported incident types from DSH. Forty-five of the102 reported incident types of alleged sexual assault, or 44.1 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 42 reported incident types under the sexual assault-OJ category, none of which met OLES criteria for investigation or monitoring.

Of the five DSH facilities, PSH and ASH reported the highest number of sexual assault allegations.

As shown in the following table, which delineates law enforcement staff from non-law enforcement staff, allegations of sexual assault involving a patient assaulting other patient(s) were the most frequently reported, with a total of 48 incident types, or 47.1 percent of the alleged 102 sexual assault incident types. The second most frequent type of alleged sexual assault involved non-law enforcement staff on a patient, with 42 incident types or 41.2 percent of the 102 alleged sexual assault incident types. There were 12 allegations of sexual assault involving an unknown assailant on a patient. These include allegations made by patients that did not implicate DSH employees or contractors. There were no allegations of sexual assault on a patient by law enforcement personnel during this reporting period. All DSH reports of alleged sexual assaults, including those that allegedly occurred before the patient was in the care of DSH, received by OLES during the reporting period are shown in the following table.

***Sexual Assault Allegations Reported July 1 through December 31, 2022***

| Allegation Type | Total |
|---|---|
| **Patient on Patient** | 48 |
| **Law Enforcement Staff on Patient** | 0 |
| **Non-Law Enforcement Staff on Patient** | 42 |
| **Unknown Person on Patient** | 12 |
| **OJ*** | 42 |
| **Total** | 144 |

*Sexual Assault-OJ is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH.

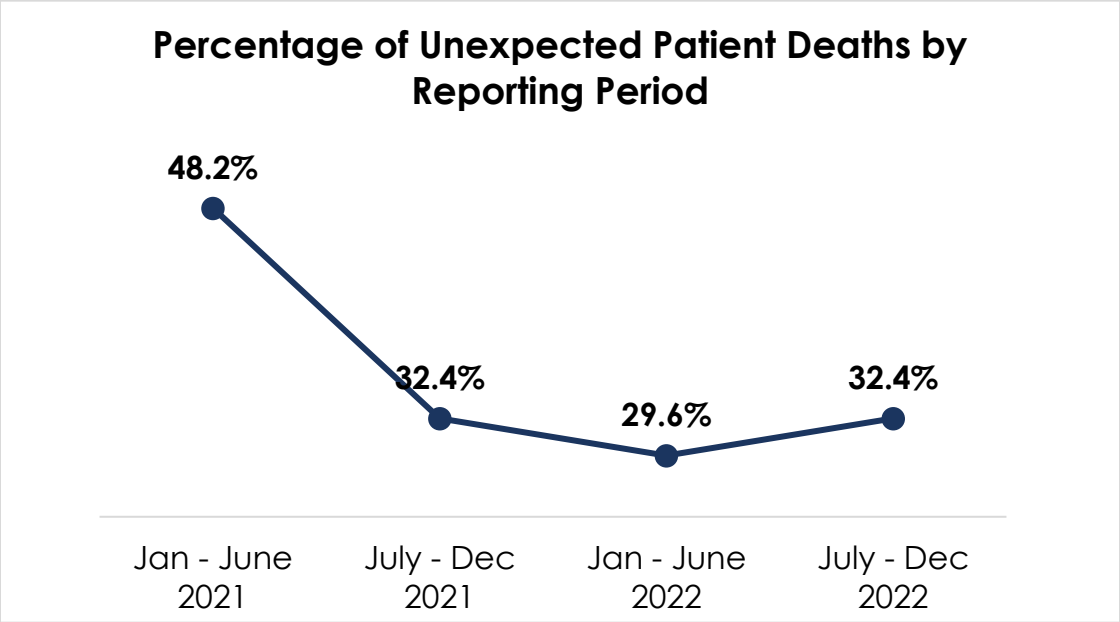
## Patient Deaths

The DSH reported 37 patient deaths to OLES during this reporting period. This number increased 37 percent from the 27 patient deaths reported in the prior reporting period of January 1 through June 30, 2022.

Twenty-five of the patient deaths were classified as "expected" primarily due to underlying health conditions, such as cancer, cardiac or respiratory issues, sepsis and COVID-19. Twelve deaths were classified as "unexpected". The percentage of unexpected patient deaths increased compared to the percentage in the prior reporting period. 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. The OLES monitored 10 of the departmental

death investigations.

The following chart depicts the percentage of unexpected patient deaths in this reporting period and the three prior reporting periods.




As shown in the following table, cardiac or respiratory issues were the most frequent cause of death amongst patients during this reporting period.

***Cause of Patient Deaths***

| Cause | Total |
|---|---|
| **Cardiac/Respiratory** | 18 |
| **Cancer** | 7 |
| **Sepsis** | 4 |
| **Other** | 8 |
| **Total** | 37 |

## Reports of Head or Neck Injuries

The DSH reported 38 head or neck injuries during this reporting period. These head or neck injuries were the result of a patient-on-patient altercation, a patient fall or a self-inflicted injury by the patient. Patient-on-patient altercations accounted for 17 of the 38 reported head or neck injuries.

## Reports of Patients Absent without Leave

A patient is Absent without leave (AWOL) when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in police intervention to recover the patient. In this reporting period, DSH reported 10 incident types under the significant interest-absent without leave (AWOL) category.

# 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 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.

On April 28, 2022, OLES changed reporting requirements for sexual assault allegations. Sexual assault allegations against staff, law enforcement or unidentified person(s) remained a priority one notification. Patient on patient sexual assault allegations and allegations of sexual assault that occurred before the patient was in the care of DSH became a priority 2 notification. Priority One and Two incident types are listed 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 and was not witnessed by staff. |
| **Deadly force** | Any use of deadly force by staff (including a strike to the head/neck). |
| **Death** | Any death of a patient, including a patient that is officially declared brain dead by a physician or other authorized medical professional noting the date and time, or a death that occurs up to 30 days from patient discharge from the facility. |
| **Genital Injury (U)** | An injury to the genitals of a patient when the cause of injury is undetermined and was not witnessed by staff. |
| **Physical Abuse** | Any report of physical abuse of a patient implicating staff. |
| **Priority 1 Sexual Assault** | Any allegation of sexual assault of a patient against staff, law enforcement personnel or unidentified person(s). |

## 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 or witnessed 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 or witnessed 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 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. Injuries that are beyond treatment beyond first aid include physical trauma resulting in an altered level of consciousness or loss of consciousness or the use of skin adhesive, staples or sutures. |
| **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. |
| **OPS Use of Force** | Any Office of Protective Services staff member within DSH that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject, regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by the subject to the officer or officers. |
| **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. Allegations against a peace officer that include a priority one incident type must be reported in accordance with the priority one reporting requirements. |
| **Pregnancy** | A patient pregnancy. |
| **Priority 2 Sexual Assault** | Any allegation of sexual assault between two patients.<br>Any allegation of sexual assault that occurred before the patient was in the care of the department (Outside Jurisdiction). |
| **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, drug trafficking or smuggling, 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

The DSH decreased in the timely reporting of incident types with 91.6 percent timely reports when compared to the prior reporting period, which had 92.4 percent timely reports.

Twenty-four of the 658 reported incident types were excluded from DSH's total incident type count when calculating timeliness. These incidents were reported directly to OLES by a patient, family member of a patient, facility staff member or by an outside law enforcement agency. Of the 634 incident types evaluated for timeliness, 581 were reported timely and 53 incident types were not timely. Eight of the 53 untimely incident types were unreported and were discovered by OLES when reviewing the DSH facility daily incident logs or incident reports.

***Timeliness by Incident Type***

The following table provides the percentage of timely notifications by incident type. The table does not include the 24 incident types that were excluded described above.

| Incident Type | Number of Timely Notifications | Number of Untimely Notifications | Total Reported Incident Types | Percentage of Timely Notifications |
|---|---|---|---|---|
| **Abuse** | 77 | 18 | 96 | 80.2% |
| **Broken Bone (Known Origin)** | 13 | 2 | 15 | 86.7% |
| **Broken Bone (Unknown Origin)** | 46 | 7 | 53 | 86.8% |
| **Burn** | 10 | 0 | 10 | 100.0% |
| **Death** | 35 | 2 | 37 | 94.6% |
| **Genital Injury (Known Origin)** | 6 | 0 | 6 | 100.0% |
| **Genital Injury (Unknown Origin)** | 10 | 0 | 10 | 100.0% |
| **Head/Neck** | 37 | 1 | 38 | 97.4% |
| **Misconduct** | 20 | 4 | 24 | 83.3% |
| **Neglect** | 19 | 1 | 20 | 95.0% |
| **OPS Use of Force** | 95 | 2 | 97 | 97.9% |
| **Patient on Patient Assault/GBI** | 14 | 3 | 17 | 82.4% |
| **Priority 1: Sexual Assault** | 36 | 8 | 44 | 81.8% |
| **Priority 2: Sexual Assault** | 95 | 3 | 98 | 96.9% |
| **Significant Interest – AWOL** | 10 | 0 | 10 | 100.0% |
| **Significant Interest – Child Porn** | 2 | 0 | 2 | 100.0% |
| **Significant Interest –** | 33 | 1 | 34 | 97.1% |

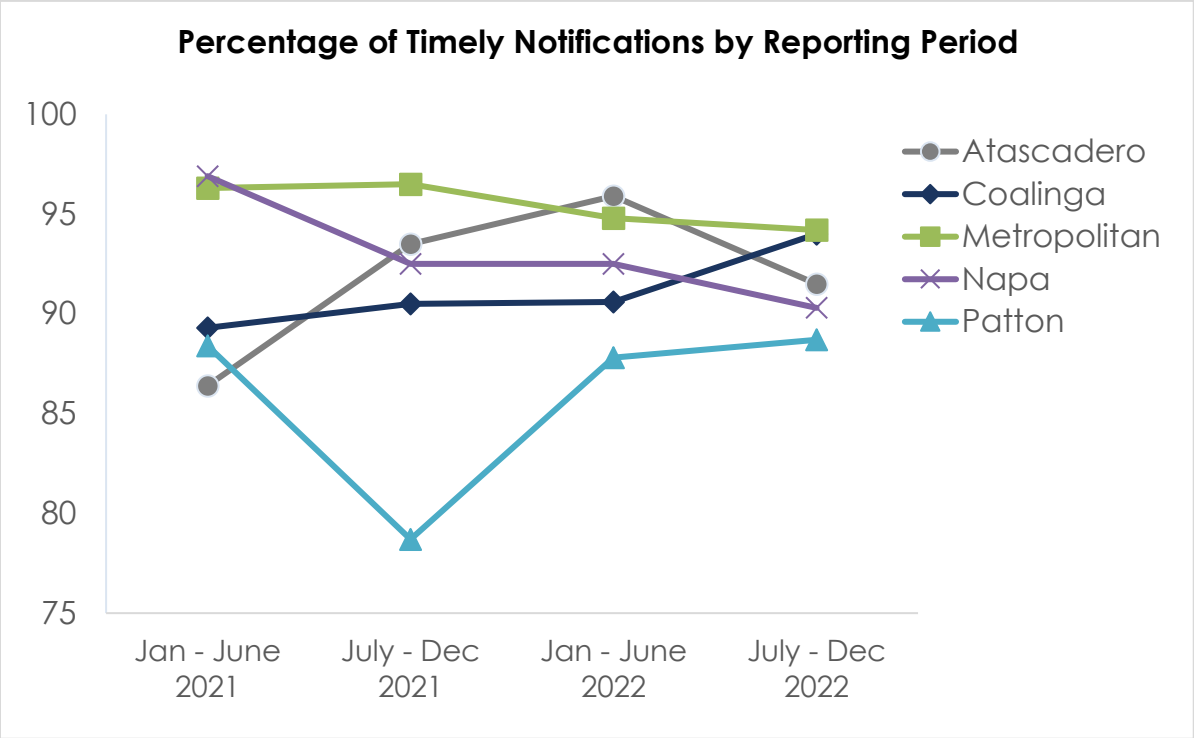
| Incident Type | Number of Timely Notifications | Number of Untimely Notifications | Total Reported Incident Types | Percentage of Timely Notifications |
|---|---|---|---|---|
| **Drugs** | | | | |
| **Significant Interest – Other** | 5 | 0 | 5 | 100.0% |
| **Significant Interest – Over-Familiarity** | 9 | 1 | 10 | 100.0% |
| **Significant Interest – Patient Arrest** | 9 | 0 | 9 | 100.0% |
| **Total** | 581 | 53 | 634 | 91.6% |

The following table compares the percentage of timely notifications by facility. MSH and CSH had the highest percentage of timely notifications. The PSH had the lowest percentage of timely notifications.

| Rank | DSH Facility | Number of Timely Notifications | Number of Untimely Notifications | Total Reported Incident Types | Percentage of Timely Notifications | |
|---|---|---|---|---|---|---|
| **1** | Atascadero | 130 | 12 | 142 | 91.5% | |
| **2** | Metropolitan | 98 | 6 | 104 | 94.2% | |
| **3** | Napa | 102 | 11 | 113 | 90.3% | |
| **4** | Coalinga | 126 | 8 | 134 | 94.0% | |
| **5** | Patton | 125 | 16 | 141 | 88.7% | |
| | **Total** | 581 | 53 | 634 | 91.6% | |

When compared to the prior reporting period, The CSH increased in the percentage of timely reports. The MSH and PSH maintained relatively the same percentage of timely reports. The ASH had a lower percentage of timely notifications this reporting period compared to the prior reporting period.

The following chart compares the percentage of timely notifications by reporting period.



# 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 F. 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 July 1 through December 31, 2022, reporting period, 348 of the total 684 cases opened for DSH incidents that occurred within DSH's jurisdiction or 50.9 percent were assigned a pending review. The OLES opened cases for 48 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 25 administrative investigations and 7 criminal investigations. The OLES opened 184 monitored criminal cases and 72 monitored administrative cases.

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

## Cases Opened in the Current Reporting Period

| OLES Case Assignments | June 1 – December 31, 2022 | Percentage of Opened Cases |
|---|---|---|
| **Pending Review** | 348 | 50.9% |
| **Monitored, Criminal** | 184 | 26.9% |
| **Monitored, Administrative** | 72 | 10.5% |
| **Outside Jurisdiction*** | 48 | 7% |
| **OLES Investigations, Criminal** | 7 | 1% |

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

| | | |
|---|---|---|
| **OLES Investigations, Administrative** | 25 | 3.7% |
| **Totals** | 684 | 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 E). 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. 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 22 investigations. Four investigations were criminal cases and 18 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, OLES did not refer any criminal investigations to a district attorney's office.

Thirteen of 18 OLES investigations into administrative wrongdoing or misconduct were forwarded to facility management for review. In this reporting period, OLES referred 13 administrative cases to DSH 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 OLES provided the department with summaries of the reviews and decisions of all criminal investigations in which OLES determined there was a lack of probable cause.

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, 2022 | Referred to prosecuting agency | Referred to facility management | Closed without referral |
|---|---|---|---|---|
| **Administrative** | 18 | N/A | 13 | 5 |
| **Criminal** | 4 | 0 | N/A | 4 |
| **Total** | 22 | 0 | 13 | 9 |

## OLES Monitored Cases

In this report, OLES provides information on 143 completed monitored cases. By the end of the reporting period, 47 monitored criminal cases had either been referred or not referred to a district attorney's office. None of the 76 criminal cases were referred to a district attorney's office.

There were 96 completed monitored pre-disciplinary administrative cases with allegations that were sustained or not sustained during this reporting period. Thirty-four of the 96 cases had sustained allegations. Sixty-two cases did not have sustained allegations. Results of OLES monitored cases are provided in the table below.

| Type of Case/Result | DSH |
|---|---|
| **Criminal-Referred to Prosecuting Agency** | 0 |
| **Criminal-Not Referred** | 47 |
| **Total Criminal** | 47 |
| **Administrative-With Sustained Allegations** | 34 |
| **Administrative-Without Sustained Allegations** | 62 |
| **Total Administrative** | 96 |
| **Grand Total** | 143 |

### *Pre-Disciplinary Phase Cases*

Of the 143 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 25 cases insufficient. Significant deficiencies found in insufficient cases include, but are not limited to, incomplete interviews by the responding officer, failure to provide the required legal admonishment prior to taking a statement and delayed investigations. Corrective action plans for deficiencies in pre-disciplinary phase cases are provided in Appendix B.

### *Disciplinary Phase Cases*

The OLES monitored the disciplinary action, *Skelly* hearings, settlements and State Personnel Board proceedings in 16 administrative cases. Four cases were insufficient due to delays in serving the disciplinary action or not providing OLES the opportunity to review the draft disciplinary action prior to serving the action. Details regarding the monitoring of these cases are in Appendix C of this report.

# DSH Tracking of Law Enforcement Compliance with Training Requirements

The DSH OPS Training Plan, approved by the DSH chief of law enforcement and executive staff in 2020, identifies and prioritizes the training requirements for law enforcement personnel. The training plan categorizes courses for each rank or position into the following categories:

- **Mandated/Job-Required**: Training in this category is required by federal law, state law or OPS policy. Unless otherwise noted, this training should be completed within one year of appointment to the position.
- **Essential/Job-Related**: This training has been designated by OPS as necessary for the professional development of an employee in his or her specified rank or task assignment
- **Desirable/Career-Related**: Upon completion of the mandatory and essential courses, an employee may pursue additional interests in their law enforcement training.
- **Necessary**: Training needed for assignments requiring specialized skills or knowledge.

The DSH inputs trainings into a training database to track training completed by law enforcement staff. The software tracks courses required in the training plan as well as any additional courses required by the legislature. Each facility has a designated training coordinator or manager that is responsible for ensuring the database accurately reflects current compliance rates.

## Self-Reported Compliance Rates for Mandated Training

The DSH reported the following percentages for law enforcement compliance with mandated training requirements as of June 30, 2022.

| DSH Facility | Percentage of Compliance |
|---|---|
| **Atascadero** | 87 |
| **Coalinga** | 87 |
| **Metropolitan** | 84 |
| **Napa** | 73 |
| **Patton** | 96 |

## Methods Used to Track Training

To more efficiently track training compliance, DSH developed a compliance monitor dashboard within the training database that would provide training managers with enhanced visibility for up-to-date information on the training. However, the compliance monitor dashboard is still in the early stages of development and training managers

reported several concerns with the accuracy of the dashboard. For example, the dashboard does not update when courses are entered in the database. In addition, the dashboard only tracks training compliance for the last 365 days, which results in the dashboard excluding pertinent records that may indicate a staff member is still in compliance.

Due to these issues, all training managers continue to use a separate excel spreadsheet to either supplant or supplement the dashboard for tracking training compliance. Each facility independently created its own tracking spreadsheet. While there is no standardized spreadsheet used across the department, all facilities have been able to sufficiently explain tracking methods and provide compliance rates when requested by OLES.

## DSH Law Enforcement Training Advisory Committee

To coordinate training efforts across the facilities, the DSH established the Law Enforcement Training Advisory Committee (LETAC). Training lieutenants, training sergeants and training officers from each facility, as well as, academy and staff from DSH OPS headquarters are invited to attend the bimonthly meeting to discuss training topics and changes to training. However, discussions with facility training managers revealed that attendance for the LETAC meeting is not enforced.

# 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 | Total Formal administrative investigations/actions completed* | Adverse action taken (Formal investigations)** | No adverse action taken*** | Direct adverse action taken** | Resigned/ retired pending adverse action**** |
|---|---|---|---|---|---|
| **Atascadero** | 17 | 6 | 10 | 1 | 0 |
| **Coalinga** | 36 | 6 | 17 | 12 | 1 |
| **Metropolitan** | 51 | 2 | 45 | 4 | 0 |
| **Napa** | 52 | 7 | 45 | 0 | 0 |
| **Patton** | 52 | 0 | 33 | 18 | 1 |
| **Total** | 208 | 21 | 150 | 35 | 2 |

* 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** | 18 | 3 | 15 | 0 |
| **Coalinga** | 4 | 0 | 4 | 0 |
| **Metropolitan** | 44 | 0 | 44 | 0 |
| **Napa** | 27 | 0 | 27 | 0 |
| **Patton** | 2 | 2 | 0 | 0 |
| **Total** | 95 | 5 | 90 | 0 |

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

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

***Criminal cases not referred to prosecuting agencies due to a lack of probable cause.

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

## Reports of Employee Misconduct to Licensing Boards

| DSH Facilities | CA Board of Behavioral Science | Registered Nursing | Vocational Nursing/ Psych Tech | CA Medical Board |
|---|---|---|---|---|
| **Atascadero** | 8 | 3 | 5 | 0 |
| **Coalinga** | 0 | 0 | 0 | 0 |
| **Metropolitan** | 0 | 0 | 0 | 0 |
| **Napa** | 0 | 0 | 0 | 0 |
| **Patton** | 0 | 0 | 0 | 0 |
| **Total** | 8 | 3 | 5 | 0 |

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

## Patient Criminal Cases

| DSH Facilities | Total cases referred or not referred* | Referred to prosecuting agencies** | Not referred*** | Rejected by prosecuting agencies**** |
|---|---|---|---|---|
| **Atascadero** | 383 | 97 | 286 | 107 |
| **Coalinga** | 301 | 77 | 224 | 64 |
| **Metropolitan** | 274 | 22 | 252 | 34 |
| **Napa** | 68 | 0 | 68 | 0 |
| **Patton** | 96 | 55 | 41 | 13 |
| **Total** | 1,122 | 251 | 871 | 218 |

* 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.

*** Criminal cases not referred to prosecuting agencies due to a lack of probable cause.

**** Cases rejected by prosecuting agencies are criminal cases that were submitted to prosecuting agencies and rejected for prosecution. This column includes rejected cases that were referred from prior reporting periods.

# 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, OLES opened two new monitored issues. Information on new and long-running monitored issues are provided below.

## New Monitored Issue: Patient Accessible Computers and Contraband

In May 2022, OLES was notified of a significant event at PSH. A bomb threat was received by telephone, which precipitated the evacuation of the hospital, and caused hundreds of hours of coordination by OPS and allied agencies. Later, the OLES was notified that OPS identified a suspect PSH patient was able to fabricate the bomb threat using the facility payphone and contraband electronic devices, which are banned by the California Code of Regulations (CCR), Title 9, Section 4350.

In June 2022, the OLES met with the PSH OPS Contraband Interdiction Team at PSH Police Headquarters. The OLES learned from OPS officers, supervisors and management that electronic contraband, specifically removable USB electronic storage devices and recordable MP3 music players, were prevalent at the facility. The PSH OPS personnel described numerous CCR, Title 9, Section 4350 violations, and challenges with attempts to enforce the regulations with PSH Administration staff. The OPS personnel stated that OPS seized electronic contraband has been returned to patients by hospital personnel. Later in June 2022, the OLES arranged with OPS to be onsite at PSH to secure digital samples of patient accessible computers, to determine compliance with CCR, Title 9, Section 4350. Analysis of the patient accessible computers showed there were numerous removable USB storage devices and MP3 players in use. The analysis showed the overwhelming majority of use on the patient accessible computers was the copying and playing of MP3 audio files. Absent a supervised checkout program, or waiver of regulations, the removable USB devices are a violation of CCR, Title 9, Section 4350. The OLES conducted a similar review of the four other state hospitals and did not find significant misuse of electronic removable USB storage. Two other hospitals run a robust USB storage drive patient issue and supervision program. The OLES requested any information from PSH about waivers requested or received on compliance with CCR, Title 9, Section 4350, but was informed there were no specific waivers. The OLES requested a response from DSH on how PSH will become compliant with the CCR regulations.

In response to the OLES request, DSH developed a plan to confiscate contraband electronic devices. The OLES will continue to work with DSH in a collaborative manner on the implementation of this plan.

## Recording of Investigatory Interviews

On January 4, 2022, OLES re-opened a former monitored issue to address deficiencies in DSH OPS Policy 600, 418 and 601 concerning the recording of investigatory interviews. The OLES recommended DSH update policy to require OPS staff to record all interviews conducted and record staff refusals to be interviewed. In addition, if there is a refusal, OPS staff should document in the investigative report the setting and circumstances surrounding the refusal to be recorded.

Since the last semi-annual report, the DSH has updated its existing recording policies, purchased additional recorders and conducted training on recordings to all OPS sworn staff. While most OPS staff have seen significant improvements in the regular recording of investigatory interviews, deficiencies remain at ASH where officers are not making a regular practice of recording. The OLES conducted an audit of 24 ASH investigations in February 2023 and discovered 14 cases in which officers did not record 26 witness interviews. The OLES recommends additional training be conducted at ASH to ensure the policy of recording investigatory interviews becomes the regular practice for OPS staff. The OLES will continue to monitor the progress on this issue.

## 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 department 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 department to use data to proactively identify potential performance problems with staff. The DSH selected the IAPro/Blue Team software for its EI system. Blue Team 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, 2016, 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. The 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 to assess DSH's implementation and usage of the Blue Team/IA Pro program at DSH. 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.

In March 2018, OLES discussed its findings with DSH. In response to the concerns, DSH scheduled additional training to refresh staff knowledge of reporting requirements. In December 2020, OLES received notification from DSH that Blue Team training had been completed, with an overall completion rate of 93.67 percent. The DSH OPS Chief advised a yearly refresher will be conducted to ensure staff remain current in their knowledge and understanding.

In August 2021, OLES reviewed the incidents DSH entered into Blue Team/IA Pro between January 1, 2021, through June 30, 2021. From this review, OLES discovered DSH was not promptly inputting reportable incidents. For example, an incident involving use of force occurred on May 11, 2021, but was not listed in Blue Team/IA Pro when OLES first reviewed the total incidents entered on August 16, 2021. The incident was subsequently discovered in the system on the August 31, 2021. Similarly, two censurable incidents that occurred on April 12, 2021, were not listed on August 16, 2021, but were listed in the system on August 31, 2021.

The OLES reviewed the 2017 DSH Early Intervention System Procedure manual, which provides guidelines for the usage and data input in the Blue Team and IAPro software. The procedure manual did not include specific timeframes for supervisors and managers to input incidents. The OLES recommended DSH input each reportable incident into Blue Team within 72 hours of discovery of the incident. In February 2022, DSH reported that the procedure manual was updated to include OLES's recommendation. The DSH also reported that entries for use of force increased substantially and the Chief of Law Enforcement now reviews all use of force reports on Blue Team.

In February 2023, OLES performed a review of Blue Team/IA Pro to determine whether facilities continued to show improvement in utilizing the program. OLES also analyzed whether DSH adhered to inputting each reportable incident into Blue Team within 72 hours of discovery of the incident. The OLES audited all use of force incidents entered in Blue Team during December 2022. The OLES found that in December 2022, DSH facilities timely entered 11 incidents in the Use of Force category. However, during the same

reporting period, the DSH notified OLES of 13 incidents of reportable use of force occurred, revealing that two use of force incidents had not been entered in Blue Team/IA Pro. While DSH has shown improvement in its use of Blue Team/IA Pro, there is still progress to be made and the OLES will continue to monitor this issue.

## Use of Force Reports, Reviews and Tracking at DSH

In 2021, OLES issued a monitored issue memorandum documenting concerns and recommendations regarding use of force on patients at DSH facilities after reviewing 42 use of force packages submitted to OLES from August 3, 2020, to July 15, 2021. For reporting purposes, the OLES reporting guidelines lists the following definition for use of force by staff from the Office of Protective Services (OPS):

*Any OPS staff member within DSH that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject shall be considered a reportable use of force incident regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by subject to the officer or officers.*

A use of force report documents an operational incident and does not necessarily indicate misconduct or excessive force by an officer.

***OPS Therapeutic Strategies and Interventions vs. Use of Force***

The OLES conducted a review and discovered five use of force incidents were not reported to OLES from August 3, 2020 to July 15, 2021. The DSH determined several of these incidents involved Therapeutic Strategies and Interventions (TSI) techniques, rather than use of force by law enforcement.

The DSH has no requirement to write a report following the use of TSI techniques on a patient. HPOs often deemed the physical force they used to be TSI and therefore their use of force was not documented and reviewed by supervision. Pursuant to Policy 300, sworn staff are required to write use of force reports anytime they use physical techniques on with a patient regardless if their actions are interpreted as TSI. Reports describing sworn staff using force must articulate the imminent threat to the safety of staff, patients, or facility that precipitated the use of force. The OLES reviewed some reports that simply stated TSI was used without providing any details of what transpired.

***Supervision's Review of UOF Reports***

The OLES determined that supervision of use of force incidents was not adequate. While the Chief of Police at each facility is ultimately responsible for the review and determinations on use of force incidents, the OLES recommends each facility have an assigned UOF coordinator, who has access to all UOF incidents and would be responsible for promptly moving the reports through all levels of review. The coordinator should also ensure that the final facility package is sent to OLES and the Chief of Law Enforcement.

One of the issues identified pertains to the supervisor's role as defined under DSH Policy

300.6.2. While most of the UOF incidents reported to OLES are immediate and not calculated, this portion of the policy addresses both. It requires the supervisor to perform specific actions, regardless if the supervisor responds to the scene. The OLES recommends that the supervisor complete a supplemental report regarding their actions in compliance with the policy. Many supervisors' use of force reports did not add anything of substance and did not address some of the requirements under this policy.

The supervisors who review use of force reports must ensure that all necessary information was obtained and all discrepancies were resolved before approving the report. In fact, DSH policy 322.4 states, "Supervisors shall review reports for content and accuracy." However, OLES discovered that supervisors approved reports which contained discrepancies and needed further clarification. The DSH policy requires that "all reports shall accurately reflect the identity of the persons involved, all pertinent information seen, heard, or assimilated by any other sense, and any actions taken."

***Use of Force Documentation***

The DSH Policy 300.5 requires sworn staff to document the use of force "promptly, completely and accurately" in their report along with the requirement to "…articulate the factors perceived and why he/she believed the use of force was reasonable under the circumstances." However, sworn staff did not always meet these requirements as many reports did not provide sufficient details regarding the factors which resulted in the use of force against the patient.

Instead, reports which contained general statements which did not provide the specific order the patient refused, the reasonableness of the decision to use force, the identity of the HPOs and staff who were involved or witnessed the use of force, and the precise actions the HPOs and staff took when used force on the patient. Incidents involving the use of force against a patient are more likely to result in allegations of excessive force; therefore it is essential the reports contain sufficient information which details the actions and observations of all involved parties.

***Tracking UOF Incidents***

Of the 42 use of force packages the OLES received, only 17 of those cases were entered into Blue Team/IA Pro. The DSH was also not consistently categorizes use of force incidents in its records management system (RMS). The RMS contains a UOF check box within the "Additional Information" section. The DSH explained the purpose of the check box is to designate the case as an UOF incident, and acknowledged the check box was not being used consistently by all facilities.

***Recommendations***

1. The OLES recommends that DSH incorporate a standard code for UOF in RMS so all UOF incidents can be quickly identified in RMS. In RMS, there is a filter that lists all the unique values in the columns that allow a user to search for uses of force but these columns are underutilized. There is no category for use of force but there are categories for assault and resisting arrest. There are at least three different categories for resisting arrest. OLES identified that some assault sections are used for assault on peace officer but there is no consistency. This system is

capable of retrieving all UOF incidents if there were better categories within these three columns of data. With the addition of some categories, such as "Officer Use of Force," and subcategories such as attack on peace officer and physical resistance, OLES and the DSH would have the ability to obtain a list of all UOF incidents for a desired timeframe, instantly.

2. OPS supervisors need to improve their communication with officers when reviewing use of force packets. Sworn staff assigned to conduct follow-up investigations should receive training, as well as, clear and specific direction regarding the additional information they need to obtain to properly complete a UOF packet.
3. The OLES also recommends the UOF policy be changed to require written reports by all personnel (sworn and non-sworn) present during a UOF incident. The practice of allowing staff members to interview other staff who witnessed force being used or who used force and write reports for them should be prohibited. Written reports by witnesses should be included with every use of force packet. Prompt, thorough and impartial documentation of an UOF incident is critical. This documentation supports future process improvements, changes to policy, promotes safety and public trust and aids in Department risk mitigation if incidents or staff actions are questioned.
4. TSI Techniques that also involve physical force by law enforcement personnel to overcome resistance or gain control of a patient should be considered a use of force requiring compliance with all use of force policies including the writing of reports and completion of a UOF packet.
5. In order to allow OPS to track uses of force, Blue Team/IA Pro and RMS should be used regularly.
6. A copy of all UOF packets should be submitted to OLES within 30 days and UOF packets should have a new section added that includes a signature line acknowledging the UOF packet has been received and reviewed by OLES and with an indicator box to request additional information or investigation if warranted.

In response to the OLES memorandum, DSH acknowledged there were opportunities for improvement in its UOF review and reporting process. DSH's Chief of Law Enforcement along with an external law enforcement use of force expert, reviewed DSH's policies and use of force reporting processes to identify opportunities to strengthen DSH's processes. In September 2022, DSH's Chief of Law Enforcement and the use of force expert provided training to DSH command level staff and front-line supervisors. The DSH is also making updates to its use of force reporting forms to clarify requirements and details to be reported including that use of therapeutic strategies and interventions by sworn staff must be documented and reported. The OLES will continue to monitor the department's progress.

## Delayed Reporting by Mandated Reporters

In December 2021, the OLES issued a monitored issue memorandum to DSH after discovering significant delays in required reporting by mandated reporters at DSH. The OLES reviewed several incidents where OPS made timely notification to OLES; however, level of care staff who are mandated reporters, did not report the incident to

OPS or delayed their notification to OPS. The delays ranged from several hours to several days after initial discovery by the mandated reporters.

These delays may have a negative impact on the investigations of the incidents. Timely notification to appropriate law enforcement is critical, especially for alleged sexual assaults or other potential crimes of violence. When an allegation is made of a recent sexual assault, time is of the essence. Valuable forensic evidence could be lost if a victim or suspect changes clothes, showers, brushes their teeth or uses the restroom. Additionally, for sexual assaults and other allegations of abuse, delays could undermine investigations in other ways. For example, delays give opportunity for collusion amongst involved parties or may cause a patient or victim to fear going forward with abuse allegations. Finally, the victims involved in these alleged incidents are a unique population with various mental, emotional and developmental conditions that may affect the accurate recall of events. As such, investigative efforts must commence immediately whenever possible.

To address this issue, OLES recommended that DSH implement a statewide policy requiring mandated reporters to make timely notifications to OPS and outside law enforcement agencies as required by law. In response, DSH has drafted Policy Directive 8010, which includes a reference to reporting confidential patient information and allegations as required by law. The DSH also created mandated reporting posters and pocket guides describing OLES reporting requirements for staff distribution. The Chief of Law Enforcement has met with level of care staff to review the reporting guidelines.

In the last reporting period of January 1 through June 30, 2022, the OLES identified 13 incidents that were not timely reported. During the current reporting period of July 1 through December 31, 2022, this number improved to 11 incidents of delayed reporting. The 11 incidents are listed below. The OLES will continue to work with the department and monitor the department's progress on this issue.

| Incident Type | Delay/Notes |
|---|---|
| **Broken Bone (Unknown Origin)** | 13 hours, 18 minutes |
| **Broken Bone (Unknown Origin)** | 19 hours, 46 minutes |
| **Broken Bone (Unknown Origin)** | 3 days |
| **Sexual Assault** | 9 hours |
| **Broken Bone (Unknown Origin)** | 4 days |
| **Genital Injury (Unknown Origin)** | Level of care staff did not report this incident to OPS. The OPS discovered the incident after reading a nurse-on-duty log 15 hours, 51 minutes after level of care staff discovered the injury. |
| **Physical Abuse** | Level of care staff did not report this incident to OPS. The OPS discovered the incident after reading a nurse-on-duty log 15 hours, 35 minutes after level of care staff discovered the injury. |
| **Broken Bone (Unknown Origin)** | 4 days |

| Incident Type | Delay/Notes |
|---|---|
| **Broken Bone (Unknown Origin)** | 2 days |
| **Broken Bone (Unknown Origin)** | 1 day, 49 minutes |
| **Broken Bone (Unknown Origin)** | 3 days |

# Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of July 1 through December 31, 2022. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

To protect the anonymity of law enforcement personnel, the OLES refers to an officer, sergeant or investigator as an "officer." The rank of lieutenant or above is referred to as "law enforcement supervisor."

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01529-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | Four officers allegedly conducted an inappropriate sexual assault investigatory interview. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00060-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly sent sexually explicit text messages to hospital employees and allegedly failed to report the misconduct. The officer allegedly provided false statements during an investigative interview, and allegedly attempted to persuade a witness to provide false statements. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00066-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly was absent from their assigned post. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00105-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly included a false statement in a report and was dishonest to his supervisor when questioned regarding the report. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00145-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly used a personal electronic device while on-duty and was dishonest to a law enforcement supervisor. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00150-1A |

| | |
|---|---|
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer was allegedly discourteous to a staff member. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00216-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An on-duty officer was allegedly inattentive. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00220-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly possessed an unauthorized personal communication device in a secure treatment area. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00327-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly verbally mistreated a patient. |

| | |
|---|---|
| **Disposition** | The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred, and the matter was closed. A summary of the investigation and decision was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00335-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly failed to report and document an allegation of sexual assault. |
| **Disposition** | The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred, and the matter was closed. A summary of the investigation and decision was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00413-1C |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly inaccurately transcribed a recorded interview, which completely changed the meaning of a significant statement in the recorded interview. |
| **Disposition** | The Office of Law Enforcement Support conducted an investigation into this matter. The case was not submitted to the district attorney's office due to a lack of probable cause. A summary was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00424-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |

| | |
|---|---|
| **Incident Summary** | An officer allegedly did not maintain proper control of his assigned facility keys, resulting in their loss in a patient housing area. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00436-2C |
| **Case Type** | Investigative |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Incident Summary** | An officer allegedly raped a patient. |
| **Disposition** | The OLES conducted an investigation into this allegation. The case was not referred to the district attorney's office due to a lack of probable cause. A summary of the investigation was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00465-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | A law enforcement supervisor allegedly conducted unauthorized firearms training that put an officer at risk of injury. |
| **Disposition** | The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred, and the matter was closed. A summary of the investigation and decision was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00501-1C |
| **Case Type** | Investigative |
| **Incident Types** | 1. Abuse |

| | |
|---|---|
| | 2. Significant Interest - Attempted Suicide<br>3. Significant Interest - Drugs |
| **Incident Summary** | An officer allegedly held a strap over a patient's neck and attempted to harm the patient. |
| **Disposition** | The OLES conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary of the investigation was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00516-2A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Abuse<br>2. Use of Force Review |
| **Incident Summary** | An officer allegedly used excessive force on a patient. |
| **Disposition** | The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred, and the matter was closed. A summary of the investigation and decision was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00563-1C |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly stalked and surreptitiously filmed a department employee. |
| **Disposition** | The OLES conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary of the investigation was provided to the department. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00668-1A |

| | |
|---|---|
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An off-duty officer was arrested for allegedly driving a vehicle while under the influence of alcohol. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00675-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly provided false information during a COVID screening process. |
| **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 Details | Description |
|---|---|
| **OLES Case Number** | 2022-00727-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Significant Interest - Other |
| **Incident Summary** | A manager allegedly sexually harassed a colleague and engaged in sexual activity while on-duty. The manager also allegedly discriminated against another colleague based on age. |
| **Disposition** | The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00789-1A |
| **Case Type** | Investigative |

| | |
|---|---|
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | Two officers allegedly were asleep while on-duty. |
| **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 Details | Description |
|---|---|
| **OLES Case Number** | 2022-00978-1A |
| **Case Type** | Investigative |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer allegedly intimated witnesses involved in a criminal investigation. |
| **Disposition** | The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred, and the matter was closed. A summary of the investigation 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 December 31, 2022, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

The OLES rated each case as sufficient or insufficient after assessing the department's performance in conducting the internal investigation. A sufficient case indicates the department complied with policies and procedures governing the pre-disciplinary process. For each case that OLES rated insufficient, OLES identified the deficiencies in the investigative assessment of the case table and listed the department's corrective action plan submitted to OLES.

The Office of Protective Services referenced in this section may include the Department of Police Services or the Office of Special Investigations.

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2020-00636-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Death |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Staff members discovered a patient unresponsive and initiated emergency life-saving measures; however, the patient died at an outside hospital. An autopsy determined the cause of death was necrosis as a probable side effect of clozapine therapy. |
| **Disposition** | The department determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2020-01022-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Head/Neck<br>2. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Sustained<br>2. Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | A dentist allegedly failed to competently extract a patient's tooth, resulting in prolonged pain. The dentist and a second dentist also allegedly failed to provide adequate follow-up treatment to the patient, resulting in unresolved, continuing pain to the patient. Additionally, the first dentist allegedly confronted the patient, accusing the patient of making complaints about treatment. |
| **Disposition** | The hiring authority sustained the allegations and determined letters of instruction and additional training were the appropriate penalties for both dentists. The OLES concurred with the hiring authority's determinations due to a significant difference in opinions between the subject matter experts retained during the investigation. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed in a timely manner, and an inappropriate subject matter expert was retained to provide an expert opinion. |
| **Pre-Disciplinary Assessment** | 1. Was the investigation thorough and appropriately conducted? • No<br>A subject matter expert was initially retained, but his contract was rescinded because he had reviewed a prior incident involving one of the dentists. A second subject matter expert was retained; however, that subject matter expert was the current supervisor of both dentists, undermining the objectivity of his opinion. A third |

| | |
|---|---|
| | independent subject matter expert was retained; however, due to the multiple expert opinions with significantly different findings, the findings could not wholly be relied upon.<br>2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>After a third subject matter expert was deemed necessary, the investigation was re-opened on September 27, 2021. The investigation was completed on June 8, 2022, 254 days later. |
| **Department Corrective Action Plan** | OSI will work with Sacramento to ensure the SMEs are vetted prior to use, to avoid these issues in the future. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00655-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly choked a patient and forced the patient's head against the floor after the patient allegedly hit the psychiatric technician. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was completed 258 days after the investigation was initially opened. The first-assigned investigator did not adequately consult with the OLES monitor. |
| **Pre-Disciplinary Assessment** | 1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • |

| | |
|---|---|
| | No<br>The first-assigned investigator did not consult with the monitor at the start of the investigation.<br><br>2. Did OPS cooperate with and provide continued real-time consultation with OLES? • No<br>The first-assigned investigator did not notify the monitor of a scheduled interview, and did not consult with the monitor prior to conducting that interview.<br><br>3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>On October 8, 2021, an investigator was assigned to investigate possible policy violations for this case. A second investigator was assigned on February 23, 2022, to complete the investigation. The investigation was completed on June 23, 2022, 258 days after the investigation was initially opened. |
| **Department Corrective Action Plan** | Cases under 120-day requirements will not be assigned to new investigators that have not attended the academy or have not received any training specific to OSI. Currently, new procedures are in place to ensure new investigators assigned to OLES monitored cases adhere to OLES AIM procedures, by implementing training and written procedures for Investigators on OLES monitor procedures, specifically regarding OLES standards of contemporaneous monitoring. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00665-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A senior psychiatric technician allegedly hit a patient on the mouth and administered the patient an injection. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred |

| | |
|---|---|
| | with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department failed to comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The criminal investigation was closed on September 27, 2021; however, the administrative investigation was not opened until November 19, 2021, and not completed until May 19, 2022, 181 days later. |
| **Department Corrective Action Plan** | Moving forward, the current SSIs will ensure an Investigator is not assigned a case prior to the start of a police academy and will promptly reassign cases. The SSIs will ensure an administrative investigation is opened without delay after a criminal investigation has been completed. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00731-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician assistant allegedly kicked a patient. |
| **Disposition** | The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with the policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The administrative investigation began on October 7, 2021; however, the investigation report was not completed until March 9, 2022, 154 days later. |

| | |
|---|---|
| **Department Corrective Action Plan** | Overall, timeliness is an area we work to monitor closely and will continue to do so. This case was delayed in part due to COVID-19 health and safety protocols. However, going forward, DSH will implement the monitoring of dates of when a monitored case transitions from a criminal to an administrative one to serve as a check and balance to ensure our overall timeliness compliance. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00810-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Applicable |
| **Penalty** | **Initial:** Other<br>**Final:** Other |
| **Incident Summary** | A nurse allegedly engaged in an overly familiar relationship with a patient. |
| **Disposition** | The nurse remained on extended leave, and the investigation was closed, pending the nurse's unlikely return to work. Therefore, the hiring authority suspended his determinations on the pending allegations. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00813-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly harassed and searched a patient without probable cause. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00819-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly pushed a wheelchair bound patient into another wheelchair. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary** | 1. Was the pre-disciplinary/investigative phase |

| | |
|---|---|
| **Assessment** | conducted with due diligence? • No<br>The administrative investigation was not completed until June 24, 2022, 238 days after the administrative investigation was opened. |
| **Department Corrective Action Plan** | The current SSI will ensure cases are assigned promptly and will work with the support team to ensure cases are assigned in a timely manner. The SSIs will work with the support team to ensure all dates are reflected on the criminal and administrative assignment sheets and are properly documented with the tracking sheet so investigations and reports are completed timely. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00935-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Death |
| **Allegations** | 1. Other |
| **Findings** | 1. Unfounded |
| **Penalty** | **Initial:** Other<br>**Final:** Other |
| **Incident Summary** | A patient died while at an outside hospital. The cause of death was bronchopneumonia and other chronic medical conditions. |
| **Disposition** | The department determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00984-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician 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** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The administrative investigation was opened on November 9, 2021; however, the administrative investigation was not completed until July 20, 2022, 253 days later. |
| **Department Corrective Action Plan** | DSH recognizes the delay in completing the report. A factor to note, is multiple OSI investigators left for the academy training requiring a reassignment of cases and workload. To prevent this issue from occurring again, the SSIs will track case progress and meet with investigators regularly monitor OLES deadlines closely. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00998-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Broken Bone (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly fractured a patient's foot. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the investigative process. |
| **Pre-Disciplinary Assessment** | 1. Did OPS cooperate with and provide continued real-time consultation with OLES? • No<br>The investigator failed to inform OLES of the victim interview.<br>2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 358 days after the incident was discovered. |
| **Department Corrective Action Plan** | Moving forward the Supervising Special Investigator (SSI) will ensure an investigator is not assigned a case prior to receiving appropriate training or attending the police academy. The SSI will ensure an investigator is assigned a manageable case load and demonstrate they are familiar with OLES monitor procedures prior to being assigned an OLES monitored case. The SSI will review each investigators case load monthly. The SSI will also ensure completed and submitted investigations are signed off in a timely manner and will not remain in the signed-off queue for an extended period. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01018-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty<br>4. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained<br>3. Sustained<br>4. Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A senior psychiatric technician allegedly provided illicit narcotics to a patient for further distribution to other patients. The senior psychiatric technician and a psychiatric technician, also allegedly engaged in sexual activity with the patient. |
| **Disposition** | The hiring authority sustained allegations against the senior psychiatric technician; however, no disciplinary action could be taken because the senior psychiatric technician had resigned before completion of the investigation. A letter indicating the senior psychiatric technician resigned under adverse circumstances was placed in the senior psychiatric technician's official personnel file. The OLES concurred. No allegations were sustained against the psychiatric technician. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>Overall, the department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01029-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A unit supervisor and three psychiatric technicians allegedly choked and scratched a patient while placing the patient in restraints. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01030-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - AWOL |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | Two psychiatric technicians allegedly did not properly monitor a patient who was subsequently located at a traffic intersection on hospital grounds. |
| **Disposition** | The hiring authority sustained the allegation and determined a letter of instruction was the appropriate penalty. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01031-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Criminal Act<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician was allegedly overly familiar with a patient, brought the patient drugs and refused to set appropriate boundaries with the patient. The psychiatric technician allegedly violated her supervisor's directive to stay away from the unit on two different occasions. The psychiatric technician was allegedly uncooperative with investigators in scheduling her interview and was intentionally misleading during her investigative interview. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations of introduction of drugs. However, the hiring authority determined there was sufficient evidence to sustain the allegations of overfamiliarity, violation of her supervisor's directive, failure to cooperate during the course of the investigation and being intentionally misleading during her investigative interview. The hiring authority determined dismissal was the appropriate penalty The OLES concurred with the hiring authority's determinations. However, the psychiatric technician resigned before disciplinary action could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES? • No<br>The hiring authority did not notify OLES of the incident. |

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| | 2. Did the department adequately respond to the incident? • No<br>The responding officer did not provide the suspect psychiatric technician the legally required Beheler admonition before asking her questions in the initial interview.<br>3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 292 after the incident was discovered. |
| **Department Corrective Action Plan** | The importance of making timely notifications to OLES has been communicated to HPD supervision/management from hospital command staff and the Office of Protective Services to meet OLES reporting guidelines. The officer that competed the preliminary report was briefed by the HPD Administrative Lieutenant to follow guidelines on proper Beheler admonishments. OSI investigators have been made aware of the 120-timeline set by OLES and will adhere by it. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01052-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly did not assist a patient who had fallen from a bed. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the investigative process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 415 days |

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| | after the incident was discovered. |
| **Department Corrective Action Plan** | DSH hired multiple investigators who had not attended the police academy or attended an OSI training program. Some investigators were assigned cases prior to being trained on OSI specifics to include OLES monitor procedures or starting the police academy. As a result, there were delays in the completion of this case, including the case being re-assigned multiple times. Moving forward the Supervising Special Investigator (SSI) will ensure an investigator is not assigned a case prior to receiving appropriate training or attending the police academy. The SSI will review each investigators case load monthly. The SSI will also ensure a completed and submitted investigation is signed off in a timely manner and does not remain in the signed off queue for an extended period. The SSI will not re- assign cases to different investigators without legitimate reason. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01094-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | An unidentified staff member allegedly hit a patient on the back of the head. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the investigative process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 282 days after the incident was discovered. |

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| **Department Corrective Action Plan** | DSH was in the process of hiring and training investigators that led to the delay in the completion of the report within the 120-day timeframe. Moving forward the Supervising Special Investigator (SSI) will ensure an investigator is not assigned a case prior to receiving appropriate training or to attending the police academy. The SSI will ensure an investigator is familiar with OLES monitor procedures prior to being assigned an OLES monitored case. The SSI will review each investigators case load monthly. The SSI will also ensure a completed and submitted investigation is signed off in a timely manner and does not remain in the signed off queue for an extended period. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01156-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Neglect<br>3. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Three psychiatric technicians allegedly forcefully moved 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** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The administrative investigation was opened on May 10, 2022; however, the investigation was not completed until November 2, 2022, 176 days later. |
| **Department Corrective Action** | Moving forward, the Supervising Special Investigator (SSI) will ensure an Investigator is not assigned a case prior to |

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| **Plan** | the start of the police academy. The SSI will also ensure any case an Investigator is assigned will be completed in a timely manner by monitoring each investigator's case status once a month at a minimum. The SSI will also ensure the criminal report is signed off within a reasonable time frame to ensure the administrative investigation is started within the prescribed time frame. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01160-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly met with a patient in a stairwell to deliver contraband items. The psychiatric technician also allegedly spends inordinate amounts of time with some patients. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01230-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Genital Injury (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A staff member observed a small abrasion on a patient's buttocks while assisting the patient take a shower. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01249-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A senior psychiatric technician allegedly brushed his body against a patient as they passed each other. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01292-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly hit a patient several times on the head. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01308-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty<br>4. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained<br>3. Not Sustained<br>4. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Four psychiatric technicians allegedly committed religiously motivated hate crimes when they confiscated or damaged a patient's property. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |

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| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
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| **OLES Case Number** | 2021-01363-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A registered nurse was allegedly overly familiar with a patient. |
| **Disposition** | The hiring authority determined there was sufficient evidence to sustain the allegations; however, the registered nurse resigned prior to the conclusion of the investigation; therefore, disciplinary action was not taken. A letter indicating the registered nurse resigned under unfavorable circumstances was placed in his official personnel file. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01370-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly hit a patient on the head. |

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| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01377-3A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Use of Force Review |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An officer allegedly used excessive force on a patient who was in full restraints. |
| **Disposition** | The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01424-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly grabbed a patient by the neck and attempted to choke the patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of |

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| | Protective Services did not open an administrative investigation due to lack of evidence. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01433-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A registered nurse allegedly failed to assist a wheelchair-bound patient in using the restroom and the patient subsequently fell. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The administrative investigation was opened on April 6, 2022; however, the investigation was not completed until November 2, 2022, 210 days later. |
| **Department Corrective Action Plan** | To prevent this issue occurring again independent of staff vacancies, the current SSI along with another newly hired additional SSI, have implemented a procedure to screen all new cases and assign cases as they are received. The new SSIs will work diligently to prevent a large volume of back logged cases that needed to be sorted and will implement<br>new procedure to ensure the SSI remains accountable when new cases are sent to OSI. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01444-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Drugs |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly sold narcotics to a patient, then threatened to harm the patient when the patient failed to pay the full price for the narcotics. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01460-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Referred |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient into a room and onto a bed. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No |

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| | The administrative investigation was opened on February 17, 2022; however, the investigation was not completed until October 10, 2022, 235 days later. |
| **Department Corrective Action Plan** | The SSI will explore the option to reassign if possible, or have interview conducted by a different investigator. Once interview is completed, SSI will have the original investigator complete case. Additionally, a telework procedure has been put into place to help mitigate these issues in the future. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01464-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault<br>2. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty<br>4. Inexcusable neglect of duty<br>5. Inexcusable neglect of duty<br>6. Inexcusable neglect of duty |
| **Findings** | 1. Sustained<br>2. Sustained<br>3. Not Sustained<br>4. Not Sustained<br>5. Not Sustained<br>6. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Two psychiatric technicians allegedly engaged in sexual activity with patients. A third psychiatric technician allegedly failed to take action after a patient exposed himself. |
| **Disposition** | The hiring authority sustained allegations against the first psychiatric technician; however, no disciplinary action could be taken because that psychiatric technician resigned before completion of the investigation. A letter indicating the first psychiatric technician resigned under adverse circumstances was placed in that psychiatric technician's official personnel file. The OLES concurred. |

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| | No allegations were sustained against the other psychiatric technicians. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01522-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Genital Injury (Unknown Origin)<br>2. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained<br>3. Sustained |
| **Penalty** | **Initial:** Counseling<br>**Final:** Counseling |
| **Incident Summary** | A nurse allegedly failed to medically assess a patient with a genital injury, and a psychiatric technician allegedly failed to document his conversation with the nurse regarding the patient's need for an assessment. |
| **Disposition** | The hiring authority sustained the allegation against the psychiatric technician and determined that a letter of expectation and corrective action was appropriate. The hiring authority determined there was insufficient evidence to sustain the allegations against the nurse. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01529-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |

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| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | Four officers allegedly conducted an inappropriate sexual assault investigatory interview. |
| **Disposition** | The hiring authority sustained the allegations and issued a letter of instruction to one officer and letters of expectation to the other three officers. Training was provided to all four officers. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00006-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Medical staff allegedly did not remove a patient's sutures in a timely manner; the sutures were not removed for 163 days. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00024-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Dishonesty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained<br>3. Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | The department received a report that a licensed vocational nurse had allegedly brought unauthorized hygiene items for patients. It was also alleged the licensed vocational nurse was dishonest to his supervisor and had engaged in unprofessional conduct. |
| **Disposition** | The hiring authority did not sustain the allegations of overfamiliarity and dishonesty; however, did sustain an allegation of unprofessional conduct and served the licensed vocational nurse with a letter of warning. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. The responding officer conducted an interview with the licensed vocational nurse without first providing the legally required Beheler admonition. The interviews conducted by the officer were cursory and did not address issues relevant to the investigation concerning the introduction of contraband, and as a result, initial reports were incomplete. |
| **Pre-Disciplinary Assessment** | 1. Did the department adequately respond to the incident? • No<br>The initial responding officer conducted cursory interviews and did not ask the licensed vocational nurse detailed relevant questions concerning introduction of contraband. The officer did not provide the legally required Beheler admonition during the first interview of |

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| | the licensed vocational nurse. The officer did not record the first interview of the licensed vocational nurse.<br><br>2. Was the incident properly documented? • No<br>The initial report contained cursory summaries of the witness interviews. Because those interviews were not recorded, there was no way of knowing whether the summaries captured all of the information that was addressed in the interviews. |
| **Department Corrective Action Plan** | The officer was counseled on the importance of staff Beheler admonition. He has since been advised, when speaking to a subject that has been named as a suspect, a Beheler admonition needs to be given. The officer has since been advised; he needs to record all pertinent interviews when conducting an investigation. The supervisor will continue to monitor the officer, ensuring future adherence. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00053-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act<br>2. Criminal Act |
| **Findings** | 1. Not Referred<br>2. Not Referred |
| **Incident Summary** | A unit supervisor allegedly pushed a patient who had been in a physical altercation, causing the patient to fall backwards into a wall. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00063-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An officer allegedly failed to properly secure and safeguard state police equipment, which was stolen from his personal vehicle. |
| **Disposition** | The hiring authority sustained the allegation and provided the officer with a letter of expectation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00066-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An officer allegedly was absent from their assigned post without approval. |
| **Disposition** | The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00067-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00084-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained<br>3. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A senior psychiatric technician allegedly hit a patient on the back of the head. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures |

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| | governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00086-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act<br>2. Criminal Act<br>3. Criminal Act |
| **Findings** | 1. Not Referred<br>2. Not Referred<br>3. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly would not allow a patient to exit a restroom, then pushed and kicked the patient's assistive walking device into the patient's shin, causing scratches to the patient's leg. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00087-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Death |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Training<br>**Final:** Training |
| **Incident Summary** | A contract nurse allegedly failed to maintain constant observation of a patient and failed to notice that the patient had stopped breathing. The patient was on a ventilator for COVID-19 and pneumonia. A doctor arrived on the unit and pronounced the patient dead. |
| **Disposition** | The hiring authority sustained the allegation against the contract nurse and determined that additional training was appropriate. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00089-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly touched, scratched, and bruised a sleeping patient |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |

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| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00095-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A senior psychiatric technician allegedly pushed a patient into a wall. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00103-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Drugs<br>2. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Criminal Act<br>2. Criminal Act<br>3. Criminal Act<br>4. Criminal Act |
| **Findings** | 1. Not Referred<br>2. Not Referred<br>3. Not Referred<br>4. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly provided contraband food, mobile phones and narcotics to a patient. |
| **Disposition** | The case was not referred to the district attorney's office |

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| | due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00105-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Dishonesty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An officer allegedly included a false statement in a report and was dishonest to his supervisor when questioned regarding the report. |
| **Disposition** | The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00125-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Training<br>**Final:** Training |
| **Incident Summary** | Two officers allegedly failed to document an attempted bribery allegation of a patient by a staff employee. |

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| **Disposition** | The hiring authority sustained the allegation against one of the officers but found insufficient evidence to sustain the allegation against the second officer. Training was provided to the first officer. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00133-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Drugs |
| **Allegations** | 1. Other |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician was allegedly going to introduce narcotics into a facility. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00145-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | An officer allegedly used a personal electronic device while on-duty and was dishonest to a law enforcement supervisor. |

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| **Disposition** | The hiring authority sustained the allegation that the officer was distracted with the personal electronic device but found insufficient evidence to sustain dishonesty. The hiring authority issued the officer a letter of instruction. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00150-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Discourteous treatment |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An officer was allegedly discourteous to a staff member. |
| **Disposition** | The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00168-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Criminal Act<br>2. Criminal Act<br>3. Criminal Act |
| **Findings** | 1. Not Referred<br>2. Not Referred<br>3. Referred |
| **Incident Summary** | A licensed vocational nurse allegedly did not immediately report that she had been assaulted by a |

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| | patient. The licensed vocational nurse also allegedly inappropriately grabbed the patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00208-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly chased and grabbed 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00214-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity<br>2. Significant Interest - Over-Familiarity<br>3. Significant Interest - Over-Familiarity<br>4. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |

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| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly engaged in ongoing overly familiar relationships with four patients. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00232-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly choked, forced a patient to the ground, then repeatedly hit the patient. On another occasion the psychiatric technician allegedly repeatedly hit the patient on the throat. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00232-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |

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|---|---|
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly choked and forced a patient to the ground, then repeatedly hit the patient. On another occasion, the psychiatric technician allegedly repeatedly hit the patient on the 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00239-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Discourteous treatment |
| **Findings** | 1. Unfounded |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An officer allegedly demonstrated unprofessional conduct towards another officer. |
| **Disposition** | The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00241-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Use of Force Review |
| **Allegations** | 1. Inexcusable neglect of duty |

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| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Staff members allegedly assaulted a patient who was refusing court-ordered medication. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00244-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient alleged that an unidentified staff member had inappropriately touched him over his clothing. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00276-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty |

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| **Findings** | 1. Not Sustained<br>2. Sustained<br>3. Not Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient, causing the patient to fall to the ground, did not follow fall protocol, and did not document the incident. A second psychiatric technician allegedly failed to properly document the incident. |
| **Disposition** | The hiring authority determined there was sufficient evidence to sustain the allegation against the first psychiatric technician but did not sustain the allegations of failure to follow fall protocol and failure to document. The hiring authority determined a letter of warning was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegation against the second psychiatric technician. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policy and procedure governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00277-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An unidentified staff member allegedly kicked a patient on the knee. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and |

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| | procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00294-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly left a patient in urine-soaked clothing for an extended period of time. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services did not notify the OLES of the incident. |
| **Pre-Disciplinary Assessment** | 1. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES? • No<br>The Office of Protective Services did not report the incident to the OLES. |
| **Department Corrective Action Plan** | All Supervisors and OLES Liaisons were provided training by OLES staff in August 2022 on the OLES reporting guidelines to prevent future reporting failures. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00301-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Broken Bone (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient complained of pain and was transported to an outside hospital where she was diagnosed with a fractured knee. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the investigative process. The fracture was discovered on March 18, 2022; however, the investigation was not completed until September 13, 2022,179 days later. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The department did not comply with policies and procedures governing the investigative process. The fracture was discovered on March 18, 2022; however, the investigation was not completed until September 13, 2022,179 days later. |
| **Department Corrective Action Plan** | To prevent this issue from occurring again, the current SSIs will screen all OLES monitored cases, work with AIM's by requesting cases to be rejected and closed by OLES and assign cases promptly. The SSIs will monitor OLES deadlines and work with investigators to ensure deadlines are being met. The new SSIs will work diligently to prevent a large volume of cases that need to be sorted and will implement new procedure to ensure the SSI remains accountable when new cases are sent to the Office of Special Investigations. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00307-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Discourteous treatment<br>2. Discourteous treatment |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Two officers allegedly allegedly created a hostile work environment by having inappropriate conversations about sexual activities in the dispatch office. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The investigation did not comply with policies and procedures governing the pre-disciplinary process because the investigation was not completed until 201 days after discovery of the incident. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 201 days after discovery of the incident. |
| **Department Corrective Action Plan** | The Chief of Police provided the assigned Lieutenant with the OPS 607 Policy (Office of Law Enforcement Support) which entails the reporting guidelines, investigative threshold incidents, and investigative process guidelines. The Chief of Police further spoke to the Command Staff at the weekly Command Staff meeting emphasizing the need to complete a Request for Extension Form prior to the OLES due date. The Chief of Police further implemented a system to track Administrative Investigations which includes sending reminders to specified personnel when deadlines are approaching. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00312-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Two psychiatric technicians were allegedly negligent while monitoring a patient who was on an enhanced level of observation. The patient swallowed a pencil. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00322-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Drugs |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A staff member allegedly gave a patient narcotics. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services did not open an administrative investigation. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00331-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient who had entered the nurses' station without permission. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00342-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly forcefully grabbed a patient by the arm. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00344-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly used excessive force on a patient during a wall containment procedure. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 174 days from the date of discovery. The Office of Protective Services took 97 days to complete and approve the initial report. |
| **Department Corrective Action Plan** | HPD supervision/management was briefed on the importance of making timely notifications to OLES. A new tracking mechanism was implemented at HPD to help track OLES monitored cases to ensure there are completed and forwarded to OSI in a timely manner. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00346-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty |

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| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly sexually assaulted a patient who was in full body restraints and on an enhanced level of observation. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00350-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient, causing the patient to fall and hit his head. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00350-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient, causing the patient to fall and hit his head. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The administrative investigation was opened on July 21, 2022; however, the investigation was not completed until November 28, 2022, 130 days later. |
| **Department Corrective Action Plan** | The supervising investigator has been tasked with creating a procedure to train new investigators, with regards to handling OLES monitored cases. OLES cases will be assigned to new investigators after they demonstrate a sufficient understanding of the OSI investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00352-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |

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|---|---|
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Two psychiatric technicians, a registered nurse and a psychiatric technician assistant allegedly dragged a patient on the floor by the hair and one of the staff stepped on the patient's face. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00358-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | An unidentified 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures regarding the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00382-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |

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| **Incident Summary** | A senior psychiatric technician allegedly inappropriately touched a patient over the patient's clothing. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00387-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Sustained |
| **Penalty** | **Initial:** Counseling<br>**Final:** Counseling |
| **Incident Summary** | A senior psychiatric technician allegedly hit a patient's foot to wake the patient, and a nurse failed to report the senior psychiatric technician's alleged behavior. |
| **Disposition** | The hiring authority sustained the allegation against the nurse and determined that a letter of expectation and training was appropriate. The hiring authority determined there was insufficient evidence to sustain the allegations against the psychiatric technician. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00392-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly slapped a patient on the leg. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00395-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct<br>2. Misconduct |
| **Allegations** | 1. Discourteous treatment<br>2. Discourteous treatment |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | An officer allegedly made sexist and disparaging comments to a subordinate officer. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations against the officer. However, the hiring authority determined a letter of expectation and additional training for the officer was appropriate. OLES concurred with the hiring authority's determinations. |
| **Investigative** | **Case Rating:** Insufficient |

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| **Assessment** | The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 142 days from the date of discovery and the initial draft report was not provided to the OLES monitor for review before it was forwarded to the hiring authority. |
| **Pre-Disciplinary Assessment** | 1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No<br>The department did not notify OLES that the initial draft investigative report was ready for review before it was forwarded to the hiring authority.<br>2. Did OPS cooperate with and provide continued real-time consultation with OLES? • No<br>The department did not provide the initial draft report to the OLES monitor before it was forwarded to the hiring authority for review.<br>3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 142 days after discovery of the incident. |
| **Department Corrective Action Plan** | The Chief of Police spoke with the Lieutenants at the weekly Command Staff meeting emphasizing the requirement to submit the monitored Administrative Investigations to the OLES AIMS prior to forwarding them to the Hiring Authority. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00402-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly choked a patient with a shirt. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative |

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| | investigation due to lack of evidence. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00405-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Discourteous treatment |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** Training<br>**Final:** Training |
| **Incident Summary** | An officer allegedly lunged at a patient in an attempt to frighten the patient. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation, however, ordered that the officer receive additional training. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00414-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Other |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A nurse allegedly documented a patient's unwitnessed fall. The following day, the nurse allegedly completed a second document regarding the patient's fall, and removed the original document from the patient's file. |
| **Disposition** | The hiring authority determined there was insufficient |

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| | evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The investigation did not comply with policies and procedures governing the pre-disciplinary process because the investigation was not completed until 192 days after discovery of the incident. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 192 days after discovery of the incident. |
| **Department Corrective Action Plan** | To correct this deficiency, the Supervising Special Investigator elected to informally counsel the assigned Investigator. Case tracking, communicating with assigned AIM's, and OLES investigative process guidelines were discussed in the one-on-one meeting. In addition, during the OSI unit's next monthly meeting, the Supervising Special Investigator conducted a brief training on those topics with all OSI Investigators. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00431-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A registered nurse allegedly gave a patient a vaccine injection and failed to properly document it. As a result, a second registered nurse gave the patient a second injection that was not prescribed. A psychiatric technician allegedly failed to properly document the first injection in a monthly report. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations against either of the two registered nurses as well as the psychiatric technician. The OLES concurred with the hiring authority's determination. |

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| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. |
| **Pre-Disciplinary Assessment** | 1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No<br>The investigation was not completed until 141 days after the incident was discovered. The initial investigation conducted by the hospital police department was not completed for 73 days. |
| **Department Corrective Action Plan** | HPD supervision/management was briefed on the importance of making sure OLES monitored reports are completed, approved, and forwarded to OSI in a timely manner. A new tracking mechanism was implemented at HPD to help track OLES monitored cases to ensure they are completed and forwarded to OSI in a timely manner. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00435-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** Letter of Instruction<br>**Final:** Letter of Instruction |
| **Incident Summary** | A registered nurse allegedly failed to ensure a patient complaining of throat pain received medical attention. A second registered nurse allegedly failed to treat the same patient. |
| **Disposition** | The hiring authority determined there was sufficient evidence to sustain the allegation against the first registered nurse but not sufficient evidence to sustain the allegation against the second registered nurse. The hiring authority served the first registered with a letter of counseling. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00436-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | Staff members allegedly allowed officers access into a housing unit in order to sexually assault a patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00437-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A staff member allegedly made several efforts to hold property for a patient temporarily transferring from a hospital facility. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00444-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Two psychiatric technicians allegedly grabbed a patient out of the medication line and forced him to the ground. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations against both of the psychiatric technicians. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00450-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act<br>2. Criminal Act |
| **Findings** | 1. Not Referred<br>2. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient's outstretched arms. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00450-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient's outstretched arms. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00454-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault<br>2. Significant Interest - Drugs |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A staff member allegedly drugged and sexually assaulted a patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the investigative process. |
| **Pre-Disciplinary** | 1. Was the pre-disciplinary/investigative phase |

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| **Assessment** | conducted with due diligence? • No<br>The investigation was not completed until 282 days after the incident was discovered. |
| **Department Corrective Action Plan** | AGPA and OT have been hired and have worked diligently through the backlogged cases. The SSI along with the AGPA are creating a procedure to handle cases in support staff absence, coupled with keeping a copy of the master case log. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00471-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly choked a patient with a spit mask. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00484-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Broken Bone (Known Origin)<br>2. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician assistant allegedly did not properly supervise a wheelchair bound patient who rolled down a ramp, crashed, and suffered a broken hand. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation and the OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00493-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly hit a patient while assisting the patient in the shower. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00514-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | An allegation was made that a registered nurse was in an inappropriate relationship with a former patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which will be monitored by the OLES. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00527-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Two psychiatric technicians allegedly left a patient unattended when the patient was under enhanced monitoring for being a danger to self. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00528-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A staff member allegedly left a patient unattended when the patient was under enhanced monitoring for being a danger to self. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00605-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Broken Bone (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient had a seizure and fell and was later diagnosed with a fractured foot. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00611-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician and a psychiatric technician assistant allegedly brought contraband hair products and body spray to a patient. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations against both psychiatric technicians. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The hiring authority did not comply with policies and procedures governing the pre-disciplinary process. |
| **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<br>The hiring authority did not consult with OLES regarding the sufficiency of the investigation and investigative findings. |
| **Department Corrective Action Plan** | To ensure future compliance, OSI will maintain a spreadsheet indicating which cases are monitored or not monitored. The spreadsheet will be accessible to both OSI and Human Resources (HR). Additionally, HR will inquire with OSI if and when an investigatory report is submitted for review at IRC that indicates the case is not monitored, but mentions an OLES monitor within the body of the report. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00613-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |

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|---|---|
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatrist allegedly inappropriately touched a patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00616-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Broken Bone (Unknown Origin)<br>3. Genital Injury (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient, causing the patient to strike a toilet, resulting in the patient suffering a fractured tailbone. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00621-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A senior psychiatric technician allegedly repeatedly hit a patient in the face. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00625-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00631-1C |
| **Case Type** | Monitored |

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|---|---|
| **Incident Types** | 1. Broken Bone (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient was diagnosed with a fractured nasal bone. The patient reported he tripped and fell, striking his nose, while receiving treatment at an outside hospital. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00650-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Death |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient lost consciousness and responding staff provided emergency life-saving measures. The patient was transported to an outside hospital where he was pronounced dead. An autopsy determined the cause of death was pulmonary embolism caused by deep leg thrombosis. |
| **Disposition** | The coroner concluded the patient died of natural causes; therefore, the case was not referred to the district attorney's office. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing death investigations. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00665-1A |

| | |
|---|---|
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A custodian allegedly provided contraband coffee to a patient. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's recommendation. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00693-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Use of Force Review |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly attempted to hit a patient who lunged at him. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00694-1A |
| **Case Type** | Monitored |

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|---|---|
| **Incident Types** | 1. Abuse<br>2. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A former patient alleged she had been sexually assaulted and abused while she was housed at a state 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00698-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician administered medication to a patient in violation of a supervisor's order. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00718-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |

| | |
|---|---|
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly flicked the brim of a patient's hat. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation which the OLES did not accept for monitoring because the incident did not meet the OLES's monitoring criteria. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00723-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Counseling<br>**Final:** Counseling |
| **Incident Summary** | A psychiatric technician allegedly grabbed and forcefully pushed a patient into his room. |
| **Disposition** | The hiring authority sustained the allegation and ordered corrective action. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00725-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |

| | |
|---|---|
| **Findings** | 1. Not Referred |
| **Incident Summary** | A registered nurse allegedly assaulted a patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00727-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Other |
| **Allegations** | 1. Discourteous treatment<br>2. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A manager allegedly sexually harassed a colleague and engaged in sexual activity while on-duty. The manager also allegedly discriminated against another colleague based on age. |
| **Disposition** | The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00778-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |

| | |
|---|---|
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A senior psychiatric technician 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00790-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Broken Bone (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient suffered a nasal bone fracture due to self-injurious behavior. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00799-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly pushed a patient. |

| | |
|---|---|
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00817-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Broken Bone (Unknown Origin) |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A senior psychiatric technician allegedly kneed a patient in the head, causing a laceration above the patient's eye. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00841-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly swatted a patient's hand. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00846-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient alleged that he had been sexually assaulted by a staff member. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00868-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | Several staff members allegedly assaulted a patient. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00890-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A registered nurse allegedly slapped a patient's hand. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00944-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly forcefully removed a patient's clothing and forcefully placed the patient in a shower. |
| **Disposition** | The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00984-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained |
| **Penalty** | **Initial:** No Penalty Imposed<br>**Final:** No Penalty Imposed |
| **Incident Summary** | A psychiatric technician allegedly scratched a patient's arm while escorting 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00989-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A staff member allegedly hit a patient on the leg. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-01028-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Drugs<br>2. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Criminal Act<br>2. Criminal Act |
| **Findings** | 1. Not Referred<br>2. Not Referred |
| **Incident Summary** | A psychiatric technician allegedly spent inappropriate time alone with a patient on several occasions and provided the patient with mobile phones and narcotics for distribution to other patients. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-01045-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A staff member allegedly pressed his forearm on the back of a patient's neck and threatened to put the patient "to sleep." |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-01054-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A staff member allegedly kicked a patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. 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** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-01136-3C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Misconduct<br>3. Use of Force Review |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | Several staff members allegedly assaulted a patient while attempting to restrain the patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-01182-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | Staff members allegedly choked a patient while restraining the patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the investigative process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-01229-1C |
| **Case Type** | Monitored |
| **Incident Types** | 1. Neglect<br>2. Priority 1: Sexual Assault |
| **Allegations** | 1. Criminal Act |
| **Findings** | 1. Not Referred |
| **Incident Summary** | A patient and a staff member allegedly sexually assaulted a patient. |
| **Disposition** | The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the investigative process. |

# Appendix C: 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. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period. Each phase was rated separately.

Investigations and other activities conducted by the departments during the pre-disciplinary phase are rated for sufficiency based on consultations with OLES and investigation activities for timeliness, quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

The disciplinary phase is rated for sufficiency based on timely consultation with OLES during the disciplinary process, and whether the entire disciplinary process was conducted in a timely fashion, 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.

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2020-00346-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Priority 1: Sexual Assault |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Discourteous treatment<br>3. Other failure of good behavior |
| **Findings** | 1. Sustained<br>2. Sustained<br>3. Sustained |
| **Penalty** | **Initial:** Dismissal<br>**Final:** Dismissal |
| **Incident Summary** | A level of care staff member allegedly engaged in overly familiar relationships with patients. |
| **Disposition** | The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. |

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| | The employee did not file an appeal with the State Personnel Board. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2020-00897-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Death |
| **Allegations** | 1. Inefficiency |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Salary Reduction |
| **Incident Summary** | A patient was found unresponsive in bed and was pronounced deceased. A senior psychiatric technician, psychiatric technician and a registered nurse allegedly failed to conduct thorough and proper periodic safety checks of the patient and likewise failed to appropriately document those checks as required by policy. |
| **Disposition** | The hiring authority determined there was sufficient evidence to sustain the allegations against the senior psychiatric technician, psychiatric technician and the registered nurse. The hiring authority imposed a five percent salary reduction for six months on the senior psychiatric technician. The hiring authority determined a letter of instruction was the appropriate action for the psychiatric technician; however, the psychiatric technician retired before corrective action could be taken. The hiring authority served the registered nurse with a letter of instruction. The OLES concurred with the hiring authority's determinations. The senior psychiatric technician did not file an appeal with the State Personnel Board. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and |

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| | procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Insufficient<br>The department did not sufficiently comply with policies and procedures governing the disciplinary process. |
| **Disciplinary Assessment Questions** | 1. Was the disciplinary phase conducted with due diligence by the department? • No<br>The notice of adverse action was not served on the senior psychiatric technician until 351 days after the hiring authority made disciplinary findings. |
| **Department Corrective Action Plan** | The Human Resources, Labor Relations Department has hired a Staff Services Analyst for a primary focus on OLES monitored cases to ensure timeliness is met. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2020-01218-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Dismissal<br>**Final:** Resigned In Lieu of Dismissal |
| **Incident Summary** | A senior psychiatric technician allegedly hit a patient on the back. |
| **Disposition** | The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The senior psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the senior psychiatric technician wherein the senior psychiatric technician resigned in lieu of dismissal, and the department agreed to issue two months of backpay. The senior psychiatric technician agreed to withdraw her appeal. The OLES concurred because the settlement was reasonable. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |

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|---|---|
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00361-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty<br>4. Inexcusable neglect of duty |
| **Findings** | 1. Not Sustained<br>2. Sustained<br>3. Sustained<br>4. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Modified Salary Reduction |
| **Incident Summary** | A psychiatric technician allegedly attempted to escort a patient who was in a wheelchair into the patient's room even though the patient did not want to go inside. The psychiatric technician allegedly closed the door on the patient's hand, causing a laceration. The psychiatric technician also allegedly was not equipped with his personal alarm device, and violated computer and electronic messaging policies. |
| **Disposition** | The hiring authority sustained the allegations of improper computer, internet, and email usage, and for violating alarm policies, but did not sustain allegations of physical abuse. The hiring authority determined a 10 percent salary reduction for eight months was the appropriate penalty. The OLES concurred. After the Skelly hearing, the hiring authority entered into a settlement agreement with the psychiatric technician, wherein the penalty was reduced to 5 percent salary reduction for eight months, due to new mitigating information provided by the psychiatric technician. The OLES concurred with the penalty reduction because it still achieved a deterrent effect, and secured finality on the matter. |
| **Investigative** | **Case Rating:** Sufficient |

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| **Assessment** | The department complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the disciplinary process. The disciplinary action was not served in a timely manner. |
| **Disciplinary Assessment Questions** | 1. Was the disciplinary phase conducted with due diligence by the department? • No<br>The hiring authority made findings and penalty determinations on April 4, 2022; however, the disciplinary action was not served until June 22, 2022. |
| **Department Corrective Action Plan** | DSH will continue to ensure OLES monitored cases remain a priority by creating calendar reminders bi-weekly with the due date. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00781-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Other failure of good behavior |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Salary Reduction |
| **Incident Summary** | An officer allegedly made inappropriate postings and messages on a social media website. |
| **Disposition** | The hiring authority sustained the allegation and determined a salary reduction of 5 percent for three months was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer did not file an appeal. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the disciplinary process. The service of the disciplinary action was delayed. |

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| **Disciplinary Assessment Questions** | 1. Was the disciplinary phase conducted with due diligence by the department? • No<br>The findings and penalty conference was conducted on March 7, 2022; however, the disciplinary action was not served until May 16, 2022, 70 days later. |
| **Department Corrective Action Plan** | DSH-C will continue to ensure OLES monitored cases remain a priority by creating calendar reminders bi-weekly with the due date. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00968-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse<br>2. Use of Force Review |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Modified Salary Reduction |
| **Incident Summary** | Two officers allegedly failed to document their use of physical force on a patient. One of the officers allegedly provided misleading information when describing the incident. |
| **Disposition** | The hiring authority sustained the allegations and determined a salary reduction of 5 percent for 12 months was the appropriate penalty for the first officer and 5 percent for six months for the second officer. The first officer filed an appeal with the State Personnel Board. Following a pre-hearing settlement conference, the department entered into a settlement agreement wherein they agreed to reduce the penalty to 5 percent for seven months. The OLES concurred as the penalty remained within the same level on the disciplinary matrix and therefore, was not unreasonable. The second officer did not file an appeal. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures |

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|---|---|
| | governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00992-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity<br>2. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inexcusable neglect of duty<br>3. Inexcusable neglect of duty<br>4. Inexcusable neglect of duty |
| **Findings** | 1. Sustained<br>2. Sustained<br>3. Sustained<br>4. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Salary Reduction |
| **Incident Summary** | A psychiatric technician was allegedly overly familiar with patients. |
| **Disposition** | The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a salary reduction of 10 percent for 12 months. The OLES concurred with the hiring authority's determinations. The psychiatric technician did not file an appeal with the State Personnel Board. |
| **Investigative Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely consult with 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<br>The investigation was approved on March 8, 2022; however, the findings and penalty conference meeting with the hiring authority did not take place until May 11, 2022, 64 days later. |

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| **Disciplinary Assessment** | **Case Rating:** Insufficient<br>The department did not comply with policies and procedures governing the disciplinary process. |
| **Disciplinary Assessment Questions** | 1. Was the disciplinary phase conducted with due diligence by the department? • No<br>The employee was not served with the disciplinary action until 156 days after the findings and penalty conference. |
| **Department Corrective Action Plan** | The Human Resources, Labor Relations Department has hired a Staff Services Analyst for a primary focus on OLES monitored cases to ensure timeliness is met. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01083-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Letter of Reprimand<br>**Final:** Letter of Reprimand |
| **Incident Summary** | An officer allegedly negligently discharged his firearm during weapons training. |
| **Disposition** | The hiring authority sustained the allegation and determined a letter of reprimand was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer did not file an appeal. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01176-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Other |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Inefficiency<br>3. Insubordination<br>4. Absence without leave<br>5. Discourteous treatment<br>6. Willful disobedience<br>7. Other failure of good behavior |
| **Findings** | 1. Sustained<br>2. Sustained<br>3. Sustained<br>4. Sustained<br>5. Sustained<br>6. Sustained<br>7. Sustained |
| **Penalty** | **Initial:** Dismissal<br>**Final:** Dismissal |
| **Incident Summary** | A psychiatric technician made inappropriate racial comments to patients. Also, the psychiatric technician displayed chronic tardiness and rudeness to hospital staff, inappropriately supervised staff, failed to complete required medical testing, and left his work area without notifying staff. |
| **Disposition** | The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board upheld the dismissal of the psychiatric technician. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01376-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Dishonesty |
| **Findings** | 1. Sustained<br>2. Sustained |
| **Penalty** | **Initial:** Dismissal<br>**Final:** Dismissal |
| **Incident Summary** | A psychiatric technician assistant was allegedly overly familiar with a patient. |
| **Disposition** | The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The psychiatric technician assistant did not file an appeal with the State Personnel Board. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01430-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Other |
| **Allegations** | 1. Inexcusable neglect of duty<br>2. Discourteous treatment |
| **Findings** | 1. Sustained<br>2. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Salary Reduction |
| **Incident Summary** | A registered nurse was allegedly uncooperative, disrespectful, and rude to a hospital investigator who was |

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| | interviewing the nurse as a witness in an official investigation. Furthermore, a doctor was allegedly uncooperative with hospital police officers attempting to interview the doctor about an incident involving one of the doctor's patients. |
| **Disposition** | The hiring authority sustained the allegations against the registered nurse for failing to cooperate with an official investigation and discourteous treatment and imposed a salary reduction of 10 percent for three months. The OLES concurred with the hiring authority's determination. The registered nurse retired prior to the effective date of the action. The hiring authority sustained the allegation against the doctor for failing to cooperate with an official investigation and served the doctor with a letter of expectation. The OLES concurred with the hiring authority's determination. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-01437-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Abuse |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Modified Salary Reduction |
| **Incident Summary** | A nurse allegedly slapped a restrained patient. |
| **Disposition** | The hiring authority sustained the allegation and determined a salary reduction of 10 percent for 14 months was the appropriate penalty. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. At the pre-hearing settlement conference, the department entered into a settlement agreement with the psychiatric technician |

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| | wherein the penalty was reduced to a salary reduction of 10 percent for five months in exchange for withdrawing the appeal. The OLES determined the settlement was reasonable because the psychiatric technician expressed remorse for his actions and had no previous adverse actions or misconduct. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Insufficient<br>The department failed to comply with policies and procedures governing the disciplinary process. Although a Skelly hearing was held, the OLES was not notified of the hearing. |
| **Disciplinary Assessment Questions** | 1. Did the hiring authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? • No<br>The department did not notify the OLES of the scheduling of the Skelly hearing, thereby preventing the monitor from attending the hearing. |
| **Department Corrective Action Plan** | OPS will meet with the Human Resource Department and restate the OLES requirements to provide timely updates to the AIM. This will include providing them with a copy of the OLES Investigation Process Guideline Threshold Incidents chart. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00222-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Inexcusable neglect of duty |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Dismissal<br>**Final:** Dismissal |
| **Incident Summary** | A psychiatric technician allegedly engaged in a sexual relationship with a patient within three years after the patient's discharge from a state hospital. |
| **Disposition** | The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The |

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| | OLES concurred. The psychiatric technician did not file an appeal with the State Personnel Board. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00366-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Misconduct |
| **Allegations** | 1. Other failure of good behavior |
| **Findings** | 1. Sustained |
| **Penalty** | **Initial:** Salary Reduction<br>**Final:** Salary Reduction |
| **Incident Summary** | An officer was arrested for allegedly driving while under the influence of alcohol. |
| **Disposition** | The hiring authority sustained the allegation and determined the appropriate penalty was a salary reduction of 5 percent for seven months. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00514-2A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Over-Familiarity |
| **Allegations** | 1. Other |

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|---|---|
| | 2. Dishonesty |
| **Findings** | 1. Sustained<br>2. Sustained |
| **Penalty** | **Initial:** Dismissal<br>**Final:** Dismissal |
| **Incident Summary** | A registered nurse allegedly engaged in an inappropriate relationship with a patient, which continued after the patient was discharged. The registered nurse was dishonest about the relationship during an 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. The registered nurse did not file an appeal with the State Personnel Board. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department sufficiently complied with the policies and procedures governing the disciplinary process. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2022-00831-1A |
| **Case Type** | Monitored |
| **Incident Types** | 1. Significant Interest - Other |
| **Allegations** | 1. Other failure of good behavior<br>2. Dishonesty |
| **Findings** | 1. Sustained<br>2. Sustained |
| **Penalty** | **Initial:** Dismissal<br>**Final:** Resigned In Lieu of Dismissal |
| **Incident Summary** | A dispatcher was arrested and convicted of driving under the influence of alcohol. The dispatcher allegedly was dishonest to outside law enforcement. The dispatcher allegedly failed to report the arrest or conviction. |
| **Disposition** | The hiring authority sustained the allegations and |

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| | rejected the dispatcher on probation. The dispatcher filed an appeal with the State Personnel Board. Prior to State Personnel Board proceedings, the dispatcher agreed to resign in lieu of rejection on probation. |
| **Investigative Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the pre-disciplinary process. |
| **Disciplinary Assessment** | **Case Rating:** Sufficient<br>The department complied with policies and procedures governing the disciplinary process. |

# Appendix D: Monitored Issues

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2020-00734-1MI |
| **Case Type** | Monitored Issue |
| **Incident Types** | 1. Significant Interest - Attack on Staff |
| **Incident Summary** | In April 2021, the OLES issued a monitored issue memorandum to the department after investigating an incident involving allegations of peace officer misconduct that was reported to OLES as an "attack on staff." Based on the investigation, OLES determined officers, supervisors and managers failed to follow department policy regarding use of force and extractions. The involved officers failed to follow department policy, when they forcibly removed a patient from a common area for placement into seclusion and restraints. Furthermore, supervisors and managers failed to conduct the review of the event or force used as required by department policy. |
| **Disposition** | The department completed supervisory training on extractions. In addition, all command level staff and front-line supervisors attended a use of force training facilitated by the Chief of Law Enforcement and subject matter expert on use of force. |

| Case Details | Description |
|---|---|
| **OLES Case Number** | 2021-00957-1MI |
| **Case Type** | Monitored Issue |
| **Incident Types** | 1. Misconduct |
| **Incident Summary** | An officer was allegedly negligent when he did not properly care for a police canine, resulting in the canine's death. The OLES investigated the incident and identified multiple deficiencies in the department's canine program. |
| **Disposition** | In response to the OLES's recommendations for |

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| | improvements, DSH implemented multiple changes to improve processes for the canine program. The changes included a documented process for regular vehicle and home inspections of canine handlers' residences with photographic evidence to support passed inspections, regular canine training records validation, canine supervisors attended a canine supervisor course, updated statewide canine policy and procedure manual, and each facility created a readily available canine program binder. |

# Appendix E: 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.

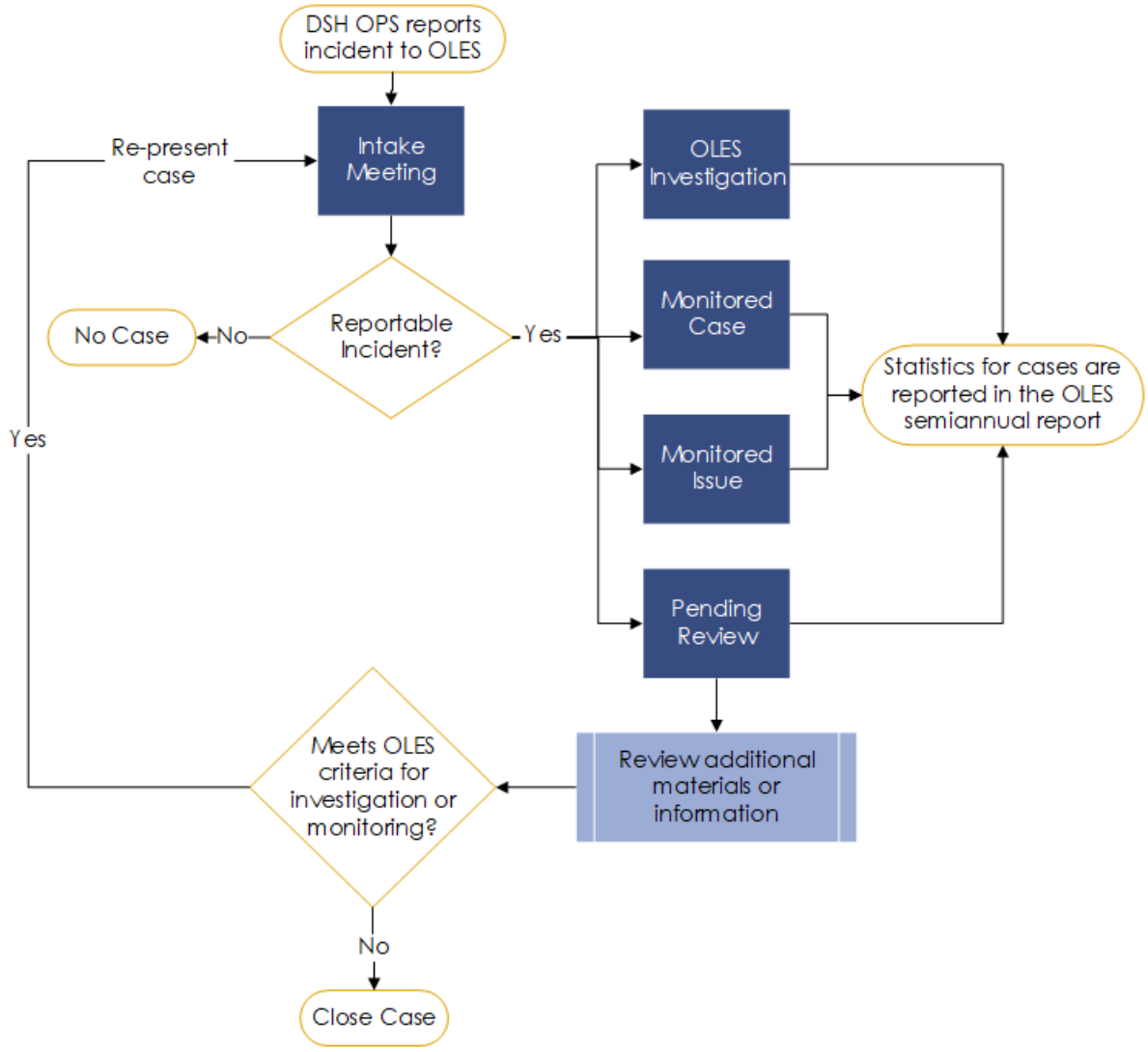
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

## 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 F: 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. No Case
    b. Pending Review
        i. If the disposition is "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.
    c. OLES Investigation Case
    d. Monitored Case
    e. Monitored Issue

# Appendix G: 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
- 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 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

[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.

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 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.

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

*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.