Office of Law Enforcement Support

Semiannual Report

JANUARY 1, 2023 – JUNE 30, 2023

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 fifteenth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health & Human Services Agency. This report details the OLES's oversight and monitoring of the Department of State Hospitals (DSH) from January 1 through June 30, 2023.

In this report, the OLES provides details on 676 reported incidents and the results of completed investigations and monitored cases.

The OLES brings attention to an important topic with DSH, and a new monitored issue related to recordkeeping of institutional and evidentiary firearms consistent with state law and best practices. Any failure to properly inventory and account for institutional firearms has the potential to create avoidable and unnecessary legal and safety issues. DSH collaborated with the OLES to inspect and account for all firearms in their control and implement a centralized and uniform firearms record. The OLES will continue to monitor their continued compliance.

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

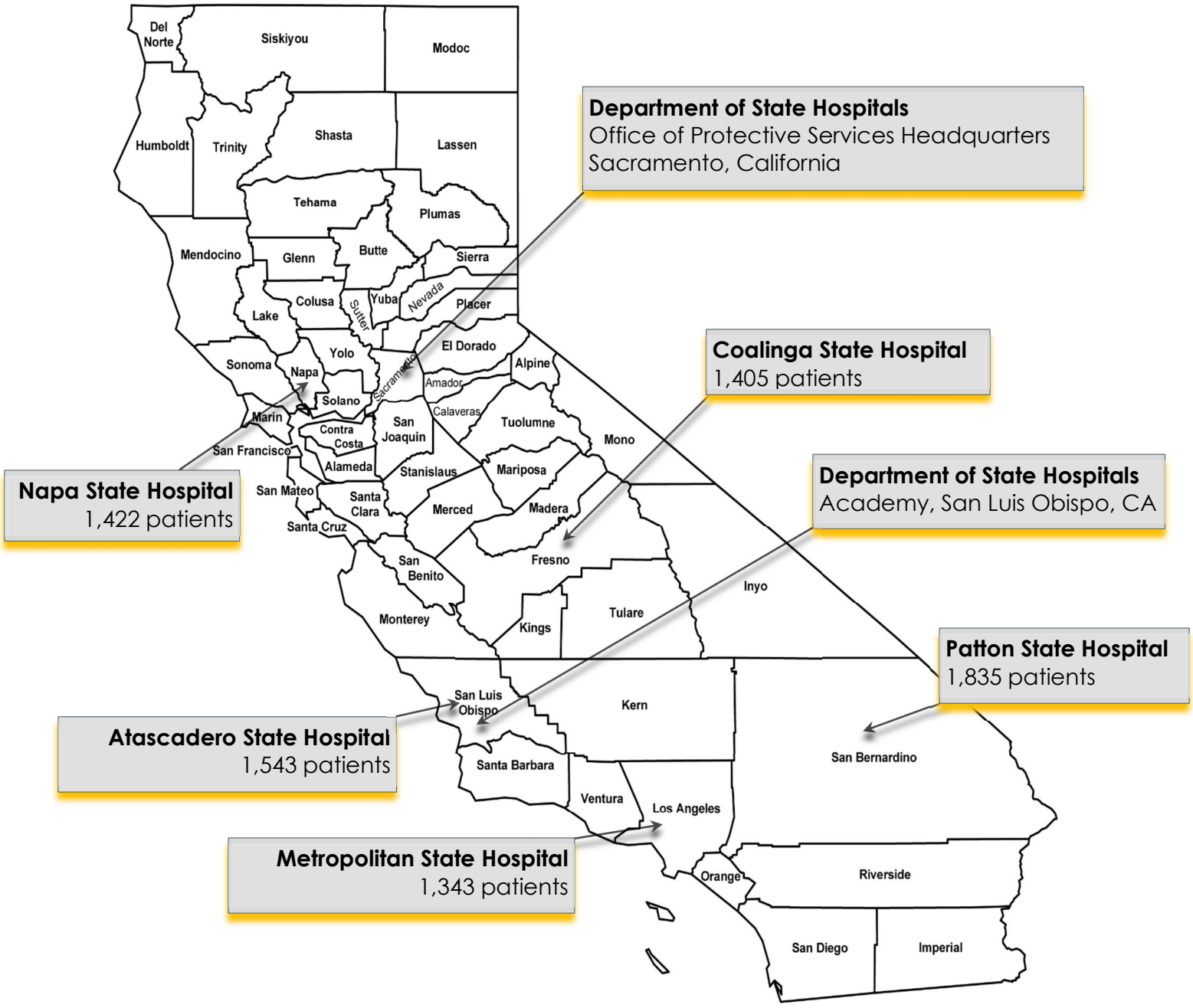
As the OLES continues its eighth year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DSH.

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 January 1 through June 30, 2023, and were provided by the department.



Total Patients Served by Facility January 1 through June 30, 2023

DSH Facility	Total Number of Patients
Atascadero	1,543
Coalinga	1,405
Metropolitan	1,343
Napa	1,422
Patton	1,835
Total	7,548

The total number of patients served by DSH from January 1 through June 30, 2023, increased 6.2 percent, from 7,108 during the prior reporting period to 7,548 in this reporting period.

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 the individual's 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 their trial to determine if they meet the criteria

Commitment Type	Description
	in the Sexually Violent Predator Act to be committed to DSH as an SVP.
WIC 6604 SVP	Sexually violent predator. Civil commitment for prisoners released from prison who have been determined by a court to meet criteria under the Sexually Violent Predator Act.
WIC 5358 LPS	Full Conservatorship for Grave Disability. Annual renewal.
WIC 1756 DJJ	Juvenile offender referred by CDCR Division of Juvenile Justice for treatment

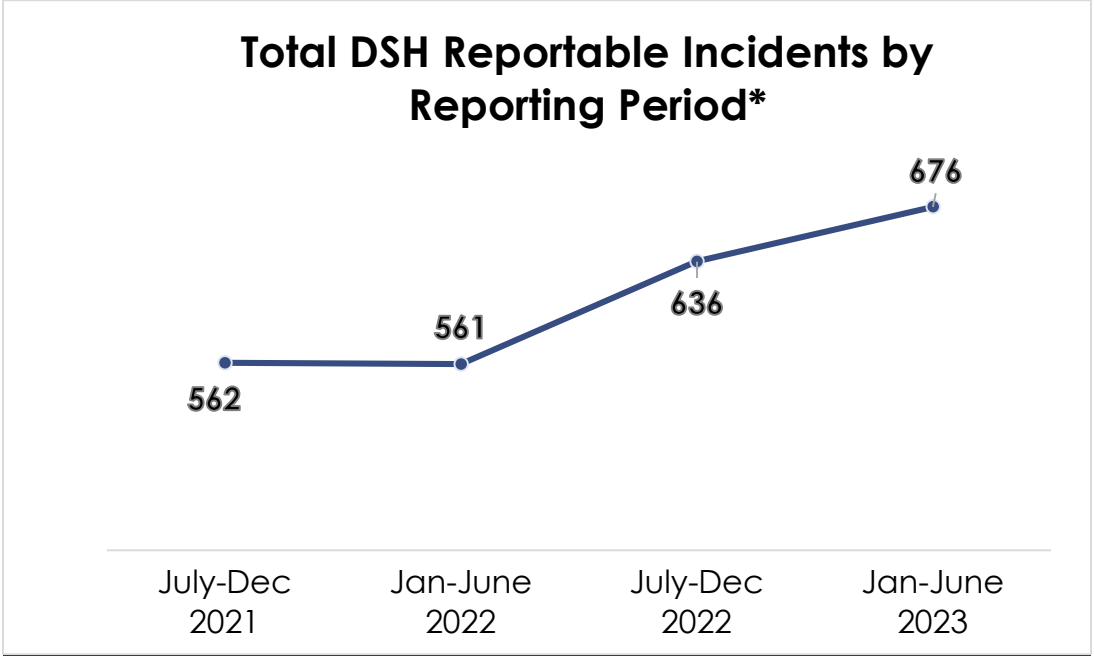
The following table provides the commitment type of patients served during the reporting period.

Commitment Type	Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST	633	0	1,055	721	778
PC 1026 NGI	***	<11	12	493	544
PC 2962/2964a OMD	408	0	<11	0	***
PC 2972 OMD	129	326	<11	***	209
WIC 6316 MDSO	0	<11	0	<11	<11
PC 2684 CDCR	118	79	0	0	21
WIC 6602/6604 SVP	<11	***	0	0	0
WIC 5358 LPS	22	<11	***	163	177
WIC 1756 DJJ	0	0	0	<11	<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 January 1 through June 30, 2023, the Office of Law Enforcement Support (OLES) received and processed 676 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, use of force incidents and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is an increase of 40 incident reports compared to the prior reporting period which had 636 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.

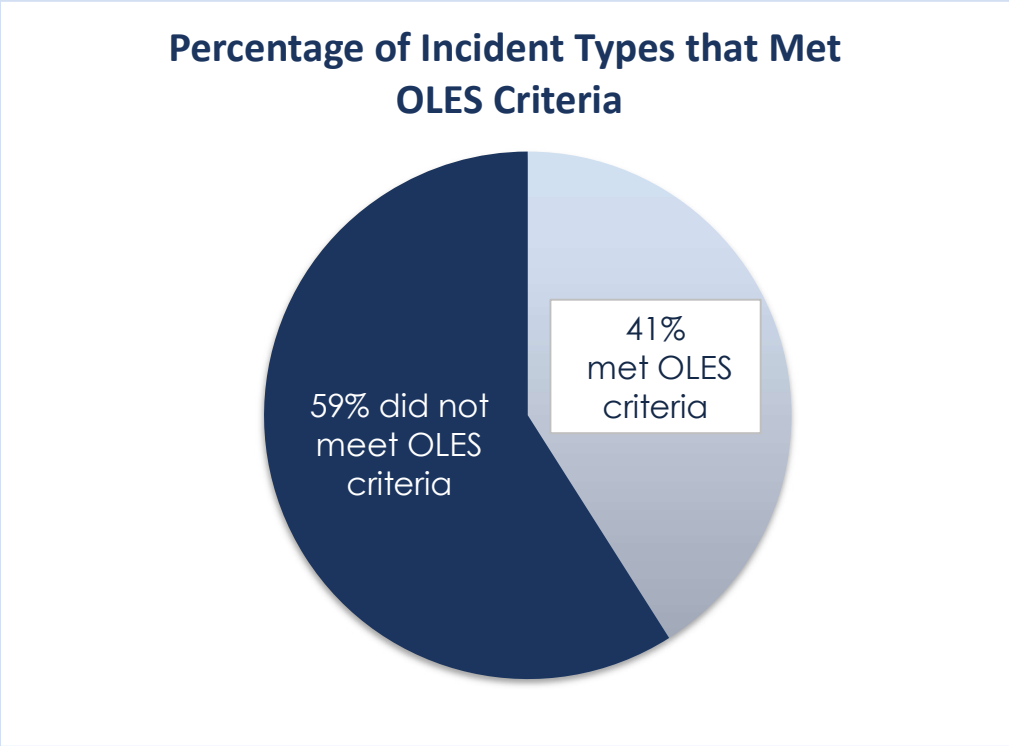
Incident Types Meeting OLES Criteria

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

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

"meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 676 reported incidents, the OLES identified 28 incidents with two or more incident types. The DSH reported a total of 704 incident types during this reporting period. Two hundred ninety, or 41 percent of the 704 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

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

Abuse represented the single largest number of incidents. The DSH reported 123 allegations of patient abuse during this reporting period, which is a 23 percent increase from the prior reporting period of 100 reports of patient abuse.

Law enforcement use of force was the second 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 100 reports of use of force, which accounted for 14 percent of all reported incident types by DSH. Five of the 100 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 remained statistically consistent the last three reporting periods from 107, 99 and 100.

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.

Allegations of sexual assault was the third most reported incident type, with 83 allegations reported, representing a 19 percent decrease compared to the 102 reported allegations in the prior reporting period.

The fourth most frequent incident type was Broken Bone (unknown origin), with 47 reports. This is a decrease of 11.3 percent, compared to the prior reporting period of 53 reports. The OLES monitored 92 percent of these incidents.

Patient Deaths

The number of patient deaths increased by 37 percent, from 37 deaths to 46 deaths during this reporting period. Ten of the reported death incident types met the OLES criteria for investigation or monitoring. Thirty-two of the 46 patient deaths were expected due to existing medical conditions. Fourteen 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 13 patient arrests, four more arrests 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 148(a)(1)	Obstruct/Resist a peace officer
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(c)	Assault with force likely to cause GBI
Penal Code section 4573.6	Possession of controlled substance or paraphernalia
Penal Code section 243.4(e)(1)	Sexual battery
Outside Warrant PC 209(b)(1)	Kidnap to commit robbery
Penal Code section 220(a)(1)	Assault with intent to commit rape
Penal Code section 236	False imprisonment
Penal Code section 311.11(b)	Possession of child pornography
Penal Code section 594(b)(1)	Malicious vandalism
Penal Code section 187(a)	Attempted murder

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 27 investigations that OLES completed during this reporting period. These investigations involved allegations against at least 37 sworn staff members. As of June 30, 2023, there were approximately 673 DSH sworn staff.

The OLES submitted 18 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process. Six OLES administrative investigations were not submitted to the hiring authority due to insufficient evidence. Administrative investigations are 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 three 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 administrative and criminal 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 82 monitored administrative cases and 56

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

monitored criminal cases that, by June 30, 2023, 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.

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

The OLES monitored 138 pre-disciplinary phase cases; 120 of the pre-disciplinary phase cases are listed in Appendix B and 18 are in Appendix C. The OLES rated 14 of the 138 pre-disciplinary phase cases insufficient. Frequent deficiencies include delayed investigations, inadequate interviews and delays in conducting the findings and penalty conference.

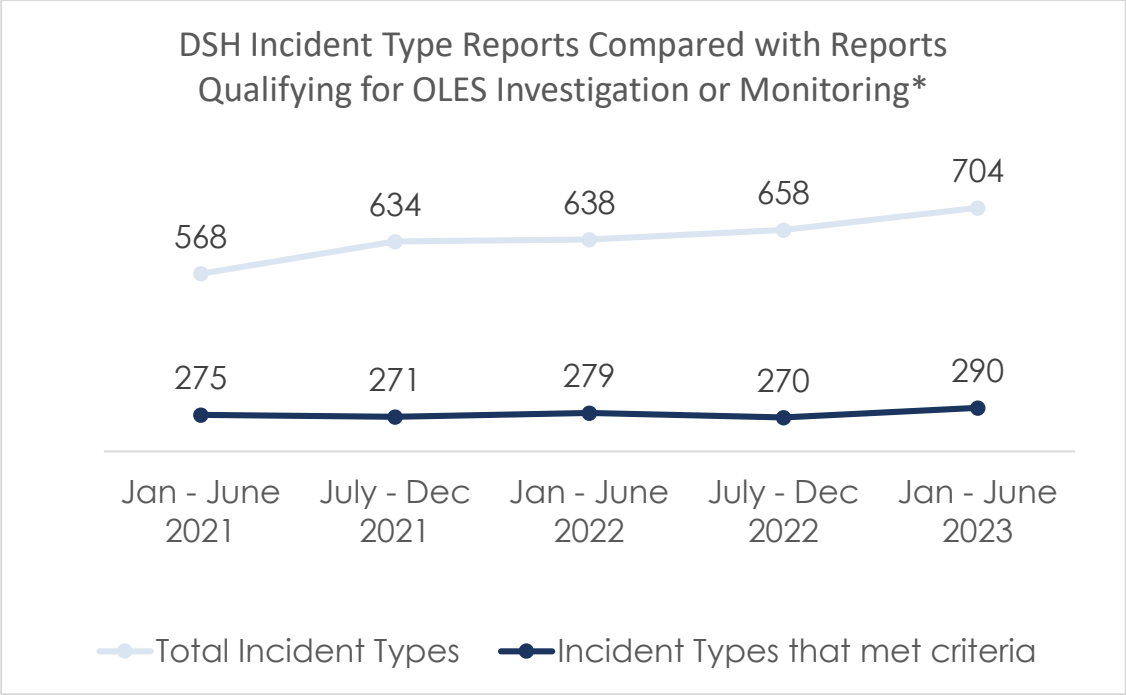
The OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in 18 administrative cases listed in Appendix C. Four of the 18 disciplinary phase cases were rated insufficient due to delays in serving a disciplinary action.

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 January 1 through June 30, 2023, increased 6.3 percent, from 636 during the prior reporting period to 676 in this reporting period. From the 676 reported incidents, the OLES identified 704 incident types, as 28 of the incidents featured two or more incident types. Two hundred and ninety of the 704 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 abuse, sexual assault, and use of force by law enforcement. These three incident type categories accounted for 306 or 43.5 percent of all incident types reported by DSH. Of the 306 incident types, 144 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was allegations of abuse. The number of abuse allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period increased by 24.5 percent, from 94 during the prior reporting

period, to 117 in this reporting period. The 123 reports of abuse accounted for 17.5 percent of the reported incident types.

The DSH's second most frequent report to OLES was use of force by law enforcement. The 100 reports of use of force accounted for 14.2 percent of the reported incident types, and up 1 percent from the last period's 99 reports. This is the fourth full reporting period of OLES requiring the department to report all use of force by law enforcement.

Allegations of sexual assault were the third most frequently reported incident type by DSH, with incident types reported. Allegations of sexual assault accounted for 11.8 percent of all incident types reported. Of the 83 sexual assault allegations reported in this period, 27 allegations qualified for investigation, monitoring or consideration of a potential systemic issue. This is a decrease of 40 percent or 33 fewer qualifying reports from the prior reporting period, which had 45 incident types of sexual assault that met OLES criteria.

Reports of patient death incident types were the fourth most reported incident type with 46 reports. This is an increase of 23.3 percent from the 37 incident types reported during the last reporting period. The OLES monitored 21.7 percent of the reported patient deaths.

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

Most Frequent Incident Types January 1 through June 30, 2023

Incident Type Category	Prior Period Incident Type Total July 1 through December 31, 2022	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Abuse	100	123	+23%	117
Use of Force	99	100*	1%	4
Sexual Assault	102	83	-18.6%	27
Death	37	46	+24.3%	10

*Five 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 January 1 - June 30, 2022 (Reported) *	Prior Period January 1 - June 30, 2022 (Meets Criteria)*	Prior Period July 1 - December 31, 2022 (Reported)	Prior Period July 1 - December 31, 2022 (Meets Criteria)	Current Period January 1 - June 30, 2023 (Reported)	Current Period January 1 – June 30, 2023 (Meets Criteria)
Abuse	84	80	100	94	123	117
Broken Bone (Known Origin)	19	3	15	0	27	5
Broken Bone (Unknown Origin)	37	37	53	47	47	43
Burn	7	0	10	1	6	1
Death	27	10	37	7	46	10
Genital Injury (Known Origin)	6	1	6	0	29	3
Genital Injury (Unknown Origin)	9	5	10	6	16	8
Head/Neck Injury	42	5	38	2	44	3
Misconduct **	41	39	26	26	31	31
Neglect	34	27	23	15	29	27
Non-patient assault/GBI on Patient	0	0	0	0	0	0
OPS Use of Force***	107	2	99	4	100	0
Patient on Patient Assault/GBI	10	0	17	2	14	3
Pregnancy	0	0	0	0	0	0
Sexual Assault	92	40	102	45	83	27
Sexual Assault-OJ******	31	0	42	0	42	0
Significant Interest-Attack on Staff*******	7	0	5	0	7	0

Incident Categories	Prior Period January 1 - June 30, 2022 (Reported) *	Prior Period January 1 - June 30, 2022 (Meets Criteria)*	Prior Period July 1 - December 31, 2022 (Reported)	Prior Period July 1 - December 31, 2022 (Meets Criteria)	Current Period January 1 - June 30, 2023 (Reported)	Current Period January 1 – June 30, 2023 (Meets Criteria)
Significant Interest-Attempted Suicide	1	0	0	0	2	0
Significant Interest-AWOL	1	0	10	0	3	0
Significant Interest-Child Pornography	2	0	2	0	4	1
Significant Interest-Drugs******	42	12	38	7	24	3
Significant Interest-Other*******	12	2	5	4	6	4
Significant Interest-Over-Familiarity	19	16	11	10	15	12
Significant Interest-Patient Arrest	8	0	9	0	13	0
Significant Interest-Riot	0	0	0	0	0	0
Total	638	279	658	270	704	290

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

**The misconduct statistics include five use of force reports including allegations of excessive force by law enforcement, as well as one sexual assault and are included in the total count for the abuse and sexual assault incident type category.

***The 100 Use of Force incidents were assigned a Pending Review and do not meet criteria. Five of the 100 included an allegation of excessive force and were assigned an investigation.

****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 June 30, 2023, reporting periods, 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 kidnapping and sexual assault, a facility director received threats, a DSH contractor was suspended for running an unsafe pain management clinic, a facility received a bomb threat and threat against a staff member, and child pornography was seized from DSH staff member's residence during a search warrant

Distribution of Incident Types

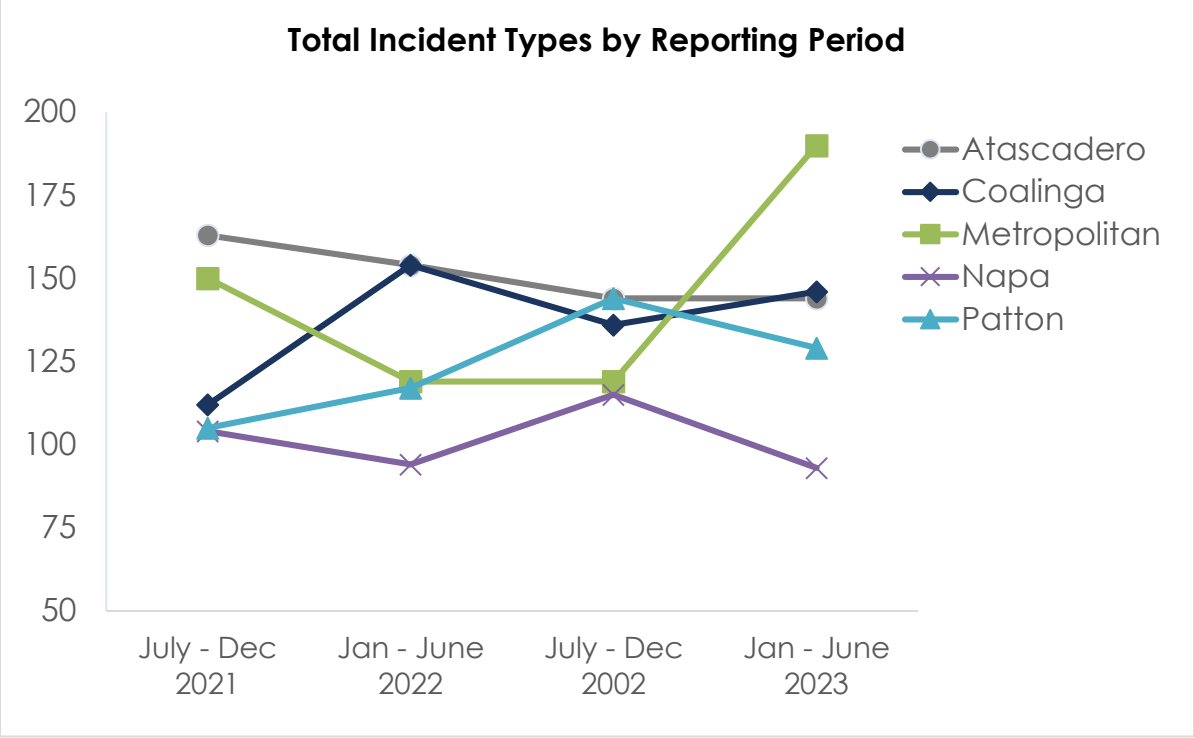
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

DSH Population and Total Incident Types

DSH Facility	Number of Patients Served*	Total Incident Types
Atascadero	1,543	144
Coalinga	1,405	146
Metropolitan	1,343	190
Napa	1,422	93
Patton	1,835	129
Total	7,548	702**

*The department provided population numbers as of June 30, 2023.
** OPS DSH Headquarters reported two incidents not included in these totals.

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 third most frequently reported incident type from January 1 through June 30, 2023. The 83 alleged sexual assault incident types reported in this reporting period accounted for 11.7 percent of all reported incident types from DSH. Twenty-seven of the 83 reported incident types of alleged sexual assault, or 32.5 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, ASH and PSH 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 41 incident types, or 49.4 percent of the alleged 83 sexual assault incident types. The second most frequent type of alleged sexual assault involved non-law enforcement staff on a patient, with 32 incident types or 38.6 percent of the 83 alleged sexual assault incident types. There were 8 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 two 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 January 1 through June 30, 2023

Allegation Type	Total
Patient on Patient	41
Law Enforcement Staff on Patient	2
Non-Law Enforcement Staff on Patient	32
Unknown Person on Patient	8
OJ*	42
Total	125

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

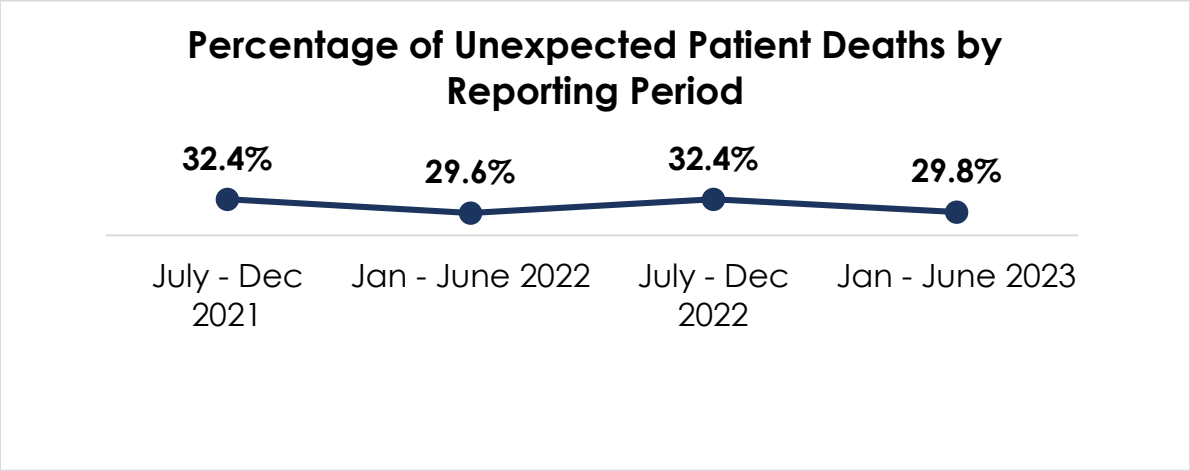
Patient Deaths

The DSH reported 46 patient deaths to OLES during this reporting period. This number increased 24 percent from the 37 patient deaths reported in the prior reporting period of July 1 through December 31, 2022.

Thirty-two of the patient deaths were classified as "expected" primarily due to

underlying health conditions, such as cardiac or respiratory issues, cancer, renal/liver and sepsis. Fourteen deaths were classified as "unexpected". 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 ten 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. The suicide death was a patient that had discharged from the state hospital within 30 days.

Cause of Patient Deaths

Cause	Total
Cardiac/Respiratory	30
Cancer	8
Other	4
Renal/Liver	2
Sepsis	1
Suicide	1
Total	46

Reports of Head or Neck Injuries

The DSH reported 44 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 14 of the 44 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 three 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. 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

Incident	Description
	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 improved in the timely reporting of incident types with 94.5 percent timely reports when compared to the prior reporting period, which had 91.7 percent timely reports.

Nineteen of the 704 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 685 incident types evaluated for timeliness, 647 were reported timely and 38 incident types were not timely. One of the 38 untimely incident types was unreported and 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 19 incident types that were excluded as described above.

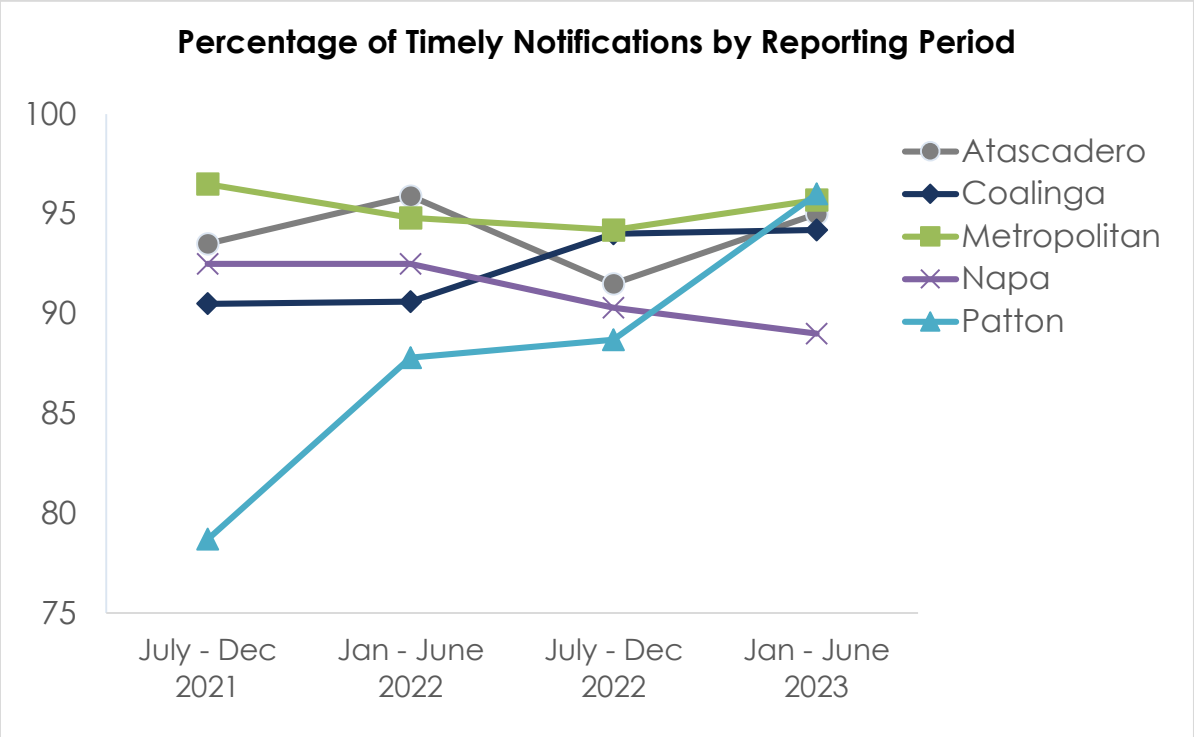
Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Abuse	111	9	120	92.5%
Broken Bone (Known Origin)	27	0	27	100.0%
Broken Bone (Unknown Origin)	40	7	47	85.1%
Burn	6	0	6	100.0%
Death	45	1	46	97.8%
Genital Injury (Known Origin)	29	0	29	100.0%
Genital Injury (Unknown Origin)	16	0	16	100.0%
Head/Neck	44	0	44	100.0%
Misconduct	18	3	21	85.7%
Neglect	28	1	29	96.6%
OPS Use of Force	96	4	100	96.0%
Patient on Patient Assault/GBI	11	3	14	78.6%
Priority 1: Sexual Assault	30	5	35	85.7%
Priority 2: Sexual Assault	89	0	89	100.0%

Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Significant Interest – Attempt Suicide	2	0	2	100.0%
Significant Interest – AWOL	2	1	3	66.7%
Significant Interest – Child Porn	3	0	3	100.0%
Significant Interest – Drugs	21	3	24	87.5%
Significant Interest – Other	5	0	5	100.0%
Significant Interest – Over-Familiarity	12	0	12	100.0%
Significant Interest – Patient Arrest	12	1	13	92.3%
Total	647	38	685	94.5%

The following table compares the percentage of timely notifications by facility. PSH and MSH had the highest percentage of timely notifications. The NSH 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	Patton	121	5	126	96.0%
2	Metropolitan	179	8	187	95.7%
3	Atascadero	134	7	141	95.0%
4	Coalinga	130	8	138	94.2%
5	Napa	81	10	91	89.0%
	DSH OPS HQ	2	0	2	100.0%
	Total	647	38	685	94.5%

The following chart compares the percentage of timely notifications by reporting period. PSH showed significant improvement from 88.7 percent from the last reporting period to 96 percent this 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 January 1 through June 30, 2023, reporting period, 372 of the total 704 cases opened for DSH incidents that occurred within DSH's jurisdiction or 52.8 percent were assigned a pending review. The OLES opened cases for 42 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 20 administrative investigations and 11 criminal investigations. The OLES opened 253 monitored criminal cases and 5 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	January 1 – June 30, 2023	Percentage of Opened Cases
Pending Review	372	50.9%
Monitored, Criminal	254	36.1%
Monitored, Administrative	5	0.7
Outside Jurisdiction*	42	5.7%
OLES Investigations, Criminal	11	1.6%
OLES Investigations, Administrative	20	2.8%

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

Totals	704	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 D). 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 27 investigations. Three investigations were criminal cases and 24 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. 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.

Eighteen of 24 OLES investigations into administrative wrongdoing or misconduct were forwarded to facility management for review. In this reporting period, OLES referred 18 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 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, 2023	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	24	N/A	18	6
Criminal	3	0	N/A	3
Total	27	0	18	9

OLES Monitored Cases

In this report, OLES provides information on 138 completed monitored cases. By the end of the reporting period, 56 monitored criminal cases had either been referred or not referred to a district attorney's office. Nine of the 56 criminal cases were referred to a district attorney's office.

There were 82 completed monitored pre-disciplinary administrative cases with allegations that were sustained or not sustained during this reporting period. Thirty of the 82 cases had sustained allegations. Fifty-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	9
Criminal-Not Referred	47
Total Criminal	56
Administrative-With Sustained Allegations	52
Administrative-Without Sustained Allegations	30
Total Administrative	82
Grand Total	138

Pre-Disciplinary Phase Cases

Of the 138 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 14 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 18 administrative cases. Four cases were insufficient due to delays in serving the disciplinary 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, 2023.

DSH Facility	Percentage of Compliance
Atascadero	96%
Coalinga	90%
Metropolitan	84%
Napa	97%
Patton	99%

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.

Due to the issues mentioned above, DSH has been working to implement a new Learning Management System that will better meet the needs of the department. The initial implementation for OPS will be the DSH HPO Academy. The new LMS system will be utilized for all OPS training needs when all phases are completed and is expected to resolve the issues that have been identified and remove the need for additional tracking.

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	36	4	20	11	1
Coalinga	46	7	8	26	5
Metropolitan	25	1	15	7	2
Napa	59	2	53	3	1
Patton	41	3	19	16	3
Total	207	17	115	63	12

* 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	22	0	22	0
Coalinga	12	2	10	0
Metropolitan	34	0	34	2
Napa	24	0	24	0
Patton	6	0	4	1
Total	98	2	94	3

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

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

***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	0	1	3	0
Coalinga	0	0	0	0
Metropolitan	0	0	0	0
Napa	0	0	0	0
Patton	0	0	2	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	347	47	300	60
Coalinga	314	126	188	62
Metropolitan	250	12	238	32
Napa	12	2	10	0
Patton	32	15	12	25
Total	955	202	748	179

* 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 one new monitored issue. Information on new and long-running monitored issues are provided below.

New Monitored Issue: Recordkeeping of Institutional Firearms and Crime/Evidence Firearms

The proper inventorying and storage of institutional and evidentiary firearms is a fundamental and critical responsibility of a law enforcement agency. The failure to do so places law enforcement agencies in serious legal jeopardy. As such, all law enforcement agencies, including the Department of State Hospital's Office of Protective Services (OPS), should have established policies to provide guidance and accountability to law enforcement personnel to avoid loss of and/or damage to such weapons.

In February 2023, the Office of Law Enforcement Support (OLES) conducted a review of DSH recordkeeping of DSH institutional firearms and crime/evidence firearms. OLES's analysis included a comparison of firearms inventory information provided by DSH facilities with data obtained from the Automated Firearms System (AFS) maintained by the California Department of Justice, Bureau of Firearms.

Results of OLES's February 2023 Firearms Review

The following issues were discovered during OLES's review of DSH records and policies in February 2023:

Gaps in DSH firearm policy: DSH policy failed to contain any directive requiring OPS staff to enter information into AFS for any recovered, found, lost or seized firearm pursuant to Penal Code section 11108.2, or enter information into AFS regarding the acquisition of institutional firearms.

Firearms not recorded in AFS: In February and September 2022, the Office of Law Enforcement Support (OLES) requested DSH send inventory lists of firearms stored at DSH headquarters and at each state hospital. OLES also requested from DOJ a list of all firearms contained in AFS under the originating agency identifier (ORI) numbers associated with DSH.

In October 2022, OLES compared the DSH lists received in February and September 2022 with the list of firearms recorded in AFS obtained from DOJ in May 2022. And while there was some improvement in record keeping by the state hospitals between February and September 2022, some discrepancies remained. Specifically, DSH

reported 132 firearms statewide; however, 62 of these firearms were not entered into AFS.

Due to the data discrepancies in the previous reports provided by DSH and discovering that nearly 47 percent of the firearms were still not entered into AFS, OLES sent a third request in February 2023 for a list of all firearms in inventory at each facility and documentary verification of each firearm's entry in AFS. Again, OLES discovered not all firearms were recorded in AFS as required by law. Specifically, DSH reported 180 firearms statewide, however, 14 of these firearms were not entered into AFS.

Moreover, OLES learned that the data entered in AFS regarding these firearms was inaccurate. For example, at one hospital, seven firearms were listed in AFS as being located in a police building but were listed on the inventory sheet as being issued to and held by investigators. In addition, four weapons were listed in AFS as being assigned to one lieutenant and three investigators (one of whom was no longer employed by DSH) but were listed on the inventory sheet as being located in a police safe.

Due to these continued issues, OLES sought a physical inspection of all weapons at every DSH facility. Each DSH chief (or his/her designee) was required to conduct a physical inspection of every firearm listed on the inventory sheet submitted to OLES to include verifying the make, model, and serial number of each weapon, and each firearm's AFS entry.

As a result of OLES' efforts and DSH's corrective action, as of February 9, 2023, all weapons at DSH were physically accounted for and listed in AFS.

Prolonged storage of seized firearms: OLES conducted inspections of the firearms in evidence at four DSH facilities who reported being in possession of seized firearms related to criminal investigations. These inspections revealed that three DSH facilities were in possession of crime guns for prolonged periods of time. These facilities were aware of the adjudications in these cases for several years – as many as 12 years at one hospital – and had yet to properly destroy or return these firearms in accordance with Penal Code section 33875. Moreover, each DSH chief confirmed that there is no policy at DSH about the return of weapons following the adjudication of cases.

Inappropriate storage of seized firearms: During the inspection of firearms at one hospital, the OLES discovered seized firearms were not appropriately identified, labeled, or stored. Specifically:

- A seized shotgun was stored in a soft-shell container and had no identifying information, such a property label, attached to either the weapon or the container;

- A semiautomatic handgun was stored inside a cardboard box and no identifying information, such as a property label, was attached to either the firearm or the box. In addition, live ammunition was stored in the same cardboard box; and

- A revolver was stored inside a green plastic ammunition box and no identifying information, such as a property label, was attached to either the firearm or the box; however, a property control sheet with identifying information was laid on top of (but not securely attached to) the green plastic box.

Recommendations by OLES in February 2023: OLES made four specific recommendations following the February 2023 review:

1. Use a standardized department firearms record among all five facilities with corresponding CLETS/AFS info.
2. Address the failure to enter firearms into CLETS/AFS in policy.
3. Address the return or destruction of seized firearms in policy and in accordance with Penal Code section 33875.
4. Address and remedy the failure to appropriately mark and label seized firearms as evidence.

DSH Response to OLES' Firearms Review in April 2023

In April 2023, DSH submitted a response to OLES' firearms review addressing the specific recommendations made by OLES in its April 2023 review:

Gaps in DSH policy: DSH updated two policies to address OLES's concerns regarding the lack of direction to OPS staff regarding the entering of firearm information into AFS.

Firearms not recorded in AFS: DSH provided an inventory sheet and corresponding AFS entry for each institutional firearm and crime/evidence firearm at every DSH facility.

Prolonged storage of seized firearms: DSH collaborated with each facility to identify the deficiencies in the storage/prolonged storage of seized firearms to ensure all seized firearms were accounted for, entered correctly in AFS, and evaluated for adjudication, and planned to add language to policy to ensure the reconciliation and proper handling of seized firearms.

Inappropriate storage of seized firearms: DSH identified, relabeled, and secured the firearms at one facility that were inappropriately stored in evidence. OLES conducted a second audit of the seized firearms and found them to be in compliance with proper evidence handling policy.

Qualification records: DSH provided copies of qualification records for sworn personnel assigned firearms as part of their official duties.

Results of OLES's Review in June 2023 of DSH's April 2023 Response

In June 2023, OLES conducted a review of the response provided by the DSH in April 2023. OLES' analysis of the response included a comparison of firearms inventory information provided by DSH facilities with data obtained from AFS. OLES found that while the accuracy of DSH's inventory and AFS entries had drastically improved, there

were still some issues. For example, there were multiple instances of incorrect/incomplete serial numbers and spelling errors in the AFS entries. Moreover, there were 15 firearms listed in AFS as being assigned to a particular facility; however, that facility had not listed these 15 firearms on their inventory sheet. It was later determined that the facility had exchanged these firearms for different firearms, but no corresponding entry was made in AFS.

Failure to address the return or destruction of seized firearms in policy

While DSH updated Policy 306 to mandate that DSH/OPS enter any firearm that was reported lost, stolen, etc., be entered in AFS within seven days, that policy only applied to institutional firearms. Moreover, nothing within DSH Policy 801 provided direction regarding the prompt return/destruction of crime/evidence firearms upon completion of an investigation.

On June 9, 2023, OLES provided a response to DSH detailing the specific errors in AFS, requesting that DSH address the issue of the prompt return/destruction of crime/evidence firearms upon completion of an investigation in policy, and recommending the use of consistent documentation regarding side-arm qualifications.

In June 2023, all DSH facilities provided updated AFS entries evidencing their corrections in the database and provided proposed language to address the prompt return/destruction of crime/evidence firearms in policy. However, DSH has not provided any response regarding OLES' recommendation for side arm qualification documentation.

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.

DSH Contraband Eradication

Implementation

The plan was implemented from April 17, 2023, through May 18, 2023. There were three phases. The first phase was a voluntary turn in of CCR 4350 prohibited contraband items for destruction. No patient names were collected regarding the turn in. All items turned in were destroyed.

The second phase involved patients submitting the CCR 4350 prohibited contraband items for mail out or storage. Each patient signed a waiver on how they wanted to handle their property. The waiver included consent for all material with computer storage to be scanned for illegal matter. The waiver explained that any illicit materials found could result in criminal prosecution. At the time of the search, devices that were turned in or confiscated were scanned for illicit content. After the patients turned in the CCR 4350 prohibited items, the units were searched. Two units were searched a week.

The third phase was a large-scale sweep occurring at the end of each week. Electronics and illegal drug sniffing canines were utilized. The Riverside District Attorney's Office, the Los Angeles County Probation, the San Bernardino County Probation, the Fontana Police Department and K-9 Teams from the Department of State Hospitals Office of Protective Services assisted in these searches.

Results

The searches were completed on May 18, 2023. As of the end of May 2023 there were no complaints from the patients, patient rights or staff members regarding the implementation plan and enforcement of CCR 4350. DSH Staff members have been trained by DSH on identifying contraband 4350 material and additional training will occur with any changes. The items turned in for mail out or storage were reviewed by the San Bernardino Sheriff's Department Crimes Against Children Division, the Fontana Police Department, Internet Crimes Against Children Division and officers from the Coalinga State Hospital. No child pornography or any files with illegal content were found.

A total of 289 contraband CCR 4350 devices were scanned during this process. The devices came from 131 patients. The CCR 4350 contraband devices scanned included

compact discs, DVDs, MP3 Players, flash drives and memory cards.

Conclusion

The OLES will continue to monitor reports of contraband at PSH and work collaboratively with DSH to ensure all facilities are in compliance with California Code of Regulations (CCR), Title 9, Section 4350.

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 its policy to require OPS staff to record all interviews conducted and record staff refusals to be interviewed. In response, DSH updated its recording policies, purchased additional recorders and conducted training on recordings to all OPS sworn staff. Since then, there has been significant improvements in the regular recording of investigatory interviews and 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 to proactively identify potential performance problems with staff. The DSH selected the IAPro/Blue Team software for its EI system. In 2016, DSH completed staff training at all facilities and staff began using Blue Team/IAPro on December 31, 2016.

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. 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, in December 2020, DSH provided additional training to refresh staff knowledge of reporting requirements with an overall completion rate of 93.67 percent. The DSH OPS Chief advised an annual training would 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. 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. The OLES found that in December 2022, DSH facilities timely entered 11 of 13 incidents in the Use of Force category. In August 2023, OLES audited all use of force incident entered in Blue Team/IA Pro between January 1, 2023, through June 30, 2023. The OLES found that DSH entered 99 incidents in Blue Team/IA Pro; however, eight incidents were entered twice, leaving 91 use of force incidents. During the same period, OLES received 102 use of force incidents from DSH, revealing that 11 use of force incidents had not been entered in Blue Team/IA Pro. Additionally, the audit uncovered one use of force incident that had been entered in Blue Team/IA Pro but not reported to OLES. 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 important 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 and social workers, who are mandated reporters, did not always timely report these incidents to OPS or just completely failed to notify OPS altogether, despite statutory requirements to timely report such incidents to law enforcement. The delays ranged from several hours to several days after initial discovery, to no notification at all by 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 drafted Policy Directive 8010, which included 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. Furthermore, the Chief of Law Enforcement met with level of care staff to review the reporting guidelines.

In the last reporting period of July 1 through December 31, 2022, the OLES identified ten

incidents that were not timely reported by mandated reporters (level of care staff, social workers, etc.) to OPS. During the current reporting period of January 1 through June 30, 2023, this number improved to five incidents of delayed reporting; however, there still remained occasional deficiencies, including a complete failure to report an allegation of physical abuse. The five incidents are listed below and represent a 50 percent improvement over the last reporting period. As mentioned, timely reporting is critical for patient wellbeing, therefore the OLES will be implementing a new statistical feature comparing the discovery date and time of a mandated reportable incident to the reporting to OPS date and time, for future SAR reporting periods. The OLES will share this information with DSH and continue to monitor the department's progress on this issue.

Incident Type	Delay
Sexual Assault	Approximately 30 minutes
Physical Abuse	No notification to OPS, OPS discovered the allegation during a review of SIRs
Physical Abuse	Approximately 30 minutes
Genital Injury (Unknown Origin)	Approximately 7 hours
Broken Bone (Unknown Origin)	Approximately 5 hours and 15 minutes

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2023. 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
Incident Date	11/16/2021
OLES Case Number	2021-01378-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly engaged in illegal narcotics activity.
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
Incident Date	03/04/2022
OLES Case Number	2022-00329-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer was allegedly dishonest regarding his return to work status.
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
Incident Date	05/31/2022
OLES Case Number	2022-00635-2C
Case Type	Investigative
Incident Types	1. Abuse 2. Broken Bone (Unknown Origin) 3. Head/Neck
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 a crime was committed, and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Case Details	Description
Incident Date	07/01/2022
OLES Case Number	2022-00774-1C
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	An officer allegedly pushed a patient.
Disposition	The OLES conducted an investigation. 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
Incident Date	07/15/2022
OLES Case Number	2022-00825-3A
Case Type	Investigative
Incident Types	1. Broken Bone (Known Origin) 2. Misconduct 3. Use of Force Review

Incident Summary	An officer allegedly did not properly document having been involved in a use of force incident involving a resistive patient.
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
Incident Date	07/28/2022
OLES Case Number	2022-00875-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly was unprofessional and used abusive language during an investigation.
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
Incident Date	08/04/2022
OLES Case Number	2022-00929-1A
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	An officer allegedly grabbed a patient's hand, causing the patient to fall.
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
Incident Date	
OLES Case Number	2022-00959-1A

Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	A law enforcement supervisor was arrested for alleged off-duty crimes.
Disposition	The investigation was completed by the OLES; however, the case was not referred to the hiring authority because the law enforcement supervisor had resigned and resolved the criminal matter, precluding any disciplinary action. A summary of the investigation and decision was provided to the department.

Case Details	Description
Incident Date	08/23/2022
OLES Case Number	2022-01008-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly took inappropriate police action.
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
Incident Date	08/23/2022
OLES Case Number	2022-01013-1A
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	An officer allegedly used unnecessary force on a patient and omitted material information in his 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

Incident Date	08/08/2022
OLES Case Number	2022-01018-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	Five officers and two law enforcement supervisors allegedly, without authorization, accessed a secure early intervention system database.
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
Incident Date	08/25/2022
OLES Case Number	2022-01040-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly challenged a patient to a fight.
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
Incident Date	09/06/2022
OLES Case Number	2022-01074-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly left a personal firearm, a holster and two ammunition magazines in a department vehicle.
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
Incident Date	09/06/2022
OLES Case Number	2022-01099-1C
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	Three officers allegedly used excessive force on a patient,
Disposition	The OLES conducted an investigation. 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
Incident Date	09/17/2022
OLES Case Number	2022-01131-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer was allegedly dishonest about misplaced state-issued clothing.
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
Incident Date	09/16/2022
OLES Case Number	2022-01136-2A
Case Type	Investigative
Incident Types	1. Abuse 2. Misconduct 3. Use of Force Review
Incident Summary	An officer allegedly failed to report a patient's complaint of excessive force by staff members and other officers.

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
Incident Date	10/05/2022
OLES Case Number	2022-01223-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer was arrested for alleged off-duty criminal offenses. Another officer allegedly identified themself as a police officer in an attempt to gain influence and failed to report an off-duty incident.
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
Incident Date	10/18/2022
OLES Case Number	2022-01311-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly bumped into a staff member and spoke to the staff member in a discourteous manner.
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
Incident Date	10/21/2022
OLES Case Number	2022-01357-1A
Case Type	Investigative
Incident Types	1. Misconduct

Incident Summary	An officer allegedly tampered with, and moved, state property, which was assigned to another employee.
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
Incident Date	10/06/2022
OLES Case Number	2022-01389-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	Two officers allegedly restrained a patient and did not report their use of force.
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
Incident Date	11/30/2022
OLES Case Number	2022-01517-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly submitted an inaccurate timesheet and was dishonest to a 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
Incident Date	12/10/2022
OLES Case Number	2022-01560-1A
Case Type	Investigative

Incident Types	1. Misconduct
Incident Summary	An officer had allegedly been engaged in assisting migrants illegally cross into the United States.
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
Incident Date	12/30/2022
OLES Case Number	2023-00014-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly left his assigned post without providing proper supervisor notification and was allegedly dishonest during the investigative process.
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
Incident Date	02/08/2023
OLES Case Number	2023-00213-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly failed to report staff misconduct and made false statements to a 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
Incident Date	03/10/2023
OLES Case Number	2023-00462-1A

Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly physically abused a patient and made discourteous comments to the patient.
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
Incident Date	
OLES Case Number	2023-00548-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	A law enforcement supervisor allegedly allowed other employees unauthorized access to a secured area where confidential materials were stored.
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
Incident Date	04/17/2023
OLES Case Number	2023-00551-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly left his assigned post without authorization and encouraged another officer to submit an inaccurate report.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2023, 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
Incident Date	03/01/2020
OLES Case Number	2020-00840-2A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault 2. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Other
Incident Summary	A psychiatric technician allegedly inappropriately touched multiple patients.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 10 percent for 24 months was the appropriate penalty. The OLES concurred. Prior to the service of the action, the psychiatric technician was terminated for being absent without leave.

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

Case Details	Description
Incident Date	05/22/2021
OLES Case Number	2021-00650-2A
Case Type	Monitored
Incident Types	1. Pregnancy 2. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A senior psychiatric technician allegedly sexually assaulted a patient, resulting in the patient's pregnancy. He was allegedly dishonest during the administrative inquiry.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. However, the senior psychiatric technician resigned before discipline could be imposed.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/23/2021
OLES Case Number	2021-01553-2A
Case Type	Monitored

Incident Types	1. Significant Interest - Drugs
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two psychiatric technicians allegedly encouraged a patient to stab two other 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/01/2022
OLES Case Number	2022-00011-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A psychiatric technician allegedly pushed a patient, causing the patient to hit his head against a wall.

Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations, but decided the psychiatric technician should receive follow-up training on therapeutic strategies and interventions, and restraint policies. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/13/2022
OLES Case Number	2022-00054-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs 2. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician was allegedly discovered in possession of multiple baggies of cannabis, contraband female cosmetic products, and a letter from a female patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/26/2022

OLES Case Number	2022-00103-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs 2. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly provided contraband food, mobile phones and narcotics to a patient. The psychiatric technician also allegedly received two cash payments from a relative of the patient.
Disposition	The hiring authority sustained the allegations, and determined dismissal was the appropriate penalty; however, the psychiatric technician had previously resigned, in lieu of being dismissed, on an unrelated case. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	
OLES Case Number	2022-00289-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty

Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A law enforcement supervisor allegedly slept several times while on duty.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations, but decided all law enforcement personnel should receive follow-up training regarding policy expectations that staff remain alert while on duty. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	03/04/2022
OLES Case Number	2022-00329-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer was allegedly dishonest regarding his return to work status.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:**

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

Case Details	Description
Incident Date	03/29/2022
OLES Case Number	2022-00357-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A patient allegedly attempted to hit a psychiatric technician. The psychiatric technician then allegedly grabbed and pushed the patient back into his room, causing the patient to fall to the floor.
Disposition	The Office of Protective Services found insufficient evidence for a probable cause referral to the district attorney's office regarding crimes allegedly committed by the psychiatric technician. The OLES concurred with the probable case determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/05/2022
OLES Case Number	2022-00374-1A
Case Type	Monitored
Incident Types	1. Death

Allegations	1. Other
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was found unresponsive in his room, and level of care staff initiated life-saving measures. Outside emergency medical staff responded, taking over life-saving efforts; however, the patient remained unresponsive, and died from acute cardio-pulmonary arrest.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	03/30/2022
OLES Case Number	2022-00381-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Incident Summary	A psychiatric technician or a pharmacy technician allegedly removed a controlled sleep medication tablet,

	and replaced it with an over-the-counter sleep medication. The psychiatric technician or the pharmacy technician also allegedly removed six tablets of the over-the-counter sleep medication.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/11/2022
OLES Case Number	2022-00392-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly slapped a patient on the leg.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with the policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	04/08/2022

OLES Case Number	2022-00424-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
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 hiring authority sustained the allegation and determined counseling was appropriate. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	04/18/2022
OLES Case Number	2022-00425-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A medical professional allegedly startled a sleeping patient by speaking loudly and pulled the patient into a seated position, despite the patient's aversion to loud noises and physical contact.

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

Case Details	Description
Incident Date	04/19/2022
OLES Case Number	2022-00426-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician, assigned to maintain enhanced observation of a patient, allegedly failed to adequately monitor the patient. During the psychiatric technician's assignment, the patient was able to ingest narcotics. The patient exhibited symptoms of acute narcotics use and was transported to an outside hospital for a higher level of care.
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	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/28/2022

OLES Case Number	2022-00490-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A senior psychiatric technician allegedly used profanity while verbally re-directing a patient, lunged towards the patient, and grabbed a roll of tape out of the patient's hands. The senior psychiatric technician then allegedly challenged the patient to fight. The senior psychiatric technician also allegedly denied the patient access to jobs and certain property, and subjected the patient to racial discrimination.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/06/2022
OLES Case Number	2022-00530-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault 2. Significant Interest - Drugs 3. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act

Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly provided narcotics to a patient. The psychiatric technician also allegedly engaged in a sexual relationship with 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	
OLES Case Number	2022-00600-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pushed a wheelchair bound patient into a wall and into the patient's bedframe.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with the policies and procedures governing the pre-disciplinary process. The investigation was not completed until 326 days after

	discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 326 days after discovery of the incident.
Department Corrective Action Plan	Investigators have been reminded of the office controls previously implemented and have been instructed to monitor the aging of their cases and request assistance from other Investigators, when needed. Effective immediately, any case that reaches the 90-day mark will be reviewed by the SSI I. The assigned Investigator will be asked to provide documentation outlining the efforts they have made and the difficulties they have encountered in getting the case completed. The SSI I and the Investigator will determine the best path forward to complete the case in the required timeframe.

Case Details	Description
Incident Date	05/27/2022
OLES Case Number	2022-00625-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A staff member allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	06/08/2022
OLES Case Number	2022-00675-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly provided false information during a COVID screening process.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	06/06/2022
OLES Case Number	2022-00676-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Use of Force Review
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Applicable

Incident Summary	A unit supervisor, a nurse and a psychiatric technician were allegedly overly aggressive as they stabilized the patient against a wall during a behavioral incident. One of the staff members allegedly choked 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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/07/2022
OLES Case Number	2022-00698-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly administered medication to a patient in violation of a supervisor's order.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	06/19/2022
OLES Case Number	2022-00705-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A nurse allegedly inappropriately touched a patient while demonstrating how to determine the proper placement of an intramuscular injection site. The nurse also allegedly inappropriately exposed the patient, and failed to adequately inform the patient during the demonstration.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/24/2022
OLES Case Number	2022-00741-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Referred

Incident Summary	A senior psychiatric technician allegedly threw a laundry bag at 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/29/2022
OLES Case Number	2022-00755-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly challenged a patient to repeat aggressive behavior that had been directed towards the psychiatric technician. The psychiatric technician then allegedly slapped the patient's hand away, and pushed the patient towards the wall, attempting an unassisted wall stabilization of the patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/29/2022
OLES Case Number	2022-00759-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient fell and sustained a fractured hip.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/06/2022
OLES Case Number	2022-00782-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	A psychiatric technician allegedly put his face too close to a patient's face while attempting to verbally re-direct

	the patient. A second psychiatric technician allegedly pushed the patient's head 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	
OLES Case Number	2022-00801-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	A psychiatric technician allegedly engaged in sexual relationships with two patients.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services intended to open an administrative investigation; however, the psychiatric technician resigned before the criminal investigation could be completed. A letter indicating the psychiatric technician assistant resigned under adverse circumstances was placed in her official personnel file.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department failed to comply with policies and

	procedures governing the investigative process. The facility investigator refused to request a search warrant of the psychiatric technician's residence and mobile phone records, thus causing a delay in the investigation and possibly the discovery of relevant evidence.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The facility investigator refused to request a search warrant of the psychiatric technician's residence and mobile phone records. A new investigator from department headquarters was assigned and requested and executed those warrants.
Department Corrective Action Plan	The Supervising Special Investigator will work with the assigned investigator to ensure there is awareness that the case had been initially assigned to OPS investigations and provide any needed assistance to ensure there are no impediments to the investigation.

Case Details	Description
Incident Date	07/10/2022
OLES Case Number	2022-00805-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly pulled a patient off a bed and onto the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:**

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

Case Details	Description
Incident Date	
OLES Case Number	2022-00820-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly inappropriately touched a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed in a timely manner.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The final report was not completed until 183 days after the date of discovery.
Department Corrective Action Plan	HPD supervision/management was briefed on the importance of reviewing cases and forwarding completed cases to the Office of Special Investigations (OSI) in a timely manner. A new white board was installed at HPD to help track OLES monitored cases to ensure the reports are completed and forwarded to OSI in a timely manner.

Case Details	Description
Incident Date	07/15/2022
OLES Case Number	2022-00825-4A
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin) 2. Misconduct 3. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	An officer allegedly did not properly document having been involved in a use of force incident involving a resistive patient.
Disposition	The hiring authority sustained the allegation and determined a letter of counseling and training was the appropriate action.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	07/26/2022
OLES Case Number	2022-00874-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly reached towards a

	patient's groin area as they sat on a bench.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/28/2022
OLES Case Number	2022-00875-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly was unprofessional and used abusive language during an investigation.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/02/2022
OLES Case Number	2022-00911-1C
Case Type	Monitored

Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly used unnecessary force while helping a patient step onto a weight scale. The psychiatric technician also allegedly continued to hold onto the patient's arm, even though the patient complained of pain.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/07/2022
OLES Case Number	2022-00955-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A medical professional allegedly refused to respond and assess a patient's nosebleed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

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

Case Details	Description
Incident Date	
OLES Case Number	2022-00965-1A
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 **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/22/2022
OLES Case Number	2022-00996-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly aggressively pushed a patient in a wheelchair, causing the patient's foot to drag on the ground.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/22/2022
OLES Case Number	2022-01005-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault 2. Priority 1: Sexual Assault 3. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act
Findings	1. Referred 2. Not Applicable 3. Not Applicable 4. Referred 5. Not Applicable
Incident Summary	A psychiatric technician engaged in a sexual relationship with a patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause

	determination. The Office of Protective Services intended to open an administrative investigation; however, the psychiatric technician transferred to a different department and subsequently resigned before the criminal investigation could be completed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department failed to comply with policies and procedures governing the investigative process. The facility investigator refused to request a search warrant of the psychiatric technician's residence and mobile phone records, thus causing a delay in the investigation and possibly delayed the discovery of relevant evidence.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The facility investigator refused to request a search warrant of the psychiatric technician's residence and mobile phone records. A new investigator from department headquarters was assigned, and he requested and executed those warrants.
Department Corrective Action Plan	To correct this deficiency, the Supervising Special Investigator will work with the assigned investigator to ensure there is awareness that the case had been initially assigned to OPS investigations and provide any needed assistance to ensure there are no impediments to the investigation.

Case Details	Description
Incident Date	08/23/2022
OLES Case Number	2022-01008-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly engaged in an off-duty vehicle pursuit of a private citizen.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/24/2022
OLES Case Number	2022-01009-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two unidentified staff members allegedly forcefully sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/24/2022
OLES Case Number	2022-01019-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two level of care staff members allegedly left a patient locked outside on the unit patio.
Disposition	The hiring authority sustained the allegations and issued letters of expectation. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/25/2022
OLES Case Number	2022-01040-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly challenged a patient to a fight.

Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/04/2022
OLES Case Number	2022-01067-1A
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 **Final:** No Penalty Imposed
Incident Summary	A registered nurse allegedly inappropriately touched a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/05/2022
OLES Case Number	2022-01071-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly hit 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures concerning the investigative process.

Case Details	Description
Incident Date	09/08/2022
OLES Case Number	2022-01082-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Incident Summary	Four level of care staff members allegedly abused a patient while placing the patient in restraints. The patient sustained superficial wounds, and bruising to his limbs.
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	**Procedural Rating:** Sufficient

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

Case Details	Description
Incident Date	
OLES Case Number	2022-01097-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly threatened a patient and also allegedly failed to take appropriate action after a second patient reported he had been sexually assaulted.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/17/2022
OLES Case Number	2022-01098-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act

Findings	1. Referred 2. Not Referred
Incident Summary	Two psychiatric technicians allegedly grabbed a patient and twisted the patient's arms behind his back.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/17/2022
OLES Case Number	2022-01098-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained 7. Not Sustained

	8. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two psychiatric technicians allegedly used excessive force while placing a patient into a seclusion room. On another occasion, six other psychiatric technicians allegedly used excessive force while placing the patient into a seclusion room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	07/15/2022
OLES Case Number	2022-01102-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act
Findings	1. Referred 2. Referred 3. Referred 4. Referred 5. Referred
Incident Summary	Several psychiatric technicians allegedly grabbed and twisted a patient's arms, then forced the patient onto the floor of a seclusion room.
Disposition	The Office of Protective Services conducted an

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

Case Details	Description
Incident Date	09/14/2022
OLES Case Number	2022-01113-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs
Allegations	1. Misuse of state property
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	During a routine audit, it was discovered that an unidentified staff member had replaced a prescription opioid pill with a non-prescription pain reliever, located in a housing unit medication dispensing machine. The prescription opioid pill was missing.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/14/2022
OLES Case Number	2022-01115-1A
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 **Final:** No Penalty Imposed
Incident Summary	A psychiatrist allegedly entered a patient's bedroom and sexually assaulted the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	
OLES Case Number	2022-01130-1A
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 **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly sexually assaulted a patient prior to her hospitalization, has stalked the patient, and continues to sexually assault her while she is

	being treated at a state hospital.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/16/2022
OLES Case Number	2022-01136-4A
Case Type	Monitored
Incident Types	1. Abuse 2. Misconduct 3. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	An officer allegedly failed to report a patient's complaint of excessive force by staff members and other officers.
Disposition	The hiring authority sustained the allegation and issued corrective action and training. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/21/2022
OLES Case Number	2022-01144-1A
Case Type	Monitored

Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A unit supervisor and an art therapist allegedly dragged a patient approximately 30 feet to a seclusion room.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and issued training to the entire unit on Therapeutic Strategies and Interventions (TSI) and transportation techniques. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/21/2022
OLES Case Number	2022-01149-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Pharmacy staff members allegedly commingled 17 boxes of expired influenza vaccinations with batches of unexpired vaccinations.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/25/2022
OLES Case Number	2022-01182-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two psychiatric technicians allegedly choked a patient while restraining the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/28/2022
OLES Case Number	2022-01193-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Assault/GBI 3. Head/Neck
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A staff member allegedly forced a patient onto the ground as the patient was being attacked by another patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/30/2022
OLES Case Number	2022-01206-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly improperly provided medication to a patient which was intended for another 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 did not accept for monitoring because the incident did not meet the OLES's monitoring criteria
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and

	procedures governing the investigatory process. The department did not assign an investigator until over one month after the incident occurred, and the investigative report was not completed until 150 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No An investigator was not assigned to the case in a timely manner, and the investigative report was not completed until 150 days after discovery of the incident.
Department Corrective Action Plan	To prevent this issue from occurring again, the SSI's will track case progress and meet with Investigators regularly to pay close attention to OLES deadlines.

Case Details	Description
Incident Date	10/04/2022
OLES Case Number	2022-01220-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient in the face.
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 probable cause.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 127 days from the date of discovery.

Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 127 days after the incident was discovered.
Department Corrective Action Plan	To address the timeliness of the completion of the report within the 120-days timeframe, the SSI's will meet with the Investigators to ensure all percipient witness interviews are conducted in a timely manner.

Case Details	Description
Incident Date	10/06/2022
OLES Case Number	2022-01243-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A unit supervisor attempted to take legal paperwork from a resistive patient, and allegedly grabbed the patient's arm too aggressively, leaving bruises and a scratch on the patient's upper arm.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/06/2022

OLES Case Number	2022-01243-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A unit supervisor attempted to take legal paperwork from a resistive patient, and allegedly grabbed, bruised and scratched the patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	10/10/2022
OLES Case Number	2022-01261-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Significant Interest - Drugs
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred

Incident Summary	A senior psychiatric technician and two psychiatric technicians allegedly grabbed and bent a patient's arms behind the patient's back, causing pain and injury to the patient's shoulder.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/17/2022
OLES Case Number	2022-01284-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly inappropriately touched a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	10/20/2022
OLES Case Number	2022-01305-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pushed and forced a patient to the ground. The psychiatric technician then allegedly kneeled on the patient's arms and hit the patient in the 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	10/19/2022
OLES Case Number	2022-01307-2A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin) 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained

	2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A unit supervisor, a nurse, and three senior psychiatric technicians allegedly failed to provide medical assistance to a patient with a fractured jaw.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	10/18/2022
OLES Case Number	2022-01311-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly bumped into a staff member and spoke to the staff member in a discourteous manner.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Details	Description
Incident Date	10/20/2022
OLES Case Number	2022-01324-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A registered nurse allegedly contaminated a patient's hygiene products with feces and urine. A senior psychiatric technician allegedly fed the same patient feces.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the pre-disciplinary process. The initial responding officer did not provide the senior psychiatric technician with the Beheler admonition before the suspect interview.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The initial responding officer did not provide the senior psychiatric technician with the required Beheler legal admonition.
Department Corrective Action	The officer will be counseled on the importance of the staff Beheler admonition. Additionally, the officer will be

Plan	advised, when speaking to a subject that has been named as a suspect, a Beheler admonition needs to be given. The supervisors have been advised to continue to monitor all reports regarding this issue, ensuring future adherence.

Case Details	Description
Incident Date	10/21/2022
OLES Case Number	2022-01357-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Misuse of state property
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly tampered with, and moved, state property, which was assigned to another employee.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	11/01/2022
OLES Case Number	2022-01365-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Not Applicable

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An off-duty officer allegedly physically assaulted his girlfriend.
Disposition	During the investigation, the officer was dismissed on an unrelated misconduct case. Prior to the hearing for the unrelated case, the department entered into a settlement agreement wherein the officer agreed to resign in lieu of dismissal.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	10/31/2022
OLES Case Number	2022-01372-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly sexually assaulted four other psychiatric technicians while on duty.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/02/2022
OLES Case Number	2022-01385-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a patient out of his room.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/02/2022
OLES Case Number	2022-01385-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pushed a patient out of his room.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	
OLES Case Number	2022-01388-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A staff member allegedly slapped a patient who was trying to change a radio station.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	11/02/2022
OLES Case Number	2022-01396-1A
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 **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly inappropriately rubbed against a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	11/06/2022
OLES Case Number	2022-01397-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A family member alleged that staff is overmedicating a patient, causing the patient to suffer heart attacks.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/08/2022
OLES Case Number	2022-01415-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit and kneed a patient in the face and forced the patient into a side room.
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	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 133 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 133 days after the incident was discovered.
Department Corrective Action Plan	To prevent this issue from occurring again, the SSI's will conduct checks of the Records Management System (RMS) for submitted reports pending approval for OLES monitored cases. This will assist the SSI's in ensuring OLES cases are reviewed and approved before the 120-business day timeframe, and the assigned monitor (s) are notified of report completion prior to the 120-day due date.

Case Details	Description
Incident Date	11/10/2022
OLES Case Number	2022-01420-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault 2. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly threatened to sexually assault a patient. The patient also alleged a second psychiatric technician is having a sexual relationship with another 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	
OLES Case Number	2022-01442-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	A psychiatric technician allegedly pulled a patient into a sitting position on the patient's bed and then pulled the patient off the bed and onto the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	
OLES Case Number	2022-01460-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A registered nurse allegedly grabbed a patient by the neck.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the pre-disciplinary process. The investigator conducted the interview of the registered nurse without notice to OLES. The investigation was not timely completed.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator conducted the subject interview without notification to OLES.

	2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 165 days after discovery of the incident.
Department Corrective Action Plan	The assigned investigator will be reminded to follow the extension protocol. The assigned investigator will be instructed to obtain the AIM's approval when submitting a request for an extension. OSI supervision /management was briefed on the importance of reviewing and approving cases by the due date. OSI supervision/management will be reminded to review the white board that contains a list of OLES monitored cases to ensure cases are approved by the due date.

Case Details	Description
Incident Date	11/18/2022
OLES Case Number	2022-01461-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly scratched a patient, and four psychiatric technicians allegedly sexually assaulted the patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative	**Procedural Rating:** Sufficient

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

Case Details	Description
Incident Date	11/19/2022
OLES Case Number	2022-01474-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly failed to monitor a patient after administering a controlled medication.
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	**Procedural Rating:** Insufficient **Substantive Rating:** The department failed to comply with policies and procedures governing the investigative process. The responding officer failed to ask the patient critical questions about the identity of the staff member who allegedly improperly administered his medications. The investigator failed to locate the patient after his discharge from the facility. The department's delay in assigning an investigator prevented the investigator from interviewing the patient prior to his discharge.
Pre-Disciplinary Assessment	1. Was the investigation thorough and appropriately conducted? • No The responding officer failed to ask critical questions of the patient regarding the identity of the staff member who allegedly failed to properly administer his medication, and the investigator failed to locate the patient after his discharge from the facility.

	2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigator was assigned one day after the patient discharged from the facility. The delay in the assignment of the investigator prevented the department from obtaining critical information about how the patient allegedly obtained his medication.
Department Corrective Action Plan	To prevent this issue from occurring again, the Supervising Special Investigator's (SSI) will ensure that the cases are assigned in a timely manner. The SSI's will also work closely with the DPS / OLES Liaison to ensure cases are forwarded to OSI in a timely manner. The SSI's will perform monthly reviews of OLES monitored cases to ensure deadlines are being met.

Case Details	Description
Incident Date	10/04/2022
OLES Case Number	2022-01494-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A senior psychiatric technician allegedly grabbed a patient's throat, pushed the patient, and hit the patient's head. A second senior psychiatric technician then allegedly hit and kicked the patient's head and legs.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/04/2022
OLES Case Number	2022-01494-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly grabbed a patient's throat, pushed the patient, and hit the patient's head. A second senior psychiatric technician then allegedly hit and kicked the patient's head and legs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/02/2022
OLES Case Number	2022-01516-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly assaulted a patient while attempting to stabilize 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/30/2022
OLES Case Number	2022-01517-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly submitted an inaccurate timesheet and was dishonest to a supervisor.

Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/05/2022
OLES Case Number	2022-01542-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly grabbed and squeezed a patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/06/2022
OLES Case Number	2022-01543-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly kicked a patient in his back, which resulted in a superficial laceration and bruising.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	11/25/2022
OLES Case Number	2022-01550-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A registered nurse allegedly pushed and kicked a patient.

Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/02/2022
OLES Case Number	2022-01554-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A licensed vocational nurse allegedly slammed a door into 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	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with the policies and procedures governing the investigative process. The investigation was not completed until 146 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 146 days after discovery of the incident.
Department Corrective Action	Investigators have been reminded of the office controls previously implemented and have been instructed to

Plan	monitor the aging of their cases and request assistance from other Investigators, when needed. Effective immediately, any case that reaches the 90-day mark will be reviewed by the SSI I. The assigned Investigator will be asked to provide documentation outlining the efforts they have made and the difficulties they have encountered in getting the case completed. The SSI I and the Investigator will determine the best path forward to complete the case in the required timeframe.

Case Details	Description
Incident Date	12/10/2022
OLES Case Number	2022-01560-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Other failure of good behavior
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer had allegedly been engaged in assisting migrants illegally cross into the United States and was dishonest during the investigation.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/13/2022
OLES Case Number	2022-01572-1C

Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified person 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/15/2022
OLES Case Number	2022-01576-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician and a psychiatric technician allegedly attempted to fracture a patient's arms while stabilizing 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/20/2022
OLES Case Number	2022-01586-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician 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.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/21/2022
OLES Case Number	2022-01587-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Applicable

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient allegedly fell and sustained two fractured ribs.
Disposition	The hiring authority found insufficient evidence of any staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/21/2022
OLES Case Number	2022-01591-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault 2. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly is engaged in a sexual relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/21/2022
OLES Case Number	2022-01597-1A

Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician allegedly pushed a patient onto a bed, forcefully administered oral mediation to the patient and failed to document the incident.
Disposition	The hiring authority did not sustain the allegations of abuse but did sustain the failure to document allegation and determined a letter of instruction and additional training on documentation was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/11/2022
OLES Case Number	2023-00001-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly assaulted a patient after the patient laid on the floor.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/04/2023
OLES Case Number	2023-00021-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly grabbed a patient by the arm and forced the patient to the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/13/2023
OLES Case Number	2023-00071-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity

Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A medical professional allegedly gave a music listening device to a patient.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The medical professional's contract was immediately terminated. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/16/2023
OLES Case Number	2023-00075-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly slapped a cup out of a patient's hands.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/16/2023
OLES Case Number	2023-00077-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient sustained a fractured eye socket and cheekbone. The patient claimed he had fallen and refused to provide further information. Another patient later cooperated with the investigation and confirmed the patient was involved in a physical altercation with 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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/24/2023
OLES Case Number	2023-00129-1A
Case Type	Monitored

Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pushed a patient against a wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the pre-disciplinary process. The initial responding officer failed to conduct adequate interviews of the involved parties and witnesses.
Pre-Disciplinary Assessment	1. Was the incident properly documented? • No The initial responding officer failed to conduct comprehensive and adequate interviews of the involved parties necessitating multiple reinterviews.
Department Corrective Action Plan	The officer was counseled on the importance of conducting thorough interviews and interview styles. During the counseling, examples were referred to and the officer was able to identify that questioning could be conducted in a much more detailed manner in the future. The supervisors have been advised to continue to monitor all reports regarding this issue, ensuring future adherence.

Case Details	Description
Incident Date	01/26/2023
OLES Case Number	2023-00151-1C
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly applied wrist restraints too tightly on a patient, causing injury.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/27/2023
OLES Case Number	2023-00153-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly attempted to hit a patient who had assaulted him.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/27/2023
OLES Case Number	2023-00153-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A psychiatric technician allegedly attempted to hit a patient who had assaulted him.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. Additional training will be provided to the psychiatric technician on therapeutic strategies and interventions.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigator did not contact OLES for the second subject matter expert interview, thereby preventing the monitor from attending the interview.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The second investigator did not contact OLES for the interview of the subject matter expert, thereby preventing the monitor from attending the interview.
Department Corrective Action Plan	To correct these deficiencies, the hospital will ensure better communication with the AIMs to ensure they are invited to attend the interview with the Supervising

	Special Investigator. We will train all Investigators on Lexipol Policy No. 607.2. The Supervising Investigator discussed and reviewed Lexipol Policy No. 607.2 INVESTIGATION PROCESS GUIDELINE THRESHOLD INCIDENTS, with the assigned Investigator. We discussed the importance of keeping the assigned OLES AIM updated on all aspects of the investigation and ensuring the attorney is provided an opportunity to participate with all scheduled interviews. The Supervising Investigator will ensure the Investigators follow a guideline on OLES monitored cases which is noted on the OSI expectation letter.

Case Details	Description
Incident Date	01/21/2023
OLES Case Number	2023-00169-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse was allegedly less than alert while assigned to constantly monitor 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 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/01/2023
OLES Case Number	2023-00173-1C

Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly inappropriately slapped a patient on two occasions.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/23/2023
OLES Case Number	2023-00183-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly grabbed and twisted a patient's arms. The patient complained of wrist pain. X-rays confirmed the patient sustained a ligament tear in his wrist.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services also opened an administrative investigation which the OLES

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

Case Details	Description
Incident Date	02/01/2023
OLES Case Number	2023-00190-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly abused 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/07/2023
OLES Case Number	2023-00194-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act

Findings	1. Not Applicable 2. Not Applicable
Incident Summary	A psychiatric technician allegedly turned lights on and conducted searches of patients' rooms in order to harass patients. The same psychiatric technician was also allegedly overly familiar with two patients when he authorized additional work hours for them, resulting in increased pay for those two 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 did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/04/2023
OLES Case Number	2023-00212-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician 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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/09/2022
OLES Case Number	2023-00217-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly forced a patient against a wall after the patient refused to have his blood drawn.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/09/2023
OLES Case Number	2023-00225-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A food service technician allegedly embraced a patient in the hallway.
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	**Procedural Rating:** Insufficient **Substantive Rating:** The department failed to comply with policies and procedures governing the investigative process because the Office of Protective Services failed to identify the location of the alleged incident and preserve video footage.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The Office of Protective Services did not obtain the exact location where the reporting witness allegedly saw the hug between a patient and a staff member, and therefore failed to preserve video recording of the hallway covering that area. Once the reporting party identified the exact area, the video footage had already been automatically erased.
Department Corrective Action Plan	To correct these deficiencies, the Supervising Special Investigator will send a memo to the assigned Investigator to ensure the investigator downloads any available incident videos surveillance at the start of the criminal investigation. This corrective action will ensure footage is obtained before the system's 45-day automatic recording purge.

Case Details	Description
Incident Date	02/25/2023
OLES Case Number	2023-00292-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Staff members discovered a patient unresponsive and initiated emergency life-saving measures; however, the patient was later pronounced dead. An autopsy determined the patient died from atherosclerotic and hypertensive cardiovascular disease.
Disposition	The department determined there was no evidence of staff misconduct, but agreed to provide additional training to staff on emergency response. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	02/28/2023
OLES Case Number	2023-00313-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient allegedly sustained a genital injury during 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. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:**

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

Case Details	Description
Incident Date	03/01/2023
OLES Case Number	2023-00323-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient on the face.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/10/2023
OLES Case Number	2023-00462-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Applicable
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	An officer allegedly physically abused a patient and made discourteous comments to the patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	03/24/2023
OLES Case Number	2023-00463-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient complained of ongoing back pain. X-rays confirmed the patient sustained a mild compression fracture.
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	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	
OLES Case Number	2023-00548-2A
Case Type	Monitored

Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	A law enforcement supervisor allowed other employees unauthorized access to a secured area where confidential materials were stored.
Disposition	The hiring authority sustained the allegation and determined corrective action was the appropriate resolution. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	04/07/2023
OLES Case Number	2023-00559-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A social worker allegedly struck a patient on 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	**Procedural Rating:** Sufficient **Substantive Rating:**

	The department sufficiently complied with the 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
Incident Date	08/11/2020
OLES Case Number	2020-00837-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal

Incident Summary	An officer was allegedly dishonest regarding the loss of a state-issued protective vest.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board upheld the dismissal.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	11/18/2020
OLES Case Number	2020-01208-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	An officer allegedly made a false statement to a supervisor regarding exposure to COVID-19.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred. The officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board upheld the dismissal. The officer filed a Petition for Writ of Mandate which was denied.
Investigative	**Procedural Rating:** Sufficient

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

Case Details	Description
Incident Date	02/25/2021
OLES Case Number	2021-00253-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A psychiatric technician allegedly gave a patient the wrong medication, after which the patient suffered adverse side effects.
Disposition	The hiring authority sustained the allegation and determined a 10 percent salary reduction for 12 months was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The psychiatric technician did not file an appeal.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	05/23/2021
OLES Case Number	2021-00646-2A
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A medical professional allegedly did not properly treat a patient who reported that she had swallowed a foreign object.
Disposition	The hiring authority sustained the allegation and imposed a salary reduction of 5 percent for six months. OLES concurred with the hiring authority's determination. After the Skelly hearing, the hiring authority entered into a settlement agreement and reduced the penalty to a 5 percent salary reduction for two months. The OLES concurred because previously unknown mitigating evidence was presented at the Skelly hearing.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	08/02/2021
OLES Case Number	2021-00943-2A
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Reprimand
Incident Summary	A psychiatric technician allegedly improperly attempted to stabilize a patient against a wall.
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. The psychiatric technician filed an appeal with the State Personnel Board. At the investigatory hearing, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a letter of reprimand. In exchange, the psychiatric technician agreed to withdraw his appeal, and waive backpay already taken as a result of the disciplinary action. The OLES concurred because the resulting penalty still documented the psychiatric technician's policy violations, and the forfeited backpay still served to deter future policy violations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the pre-disciplinary process. The department delayed in completing the disciplinary action, and did not promptly notify the OLES of the psychiatric technician's appeal filed with the State Personnel Board.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those

	related to a writ? • No The discipline officer did not advise the OLES that the psychiatric technician filed an appeal with the State Personnel Board. 2. Was the disciplinary phase conducted with due diligence by the department? • No The disciplinary action was not completed until 104 days after the hiring authority decided to take action.
Department Corrective Action Plan	During this time, ERO had one discipline analyst completing actions, DSH continues to strive to meet the 60 days' time frame and have created calendar reminders bi-weekly with the due date.

Case Details	Description
Incident Date	09/09/2021
OLES Case Number	2021-01066-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Suspension
Incident Summary	Four psychiatric technicians, a nurse and a chaplain allegedly provided patients with contraband items. One of the psychiatric technicians was allegedly dishonest during the investigatory interview.
Disposition	The hiring authority sustained the allegations against the chaplain and one psychiatric technician and imposed a five percent salary reduction for seven months for the chaplain and dismissed the psychiatric technician. The

	chaplain did not file an appeal. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the penalty was reduced to a suspension for six months. The OLES concurred with the settlement because this was the first formal action against the psychiatric technician and he expressed remorse for his actions. The hiring authority found insufficient evidence to sustain the allegations against the other psychiatric technicians and the nurse. The OLES concurred with all of the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not comply with policies and procedures governing the disciplinary process. The disciplinary actions were not timely served.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The psychiatric technician was not served with the disciplinary action until 163 days after the disciplinary findings were made. The chaplain was not served until 152 days later.
Department Corrective Action Plan	The Human Resources Department, Labor Relations Unit has hired a Staff Services Analyst for a primary focus on OLES monitored cases to ensure timeliness is met.

Case Details	Description
Incident Date	10/21/2021
OLES Case Number	2021-01284-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment

	2. Dishonesty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Instruction
Incident Summary	An officer allegedly was dishonest and discourteous during a COVID-19 mask audit.
Disposition	The hiring authority sustained the allegation that the officer was discourteous but found insufficient evidence to sustain dishonesty. The hiring authority determined the appropriate penalty was a salary reduction of 5 percent for six months. The OLES concurred with the hiring authority's determinations. At the pre-hearing settlement conference, the department entered into a settlement agreement wherein the department agreed to reduce the penalty to a letter of instruction and the officer agreed to withdraw his appeal. The OLES concurred with the settlement as there were concerns with inconsistent witness statements and the misconduct was not likely to recur.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	01/13/2022
OLES Case Number	2022-00060-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Dishonesty

	3. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	An officer allegedly sent sexually explicit text messages to hospital employees and failed to report the misconduct. The officer also allegedly provided false statements during an investigative interview and attempted to persuade a witness to provide false statements.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Prior to the evidentiary hearing, the department and the officer entered into a settlement agreement whereby the officer agreed to resign in lieu of dismissal. The OLES concurred with the settlement as it achieved the ultimate goal of ending the officer's employment with the department.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	02/25/2022
OLES Case Number	2022-00216-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty

Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	An officer allegedly was less than alert.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 5 percent for six months was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer filed an appeal with the State Personnel Board. Prior to the pre-hearing settlement conference, the department and officer entered into a settlement agreement whereby the salary reduction was reduced to 5 percent for three months. The OLES concurred with the settlement as it was still significant enough to deter future misconduct and the penalty remained within the same level on the department's disciplinary matrix.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	02/26/2022
OLES Case Number	2022-00220-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction

Incident Summary	An officer allegedly possessed an unauthorized personal communication device in a secure treatment area.
Disposition	The hiring authority sustained the allegation and determined the appropriate penalty was a 10 percent salary for five months. The OLES concurred with the hiring authority's determinations. Following a Skelly hearing, the department entered into a settlement agreement wherein the department agreed to reduce the penalty to a salary reduction of 10 percent for three months and the officer agreed not to file an appeal. The OLES concurred with the settlement as mitigating factors were presented at the Skelly hearing and the salary reduction was still a significant penalty.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** 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 The penalty conference took place on October 19, 2022; however, the disciplinary action was not served until January 24, 2023, 97 days later.
Department Corrective Action Plan	The Employee Relations Office (ERO) completed and served this adverse action, however, during this time, ERO had one discipline analyst completing actions, we continue to strive to meet the 60 days' time frame and have created calendar reminders bi-weekly with the due date to assist with completing the disciplinary action timely.

Case Details	Description
Incident Date	04/14/2022
OLES Case Number	2022-00410-1A

Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Discourteous treatment 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A psychiatric technician was allegedly using her mobile phone while assigned to continuously monitor a patient. The psychiatric technician was allegedly dishonest to her supervisor, uncooperative with the investigation, and rude and dishonest during her investigatory interview.
Disposition	The hiring authority sustained the allegations and determined that a salary reduction of 10 percent for 24 months was the appropriate penalty. OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. Prior to an evidentiary hearing, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a 10 percent salary reduction for 18 months. The psychiatric technician agreed to withdraw her appeal. The OLES concurred with the settlement.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** The department did not follow policies and procedures governing the disciplinary process. The department did not timely serve the disciplinary action.
Disciplinary	1. Was the disciplinary phase conducted with due

Assessment Questions	diligence by the department? • No The department did not serve the employee with the disciplinary action until 103 days after the hiring authority made the penalty determination.
Department Corrective Action Plan	DSH continues to strive to meet the 60 days' time frame and have created calendar reminders bi-weekly with the due date to assist with completing the disciplinary action timely.

Case Details	Description
Incident Date	06/07/2022
OLES Case Number	2022-00668-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	An off-duty officer was arrested for allegedly driving a vehicle while under the influence of alcohol.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 5 percent for 12 months was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The department subsequently entered into a settlement agreement wherein the department agreed to reduce the salary reduction to 5 percent for six months. In exchange, the officer agreed not to file an appeal with the State Personnel Board. The OLES concurred with the settlement as the penalty was still a significant penalty and stayed within the appropriate range of the disciplinary matrix.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures

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

Case Details	Description
Incident Date	07/07/2022
OLES Case Number	2022-00789-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	Two officers allegedly were asleep while on-duty.
Disposition	The hiring authority sustained the allegations and determined a penalty of 5 percent for six months was the appropriate penalty for both officers. Both officers filed appeals with the State Personnel Board. Prior to an evidentiary hearing, the department entered into a settlement agreement wherein the department agreed to reduce the salary reductions to 5 percent for three months and the officers agreed to withdraw their appeals. The OLES concurred as the settlement was not unreasonable.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	08/21/2022
OLES Case Number	2022-01001-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin) 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A registered nurse allegedly failed to provide a patient with a fractured finger immediate and appropriate medical care. Additionally, the registered nurse allegedly failed to fill out all required documentation and falsified other documents.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 10 percent for 12 months 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	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	09/21/2022
OLES Case Number	2022-01145-1A

Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A psychiatric technician was allegedly sleeping while assigned to enhanced observation of a patient at an outside facility.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 10 percent salary reduction for 13 months. The OLES concurred with the hiring authority's determination. The psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department sufficiently complied with the policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	10/13/2022
OLES Case Number	2022-01273-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Discourteous treatment
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand

	Final: Letter of Reprimand
Incident Summary	A law enforcement supervisor allegedly engaged in inappropriate horseplay and discourteous treatment of subordinate officers. The law enforcement supervisor also allegedly inappropriately denied family leave to a subordinate officer.
Disposition	The hiring authority sustained the allegation that the supervisor engaged in horseplay and was discourteous but did not sustain the allegation that leave was inappropriately denied. The hiring authority determined the appropriate penalty was a letter of reprimand. The OLES concurred with the hiring authority's determinations. There was no appeal filed with the State Personnel Board.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	10/31/2022
OLES Case Number	2022-01372-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Discourteous treatment
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained

	5. Sustained 6. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A psychiatric technician allegedly sexually assaulted four other psychiatric technicians while on duty.
Disposition	The hiring authority sustained all allegations against the psychiatric technician, and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The disciplinary action was served on the psychiatric technician; however, the psychiatric technician resigned before the dismissal became effective. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in his official personnel file. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** The department complied with policies and procedures governing the disciplinary process.

Appendix D: 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.

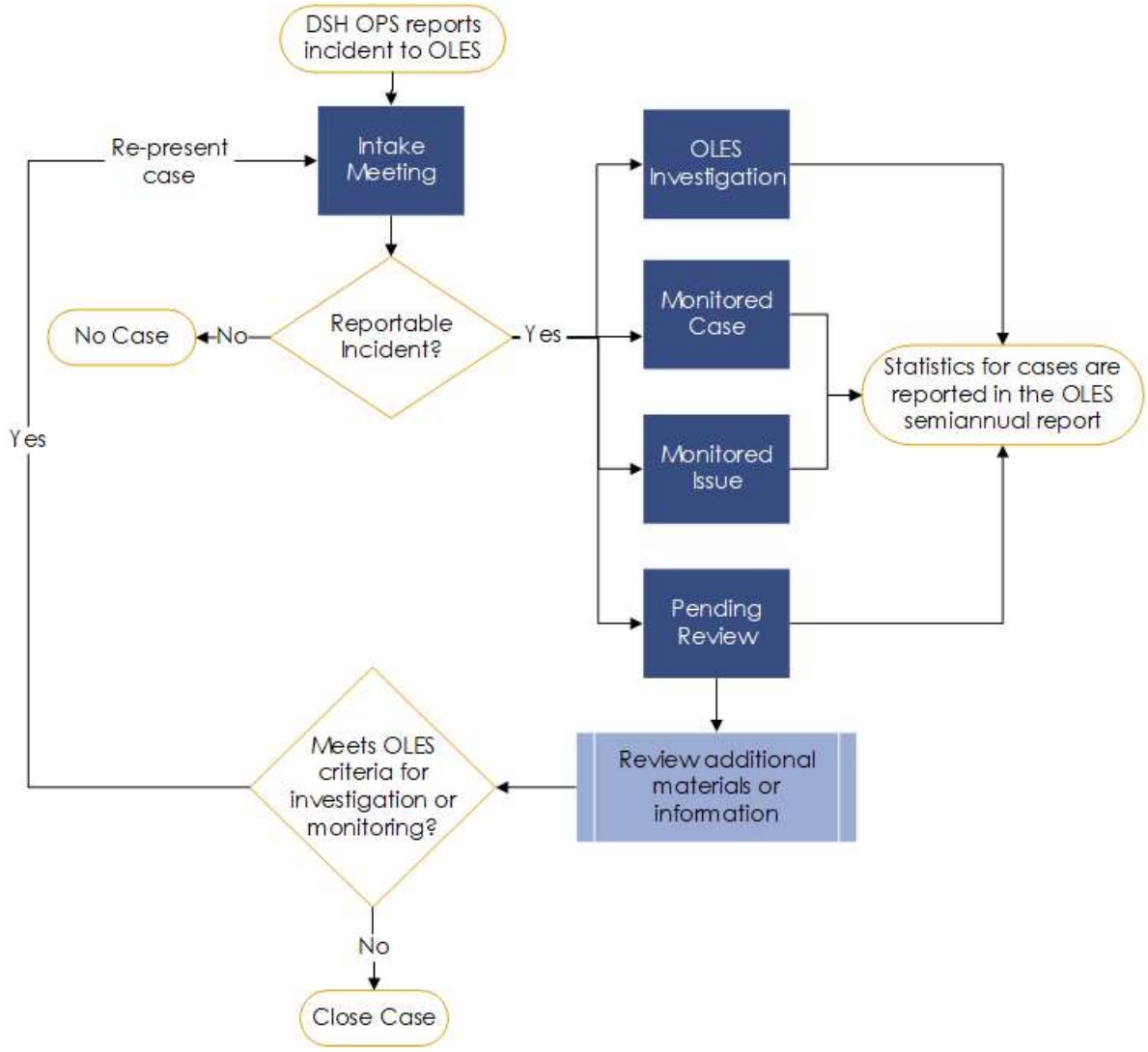
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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 E: 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 F: 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.