Office of Law Enforcement Support

Semiannual Report

JULY 1, 2023 – December 31, 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 sixteenth 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 July 1 through December 31, 2023.

In this report, the OLES provides details on 655 reported incidents and the results of completed investigations and monitored cases.

The OLES continues to bring attention to an important topic within DSH – Firearms. In an effort to ensure consistency with state law and best practices, OLES previously raised an issue concerning the recordkeeping of institutional and evidentiary firearms. DSH collaborated with the OLES to inspect and account for all firearms in their control and implement a centralized and uniform firearms record of departmental firearms consistent with state law.

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.

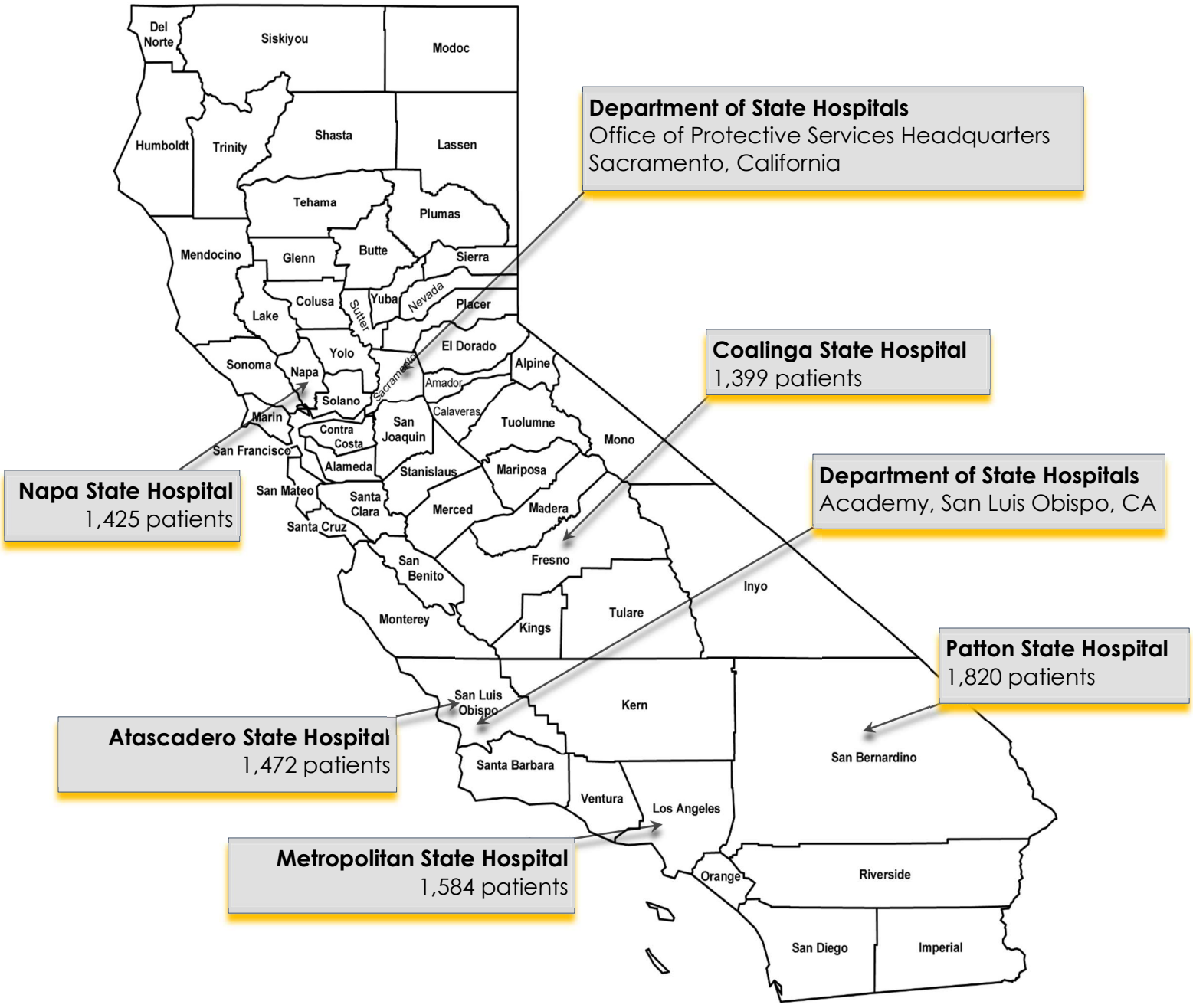
As the OLES begins its ninth year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DSH.

We are grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DSH management and personnel. We welcome comments and questions. Please visit the OLES website at https://www.oles.ca.gov/.

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities and Population Served

The OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers reflect the total patients served from July 1 through December 31, 2023, and were provided by the department.



Total Patients Served by Facility July 1, through December 31, 2023

DSH Facility	Total Number of Patients
Atascadero	1,472
Coalinga	1,399
Metropolitan	1,584
Napa	1,425
Patton	1,820
Total	7,700

The total number of patients served by DSH from July 1 through December 31, 2023, increased 2 percent, from 7,548 during the prior reporting period to 7,700 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.

Commitment Type	Description
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 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.

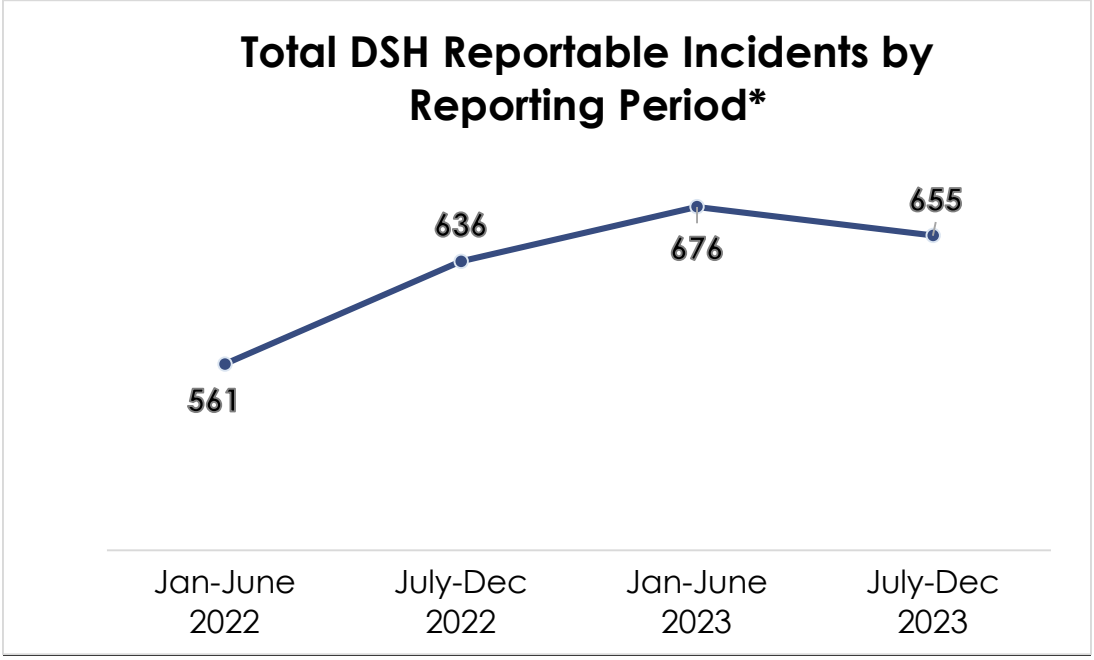
The following table provides the commitment type of patients served during the reporting period.

Commitment Type		Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST		557	0	1,304	724	806
PC 1026 NGI		228	<11	***	483	543
PC 2962/2964a OMD		409	0	0	0	93
PC 2972 OMD		127	326	<11	***	218
WIC 6316 MDSO		0	<11	0	<11	<11
PC 2684 CDCR		133	***	0	0	***
WIC 6602/6604 SVP		0	971	0	0	0
WIC 5358 LPS		18	11	265	176	137

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

Executive Summary

During the reporting period of July 1, through December 31, 2023, the Office of Law Enforcement Support (OLES) received and processed 655 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 (UOF) incidents and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is a decrease of 21 incident reports compared to the prior reporting period which had 676 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.

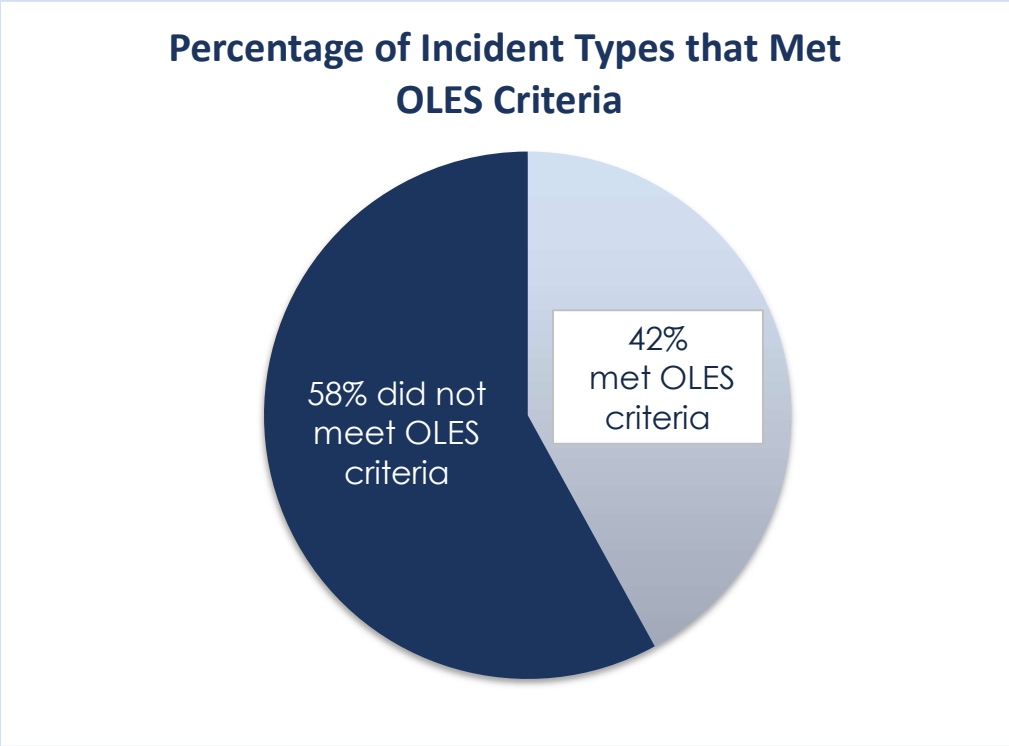
Incident Types Meeting OLES Criteria

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 655 reported incidents, the OLES identified 21 incidents with two or more incident types. The DSH reported a total of 679 incident types during this reporting period. Two hundred eighty-nine, or 42.5 percent of the 679 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

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

Law enforcement use of force was the most reported incident type. A use of force report documents an operational incident and does not indicate misconduct or excessive force by an officer. The OLES received 122 reports of use of force, which accounted for 18 percent of all reported incident types by DSH. Two of the 122 use of force reports included an allegation of excessive force which are included in the Abuse and Misconduct totals, and both received an OLES investigation.

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 if no resistance is offered by subject to the officer or officers.

Allegations of abuse was the second most reported incident type, with 89 allegations reported, representing a significant decrease of 28 percent compared to the 123 reported allegations in the prior reporting period.

Allegations of sexual assaults were the third most reported incident type, with 80 incidents reported, compared to 83 during the prior six-month reporting period.

The fourth most frequent incident type was Broken Bone (unknown origin), with 78 reports. This is a significant increase of 49.6 percent, compared to the prior reporting period of 47 reports. The OLES monitored 94 percent of these incidents.

Patient Deaths

The number of patient deaths decreased 30.4 percent, from 46 deaths to 32 deaths during this reporting period. Nine of the reported death incident types met the OLES criteria for monitoring. Twenty-one of the 32 patient deaths were expected due to existing medical conditions. Eleven patient deaths were classified as "unexpected" and received two levels of review by DSH, per department policy.

The largest number of patient deaths were reported from Coalinga State Hospital (CSH) with thirteen deaths and Napa State Hospital (NSH) with nine 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 seven patient arrests, which was six fewer arrests compared to the prior reporting period. The patients were arrested for violations of the statutes listed in the following table. Three patients were arrested at CSH for possession of child sexual abuse material.

Statute	Description
Penal Code section 245(c)	Assault with force likely to cause GBI
Penal Code section 311.11(b)	Possession of child pornography
Penal Code section 187(a)	Attempted murder
Penal Code section 220(a)(1)	Assault with intent to commit rape
Penal Code section 69	Knowingly resists, using force or violence, an officer, in the performance of his or her duty

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 42 sworn staff members. As of December 31, 2023, there were approximately 715 DSH sworn staff.

The OLES submitted 23 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process. 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 six 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 74 monitored administrative cases and 81 monitored criminal cases that, by December 31, 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.

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

The OLES monitored 155 pre-disciplinary phase cases; 146 of the pre-disciplinary phase cases are listed in Appendix B and nine are in Appendix C. The OLES rated 15 of the 155 pre-disciplinary phase cases insufficient. Deficiencies found in insufficient cases include, but are not limited to, incomplete interviews by the responding officer, failure to

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

provide the required legal admonishment prior to taking a statement and delayed investigations.

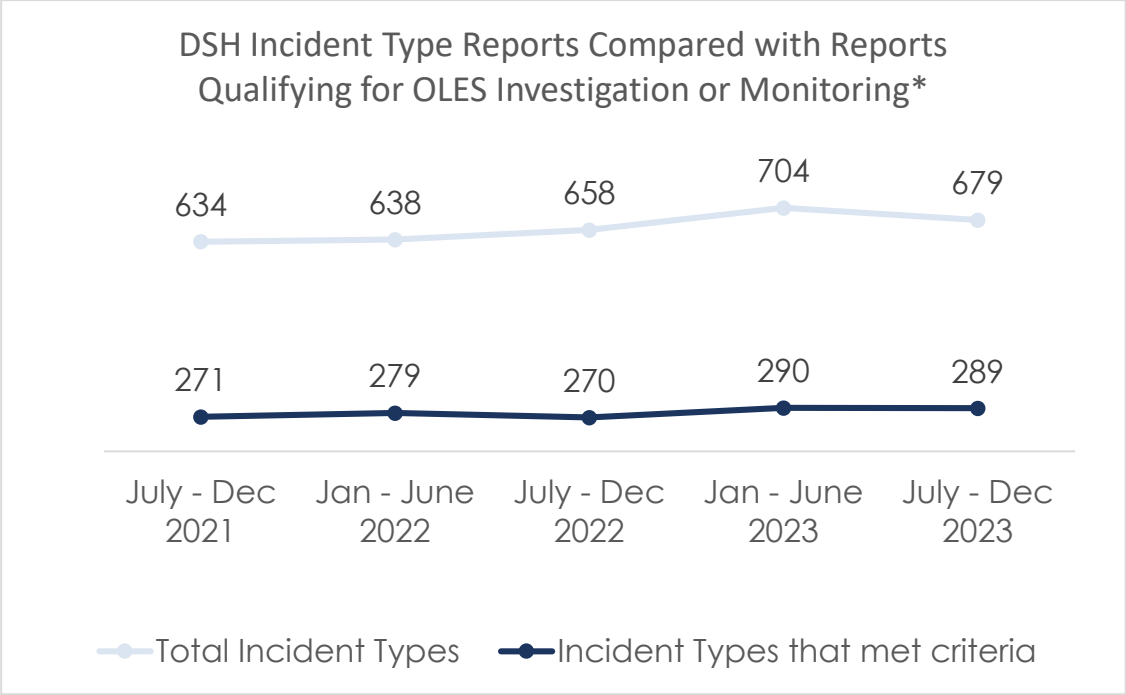
The OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in nine administrative cases listed in Appendix C. Three of the nine disciplinary phase cases were rated insufficient due to delays in serving a disciplinary action.

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.

Decrease in Reported Incident Types

The number of DSH incidents reported to OLES from July 1 through December 31, 2023, decreased 3.1 percent, from 676 during the prior reporting period to 655 in this reporting period. From the 655 reported incidents, the OLES identified 679 incident types, as 20 of the incidents featured two or more incident types. Two hundred and ninety of the 679 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, use of force by law enforcement, allegations of abuse, and sexual assault. These three incident type categories accounted for 312 or 46 percent of all incident types reported by DSH. Of the 312 incident types, 111 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was use of force by law enforcement. The 122 reports of use of force accounted for 17.9 percent of the reported incident types, and up 22 percent from the last period's 100 reports. This is the fifth full reporting period of

OLES requiring the department to report all use of force by law enforcement.

The DSH's second most frequent report to OLES was allegations of abuse with 89 reports. This represents a significant decrease of 27.6 percent from the prior reporting period of 123 reports. The number of abuse allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period was 85. The 89 reports of abuse accounted for 17.5 percent of the reported incident types.

Allegations of sexual assault were the third most frequently reported incident type by DSH, with incident types reported. Allegations of sexual assault accounted for 12 percent of all incident types reported. Of the 80 sexual assault allegations reported in this period, 25 allegations or 31 percent qualified for investigation, monitoring or consideration of a potential systemic issue.

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

Most Frequent Incident Types July 1 through December 31, 2023

Incident Type Category	Prior Period Incident Type Total January 1 through June 30, 2023	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Use of Force*	100	122	+22%	2
Abuse	123	89	-27.6%	85
Sexual Assault**	83	80	-1.2%	25

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

**These statistics do include sexual assaults alleged to have occurred to patients before they were admitted to a state hospital.

Incident Types by Reporting Period

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

Incident Categories	Prior Period July 1 - December 31, 2022 (Reported)*	Prior Period July 1 – December 31, 2022 (Meets Criteria)*	Prior Period January 1 - June 30, 2023 (Reported)*	Prior Period January 1 - June 30, 2023 (Meets Criteria)*	Current Period July 1 - December 31, 2023 (Reported)	Current Period July 1 - December 31, 2023 (Meets Criteria)
Abuse	100	94	123	117	89	85
Broken Bone (Known Origin)	15	0	27	5	35	3

Incident Categories	Prior Period July 1 - December 31, 2022 (Reported)*	Prior Period July 1 – December 31, 2022 (Meets Criteria)*	Prior Period January 1 - June 30, 2023 (Reported)*	Prior Period January 1 - June 30, 2023 (Meets Criteria)*	Current Period July 1 - December 31, 2023 (Reported)	Current Period July 1 - December 31, 2023 (Meets Criteria)
Broken Bone (Unknown Origin)	53	47	47	43	78	73
Burn	10	1	6	1	6	0
Death	37	7	46	10	32	9
Genital Injury (Known Origin)	6	0	29	3	10	1
Genital Injury (Unknown Origin)	10	6	16	8	12	9
Head/Neck Injury	38	2	44	3	51	3
Misconduct **	26	26	31	31	27	26
Neglect	23	15	29	27	45	36
Non-patient assault/GBI on Patient	0	0	0	0	0	0
OPS Use of Force***	99	4	100	0	122	1
Patient on Patient Assault/GBI	17	2	14	3	14	3
Pregnancy	0	0	0	0	0	0
Sexual Assault	102	45	83	27	80	25
Sexual Assault-OJ****	42	0	42	0	21	0
Attack on Staff*****	5	0	7	0	4	0
Attempted Suicide	0	0	2	0	1	0
AWOL	10	0	3	0	4	0
Child sexual abuse material	2	0	4	1	4	0

Incident Categories	Prior Period July 1 - December 31, 2022 (Reported)*	Prior Period July 1 – December 31, 2022 (Meets Criteria)*	Prior Period January 1 - June 30, 2023 (Reported)*	Prior Period January 1 - June 30, 2023 (Meets Criteria)*	Current Period July 1 - December 31, 2023 (Reported)	Current Period July 1 - December 31, 2023 (Meets Criteria)
Drugs******	38	7	24	3	23	3
Significant Interest *******	5	4	6	4	2	0
Over-Familiarity	11	10	15	12	12	12
Patient Arrest	9	0	13	0	7	0
Riot	0	0	0	0	0	0
Total	658	270	704	290	679	289

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

**The misconduct statistics include two use of force reports including allegations of excessive force by law enforcement and are included in the total count for the abuse incident type category.

***The 122 Use of Force incidents were assigned a Pending Review. Two of the 122 incidents of Use of Force included allegations of excessive force and were assigned investigations.

****These incidents occurred outside the jurisdiction of DSH.

*****The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department reported to OLES and therefore does not reflect all attacks on staff that may have occurred.

******Beginning in the July 1, 2021, through December 31, 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 incident of significant interest that may draw media attention, e.g., a department canine bit a technician at a boarding facility, and a department employee was arrested for sex crimes with a child under 14 years old.

Distribution of Incident Types

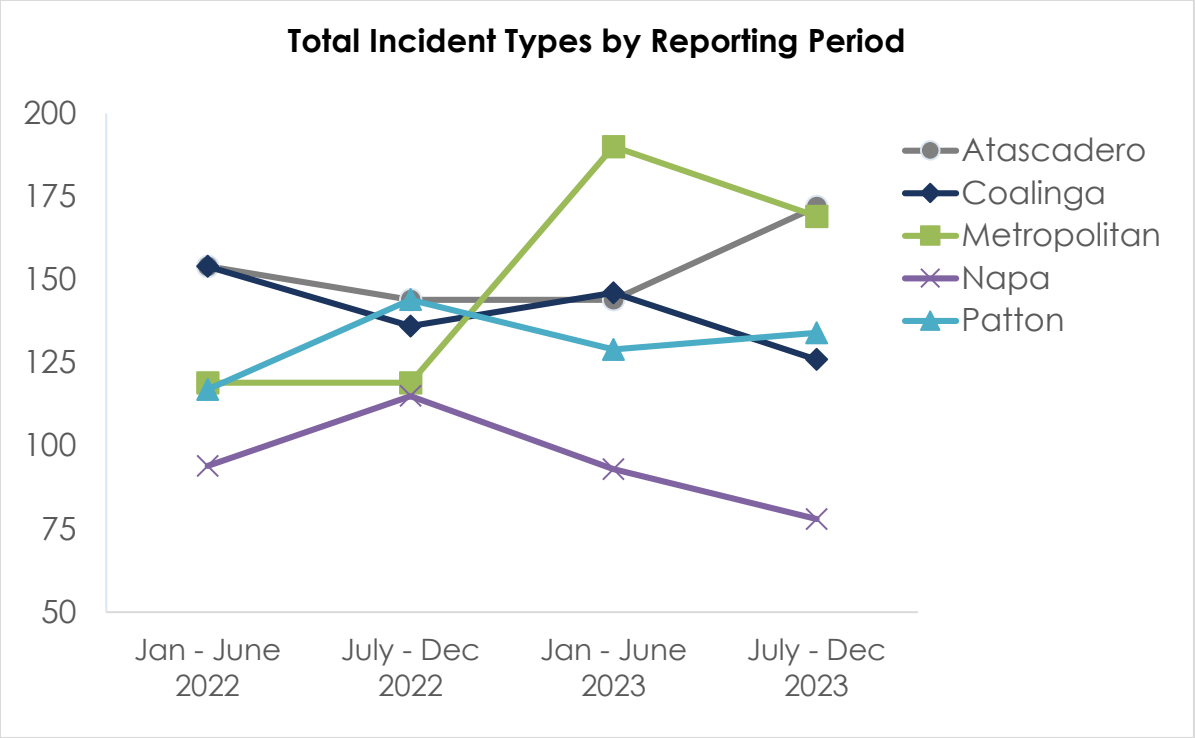
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

DSH Population and Total Incident Types

DSH Facility	Number of Patients Served*	Total Incident Types
Atascadero	1,472	172
Coalinga	1,399	126
Metropolitan	1,584	169
Napa	1,425	78
Patton	1,820	134
Total	7,700	679

*The department provided population served from July 1 through December 31, 2023.

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 July 1 through December 31, 2023. The 80 alleged sexual assault incident types reported in this reporting period accounted for 11.7 percent of all reported incident types from DSH. Twenty-five of the 80 reported incident types of alleged sexual assault, or 31.5 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 21 reported incident types under the sexual assault-OJ category, none of which met OLES criteria for investigation or monitoring.

Of the five DSH facilities, MSH 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 80 sexual assault incident types. The second most frequent type of alleged sexual assault involved non-law enforcement staff on a patient, with 17 incident types or 21 percent of the 80 alleged sexual assault incident types. There were 18 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. All DSH reports of alleged sexual assaults, including those that allegedly occurred before the patient was in the care of DSH, received by OLES during the reporting period are shown in the following table.

Sexual Assault Allegations Reported July 1 through December 31, 2023

Allegation Type	Total
Patient on Patient	41
Law Enforcement Staff on Patient	0
Non-Law Enforcement Staff on Patient	17
Unknown Person on Patient	18
Other	4
OJ*	21
Total	101

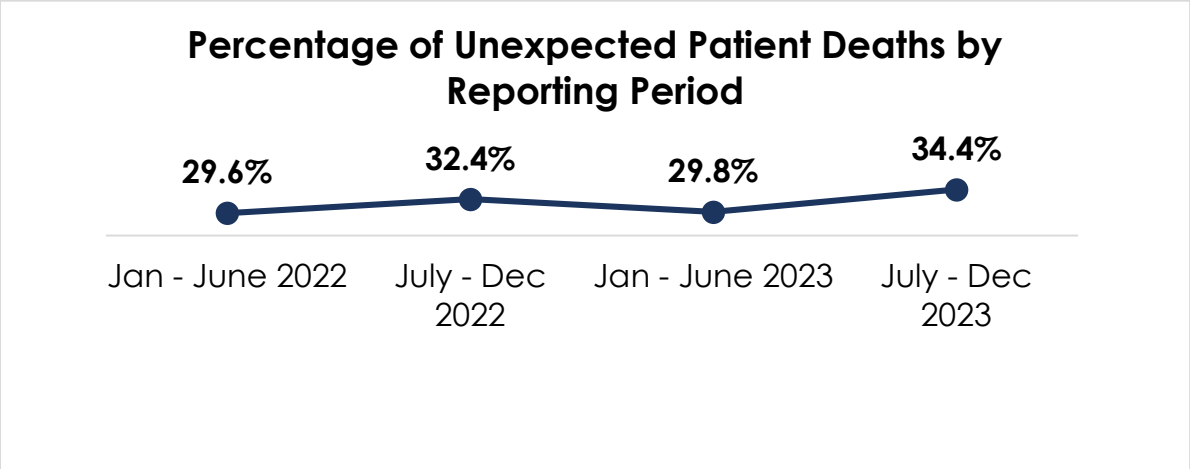
*Sexual Assault-OJ is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH.

Patient Deaths

The DSH reported 32 patient deaths to OLES during this reporting period. This number decreased 30 percent from the 46 patient deaths reported in the prior reporting period of January 1 through June 30, 2023.

Twenty-one of the patient deaths were classified as "expected" primarily due to underlying health conditions, such as cardiac or respiratory issues, and cancer. Eleven 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 death by suicide was for a patient where the death occurred within 30 days after the patient discharged from the state hospital.

Cause of Patient Deaths

Cause	Total
Cardiac/Respiratory	22
Cancer	3
Pending Coroner's Report	5
Cerebral	1
Suicide	1
Total	32

Reports of Head or Neck Injuries

The DSH reported 51 head or neck injuries during this reporting period. These head or neck injuries were the result of patient-on-patient altercations, a patient fall or a self-inflicted injury by the patient. Patient-on-patient altercations accounted for 16 of the 51 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 four 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 or any incident which may potentially draw media attention.
AWOL	A patient is 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.
Attempted Suicide	A patient suicide attempt requiring treatment beyond first aid.
Serious Crimes	The commission of serious crimes by patient(s) or staff.

Incident	Description
Drugs	Drug trafficking or smuggling.
Riot	As defined for OLES reporting purposes.
Over-Familiarity	Over-familiarity between staff and patients.

Timeliness of Notifications

The DSH timely reported incident types 94.4 percent compared to the prior reporting period, which had 94.5 percent timely reports.

Fifteen of the 679 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 664 incident types evaluated for timeliness, 627 were reported timely and 37 incident types were not timely.

Timeliness by Incident Type

The following table provides the percentage of timely notifications by incident type. The table does not include the 15 incident types that were excluded as described above.

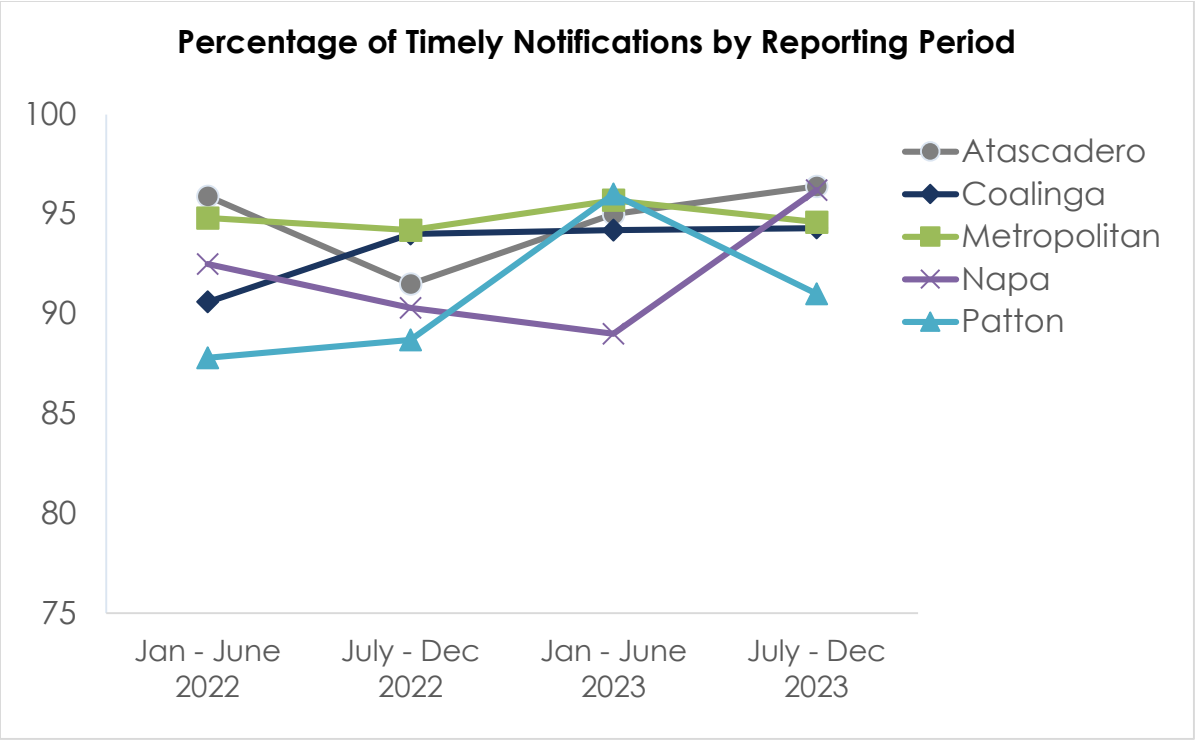
Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Abuse	73	14	87	83.9%
Broken Bone (Known Origin)	34	1	35	97.1%
Broken Bone (Unknown Origin)	67	11	78	85.9%
Burn	6	0	6	100.0%
Death	31	1	32	96.9%
Genital Injury (Known Origin)	10	0	10	100.0%
Genital Injury (Unknown Origin)	12	0	12	100.0%
Head/Neck	49	2	51	96.1%
Misconduct	17	2	19	89.5%
Neglect	42	0	42	100.0%
OPS Use of Force	122	0	122	100.0%
Patient on Patient Assault/GBI	14	0	14	100.0%
Attack on Staff	3	0	3	100.0%
Priority 1: Sexual Assault	27	3	30	90.0%
Priority 2: Sexual Assault	68	2	70	97.1%
Attempt Suicide	1	0	1	100.0%

Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
AWOL	4	0	4	100.0%
Child Sexual Abuse Material	4	0	4	100.0%
Drugs	22	1	23	95.7%
Significant Interest	2	0	2	100.0%
Over-Familiarity	12	0	12	100.0%
Patient Arrest	7	0	7	100.0%
Total	627	37	664	94.4%

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

Rank	DSH Facility	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
1	Patton	121	12	133	91.0%
2	Metropolitan	157	9	166	94.6%
3	Atascadero	159	6	165	96.4%
4	Coalinga	115	7	122	94.3%
5	Napa	75	3	78	96.2%
	Total	647	38	685	94.5%

The following chart compares the percentage of timely notifications by reporting period. NSH 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 E. To ensure OLES is independently assessing whether an allegation meets its criteria, OLES requires the departments to broadly report misconduct allegations.

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

For the July 1 through December 31, 2023, reporting period, 390 of the total 679 cases opened for DSH incidents that occurred within DSH's jurisdiction or 57.4 percent were assigned a pending review. The OLES opened cases for 21 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 23 administrative investigations and five criminal investigations. The OLES opened 258 monitored criminal cases and 3 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.

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

Cases Opened in the Current Reporting Period

OLES Case Assignments	July 1 – December 31, 2023	Percentage of Opened Cases
Pending Review	369	54.3%
Monitored, Criminal	258	38.0%
Monitored, Administrative	3	0.4%
Outside Jurisdiction*	21	3.1%
OLES Investigations, Criminal	5	0.7%
OLES Investigations, Administrative	23	3.4%
Totals	679	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. Six investigations were criminal cases and 21 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.

Twenty-one OLES investigations into administrative misconduct were forwarded to facility management for review. 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 July 1 - December 31, 2023	Referred to prosecuting agency	Referred to facility management
Administrative	21	N/A	21
Criminal	6	0	N/A
Total	27	0	21

OLES Monitored Cases

In this report, OLES provides information on 155 completed monitored cases. By the end of the reporting period, 81 monitored criminal cases had either been referred or not referred to a district attorney's office. Four of the 81 criminal cases were referred to a district attorney's office.

There were 74 completed monitored pre-disciplinary administrative cases with allegations that were sustained or not sustained during this reporting period. Eighteen of the 74 cases had sustained allegations. Fifty-six 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	4
Criminal-Not Referred	77
Total Criminal	81
Administrative-With Sustained Allegations	18
Administrative-Without Sustained Allegations	56
Total Administrative	74
Grand Total	155

Pre-Disciplinary Phase Cases

Of the 155 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 15 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 nine administrative cases. Three 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 December 31, 2023.

DSH Facility	Percentage of Compliance
Atascadero	99%
Coalinga	95%
Metropolitan	93%
Napa	81%
Patton	100%

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 (LMS) 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	39	10	13	14	2
Coalinga	42	7	9	22	4
Metropolitan	25	1	21	3	0
Napa	32	1	25	5	1
Patton	45	1	18	23	3
Total	183	20	86	67	10

* 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	21	0	21	0
Coalinga	16	1	15	0
Metropolitan	57	1	56	0
Napa	15	1	14	0
Patton	5	5	0	1
Total	114	8	106	5

* 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	0	3	0
Coalinga	0	0	0	0
Metropolitan	0	0	0	0
Napa	0	0	0	0
Patton	0	0	0	0
Total	0	0	3	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	396	81	316	118
Coalinga	247	47	200	28
Metropolitan	271	23	248	12
Napa	9	2	7	0
Patton	161	155	0	21
Total	1,084	308	771	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, the 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. Information on new and long-running monitored issues are provided below.

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.

The Office of Law Enforcement Support (OLES) conducted a review of DSH recordkeeping of DSH institutional firearms and crime/evidence firearms in February 2023 by comparing 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.

The review revealed the following four issues: (1) DSH did not have a policy containing any requirement that OPS staff enter information into AFS for any recovered, found, lost, or seized firearm, or the acquisition of institutional firearms; (2) numerous firearms in the possession of DSH were not recorded in AFS; (3) DSH facilities were in possession of crime guns for long periods of time and had yet to properly destroy or return these firearms in accordance with law; and (4) one DSH facility inappropriately identified, labeled and/or stored seized firearms.

DSH took the following actions based on OLES' recommendations and findings:

- All weapons at DSH were physically accounted for and listed in AFS;
- 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;
- DSH ensured each facility properly accounted for and entered into AFS all seized firearms; and
- DSH identified, relabeled, and secured the firearms at one facility that were inappropriately stored in evidence.

Although DSH has made significant improvement, there are still two issues left unresolved following OLES's review. First, a review of the documentation submitted by the facilities relating to "side arm qualifications" revealed a lack of consistent paperwork being used by the facilities for this activity. DSH has not provided any

response regarding OLES' recommendation for side arm qualification documentation. And second, while DSH updated its policy 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 and there is nothing in policy providing direction regarding the prompt return/destruction of crime/evidence firearms upon completion of an investigation.

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 patient, who was able to fabricate the bomb threat using the facility payphone and contraband electronic devices, which are banned by the 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. Several OPS personnel described numerous CCR, Title 9, Section 4350 violations, and challenges with attempts to enforce the regulations with PSH Administration staff. Several 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 majority of use on 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 devices. 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.

CCR 4350 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 during this process. 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: no illicit or illegal material was found. 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 has worked collaboratively with DSH to ensure all facilities are in compliance with CCR, Title 9, Section 4350. The DSH and the OLES have agreed that going forward, all contraband devices discovered by DSH, in violation of CCR, Title 9, Section 4350 will be reported to OLES as a Priority 2 incident. The OLES will close this monitored issue.

Recording of Investigatory Interviews

In 2017, the OLES issued a memorandum to the department recommending that OPS staff record investigatory interviews. In response, the department updated its policies and procedures to require recordings. However, in 2020 and 2021, it was noted that OPS staff were still not regularly recording interviews. Therefore, in January 2022, OLES re-opened this monitored issue to address this deficiency. The OLES recommended DSH update its policy and provide re-training. In response, DSH updated its recording policies, purchased additional recorders, and conducted training on recording

interviews to all OPS sworn staff. Since then, there has been an overall improvement in the recording of investigatory interviews. However, there continue to be instances in which staff are being offered the option of whether the interviews will be recorded and in at least one case, the investigator claimed they did not attempt to record interviews out of a fear of alarming the witnesses. The OLES recommends that the department continue to work with its OPS staff on normalizing the recording of interviews. The OLES will continue to monitor 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 system (EIS) 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 Blue Team/IAPro software as its EIS. In 2016, DSH reported they 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/IAPro 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 the Blue Team/IAPro data did not accurately reflect the number of incidents that met the criteria as a reportable incident to both Blue Team/IAPro and OLES. Also, some reportable use of force incidents were discovered in DSH's Records Management System (RMS), but they were not in Blue Team/IAPro. There appeared to be a lack of responsibility and data consistency 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 despite having access to other data showing information was not being entered consistently or at all.

In March 2018, OLES again 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 of the system requirements.

In August 2021, OLES reviewed the incidents DSH entered into Blue Team/IAPro between January 1, 2021, through June 30, 2021. From this review, OLES discovered DSH continued to fail to promptly input 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/ 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 DSH Chief of Law Enforcement now reviews all use of force reports on Blue Team/IAPro.

In February 2024, OLES audited all use of force incidents entered in Blue Team/IAPro between July 1, 2023, through December 31, 2023. The OLES found that DSH entered 116 incidents in Blue Team/IAPro; however, two incidents were entered twice, leaving 114 use of force incidents entered in Blue Team/IAPro.

During the same period, OLES received 122 use of force incidents from DSH between July 1, 2023, through December 31, 2023. A review of these incidents revealed that 16 had not been entered into Blue Team/IAPro. The data also reflected that five incidents entered into Blue Team/IAPro had not been reported to OLES during this period. The OLES will continue to monitor the department's usage of Blue Team/IAPro.

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 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 if 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.

In subsequent SAR reporting periods, 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 2023, the OLES use of force consultant and DSH Chiefs of Police and representatives from their command participated in a meeting dedicated to developing an updated use of force policy, with field-level input. The development of the new policy and procedures has been ongoing but is nearing completion. The OLES will continue to monitor the department's progress and implementation.

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 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 to OPS.

These delays have the potential to negatively impact the investigation 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 an allegation of sexual assault or abuse. 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 to ensure understanding. Since these changes were implemented, there has been a steady improvement in the number of delayed reports. During this reporting period, there were no incidents of delayed or failed reporting by mandated reporters. The OLES commends the department for its work on this issue and the progress that has been made. The OLES will continue to monitor this issue.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of July 1 through December 31, 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	11/12/2020
OLES Case Number	2021-00348-2A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly provided false testimony at a civil deposition.
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	09/25/2022
OLES Case Number	2022-01253-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	Four officers allegedly failed to report a patient's allegation of excessive force.
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	2022-01275-1C
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	Two officers allegedly falsified a police report.
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	11/01/2022
OLES Case Number	2022-01365-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly physically assaulted his girlfriend.
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	07/30/2022
OLES Case Number	2023-00160-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An off-duty officer allegedly did not properly secure a firearm in a personal vehicle and failed to report that the firearm was stolen.
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	12/11/2022
OLES Case Number	2023-00187-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	Two officers allegedly failed to accurately report damage to a state 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	02/19/2023
OLES Case Number	2023-00255-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An off-duty officer was allegedly discourteous to a staff member.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Details	Description
Incident Date	01/30/2023
OLES Case Number	2023-00369-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer was allegedly asleep while on duty.
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	04/27/2023
OLES Case Number	2023-00623-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly broke a patient's personal property.
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	2023-00668-1C
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly sexually assaulted several individuals.
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	04/22/2023
OLES Case Number	2023-00676-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly drove a department vehicle at an excessive rate of speed on multiple occasions.
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	04/27/2023
OLES Case Number	2023-00723-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	Two law enforcement supervisors and an officer allegedly failed to properly process evidence in a criminal case.
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	03/02/2023
OLES Case Number	2023-00758-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly made inappropriate comments regarding sexual activity to another officer.
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	01/26/2023
OLES Case Number	2023-00790-1C
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly claimed more hours than he had worked hours on his official timesheet and engaged in sexual activities while at work.
Disposition	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	06/06/2023
OLES Case Number	2023-00827-1C
Case Type	Investigative
Incident Types	1. Priority 1: Sexual Assault
Incident Summary	An officer allegedly sexually assaulted 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	05/31/2023
OLES Case Number	2023-00834-2A
Case Type	Investigative
Incident Types	1. Neglect 2. Priority 1: Sexual Assault
Incident Summary	An officer allegedly witnessed inappropriate contact between a staff member and a patient and did not report it.
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	06/06/2023
OLES Case Number	2023-00837-1A
Case Type	Investigative
Incident Types	1. Misconduct

Incident Summary	An officer allegedly changed information in another officer's written report without their knowledge.
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	06/20/2023
OLES Case Number	2023-00902-1C
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	Five officers allegedly used excessive force while extracting a patient from a vehicle.
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	07/05/2023
OLES Case Number	2023-00961-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An on-duty officer was allegedly intoxicated, and another officer allegedly failed to take appropriate action with respect to the intoxicated officer.
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	07/12/2023
OLES Case Number	2023-01005-1A
Case Type	Investigative

Incident Types	1. Misconduct
Incident Summary	The Office of Law Enforcement Support received a complaint that a facility's Field Training Program (FTO) was not complying with the Commission on Peace Officer Standards and Training (POST) requirements.
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	07/14/2023
OLES Case Number	2023-01019-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly assaulted a 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	07/16/2023
OLES Case Number	2023-01028-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An off-duty officer allegedly failed to properly secure a personal firearm in his personal 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	07/22/2023
OLES Case Number	2023-01050-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An off-duty officer was arrested for allegedly driving while intoxicated.
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	04/13/2023
OLES Case Number	2023-01083-1C
Case Type	Investigative
Incident Types	1. Abuse 2. Use of Force Review
Incident Summary	Three officers allegedly used excessive force while a patient was administered medications.
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	06/28/2023
OLES Case Number	2023-01137-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly conducted a racially motivated search of a patient's room in order to harass the patient.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter and determined there was

	insufficient evidence that misconduct occurred, and the matter was closed. A summary of the investigation and decision was provided to the department.

Case Details	Description
Incident Date	07/27/2023
OLES Case Number	2023-01230-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly copied another officer's report and submitted it as his own.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred, and the matter was closed. A summary of the investigation and decision was provided to the department.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by December 31, 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	03/01/2022
OLES Case Number	2022-00230-1C
Case Type	Monitored
Incident Types	1. Head/Neck 2. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly failed to properly respond to an emergency situation which resulted in a patient being sent out to an outside medical facility for treatment.
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	**Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The investigation was not completed timely.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 406 days after the incident was discovered.
Department Corrective Action Plan	While DSH-Napa continues to work towards filling vacant investigator positions, which can impact the timely completion, 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 Supervising Investigator (A). 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 Supervising Investigator and the Investigator will determine the best path forward to complete the case within the required timeframe.

Case Details	Description
Incident Date	03/01/2022
OLES Case Number	2022-00230-2A
Case Type	Monitored
Incident Types	1. Head/Neck 2. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Applicable
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly failed to properly respond to an emergency situation when a patient fell and lost consciousness.
Disposition	The psychiatric technician was dismissed on an unrelated case prior to the completion of the investigation; therefore, no disciplinary action was taken.
Investigative Assessment	**Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The administrative case was completed 264 days after the case was initiated.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The administrative case was completed 264 days after the case was initiated.
Department Corrective Action Plan	While DSH-Napa continues to work towards filling vacant investigator positions, which can impact the timely completion, 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 Supervising Investigator (A). 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 Supervising Investigator and the Investigator will determine the best path forward to complete the case within the required timeframe.

Case Details	Description
Incident Date	05/31/2022
OLES Case Number	2022-00635-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Unknown Origin) 3. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A program director allegedly attempted to restrain an agitated patient, causing the patient to suffer several facial injuries.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/06/2022
OLES Case Number	2022-00676-3A
Case Type	Monitored
Incident Types	1. Abuse 2. Use of Force Review
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, a nurse, and a psychiatric technician allegedly used excessive force while stabilizing a patient during a behavioral incident. One of the staff members allegedly choked 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/27/2022
OLES Case Number	2022-00869-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was found unresponsive in his single-person bedroom, and a medical alarm was activated. Although life-saving measures were attempted, the patient later died.
Disposition	The Office of Protective Services conducted an investigation, and determined there was no evidence that a crime caused or contributed to the patient's death. The OLES concurred. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/01/2022
OLES Case Number	2022-01057-2A
Case Type	Monitored
Incident Types	1. Drugs
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly possessed drugs and a loaded firearm in her vehicle while on hospital grounds.
Disposition	The hiring authority sustained the allegations and OLES concurred; however, the psychiatric technician resigned during the investigation. Therefore, no disciplinary action could be taken. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/01/2022
OLES Case Number	2022-01112-2A
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 failed to report another officer's misconduct.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/25/2022
OLES Case Number	2022-01253-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	Four officers allegedly failed to report a patient's allegation of excessive force.
Disposition	The hiring authority sustained the allegations and issued letters of counseling. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/10/2022
OLES Case Number	2022-01261-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Drugs
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 and two psychiatric technicians allegedly used excessive force while attempting to restrain 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/08/2022
OLES Case Number	2022-01411-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly repeatedly hit a patient in the back of the head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	**Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator refused to conduct an interview of a staff witness until nine months after the incident, the Office of Special Investigations did not respond to emails from the OLES monitor for approximately three months, and investigation was not completed until 314 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The Office of Special Investigations did not respond to emails from the OLES monitor for approximately three months regarding whether an interview of a staff witness would be conducted by the assigned investigator. 2. Was the investigation thorough and appropriately conducted? • No The investigator refused to conduct an interview of a staff witness and did not conduct the interview until nearly nine months after the alleged incident.

	3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 314 days after discovery of the incident.
Department Corrective Action Plan	The Investigation was sent to hospital police for recorded interviews as they were not conducted prior to the case being referred to OSI. After hospital police interviews were conducted, OSI discovered one witness interview was not completed. OSI and hospital police are in the process of establishing a procedure on how to hospital police will refer cases to OSI. In addition, OSI and hospital police are working on a procedure on how to track cases that are sent back to hospital police for follow-up. OSI is also working on a OSI case tracking system to ensure monitored cases do not have extended delays and can be signaled as late following the 120-day OLES procedure for case completion.

Case Details	Description
Incident Date	11/13/2022
OLES Case Number	2022-01421-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient experienced difficulty breathing, fell, and became unresponsive. Hospital staff initiated emergency life-saving measures; however, the patient was declared dead. An autopsy determined the patient died from a pulmonary thromboembolism.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/13/2022
OLES Case Number	2022-01421-2A
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	A patient experienced difficulty breathing, fell, and became unresponsive. Hospital staff initiated emergency life-saving measures; however, the patient was declared dead. An autopsy determined the patient died from a pulmonary thromboembolism.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/04/2023
OLES Case Number	2023-00022-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pulled a patient's hair.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/11/2023
OLES Case Number	2023-00062-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Three staff members allegedly assaulted a patient and injured her eye.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/05/2022
OLES Case Number	2023-00099-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly shoved 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 accepted for monitoring.
Investigative Assessment	**Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed timely.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 207 after the date of discovery.
Department Corrective Action Plan	The supervising special investigator shall ensure all OLES cases are properly tracked and immediately assign closed criminal cases for an administrative investigation if warranted. The tracking system will consist of a spread sheet to be updated by the AGPA assigned to the OSI division weekly. The AGPA will then provide weekly updates to the OSI supervisor so they can determine, in collaboration with OLES, if an administrative investigation is needed. This will also assist the OSI supervisor with ensuring the OLES timelines are being met.

Case Details	Description
Incident Date	11/05/2022
OLES Case Number	2023-00099-2A
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 shoved 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/19/2023
OLES Case Number	2023-00100-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A rehabilitation therapist allegedly paid a patient to attack another 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	**Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed timely.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 182 days after the date of discovery.
Department Corrective Action Plan	Due to multiple cases and the assignment of high-profile case, this case took longer the 120-day standard. This investigator is cognizant of meeting the time frame of 120 days in which to complete an investigation and the procedure of requesting an extension if the investigation will move beyond the 120 days. A request for extension will be discussed with the assigned OLES monitor, according to the parameters set out in the issued memorandum. OSI will have a tickler file as a reminder of the due date. OSI will put the due date in the calendar. OSI will put the due date on top of the chronological sheet with the date highlighted.

Case Details	Description
Incident Date	01/24/2023
OLES Case Number	2023-00137-1A
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 rehabilitation therapist allegedly was using a personal mobile phone and failed to provide constant monitoring of a patient, who swallowed a screw.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/30/2023
OLES Case Number	2023-00159-1C
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 evidence. The OLES concurred.
Investigative Assessment	**Rating:** Insufficient The department did not sufficiently comply with policies or procedures governing the investigative process. The responding officer did not conduct a thorough investigation; no steps were taken to identify the alleged perpetrator or percipient witnesses. The officer did not ask witnesses whether they hit the patient or saw any staff hit the patient. The OPS did not consult with OLES during the course of the investigation. The investigator did not notify OLES prior to interviewing the subject psychiatric technician and a percipient witness thereby prevent OLES from monitoring the interviews. The investigator did not provide the subject psychiatric technician the legally required Beheler admonition prior to conducting the interview. The investigator did not conduct thorough interviews of the two witnesses in an effort to determine how the patient sustained an injury to his face. The report was not completed until 149 days after the date of discovery.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The responding officer did not take steps to identify the

	alleged perpetrator or percipient witnesses to the incident. The officer did not ask the involved staff whether they hit the patient or saw any other staff hit the patient. 2. Was the incident properly documented? • No The incident was not fully documented due to the officer failing to complete a full investigation. 3. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The OPS did not consult with OLES after the case was opened and prior to finalizing the investigative plan other than requesting OLES reject the case for monitoring. 4. Were all of the interviews thorough and appropriately conducted? • No The investigator did not provide the subject psychiatric technician with the legally required legal Beheler admonition. The interviews were not thorough and did not attempt to determine how the patient may have sustained the injury to his face. The interviews that were conducted were cursory and failed to elicit necessary information. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No OPS did not provide continued real-time consultation with OLES. The investigator did not consult with OLES at the inception of the investigation, other than providing an investigative plan. The investigator only conducted two interviews and did not provide notice to OLES thereby preventing OLES from monitoring the investigation. 6. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? • No The investigation was conducted without consultation with OLES. 7. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 149 days

	after the date of discovery.
Department Corrective Action Plan	OSI has established a procedure that covers what investigators are required to do with OLES monitored investigations. The procedure states investigators are required to provide real time communication with OLES monitors in regard to every interview. The procedure outlines the 120-day OLES deadline that OSI follows. The Investigator has been retrained on the OPS Beheler policy to ensure it is used appropriately in each interview. In addition, OSI will send each investigator to interview and interrogation training through appropriate POST courses.

Case Details	Description
Incident Date	02/01/2023
OLES Case Number	2023-00173-2A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly inappropriately slapped a patient on two occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/26/2023
OLES Case Number	2023-00174-1A
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 verbally threatened a patient and threw the patient's shoes and clothes at her, striking the patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Insufficient The department did not sufficiently comply with policies or procedures governing the investigative process. The responding officer made a clerical error and did not properly note the due date for this investigation. The investigation took 154 days, however, from the date of discovering her oversight, the investigator made efficient use of her time and completed a thorough investigation in a very short time period.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 154 days after the incident was discovered. The due date was miscalculated due to a clerical error made by the responding officer. As soon as the error was discovered, the investigator completed a thorough investigation in an efficient manner.
Department Corrective Action Plan	Upon receipt of the file, the investigator will make note of the intended date of completion and know that date will be the expected completion date. The completion date will be noted in an obvious place within the file. This will

	serve as a noticeable reminder of the "due date." For example, the investigator has begun listing and highlighting the expected completion date on every chrono page in the file in a spot where it is in plain sight. The investigators are reminded of meeting the time frame of 120 days in which to complete an investigation and the procedure of requesting an extension if the investigation will move beyond the 120 days.

Case Details	Description
Incident Date	01/01/2021
OLES Case Number	2023-00203-1A
Case Type	Monitored
Incident Types	1. Significant Interest
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	A psychiatric technician allegedly disclosed a patient's confidential information to a second 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/09/2023
OLES Case Number	2023-00208-1A
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 senior psychiatric technician, assigned to monitor a patient, allegedly failed to prevent the patient from swallowing two batteries.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	02/08/2023
OLES Case Number	2023-00213-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly misstated facts regarding an allegation of harassment.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the determinations.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/09/2022
OLES Case Number	2023-00217-2A
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 forced a patient against a wall after the patient refused to have his blood drawn.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/11/2023
OLES Case Number	2023-00229-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	A psychiatric technician allegedly repeatedly hit a patient in the face.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/12/2023
OLES Case Number	2023-00234-1A
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	Staff members allegedly denied water to a patient being held in a seclusion room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/19/2023
OLES Case Number	2023-00255-2A
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 off-duty officer was allegedly discourteous to a staff member.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/01/2023
OLES Case Number	2023-00259-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Applicable
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly traded coffee for favors with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/23/2023
OLES Case Number	2023-00282-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician allegedly failed to properly monitor a patient on enhanced monitoring status for self-injurious behavior.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and issued a letter of warning. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/24/2023
OLES Case Number	2023-00314-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A certified nursing assistant allegedly abandoned her post and failed to maintain continuous observation of patient who was a danger to herself.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/01/2023
OLES Case Number	2023-00326-1A
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 forced a patient to the floor.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/01/2023
OLES Case Number	2023-00330-1C
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 conducted an unlawful search of a patient's room, grabbed and placed the patient in restraints, causing bruising to the patient's wrist and forearm areas. A psychiatric technician also allegedly denied the patient the use of the restroom and used discourteous language when speaking to 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/27/2023
OLES Case Number	2023-00335-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inefficiency
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A patient allegedly refused a medication. A psychiatric technician then allegedly mixed the patient's medication in water and told the patient he was drinking only water. A psychiatrist allegedly failed to timely report the actions of the psychiatric technician.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the psychiatric technician and issued a letter of warning. The hiring authority also determined there was sufficient evidence to sustain the allegation against the psychiatrist and issued a letter of expectation. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/04/2023
OLES Case Number	2023-00342-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Sustained
Incident Summary	Staff members allegedly neglected a patient who developed pressure wounds.
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 indicated it will open an administrative investigation; the OLES will accept for monitoring.
Investigative Assessment	**Rating:** Insufficient The department did not sufficiently comply with policies or procedures governing the investigative process. The responding officer did not conduct a thorough investigation. The OPS did not consult with OLES during all parts of the investigation. The investigator did not notify OLES prior to interviewing the subject physician thereby preventing OLES from monitoring the interview. The investigator did not provide the subject physician the legally required Beheler admonition prior to conducting the interview. The investigator did not conduct thorough interviews of the witnesses. The investigation was not completed timely.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not consult with OLES prior to conducting the interview with the physician. 2. Were all of the interviews thorough and appropriately conducted? • No The investigator did not provide the subject physician with the legally required legal Beheler admonition. The investigator did not ask questions specific to the medical

	record and the wound care treatment plan. The investigator did not ask the doctor to retrieve her notes so that he could review them or so that she could provide information specific to the patient. The investigator did not ask questions about the appropriate stand of care compared to the care provided to the patient. The investigator did not ask the physician if they could have used some form of non-excessive restraint to prevent the patient from causing self-harm. The investigator failed to ask the physician about any attempt to get approval for use of any form of restraints. The investigator failed to question medical staff regarding the adequacy of the medical wound care documentation and if it met state standards and requirements. The investigator failed to ask whether the patient, who was non-ambulatory and incontinent, was assigned to the appropriate unit for the level of care he required. 3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The investigator determined there was no evidence of patient abuse or neglect without considering properly the elements of relevant criminal statutes. The investigator focused on the care that was provided to the patient, not whether if it was adequate. 4. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator failed to adequately notify the monitor and coordinate the interview with the subject. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The report was not completed until 150 days after the date of discovery.
Department Corrective Action Plan	OSI has retrained all investigators on OPS policy in regard to Beheler and its use in interviews. OSI is in the process of sending all investigators to interview and interrogation training through a POST mandated course. OSI has recently established a procedure to address

	continuous communication with OLES throughout the entire investigative process. The OSI procedure addresses the 120-day OLES standard for completing cases, which OSI adheres to. The interview and interrogation course will provide guidance to OSI respective investigators in regard to the questions asked in their respective cases on a case-by-case basis. OSI has also established a working relationship with the Los Angeles County District Attorney's Office, to contact and gather real time guidance on the prosecution of criminal charges and required elements of criminal charges.

Case Details	Description
Incident Date	07/01/2022
OLES Case Number	2023-00358-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly stabbed a patient in the neck with a syringe.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/03/2023
OLES Case Number	2023-00374-1A
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 grabbed a patient by the arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigatory process. The investigation was not timely completed.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 199 days discovery of the incident.
Department Corrective Action Plan	Reason for the extension: OSI had an additional witness that needed to be interviewed that widened the scope of the investigation as well as other extenuating circumstances with staff out due to COVID-19. Given these circumstances additional time was needed to complete the final report as there was not adequate time remaining to complete the investigation by the due date. An extension was granted based on the unavailability of the witness. DSH strives to be timely in the completion of the investigations and moving forward, will contact witnesses more often in attempt to schedule the earliest possible interview to expedite the investigation. In addition, the investigator will work with HR on other contact methods.

Case Details	Description
Incident Date	03/16/2023
OLES Case Number	2023-00392-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician was allegedly using a personal mobile phone and failed to continuously monitor a patient who was on an enhanced level of observation.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/18/2023
OLES Case Number	2023-00407-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly jumped on top of a patient and forcibly removed the patient's clothing.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/20/2023
OLES Case Number	2023-00409-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two psychiatric technicians allegedly hit a patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/28/2023
OLES Case Number	2023-00416-1A
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 psychiatric technician assigned to enhanced observation of a patient allegedly failed to protect the patient from an assault 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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/18/2023
OLES Case Number	2023-00417-1A
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 restrained a patient against a wall and scratched the patient's nose.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/23/2023
OLES Case Number	2023-00435-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient died unexpectedly while being continuously monitored by staff. An autopsy determined the cause of death was bronchopneumonia with contributing factors of atherosclerotic cardiovascular disease, and emphysema. No staff misconduct was identified.
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.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/01/2023
OLES Case Number	2023-00445-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly grabbed and forced a patient against 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/25/2023
OLES Case Number	2023-00451-1A
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's hair. A registered nurse allegedly struck the patient in the face multiple times with a key.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the psychiatric technician and the registered nurse. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/23/2023
OLES Case Number	2023-00466-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Sustained
Incident Summary	An unidentified person allegedly hit a patient on the back of the head during a fight.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/31/2023
OLES Case Number	2023-00482-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed and pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/01/2023
OLES Case Number	2023-00484-1A
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 hit a patient.
Disposition	The hiring authority determined the investigation was sufficient; but there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/04/2023
OLES Case Number	2023-00492-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Head/Neck
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Staff members allegedly injured a patient while attempting to restrain 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	**Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigatory process. The investigation was not timely completed.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 162 days after discovery of the incident.
Department Corrective Action Plan	This case was assigned to OSI 30 days after initially being taken by the hospital police department. Prior to starting this case, OSI was simultaneously working three other OLES cases. One of the main subjects in this case worked out of Registry and only worked sporadically throughout the month and was difficult to locate. OSI was advised by a supervisor of his next worked date. OSI called on the date he was supposed to return and was told he called off. OSI eventually contacted the subject on 8/29/2023 and set up the interview for 8/30/2023. This investigator is cognizant of meeting the time frame of 120 days in which to complete an investigation and the procedure of requesting an extension if the Investigation

	will move beyond the 120 days. A request for extension will be discussed with the assigned OLES monitor, according to the parameters set out in the issued memorandum. OSI will have a tickler file as a reminder of the due date. OSI will put the due date in the calendar. OSI will put the due date on top of the chronological sheet with the date highlighted.

Case Details	Description
Incident Date	03/01/2023
OLES Case Number	2023-00496-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly engaged in sexual activity with 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/04/2023
OLES Case Number	2023-00500-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly shoved a patient onto a bed.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/04/2023
OLES Case Number	2023-00500-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A senior psychiatric technician allegedly forced a patient onto a bed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation, however, felt that unit-wide training on contraband searches was appropriate. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/13/2023
OLES Case Number	2023-00524-1C
Case Type	Monitored
Incident Types	1. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient allegedly fell out of bed and sustained a laceration to his chin.
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 will not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigator did not coordinate the investigation with the assigned monitor and as a result this case was not properly monitored. The investigation was not completed until 188 days after the date of discovery.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No A draft copy if the investigation was not provided to the assigned monitor. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator did not coordinate with the assigned monitor. The investigation was completed before the investigator consulted with the OLES monitor. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 188 days

	after the date of discovery.
Department Corrective Action Plan	OSI has established procedures to address OLES monitored investigations. Specifically, the procedure covers, how each investigator needs to provide real time continuous communication with OLES during the course of the entire investigation. The procedure covers the OLES 120-day time frame to complete OLES monitored investigations. Every new Investigator and current investigators have been provided with a copy of the new OSI procedures and have been given training. If staffing levels allow, mentors will be assigned to new investigators to walk them through an OLES monitored investigation from start to finish.

Case Details	Description
Incident Date	02/03/2023
OLES Case Number	2023-00525-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly elbowed a patient in the mouth and bent his wrist backwards.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/13/2023
OLES Case Number	2023-00528-1C
Case Type	Monitored
Incident Types	1. Significant Interest
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Referred 3. Not Referred
Incident Summary	A rehabilitation therapist allegedly drove her personal vehicle while under the influence of alcohol and struck two vehicles parked in the facility parking lot.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/12/2023
OLES Case Number	2023-00529-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly grabbed and twisted a patient's arm in an attempt to take a cup of suspected patient-manufactured alcohol from 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/21/2023
OLES Case Number	2023-00544-1C
Case Type	Monitored
Incident Types	1. Child Sexual Abuse Material 2. Drugs 3. Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	A unit supervisor, and two psychiatric technicians allegedly brought narcotics into the facility for patients' use and distribution.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/17/2023
OLES Case Number	2023-00551-2A
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 left his assigned post without authorization and encouraged another officer to submit an inaccurate report.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/19/2023
OLES Case Number	2023-00558-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly kicked and injured 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/12/2023
OLES Case Number	2023-00560-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A registered nurse allegedly hit a patient, forced the patient to the ground and twisted the patient's arm behind his back. A psychiatric technician allegedly placed a knee on the back of the patient's 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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/18/2023
OLES Case Number	2023-00561-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pushed a patient to the ground. A second psychiatric technician allegedly directed profanity towards 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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/20/2023
OLES Case Number	2023-00566-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A bedridden patient was discovered to have deep tissue injuries to his buttocks.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/20/0202
OLES Case Number	2023-00568-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a patient who was arguing 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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/19/2023
OLES Case Number	2023-00571-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** Disciplinary Phase Pending
Incident Summary	A patient sustained a fractured wrist from an unwitnessed fall.
Disposition	The hiring authority found insufficient evidence of staff misconduct; therefore, no allegations were sustained. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/18/2023
OLES Case Number	2023-00572-1A
Case Type	Monitored
Incident Types	1. Abuse 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 senior psychiatric technician allegedly threatened a patient with a bat 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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/26/2023
OLES Case Number	2023-00599-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Multiple staff members allegedly hit a patient during a stabilization procedure, causing injuries to the patient's face and leg.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/26/2023
OLES Case Number	2023-00605-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
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:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	An officer allegedly posted inappropriate comments on social media about another employee.
Disposition	The hiring authority sustained the allegation and determined a letter of instruction was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/12/2023
OLES Case Number	2023-00609-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	A unit supervisor, a senior psychiatric technician, and a psychiatric technician allegedly injured a patient while attempting to restrain the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/28/2023
OLES Case Number	2023-00615-1C
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 stomach with a table.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/25/2023
OLES Case Number	2023-00617-1A
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 grabbed a patient by the hair and waistband during an escort, forced the patient's head onto a bed, and inappropriately grabbed 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/27/2023
OLES Case Number	2023-00623-2A
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 broke a patient's personal property.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/02/2023
OLES Case Number	2023-00635-1C
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 and a psychiatric technician allegedly dragged a patient to a seclusion room. The senior psychiatric technician also allegedly forced the patient's head against the 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/29/2023
OLES Case Number	2023-00641-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Known Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Unidentified staff members allegedly hit and forced a patient to the ground, then placed the patient in restraints. The patient sustained a broken foot.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/04/2023
OLES Case Number	2023-00650-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was diagnosed with a fractured rib.
Disposition	No staff misconduct was identified; therefore, the hiring authority did not sustain any allegations. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/05/2023
OLES Case Number	2023-00658-1A
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 registered nurse, a psychiatric technician and a senior psychiatric technician allegedly grabbed a patient who uses a walker, forced him to walk at a fast pace and pushed him onto a bed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/08/2023
OLES Case Number	2023-00673-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A unit supervisor 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. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/13/2023
OLES Case Number	2023-00691-1C
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 department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/13/2023
OLES Case Number	2023-00691-2A
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 kicked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/16/2023
OLES Case Number	2023-00706-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	A patient was found unresponsive in bed and was pronounced deceased. A psychiatric technician allegedly failed to conduct proper checks during the night, causing a delay in discovering the patient unresponsive and in medical distress.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process because the initial draft report was not provided to the OLES monitor for review before it was forwarded to the district attorney.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No The department did not notify OLES that the initial draft investigative report was ready for review before it was forwarded to the district attorney.
Department Corrective Action	The assigned Investigator will receive training and development to ensure they adhere to Lexipol Policy No.

Plan	607.2 Investigation "Process Guideline Threshold Incidents", with the assigned OLES Attorney (AIM). The OLES AIM will be kept updated on all aspects of the investigation, including providing a draft report to the AIM prior to submitting the investigating report to the Hiring Authority or District Attorney's office.

Case Details	Description
Incident Date	05/15/2023
OLES Case Number	2023-00709-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Multiple level of care staff members allegedly allowed a patient to remain in urine-soaked clothing for approximately five hours.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/16/2023
OLES Case Number	2023-00720-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A registered nurse allegedly kicked and pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/27/2023
OLES Case Number	2023-00723-2A
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	Two law enforcement supervisors and an officer allegedly failed to properly process evidence in a criminal case.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. However, in order to address systemic concerns, department-wide training on the processing of evidence was provided. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/20/2023
OLES Case Number	2023-00749-1A
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 hit, choked, and dragged 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	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/20/2023
OLES Case Number	2023-00750-1A
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 put a patient in an unauthorized chokehold and hit 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	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing investigative process.

Case Details	Description
Incident Date	05/22/2023
OLES Case Number	2023-00756-1A
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin) 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 level of care staff member allegedly sexually assaulted a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/24/2023
OLES Case Number	2023-00768-1A
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 healthcare staff member allegedly twisted a patient's arm behind his back.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/22/2023
OLES Case Number	2023-00788-1A
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 pulled a patient by the hand.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/27/2023
OLES Case Number	2023-00789-1A
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 licensed vocational nurse allegedly failed to properly supervise 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	**Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/28/2023
OLES Case Number	2023-00795-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A level of care staff member allegedly grabbed a patient, pulled her to him and hugged her.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/28/2023
OLES Case Number	2023-00798-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A level of care staff member allegedly engaged in nonconsensual hugging and kissing of 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. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/28/2023
OLES Case Number	2023-00802-1A
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 threatened a patient and pressed her forehead against the patient's forehead without provocation.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator did not identify a staff witness who was named in an allegation checklist that was an attachment to the investigative report. The investigator completed a draft investigative report which did not include an interview of the unidentified staff member listed in the allegation checklist.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not identify a staff witness who was named in an allegation checklist that he included with his investigative report. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The OLES identified a staff witness listed in an attachment that had not been identified or interviewed by the investigator.
Department	The Office of Special Investigations and the operations

Corrective Action Plan	division will work collaboratively with program staff members to obtain the allegation checklist in as timely a manner as possible. The Office of Protective Services will educate program staff members the importance of the allegation checklist to the investigation as this checklist provides the names of witnesses who might not be known to the hospital police department.

Case Details	Description
Incident Date	06/01/2023
OLES Case Number	2023-00820-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A unit supervisor allegedly grabbed a patient's arm, and three psychiatric technicians then allegedly restrained the patient on the floor. The patient sustained pain and bruising to his left elbow.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/08/2023
OLES Case Number	2023-00826-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly bent a patient's wrist backwards while he was in restraints.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/31/2023
OLES Case Number	2023-00834-1C
Case Type	Monitored
Incident Types	1. Neglect 2. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly inappropriately rubbed 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/06/2023
OLES Case Number	2023-00836-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient had an irritation of unknown origin on her left buttock.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/07/2023
OLES Case Number	2023-00843-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly slapped a patient on the back of the head. A psychiatric technician allegedly grabbed and inappropriately touched 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/06/2023
OLES Case Number	2023-00856-1C
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 pelvic bone. The patient reported she had fallen from her wheelchair.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/08/2023
OLES Case Number	2023-00861-1A
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	A psychiatric technician allegedly fell asleep twice while monitoring a patient on an enhanced level of observation.
Disposition	The psychiatric technician resigned before the administrative investigation could be completed, The hiring authority sustained all allegations against the psychiatric technician. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/08/2023
OLES Case Number	2023-00865-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician was allegedly in an overly familiar relationship with 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 accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/08/2023
OLES Case Number	2023-00865-2A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician was allegedly in an overly familiar relationship with a patient.
Disposition	The hiring authority sustained allegations against the psychiatric technician; however, no disciplinary action could be taken because the senior psychiatric technician had resigned before completion of the investigation. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in the psychiatric technician's official personnel file. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/15/2023
OLES Case Number	2023-00877-1C
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 head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/25/2023
OLES Case Number	2023-00884-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient returned from an outside hospital with a genital lesion.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/16/2023
OLES Case Number	2023-00891-1A
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 grabbed a patient by his shirt.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/20/2023
OLES Case Number	2023-00899-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatrist allegedly allowed a patient to inappropriately touch 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 Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/21/2023
OLES Case Number	2023-00907-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient sustained injuries to the genital area.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/24/2023
OLES Case Number	2023-00916-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly failed to monitor patients during shower time.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/23/2023
OLES Case Number	2023-00919-1C
Case Type	Monitored
Incident Types	1. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly failed to adequately maintain enhanced observation of a patient. During the enhanced observation, the patient fell and sustained lacerations to his 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. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/24/2023
OLES Case Number	2023-00921-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly dragged a patient by the hair.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/23/2023
OLES Case Number	2023-00924-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with a fractured toe.
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.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/17/2023
OLES Case Number	2023-00944-1A
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	Staff members allegedly used excessive force while placing the patient in restraints and held the patient in restraints for an excessive amount of time.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/29/2023
OLES Case Number	2023-00945-1A
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 hit a patient on the back.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/05/2023
OLES Case Number	2023-00969-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A doctor allegedly failed to properly assess and diagnose multiple patients under his 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	**Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/10/2023
OLES Case Number	2023-00986-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with a fractured lower spine.
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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/10/2023
OLES Case Number	2023-00987-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Several staff members were allegedly asleep and failed to respond to a patient who had fallen in the shower..
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/09/2023
OLES Case Number	2023-00993-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Level of care staff allegedly delayed assisting a patient who fell. The patient was later taken to an outside hospital where x-rays confirmed the patient sustained a fractured right hip which required surgery.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/11/2023
OLES Case Number	2023-00998-1A
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 used excessive force to break up a fight between two 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	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/11/2023
OLES Case Number	2023-01000-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with two fractured ribs.
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 administration investigation due to a lack of evidence. The OLES concurred.
Investigative Assessment	**Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The assigned investigator did not consult with OLES.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The assigned investigator did not coordinate with OLES at any stage of the investigation.
Department Corrective Action Plan	OSI established a new set of procedures to train new investigators and keep existing investigators accountable to policies and procedures of OSI. Each new investigator will be assigned a mentor, and provided with a copy of the OSI procedures, detailing the day-to-day expectations and functions of a OSI investigator. The procedure explicitly addresses how to conduct OLES monitored investigations. The procedure covers, continuous communication with OLES monitored cases, initial case conference, 120-day OLES deadline to complete OLES monitored cases. The new investigator will be trained in all aspects of investigations as mandated by the OPS training guide.

Case Details	Description
Incident Date	07/05/2023
OLES Case Number	2023-01008-1A
Case Type	Monitored
Incident Types	1. Significant Interest
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An office employee allegedly released confidential patient information.
Disposition	The hiring authority found insufficient evidence to sustain the allegation that the employee released information. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/13/2023
OLES Case Number	2023-01011-1A
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 psychiatric technician allegedly gave a patient an injection with a contaminated needle.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/14/2023
OLES Case Number	2023-01019-2A
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 assaulted a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/16/2023
OLES Case Number	2023-01028-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	An off-duty officer allegedly failed to properly secure a personal firearm in his personal vehicle.
Disposition	The hiring authority sustained the allegation and issued a letter of expectation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/15/2023
OLES Case Number	2023-01036-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was diagnosed with a dislocated shoulder.
Disposition	No staff misconduct was identified; therefore, no allegations were sustained. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/19/2023
OLES Case Number	2023-01040-1C
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. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/23/2023
OLES Case Number	2023-01054-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with an open pressure sore on his buttocks.
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 did not open an administrative investigation.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/01/2022
OLES Case Number	2023-01055-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department did not open an administrative investigation.
Investigative Assessment	**Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/24/2023
OLES Case Number	2023-01072-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A chaplain 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. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/24/2023
OLES Case Number	2023-01077-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Referred
Incident Summary	A senior psychiatric technician allegedly hit 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 case determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/25/2023
OLES Case Number	2023-01088-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly broke a restrained patient's finger. A second staff member allegedly choked the patient with a blanket.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/26/2023
OLES Case Number	2023-01090-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with vertebral fractures.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/30/2023
OLES Case Number	2023-01107-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with two fractured ribs.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/01/2023
OLES Case Number	2023-01116-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse and a psychiatric technician allegedly failed to change a patient out of his urine-soaked clothing.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2023
OLES Case Number	2023-01126-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly hit a patient in the head while attempting to restrain the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2023
OLES Case Number	2023-01128-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed and pulled a patient out of a wheelchair and forced the patient to the ground.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2023
OLES Case Number	2023-01144-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse was allegedly involved in an overly familiar sexual relationship with 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 accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2023
OLES Case Number	2023-01146-1C
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 assistant allegedly pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/18/2023
OLES Case Number	2023-01198-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly slapped a restrained patient. A registered nurse then allegedly hit 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/21/2023
OLES Case Number	2023-01213-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with a fractured finger.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/24/2023
OLES Case Number	2023-01231-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly trimmed a patient's mustache while he slept.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/04/2023
OLES Case Number	2023-01275-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a patient, causing the patient to fall and fracture his knee.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/08/2023
OLES Case Number	2023-01294-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with two fractured ribs.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/17/2023
OLES Case Number	2023-01337-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Five unidentified persons allegedly sexually assaulted a sleeping 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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/27/2023
OLES Case Number	2023-01378-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient sustained multiple fractured bones after allegedly tripping and falling.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/04/2023
OLES Case Number	2023-01423-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly failed to assess a patient who complained of dizziness.
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	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases

On the following pages are cases that, in this reporting period, OLES monitored in both their pre-disciplinary phase as well as the discipline phase. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period. Each phase was rated separately.

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

The disciplinary phase is rated for sufficiency based on timely consultation with OLES during the disciplinary process, and whether the entire disciplinary process was conducted in a timely fashion, the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

Case Details	Description
Incident Date	01/31/2021
OLES Case Number	2021-00149-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A nurse and a senior psychiatric technician allegedly failed to assess an at-risk patient who had fallen. The nurse and senior psychiatric technician also allegedly failed to make required notifications and complete required documentation about the incident. X-rays later confirmed the patient sustained a fractured ankle.

Disposition	The hiring authority sustained all allegations against the nurse and determined dismissal was the appropriate penalty. No allegations were sustained against the senior psychiatric technician. The OLES concurred. The nurse filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board upheld the nurse's dismissal.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The department did not timely serve the disciplinary action.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The hiring authority served the disciplinary action 262 days after making findings and penalty determinations.
Department Corrective Action Plan	DSH recognizes the timeliness issue in this case and have provided additional training and resources to address moving forward. Due to the pandemic and staffing impact on the Human Resources Department, the process for service was delayed. Staff turnover, including resignations, transfers, retirement, and promotions occurred within the Human Resources Department during this period. The Employee Relations Officer (ERO) did not have formal training offered through CalHR on writing and serving Adverse Actions until October 2023. Now that the ERO has received their formal training, there will be additional support to draft and serve Notices of Adverse Action. Additionally, the Human Resources Department, Labor Relations Unit has hired a Staff Services Analyst specifically to primarily focus on OLES-monitored cases to ensure timeliness is met. The new analyst has been appointed permanent full-time effective January 1, 2024.

Case Details	Description
Incident Date	02/05/2022
OLES Case Number	2022-00186-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Insubordination 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A psychiatric technician was allegedly involved in an overly familiar relationship with a patient, violated a direct order by her supervisor not to be on the unit where the patient was housed, and was less than truthful during her investigatory interview. It is also alleged that a program director failed to initiate a formal investigation into the allegations against the psychiatric technician.
Disposition	The hiring authority sustained the allegations against the psychiatric technician and determined a salary reduction of 10 percent for 24 months was the appropriate penalty. The hiring authority sustained the allegation against the program director and determined corrective action was the appropriate action. The OLES concurred with the hiring authority's determinations. The psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The disciplinary action was not timely served.

Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The disciplinary action was not served until 252 days after disciplinary determinations were made.
Department Corrective Action Plan	DSH recognizes the timeliness issue in this case and have provided additional training and resources to address moving forward. Due to the pandemic and staffing impact on the Human Resources Department, the process for service was delayed. Staff turnover, including resignations, transfers, retirement, and promotions occurred within the Human Resources Department during this period. The Employee Relations Officer (ERO) position was filled permanent and full-time effective April 1, 2023. The ERO did not have formal trainings offered through CalHR on writing and serving Adverse Actions until October 2023. Now that the vacancy is filled and the ERO has received their formal training, there will be additional support to draft and serve Notices of Adverse Action. Additionally, the Human Resources Department, Labor Relations Unit has hired a Staff Services Analyst specifically to primarily focus on OLES monitored cases to ensure timeliness is met. This analyst position was filled permanent and full-time effective January 1, 2024.

Case Details	Description
Incident Date	06/02/2022
OLES Case Number	2022-00641-1A
Case Type	Monitored
Incident Types	1. Significant Interest
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A nurse allegedly became confrontational with a patient, yelling and using profanity. The nurse also allegedly challenged the patient to engage in a physical altercation then later threatened to physically batter the patient.
Disposition	The hiring authority sustained the allegations against the nurse. The hiring authority determined a 10 percent salary reduction for five months was the appropriate penalty. The OLES concurred. At a Skelly hearing, the nurse expressed remorse, and accepted responsibility for his actions which reduced the likelihood of recurrence. Due to this mitigating information, the hiring authority modified the penalty to a salary reduction of 10 percent for three months and entered into a settlement agreement with the nurse wherein he agreed not to file an appeal with the State Personnel Board. The OLES concurred with the hiring authority's determination based on the factors learned at the Skelly hearing.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The disciplinary action was not timely served.
Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No

	The hiring authority served the disciplinary action 70 days after making findings and penalty determinations.
Department Corrective Action Plan	A disposition was held on 12/2/22. The action was drafted by ERO analyst and sent for legal and OLES review on 1/19/23. Edits were requested by the OLES and DSH. All edits were completed by 1/24/23, however, with reduction in salary adverse actions, due to Personnel keying, if the action was served on 1/24/23, the effective date would have landed beyond the pay period, which in turn interrupts payroll keying. Due to this, the action was served within the next pay period, to be effective by 3/1/23. While DSH-C's ERO office understands the service of this action was 70 days beyond the disposition date, the department diligently worked on drafting this action to be timely. In addition to this, the department was working on three OLES monitored cases that were due within a few days apart, one of which was a dismissal, and therefore prioritized. Going forward, the department will continue to prioritize OLES monitored cases to meet established OLES guidelines.

Case Details	Description
Incident Date	08/25/2022
OLES Case Number	2022-01028-2A
Case Type	Monitored
Incident Types	1. Drugs 2. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A psychiatric technician allegedly spent inappropriate time alone with a patient and provided the patient with mobile phones and narcotics for distribution to other patients.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty; however, the psychiatric technician resigned before the dismissal could take effect. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	09/06/2022
OLES Case Number	2022-01074-2A
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 left a personal firearm, a holster, and two ammunition magazines, unsecured in a department vehicle.
Disposition	The hiring authority sustained the allegations and determined the proper penalty was a salary reduction of 5 percent for 12 months. The OLES concurred with the hiring authority's determinations. At a pre-hearing settlement conference, the department entered into a settlement agreement wherein the officer agreed to withdraw his appeal and the department agreed to reduce the salary reduction to 5 percent for six months. The OLES concurred as new evidentiary concerns were raised.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	10/05/2022
OLES Case Number	2022-01223-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Suspension **Final:** Suspension
Incident Summary	An officer was allegedly publicly intoxicated and was discourteous with outside law enforcement. A second officer allegedly failed to report negative contact with outside law enforcement.
Disposition	The hiring authority sustained the allegations and imposed a 48-working-day-suspension on the first officer and counseling for the second officer. The OLES concurred with the hiring authority's determinations. There was no appeal filed with the State Personnel Board.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	11/07/2022
OLES Case Number	2022-01410-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	A social worker allegedly sent a large sum of money to a discharged patient. The discharged patient had previously been assigned to the social worker's caseload; however, continued contact was not authorized.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. The social worker filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the social worker whereby the social worker resigned in lieu of dismissal and agreed to withdraw her appeal. The OLES concurred with the settlement.
Investigative Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	12/06/2022
OLES Case Number	2022-01582-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Training
Incident Summary	Three officers allegedly failed to properly escort multiple patients, resulting in a patient attempting to escape.
Disposition	The hiring authority sustained the allegations and determined letters of reprimand were the appropriate discipline. The OLES concurred with the hiring authority's determinations. Following a Skelly hearing, the department reduced the penalty to a letter of counseling and training. The OLES concurred based on factors learned at the Skelly hearing.
Investigative Assessment	**Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Rating:** Sufficient Overall, the department sufficiently 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.

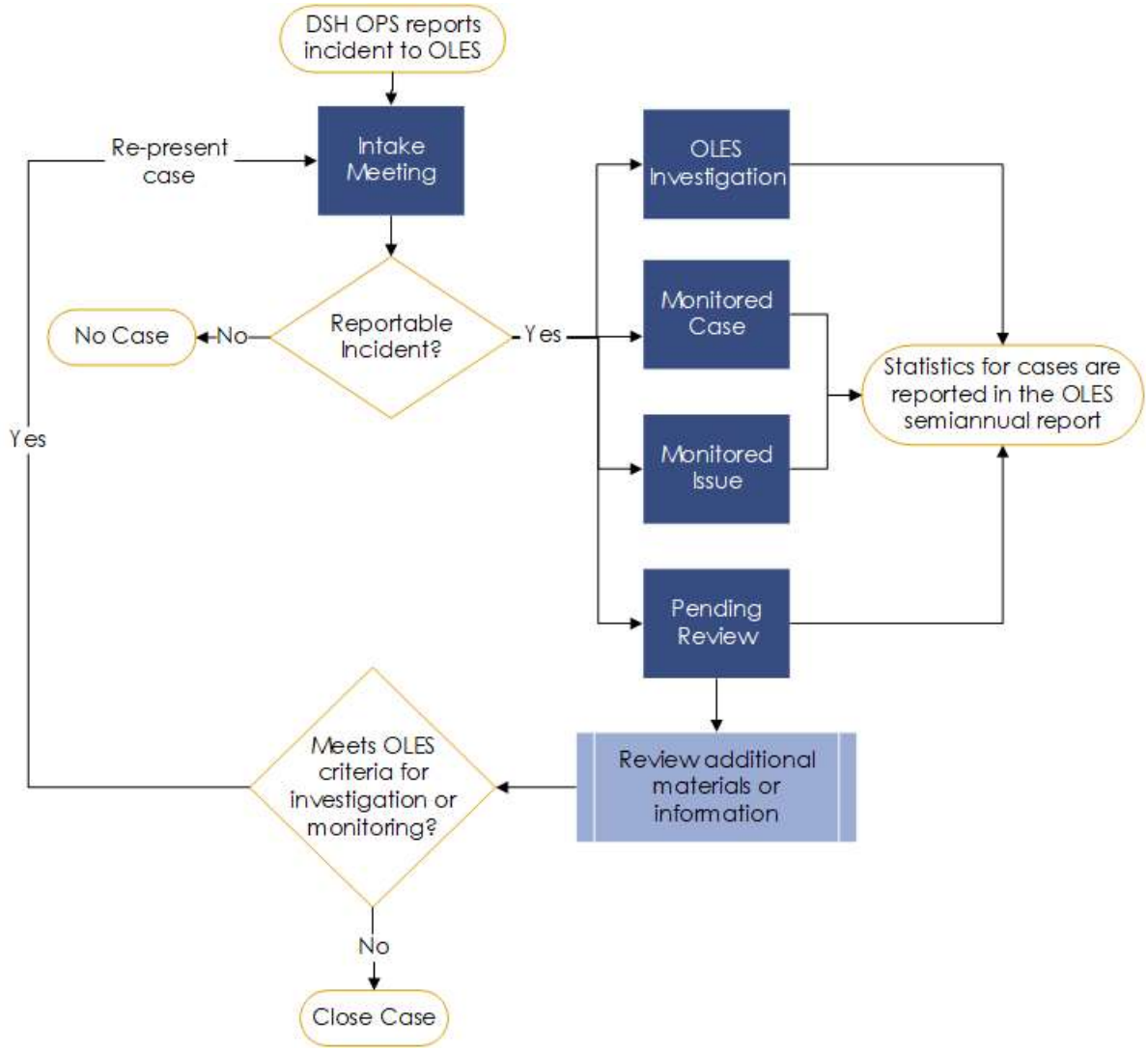
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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.