Office of Law Enforcement Support

Semiannual Report

July 1, 2024 – December 31, 2024

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 **5**

Facilities and Population Served **6**

Executive Summary **9**

Incident Types Meeting OLES Criteria *9*

Most Frequent Incident Types *10*

Patient Deaths *11*

Patient Arrests *11*

Results of Completed OLES Investigations on DSH Law Enforcement *12*

Results of Completed OLES Monitored Cases *12*

Incidents and Incident Types **13**

Decrease in Reported Incident Types *13*

Most Frequent Incident Types Reported *14*

Incident Types by Reporting Period *15*

Distribution of Incident Types *17*

Sexual Assault Allegations *18*

Patient Deaths *19*

Reports of Head or Neck Injuries *20*

Reports of Patients Absent Without Leave *20*

Notification of Incident Types **20**

Priority 1 Incident Type Descriptions *21*

Priority 2 Incident Type Descriptions *21*

Timeliness of Notifications *23*

Intake **24**

Cases Opened in the Current Reporting Period *25*

Completed Investigations and Monitored Cases **25**

OLES Investigations *25*

OLES Monitored Cases *26*

DSH Tracking of Law Enforcement Compliance with Training Requirements **27**

Self-Reported Compliance Rates for Mandated Training *27*

Methods Used to Track Training *28*
DSH Law Enforcement Training Advisory Committee *28*

Additional Mandated Data **28**
Adverse Actions against Employees *29*
Criminal Cases against Employees *30*
Reports of Employee Misconduct to Licensing Boards *30*
Patient Criminal Cases *31*

Monitored Issues **31**
Recordkeeping of Institutional Firearms and Crime/Evidence Firearms *31*
Purchase of Off-Roster Firearms by Sworn Personnel *32*
Underutilization of Blue Team/IAPro *32*
Use of Force Reports, Reviews and Tracking at DSH *33*
Delayed Reporting by Other Mandated Reporters *34*
Recording of Investigatory Interviews *36*

Appendix A: Completed OLES Investigations **37**

Appendix B: Pre-Disciplinary Cases Monitored by OLES **42**

Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases **137**

Appendix D: Statutes **161**
California Welfare and Institutions Code 4023.6 et seq. *161*
California Welfare and Institutions Code 4427.5 ..... *163*
California Welfare and Institutions Code 4023 ..... *164*
California Welfare and Institutions Code 15610.63 (Physical Abuse) *164*

Appendix E: OLES Intake Flow Chart **165**

Appendix F: Guidelines for OLES Processes **166**
Administrative Investigation Process *166*

Introduction

I am pleased to present the semiannual report by the Office of Law Enforcement Support (OLES) in the California Health & Human Services Agency. This report details OLES's oversight and monitoring of the Department of State Hospitals (DSH) from July 1 through December 31, 2024.

In this report, the OLES provides details on 563 reported incidents and the results of completed investigations and monitored cases.

OLES provides updates on previous monitored issues regarding the use of the department's early intervention system, use of force reporting and documentation, and ongoing deficiencies in mandated reporting as required by Welfare and Institutions Code section 15630, et.al.

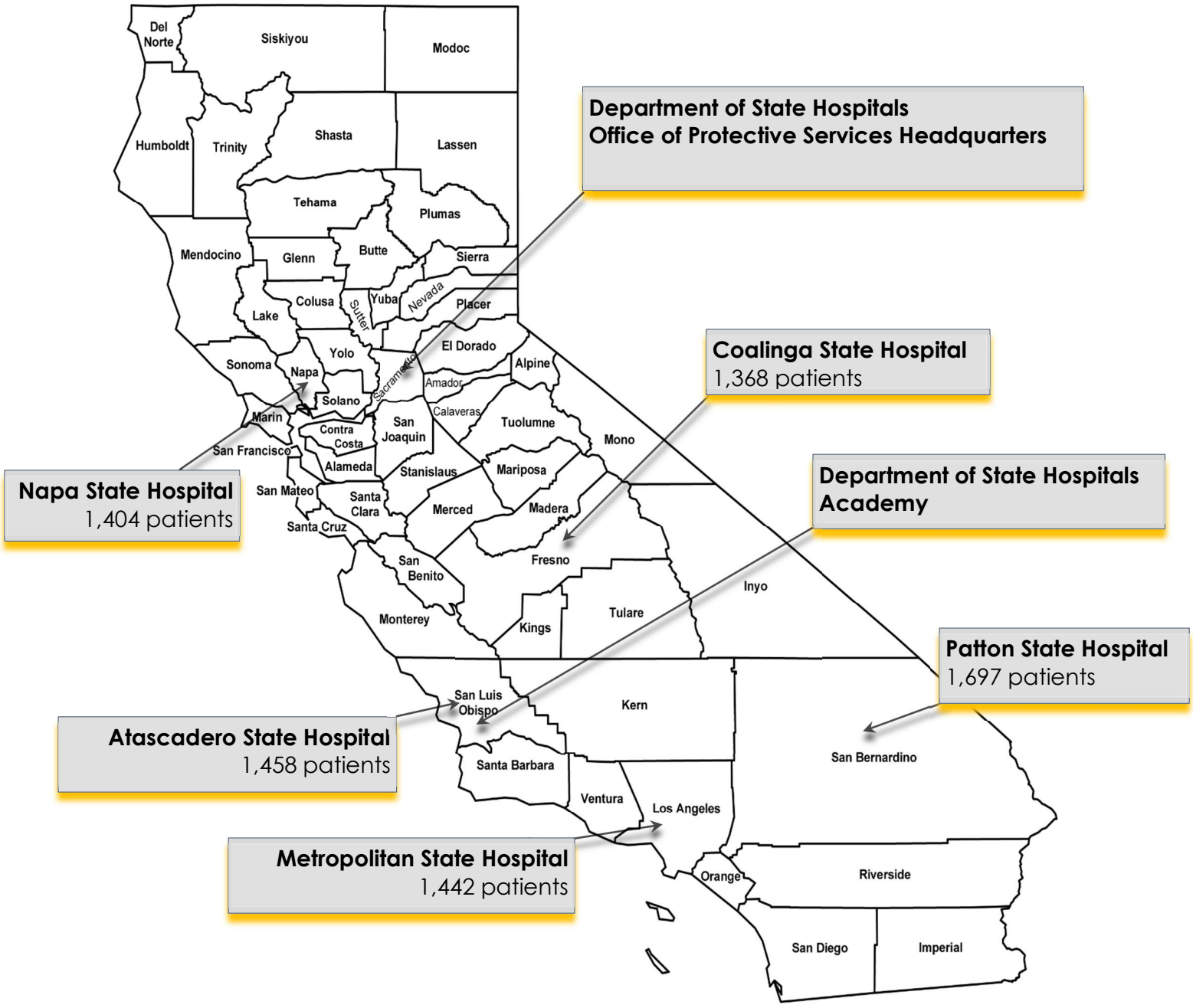
OLES continues to bring attention to an important topic within DSH – Firearms. OLES previously raised an issue concerning the recordkeeping of institutional and evidentiary firearms that has since been resolved with the collaborative efforts of DSH. In the course of OLES' review of this issue, a new concern was identified regarding the purchase of off-roster firearms by sworn personnel, potentially in violation of California law. In an effort to ensure compliance with state law and best practices, OLES has reviewed this issue and provided recommendations to DSH. We look forward to working with DSH on a resolution to this new issue.

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/.

Christine Allen
Acting Chief
Office of Law Enforcement Support

Facilities and Population Served

OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers reflect the total patients served from July 1 through December 31, 2024, and were provided by the department.



Total Patients Served by Facility July 1, through December 31, 2024

DSH Facility	Total Number of Patients
Atascadero	1,458
Coalinga	1,368
Metropolitan	1,442
Napa	1,404
Patton	1,697
Total	7,369

The total number of patients served by DSH from July 1 through December 31, 2024, decreased 2.50 percent, from 7,558 during the prior reporting period to 7,369 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 (IST). 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.

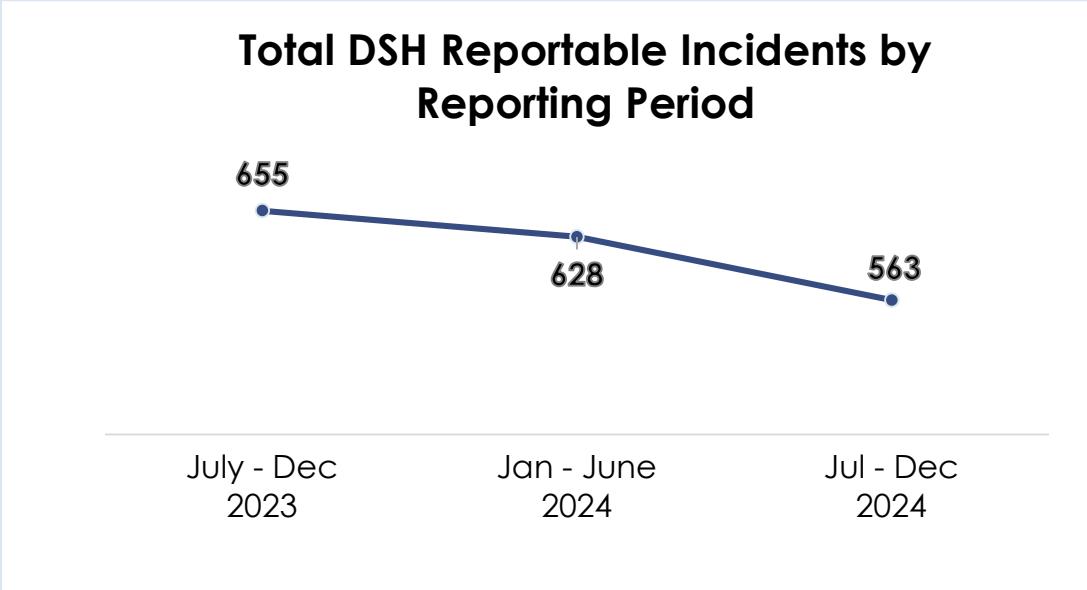
The following table provides the commitment type of patients served during the reporting period.

Commitment Type	Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST	400	0	1,147	722	752
PC 1026 NGI	285	<11	***	456	475
PC 2962/2964a OMD	436	0	<11	0	***
PC 2972 OMD	***	294	27	***	213
WIC 6316 MDSO	0	<11	0	<11	<11
PC 2684 CDCR	201	***	0	0	***
WIC 6602/6604 SVP	0	973	0	0	0
WIC 5358 LPS	***	<11	253	184	151

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, 2024, the Office of Law Enforcement Support (OLES) received and processed 563 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 65 incident reports compared to the prior reporting period which had 628 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



Numbers are unadjusted and are provided as they were previously published.

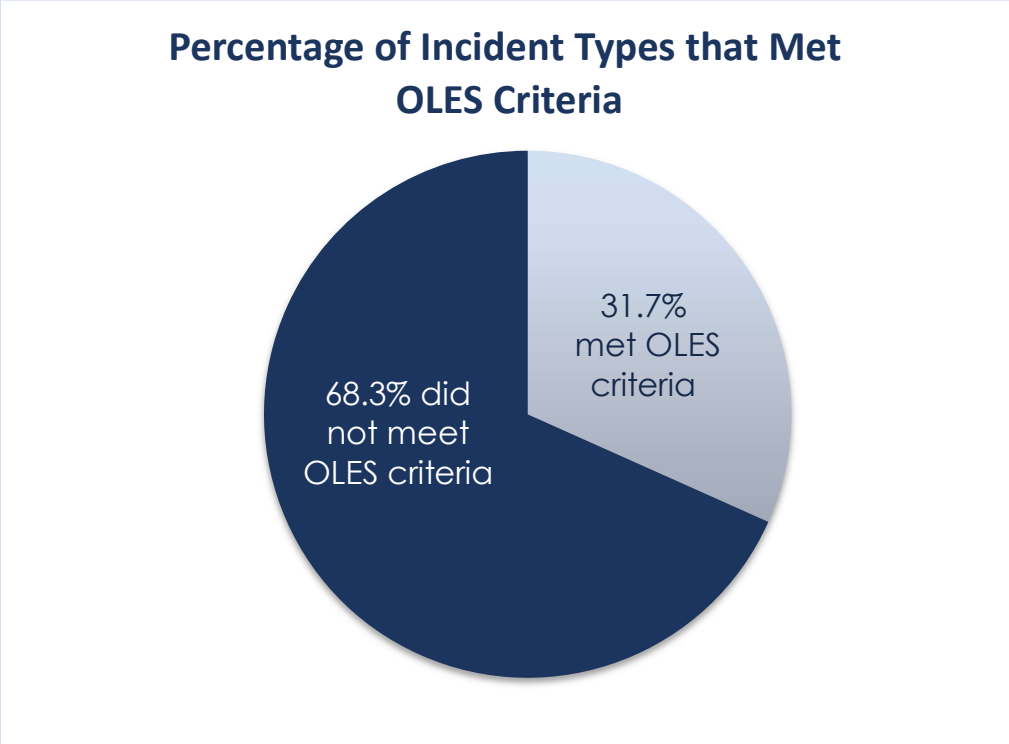
Incident Types Meeting OLES Criteria

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.

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

An incident type meeting criteria is an occurrence that OLES determined to meet OLES criteria for investigation, monitoring, or consideration for research as a potential departmental systemic issue. From the 563 reported incidents, OLES identified 13 incidents with two or more incident types. The DSH reported a total of 587 incident types during this reporting period. One hundred eighty-six, or 31.7 percent of the 587 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported by DSH include allegations of abuse, use of force by law enforcement and allegations of sexual assault.

Allegations of abuse were the most reported incident type, with 101 allegations reported, compared to 90 in the prior reporting period. Allegations of abuse accounted for 17.2 percent of all reported incident types by DSH.

Law enforcement use of force was the second most reported incident type. A use of force report documents an operational incident and does not indicate misconduct or excessive force by an officer. OLES received 92 reports of use of force, which accounted for 15.7 percent of all reported incident types by DSH. Five of the 92 use of force reports included an allegation of excessive force which are included in the Abuse and Misconduct totals and were assigned an OLES investigation.

For reporting purposes, 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 sexual assault were the third most reported incident type, with 79 incidents reported, compared to 77 in the prior reporting period.

The fourth most frequent incident type was broken bone (unknown origin), with 52 reports, compared to 63 in the prior reporting period.

Patient Deaths

The number of patient deaths decreased 10.5 percent, from 38 deaths to 34 deaths during this reporting period. Six of the reported death incident types met OLES criteria for monitoring. Twenty-one of the 34 patient deaths were expected due to existing medical conditions. Thirteen 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 15 deaths and Napa State Hospital (NSH) with 9 deaths.

Patient Arrests

OLES works collaboratively with DSH to ensure patients receive the best possible treatment and care at the local jurisdiction holding facility. 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 one less arrest compared to the prior reporting period. The patients were arrested for violations of the statutes listed in the following table. Two patients were arrested at CSH, one patient at MSH, three patients at NSH and one patient at PSH.

Statute	Description
Penal Code section 243(d)	Battery with force likely to cause great bodily injury (GBI)
Penal Code section 243.4(a)	Sexual battery
Penal Code section 245 (a)	Assault by means of force likely to cause GBI
Penal Code section 236	False imprisonment
Penal Code section 182(a)(1)	Conspiracy
Penal Code section 311.11(a)	Possession of child pornography
Penal Code section 314(1)	Indecent exposure
Penal Code section 187(a)	Murder
Penal Code section 242	Assault and battery

Results of Completed OLES Investigations on DSH Law Enforcement

Per statute,[3] an OLES investigation is initiated after OLES is notified of an allegation that a DSH law enforcement officer of any rank committed serious administrative or criminal misconduct.

Appendix A provides information on the 12 investigations that OLES completed during this reporting period. As of December 31, 2024, there were approximately 742 DSH sworn staff.

OLES submitted all 12 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. OLES did not undertake any criminal investigations. A summary of the review and decision for each administrative 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 79 monitored administrative cases and 74 monitored criminal cases that, by December 31, 2024, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These monitored cases included allegations against psychiatric technicians, psychiatric technician assistants, officers, registered nurses, unit supervisors and several other types of staff members.

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

OLES monitored 153 pre-disciplinary phase cases; 133 of the pre-disciplinary phase

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

cases are listed in Appendix B and 20 are listed in Appendix C. OLES rated 18 of the 153 pre-disciplinary phase cases insufficient. 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.

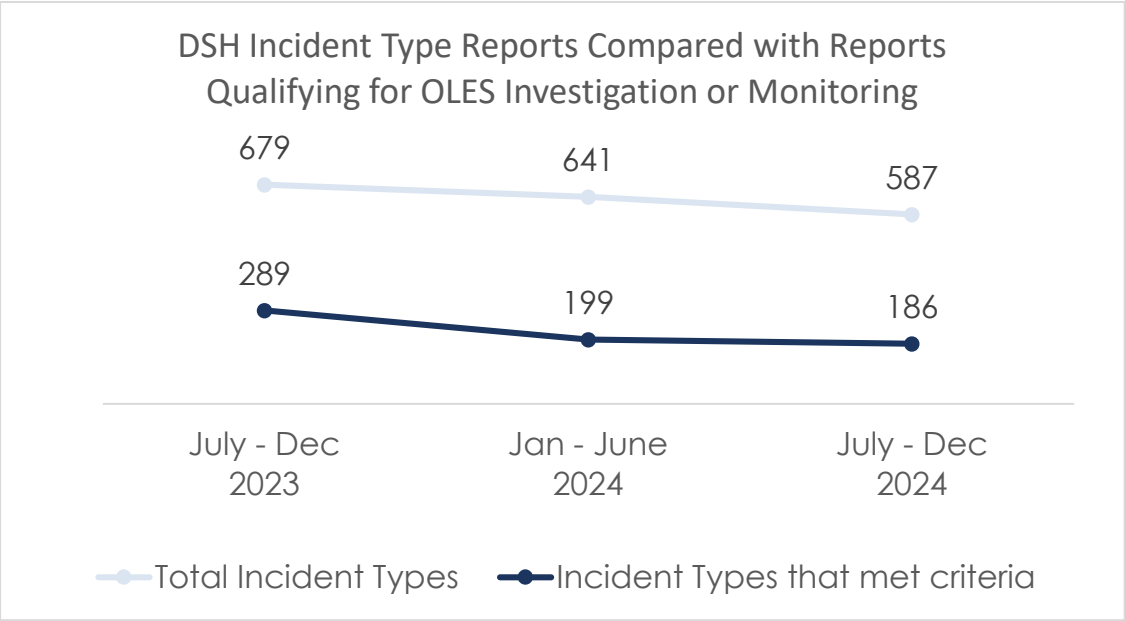
OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in 21 administrative cases listed in Appendix C. Five of the 21 disciplinary phase cases were rated insufficient due to a delay in serving a disciplinary action, failure to consult with OLES, and improperly conducted *Skelly* hearing, among other things.

Incidents and Incident Types

Every OLES case is initiated by a report of an incident or allegation. 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, 2024, decreased 12.2 percent, from 641 during the prior reporting period to 563 in this reporting period. From the 563 reported incidents, OLES identified 587 incident types, as 13 of the incidents featured two or more incident types. One hundred eighty-six of the 587 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic issue.



Numbers are unadjusted and are provided as they were previously published.

Most Frequent Incident Types Reported

The most frequent incident types reported were allegations of abuse, use of force by law enforcement, sexual assault, and broken bone (unknown origin). These four incident type categories accounted for 324 or 55.2 percent of all incident types reported by DSH. Of the 324 incident types, 134 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was allegations of abuse with 101 reports. The number of abuse allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period was 98. The 101 reports of abuse accounted for 17 percent of the reported incident types.

The DSH's second most frequent report to OLES was use of force by law enforcement. The 92 reports of use of force accounted for 15.7 percent of the reported incident types, and down 20 percent from the last period's 115 reports. This is the seventh full reporting period of OLES requiring the department to report all use of force by law enforcement.

Allegations of sexual assault were the third most frequently reported incident type by DSH, with 79 incidents reported. Allegations of sexual assault accounted for 12 percent of all incident types reported. Of the 79 sexual assault allegations reported in this period, 31 allegations or 39 percent qualified for investigation or monitoring.

Allegations of broken bones of unknown origin were the fourth most frequently reported incident type by DSH, with 52 incidents reported. The 52 reports of broken bones of unknown origin accounted for 8.9 percent of the reported incident types.

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, 2024

Incident Type Category	Prior Period Incident Type Total January 1 through June 30, 2024	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Abuse	90	101	+12.2%	98
Broken Bone (Unknown Origin)	63	52	-17.5%	5
OPS Use of Force [1]	115	92	-20%	0
Sexual Assault [2]	77	79	+2.6%	31

[1] Five use of force reports included allegations of excessive force by law enforcement and are also included in the total count for the abuse incident type category.

[2] These statistics do not 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. Numbers in these columns are unadjusted and provided as they were previously published.

Incident Categories	Prior Period July 1 - December 31, 2023 (Reported)	Prior Period July 1 – December 31, 2023 (Meets Criteria)	Prior Period January 1 - June 30, 2024 (Reported)	Prior Period January 1 - June 30, 2024 (Meets Criteria)	Current Period July 1 - December 31, 2024 (Reported)	Current Period July 1 - December 31, 2024 (Meets Criteria)
Abuse	89	85	90	85	101	98
Attack-on-Staff [1]	4	0	5	0	6	0
AWOL	4	0	4	0	5	0
Broken Bone (Known Origin)	35	3	39	1	24	0
Broken Bone (Unknown Origin)	78	73	63	22	52	5
Burn	6	0	8	1	3	0
Child Sexual Abuse Material	4	0	5	0	4	0
Contraband (CCR Title 9 section 4350) [2]	N/A	N/A	N/A	N/A	1	0
Contraband Phones [2]	N/A	N/A	N/A	N/A	2	0
Death	32	9	38	15	34	6
Drugs [3]	23	3	25	2	19	0
Genital Injury (Known Origin)	10	1	6	0	9	0
Genital Injury (Unknown Origin)	12	9	8	1	5	0
Head/Neck Injury	51	3	46	2	47	1
Misconduct [4]	27	26	21	13	22	22
Neglect	45	36	14	11	17	13
Non-patient assault/GBI on Patient	0	0	0	0	0	0
OPS Use of Force [5]	122	1	115	0	92	0

Incident Categories	Prior Period July 1 - December 31, 2023 (Reported)	Prior Period July 1 – December 31, 2023 (Meets Criteria)	Prior Period January 1 - June 30, 2024 (Reported)	Prior Period January 1 - June 30, 2024 (Meets Criteria)	Current Period July 1 - December 31, 2024 (Reported)	Current Period July 1 - December 31, 2024 (Meets Criteria)
Over-Familiarity	12	12	15	15	10	10
Patient Arrest	7	0	8	0	7	0
Patient-on-Patient Assault/GBI	14	3	4	0	10	0
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Sexual Assault	80	25	77	31	79	31
Sexual Assault-Outside Jurisdiction [6]	21	0	49	0	37	0
Significant Interest [7]	2	0	0	0	1	0
Suicide (Attempted)	1	0	1	0	0	0
Total	679	289	641	199	587	186

[1] 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.
[2] Beginning in the July 1, 2024, through December 31, 2024, reporting period, OLES established the reporting of California Code of Regulations, Title 9, Section 4350 contraband items. Contraband phones are reported separately.
[3] Beginning in the July 1, 2021, through December 31, 2021, reporting period, 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.
[4] The misconduct statistics include five allegations of excessive force by law enforcement, and alleged sexual assault and are included in the total count for these incident types meeting criteria.
[5] The 92 use of force incidents were assigned a pending review. Five of the 92 incidents of use of force included allegations of excessive force and were assigned investigations. These incidents are included in the allegations of abuse meeting criteria.
[6] Outside Jurisdiction sexual assault occurred outside the jurisdiction of DSH.
[7] Significant Interest is an incident that may draw media attention. There was a patient-on-patient attack that resulted in a patient death. The suspect patient was arrested for alleged homicide.

Distribution of Incident Types

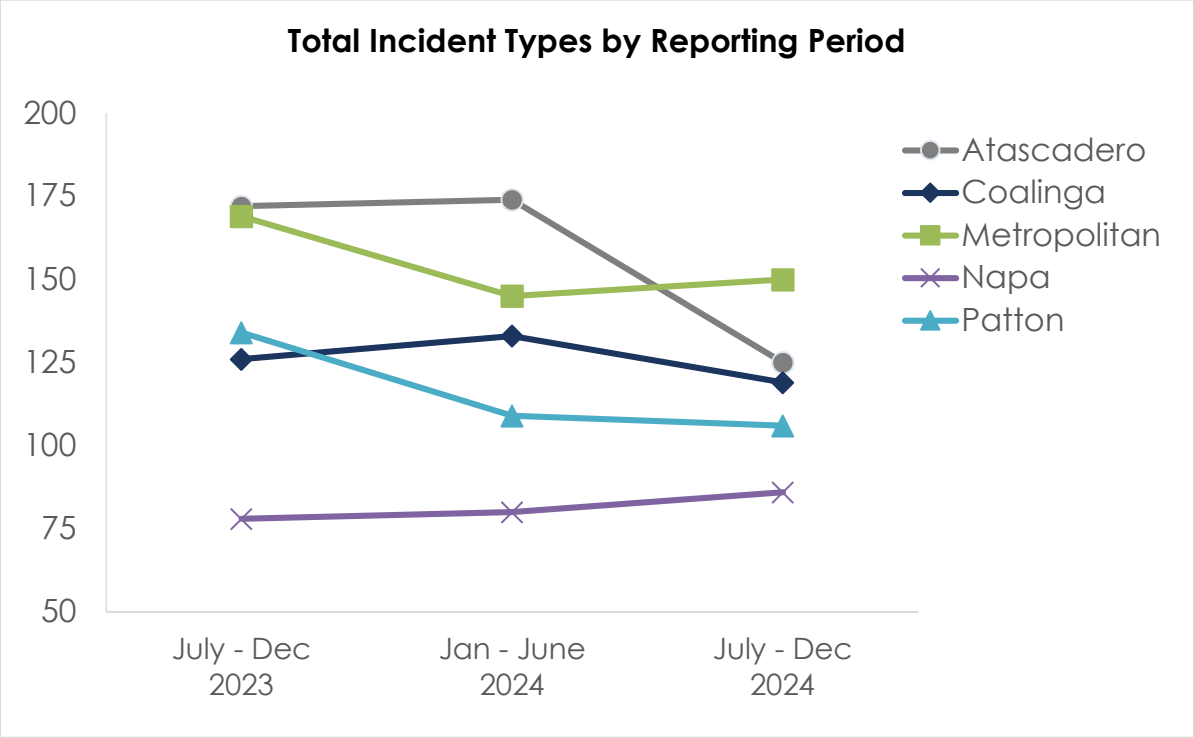
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

DSH Population and Total Incident Types

DSH Facility	Number of Patients Served	Total Incident Types
Atascadero	1,458	125
Coalinga	1,368	119
Metropolitan	1,442	150
Napa	1,404	87
Patton	1,697	106
Total	7,369	587

The department provided population served from July 1 through December 31, 2024.

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



Sexual Assault Allegations

During this reporting period, sexual assault allegations were the second most frequently reported incident type from July 1 through December 31, 2024. The 79 alleged sexual assault incident types reported in this reporting period accounted for 13.5 percent of all reported incident types from DSH. Thirty-one of the 81 reported incident types of alleged sexual assault, or 39.2 percent, met OLES criteria for investigation or monitoring. There were 37 reported incident types under the sexual assault outside jurisdiction category, none of which met OLES criteria for investigation or monitoring.

Of the five DSH facilities, PSH (22), CSH (16) and MSH (16) 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 42 incident types, or 53.2 percent of the alleged 79 sexual assault incident types. The second most frequent type of alleged sexual assault involved non-law enforcement staff on a patient, with 31 incident types or 39.2 percent of the 79 alleged sexual assault incident types. There were five allegations of sexual assault involving an unknown assailant on a patient. 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, 2024

Allegation Type	Total
Patient-on-Patient	42
Law Enforcement Staff-on-Patient	1
Non-Law Enforcement Staff-on-Patient	31
Unknown Person-on-Patient	5
Outside Jurisdiction [1]	37
Total	116

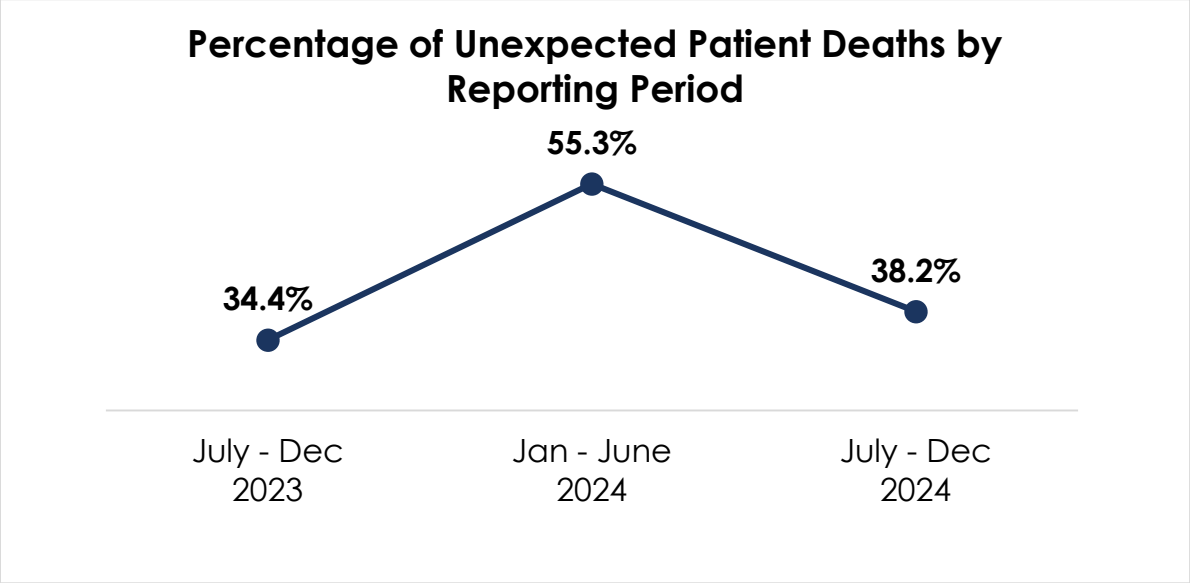
[1] Sexual assault outside Jurisdiction is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH.

Patient Deaths

The DSH reported 34 patient deaths to OLES during this reporting period. This number decreased 10.5 percent from the 38 patient deaths reported in the prior reporting period of January 1 through June 31, 2024.

Twenty-one of the patient deaths were classified as expected primarily due to underlying health conditions, such as cardiac or respiratory issues and cancer. Thirteen deaths were classified as unexpected. Each unexpected patient death receives two levels of review within DSH, per department policy. OLES monitored six of the departmental death investigations.

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



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

Cause of Patient Deaths

Cause	Total
Cancer	7
Cardiac/Respiratory	22
Renal/Liver	1
Sepsis	2
Gastrointestinal Hemorrhage	1
Alleged Homicide	1
Total	34

As shown in the following table, Coalinga State Hospital (CSH) had the most patient deaths during this reporting period.

Patient Deaths by Facility

DSH Facility	Total Number of Deaths
Atascadero	1
Coalinga	15
Metropolitan	5
Napa	9
Patton	4
Total	34

Reports of Head or Neck Injuries

The DSH reported 47 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 47 reported head or neck injuries. One head or neck injury occurred with an altercation with staff. This incident was monitored by OLES.

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 five AWOL incident types. All patients were returned to safety at the facility; however, one patient was AWOL for five days.

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 Priority 1 incident types is 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 2 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 1 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 1 and 2 incident types are listed in the tables below.

Priority 1 Incident Type Descriptions

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.
Sexual Assault	Any allegation of sexual assault of a patient against staff, law enforcement personnel or unidentified person(s).

Priority 2 Incident Type Descriptions

Incident	Description
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.
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.
Drugs	Drug trafficking or smuggling.
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.

Incident	Description
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.
Over-Familiarity	Over-familiarity between staff and patients.
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 1 incident type must be reported in accordance with the Priority 1 reporting requirements.
Pregnancy	A patient pregnancy.
Riot	As defined for OLES reporting purposes.
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).
Serious Crimes	The commission of serious crimes by patient(s) or staff.
Significant Interest	Any incident of significant interest to the public or any incident which may potentially draw media attention.
Suicide (Attempted)	A patient suicide attempt requiring treatment beyond first aid.

Timeliness of Notifications

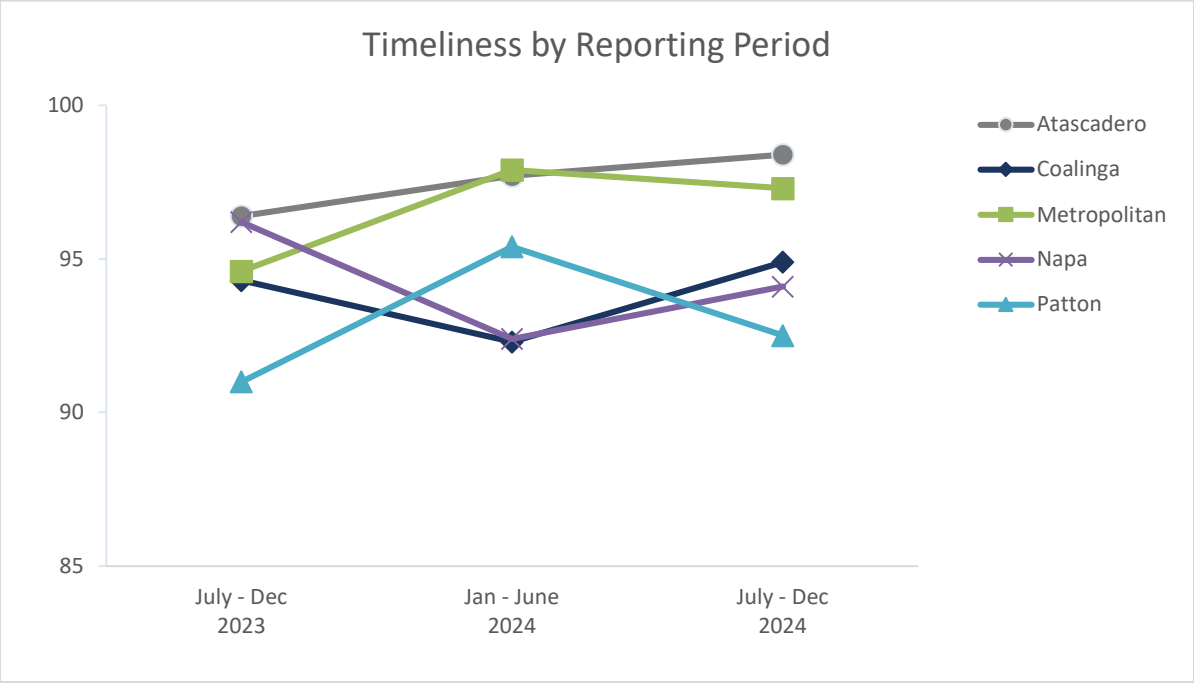
The DSH timely reported incident types 95.7 percent compared to the prior reporting period, which had 95.6 percent timely reports.

Five of the 587 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 582 incident types evaluated for timeliness, 557 were reported timely and 19 incident types were not timely. There were six unreported incidents that met criteria and were discovered by OLES daily log reviews. These unreported incidents are included in the untimely numbers listed below.

The following table compares the percentage of timely notifications by facility.

DSH Facility	Total Reported Incident Types	Number of Timely Notifications	Number of Untimely Notifications	Percentage of Timely Notifications
Atascadero	124	122	2	98.4
Coalinga	117	111	6	94.9
Metropolitan	149	145	4	97.3
Napa	86	81	5	94.2
Patton	106	98	5	92.5
Total	582	557	25	95.7

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



Intake

All incidents received by OLES during the six-month reporting period are reviewed at a daily intake meeting by a panel of assigned OLES staff members. Based on statutory requirements, the panel determines whether allegations against law enforcement officers warrant an internal affairs investigation by OLES. If the allegations are against other DSH staff members and not law enforcement personnel, the panel determines whether the allegations warrant OLES monitoring of any departmental investigation. A flowchart of all the possible OLES outcomes from Intake is shown in Appendix 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, 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, 2024, reporting period, 363 of the total 587 cases opened for DSH incident types that occurred within DSH's jurisdiction or 68.8 percent were assigned a pending review. OLES opened cases for 37 incidents that may have occurred while the patient was not housed within a DSH facility and assigned those cases a pending review. OLES opened 16 administrative investigations and 10 criminal investigations. OLES opened 158 monitored criminal cases and two 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, 2024	Percentage of Opened Cases
Pending Review	364	61.0%
Monitored, Criminal	158	27.5%
Monitored, Administrative	2	0.3%
Outside Jurisdiction [1]	37	7.6%
OLES Investigations, Criminal	10	1.1%
OLES Investigations, Administrative	16	2.0%
Totals	587	100%

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

Completed Investigations and Monitored Cases

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 12 investigations. All 12 investigations were administrative. OLES did not undertake any criminal investigations.

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. OLES provides the department with summaries of the reviews and decisions of all criminal investigations in which OLES determined there was a lack of probable cause.

All 12 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, 2024	Referred to Prosecuting agency	Referred to facility management
Administrative	12	N/A	12
Criminal	0	0	N/A
Total	12	0	12

OLES Monitored Cases

In this report OLES provides information on 153 completed monitored cases. Seventy-four of the 153 cases were criminal cases, five of the 74 cases were referred to a district attorney's office.

There were 79 completed monitored pre-disciplinary administrative cases during this reporting period. Twenty-nine of the 79 cases had sustained allegations, fifty 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	5
Criminal-Not Referred	69
Total Criminal	74
Administrative-With Sustained Allegations	29
Administrative-Without Sustained Allegations	50
Total Administrative	79
Grand Total	153

Pre-Disciplinary Phase Cases

Of the 153 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 18 cases insufficient. 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
OLES monitored the disciplinary action, *Skelly* hearings, settlements, and State Personnel Board proceedings in twenty-one administrative cases. Five cases were insufficient due to, among other things, untimeliness, failure to consult with OLES, delays in serving the disciplinary action, and an improperly conducted Skelly hearing. 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, 2024.

DSH Facility	Percentage of Compliance
Atascadero	98.7%
Coalinga	95.5%
Metropolitan	92.6%
Napa	100%
Patton	99.3%

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 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 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 bi-monthly 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, 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 administrative investigations/actions completed [1]	Adverse action taken [2]	No adverse action taken [3]	Direct adverse action taken [4]	Resigned/ retired pending adverse action [5]
Atascadero	35	6	14	10	5
Coalinga	42	9	16	16	1
Metropolitan	15	1	12	2	0
Napa	22	1	21	0	0
Patton	68	11	50	7	0
Total	182	28	113	35	6

1 Administrative investigations completed includes all 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.

2 Adverse action taken refers to a Notice of Adverse Action being served to an employee after an investigation was completed. These numbers include rejecting employees during their probation periods.

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

4 Direct adverse action taken refers to a Notice of Adverse Action being served to an employee without the completion of an investigation. These numbers include rejecting employees during their probation periods.

5 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 investigations.

Criminal Cases against Employees

DSH Facilities	Total cases [1]	Referred to prosecuting agencies [2]	Not referred [3]	Rejected by prosecuting agencies [4]
Atascadero	15	0	15	0
Coalinga	15	2	13	1
Metropolitan	52	10	51	1
Napa	22	0	22	0
Patton	2	35	0	0
Total	106	47	101	2

1 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.
2 Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to an outside prosecuting entity.
3 Criminal cases not referred to prosecuting agencies due to a lack of probable cause.
4 Cases rejected by prosecuting agencies are criminal cases that were submitted to a prosecuting agency and rejected for prosecution by that agency. This column includes rejected cases that were referred from prior reporting periods. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

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	2	2	0
Coalinga	0	0	0	0
Metropolitan	0	0	0	0
Napa	0	0	0	0
Patton	0	0	1	0
Total	0	2	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 [1]	Referred to prosecuting agencies [2]	Not referred [3]	Rejected by prosecuting agencies [4]
Atascadero	386	50	336	87
Coalinga	306	87	219	59
Metropolitan	194	82	112	58
Napa	16	7	9	1
Patton	72	72	0	3
Total	974	298	676	208

1 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.
2 Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to outside prosecuting entities.
3 Criminal cases not referred to prosecuting agencies due to a lack of probable cause.
4 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. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

Monitored Issues

In the course of its oversight duties, OLES may observe issues that reveal potential patterns, shortcomings, or systemic issues at the facilities. In these situations, the chief of OLES instructs OLES staff to research and document the issues. These issues are then brought to the attention of the departments. In most instances, OLES requests corrective plans. Information on new and long-running monitored issues are provided below.

Recordkeeping of Institutional Firearms and Crime/Evidence Firearms

In February 2023, OLES conducted a review of DSH recordkeeping of DSH institutional firearms and crime/evidence firearms 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 guns used in crimes 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.

In response to OLES' recommendations to address these concerns, DSH accounted for

and listed in AFS all weapons at DSH, updated its policies, ensured each facility properly accounted for and entered into AFS all seized firearms, and identified, relabeled and secured inappropriately stored firearms. DSH has adequately addressed all of the identified concerns and this monitored issue will be closed.

Purchase of Off-Roster Firearms by Sworn Personnel

In the course of OLES' review of the recordkeeping of institutional firearms and crime/evidence firearms, it was discovered that some sworn personnel were purchasing off-roster firearms to carry off duty using DSH credentials, potentially in violation of California Penal Code section 32000, subdivision (b)(6)(F). This statute requires that DSH sworn personnel meet certain qualifications in order to purchase off-roster firearms. In order to address this concern, OLES recommended that DSH review and update its policies concerning off duty firearm qualification standards, rangemaster qualifications, qualification records, and off duty carry authorizations on identification cards to ensure consistency with the law.

In response to OLES' recommendations, DSH has formed a work group to study and address the newly identified concerns. OLES will continue to monitor the department's response to this issue.

Underutilization of Blue Team/IAPro

In March 2015, OLES provided the Legislature with a report detailing the challenges faced by law enforcement at DSH and recommended adopting an early intervention system to monitor incidents and identify potential performance problems. Subsequently, DSH selected the Blue Team/IAPro software for this purpose. DSH facilities were to enter incident data into the system, and DSH-HQ would track eight incident types: Use of Force, Patient Complaints, Citizens Complaints, Citizens Complaints-Other, Vehicle Accidents, Administrative Investigation, Censurable Incident Report, and Merit Salary Advance Denial. Despite completing staff training in 2016, DSH failed to effectively utilize Blue Team/IAPro. Therefore, OLES initiated a monitored issue in July 2017 to assess the implementation and usage of the program as part of OLES's ongoing commitment to addressing the issue. It was found that the data inaccurately reflected reportable incidents, with discrepancies between Blue Team/IAPro and the department's Records Management System (RMS).

In subsequent reviews, OLES highlighted ongoing concerns about DSH's delays in promptly entering reportable incidents into Blue Team/IAPro while acknowledging DSH's commitment to improvement through additional training and updates to the procedure manual. OLES recommended that DSH immediately address reporting inaccuracies by implementing stricter protocols and ensuring timely data entry. Enhanced oversight through regular audits, accountability for leadership, and comprehensive employee training were also advised to improve compliance and accuracy in incident reporting.

During the current reporting period, DSH reported that revisions to the Early Intervention System Procedure manual are in progress to address changes in the process.

Specifically, DSH reported transitioning from a management-centric to a supervisor-centric use, which will be monitored through quarterly audits. Additionally, the Office of Protective Services (OPS) delegated the day-to-day maintenance and updates of Blue Team/IAPro to local administrators at each hospital while retaining oversight responsibilities for the hospital police department's use. OPS Sacramento completed training through CI-Technologies to use Blue Team/IAPro more effectively, facilitating updates to the procedure manual and developing training for local administrators and hospital police sergeants. The training for local administrators has been completed while training for sergeants is underway.

The most recent audit, in January 2025, showed that DSH entered 100 use-of-force cases into Blue Team/IAPro in the previous six months. The review found that nine incidents reported to OLES were not entered into Blue Team/IAPro, and one incident had been entered twice.

OLES will continue monitoring the department's use of Blue Team/IAPro.

Use of Force Reports, Reviews and Tracking at DSH

On July 15, 2021, OLES issued a monitored issue memorandum documenting concerns and recommendations regarding the 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. A use of force report documents an operational incident and does not necessarily indicate misconduct or excessive force by an officer.

On December 28, 2021, DSH acknowledged there were opportunities for improvement in its UOF review and reporting process. The DSH's Chief of Law Enforcement and 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. By September 2023, an OLES use of force consultant and DSH chiefs and representatives from their command participated in a meeting dedicated to developing an updated use of force policy, with field-level input. After completing a use of force policy update in July 2024, DSH released it departmentwide for review and acknowledgment, advising statewide training on the updated policy was forthcoming. In August 2024, OLES and DSH executive and command staff previewed the use of force training video the DSH Academy staff produced, which would be disseminated to each facility to train the OPS staff.

In January 2025, DSH's Chief of Law Enforcement reported that all staff have completed the use of force training using the academy-produced video, marking the full implementation of the training component. This reinforces the department's commitment to ensuring staff are properly trained and prepared to apply the updated policy effectively.

OLES acknowledges this achievement and will continue to monitor the department's adherence to and application of the policy.

Delayed Reporting by Other Mandated Reporters

In December 2021, the OLES provided a monitored issue memorandum to DSH after discovering significant delays in required reporting of reportable incidents by level of care staff and social workers (collectively hereinafter as, "Other Mandated Reporters") at DSH. The OLES reviewed reportable incidents it received notification on, noting OPS often made timely notification to OLES. However, Other Mandated Reporters did not always timely report these incidents to OPS or just completely failed to notify OPS altogether, despite specific 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 these Other Mandated Reporters.

Such delays may have a negative impact on the investigation of these reportable 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 his/her teeth, or uses the restroom. Additionally, for sexual assaults and other allegations of abuse, delays could undermine investigations in other ways. For example, delays create an opportunity for collusion amongst involved parties, or may cause a patient or victim to fear going forward with reporting abuse allegations. Finally, the victims involved in these alleged incidents are a unique population with various mental, emotional, and developmental conditions that may affect the accurate recall of events. As such, investigative efforts must commence immediately whenever possible.

To address this issue, OLES recommended (in its original 2021 monitored issue memorandum) that DSH implement a statewide policy requiring all mandated reporters to make timely notifications to OPS and/or outside law enforcement agencies as required by law. In 2022, DSH responded by developing language for 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 for staff distribution which described reporting requirements for OPS to make notifications to OLES. OPS also met with level of care staff to review these OLES reporting guidelines. These efforts may have increased awareness of Other Mandated Reporters to make timely notification to OPS. However, continued efforts to ensure thorough knowledge of reporting requirements are needed.

In the last reporting period of January 1, 2024, through June 30, 2024, the OLES identified eight incidents that were not timely reported by Other Mandated Reporters to OPS. In the reporting period prior to that, there were only six late-reported incidents. Unfortunately, during the current reporting period of July 1, 2024, through December 31, 2024, this number has increased to nine incidents of delayed reporting. Additionally, there were still some egregious deficiencies, including a broken bone of unknown origin that was not reported to OPS until three days later, and an allegation of sexual assault that was not reported to OPS for over two days. The nine incidents are listed below:

Incident Type	Estimated Delayed Reporting to OPS
Broken bone (unknown origin)	Over 19 hours
Broken bone (unknown origin)	Over 3 days
Sexual assault	Over 19 hours
Broken bone (unknown origin)	Over 2 days
Broken bone (unknown origin)	Over 4 hours
Sexual assault	Over 2 days and 18 hours
Genital Injury (unknown origin)	Over 20 hours
Physical abuse	Over 22 hours
Physical abuse	2.6 hours

It should be further noted, OLES' original memorandum to DSH identified two types of required notification by Other Mandated Reporters:

1) Notification to OPS *and* outside law enforcement agency within two hours of discovery is required:
    a. Whenever a mandated reporter (regardless of classification; LOC staff, social workers, law enforcement, etc.) has observed, has knowledge of, reasonably suspects, or has been told by a dependent adult (i.e., DSH patient) about alleged abuse that resulted in:
        i. Death
        ii. Sexual assault
        iii. Assault with a deadly weapon (by a non-patient)
        iv. Assault with force likely to cause great bodily injury
        v. Genital injury (including when cause of injury is undetermined), or
        vi. Broken bone (including when cause of injury is undetermined),
    b. The mandated reporter shall notify both OPS *and* outside law enforcement agency within two hours of discovering the possible abuse.
    c. These types of reportable incidents are similar to the OLES Priority 1 category of incidents requiring OPS notification to OLES within two hours of OPS discovery.

2) Notification to *either* OPS *or* outside law enforcement agency within two hours of discovery is required:
    a. Whenever a mandated reporter has observed, has knowledge of, reasonably suspects, or has been told by a dependent adult/DSH patient about any other allegation of abuse or neglect not resulting in any of the above criteria,
    b. The mandated reporter shall notify either OPS or an outside law enforcement agency within two hours of discovering the possible abuse or neglect.

While DSH facilities have made efforts to reduce Other Mandated Reporters' late notifications to OPS, there is no documentation or information regarding Other Mandated Reporters' compliance with making timely notification to not only OPS, but

also to an outside law enforcement agency when required.[5]

Although OPS often notifies outside law enforcement agencies about these specific reportable incidents as required, OPS' notification might not always satisfy the original two-hour reporting requirement the Other Mandated Reporter who first discovered the alleged abuse is obligated to comply with. That is because OPS staff are also mandated reporters. OPS has its own two-hour reporting requirement that is triggered once OPS first discovers the alleged abuse or is first notified of it.

OLES renews its recommendations again that DSH implement a statewide policy to ensure all DSH mandated reporters (regardless of classification) are made aware of and comply with their obligations as mandated reporters to timely report possible abuse and neglect to law enforcement within two hours. Additionally, DSH statewide policy should further clarify that timely notification to both OPS *and* outside law enforcement, not just OPS alone, may sometimes be required. Doing so would ensure accurate, thorough investigations are completed without delay or compromise. The OLES will continue to work with the department and monitor the department's progress on this issue.

Recording of Investigatory Interviews

In 2017, 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 not regularly recording interviews. Therefore, in January 2022, OLES reopened this monitored issue to address this concern. In response to OLES recommendations, DSH updated its policy related to the recording of investigatory interviews, purchased additional recorders, and provided training for all OPS sworn staff. Since then, there has been significant improvement in the recording of investigatory interviews and OLES will close this monitored issue.

[5] Although OPS often notifies outside law enforcement agencies about these specific reportable incidents as required, the OPS notification may not satisfy the original two-hour reporting requirement the Other Mandated Reporter who first discovered the alleged abuse is obligated to comply with. That is because OPS staff are also mandated reporters. OPS has its own two-hour reporting requirement that is triggered once OPS first discovers the alleged abuse or is first notified of it.

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, 2024. 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, 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	11/01/2022
OLES Case Number	2023-00578-2A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement supervisor allowed an officer to work from home and an officer submitted fraudulent timesheets.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	11/13/2023
OLES Case Number	2023-01578-1A
Case Type	Investigative
Incident Types	1. Abuse - Physical
Incident Summary	An officer allegedly used excessive force.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	11/29/2023
OLES Case Number	2023-01670-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct 2. Peace Officer Misconduct
Incident Summary	An officer allegedly misused his state vehicle and was dishonest with a supervisor.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	11/29/2023
OLES Case Number	2023-01670-2A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct 2. Peace Officer Misconduct
Incident Summary	A law enforcement supervisor allegedly violated an officer's right under the Public Safety Officers Procedural Bill of Rights Act.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	01/25/2024
OLES Case Number	2024-00119-1A
Case Type	Investigative
Incident Types	1. Abuse - Physical
Incident Summary	An officer allegedly used excessive force on a patient.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	02/29/2024
OLES Case Number	2024-00343-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An officer allegedly made inappropriate comments and posted images of his police services badge on a social media site.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	05/02/2024
OLES Case Number	2024-00660-1A
Case Type	Investigative
Incident Types	1. Over-Familiarity
Incident Summary	An officer allegedly was overly familiar with a patient.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/03/2024
OLES Case Number	2024-00819-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An officer was arrested for allegedly being under the influence and in possession of oxycodone.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	05/16/2024
OLES Case Number	2024-00897-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An officer allegedly failed to report alleged Equal Employment Opportunity violations as required by policy. The officer also was allegedly insubordinate to a supervisor who had directed the officer to timely make the required report.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/23/2024
OLES Case Number	2024-00914-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An officer was arrested by local police for an off-duty domestic violence incident.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/01/2024
OLES Case Number	2024-00948-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An officer was arrested for allegedly being under the influence of a narcotic, possession of a narcotic controlled substance, and possession of controlled substance.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/21/2024
OLES Case Number	2024-01051-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An officer sent a photograph of their officer identification badge to a prison inmate.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Appendix B: Pre-Disciplinary Cases Monitored by OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2024, 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.

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	08/28/2021
OLES Case Number	2021-01031-2C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	A psychiatric technician allegedly provided patients with marijuana edibles and engaged in sexual activity with a patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. An administrative investigation was opened and monitored by OLES.

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

Case Details	Description
Incident Date	12/04/2022
OLES Case Number	2022-01518-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly sexually assaulted a patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/30/2023
OLES Case Number	2023-00147-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Broken Bone (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A psychiatric technician allegedly pulled a patient's meal tray away and slapped the patient's hand.
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	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 487 days from the date of discovery. The investigator did not provide the legally required Beheler admonishment prior to conducting the suspect interview, and did not accurately report his pre-interview, off-the-record, discussion with the suspect in the report. The Office of Special Investigations did not address the monitor's concerns about the investigator's conduct in the final report. Moreover, throughout the investigation, the Office of Special Investigations did not timely respond to the monitor's repeated inquiries regarding the status of the investigation. The investigation was unreasonably delayed by the frequent personnel changes within the Office of Special Investigations, as well as a belief that the investigation could not be conducted due to a question about the peace officer status of the responding hospital police officer. The delay caused the suspect to not have an accurate recollection of the incident, as she was interviewed nearly one year after the alleged incident, and the statute of limitations for any possible misdemeanor charge expired.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? • No The investigator did not provide the required Beheler admonishment before conducting an interview of the subject. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The investigator did not accurately report his off-the-

	record conversation with the subject psychiatric technician and the admonishment provided prior to the interview. 3. Was the final investigative report thorough and appropriately drafted? • No The department did not address the monitor's concerns regarding the accuracy of the report in the final investigative report. 4. Did the deadline for taking disciplinary action or filing charges expire before the investigation was complete? • Yes The statute of limitations for a possible misdemeanor charge expired prior the completion of the investigation. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No Throughout the investigation, the Office of Special Investigations did not respond to the monitor's inquiries regarding the status of the investigation. 6. Was the investigation thorough and appropriately conducted? • No The investigation was unreasonably delayed by the frequent staffing changes within the Office of Special Investigations, and by a temporary decision to not conduct any investigation due to a possible issue regarding the lack of peace officer status by the responding hospital police officer. 7. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 487 days after the incident was discovered.
Department Corrective Action Plan	In the future, should there be an issue with an investigating officer we will continue the investigative process with another investigator whenever possible without tolling time. OSI conducts monthly meetings and training sessions, where it will be briefed that Miranda v. Arizona requires the

	government officer to communicate the Miranda warnings to a suspect, only under specific circumstances. The "Beheler" advisement will be briefed, and training will be provided. The investigator relayed the required verbiage in the "Beheler" case to the interviewee, while the interviewee was walking with the investigator to a room for the interview. To address this "pre-conversation" the investigators will activate their recorders immediately upon entering the unit to capture these situations on recording or will readvise the interviewee after the recorder is activated. OSI will continue to work collaboratively with OLES and address monitors concerns and recommendations to ensure investigations are completed timely.

Case Details	Description
Incident Date	03/31/2023
OLES Case Number	2023-00482-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 pushed 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	**Overall 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	2023-00528-2A
Case Type	Monitored
Incident Types	1. Significant Interest
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A rehabilitation therapist allegedly drank alcohol while on duty and interacted with patients. The rehabilitation therapist then allegedly drove her personal vehicle while under the influence of alcohol and struck two vehicles parked in the facility parking lot.
Disposition	The hiring authority sustained an allegation against the rehabilitation therapist for being intoxicated while on duty; however, no disciplinary action could be taken because the rehabilitation therapist resigned before completion of the investigation. A letter indicating the rehabilitation therapist resigned under adverse circumstances was placed in the rehabilitation therapist's official personnel file. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/20/2023
OLES Case Number	2023-00592-1C
Case Type	Monitored
Incident Types	1. Drugs
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	An unidentified person sent narcotics into a state hospital.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/29/2023
OLES Case Number	2023-00736-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review 2. Attorney Administrative Review 3. Attorney Administrative Review 4. Attorney Administrative Review 5. Attorney Administrative Review
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 law enforcement supervisors allegedly ordered retaliatory searches of patient areas following the marriage of a patient to a former employee.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 381 days from the

	date of discovery and 15 days after the deadline for taking disciplinary action expired.
Pre-Disciplinary Assessment	1. Did the deadline for taking disciplinary action or filing charges expire before the investigation was complete? • Yes The investigation was not completed until 15 days after the deadline for taking disciplinary action expired. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 381 days after the department discovered the alleged misconduct.
Department Corrective Action Plan	SAC OPS has created the limited term SI position as of February 2024 to assist with meeting those guidelines – periodic consulting with OLES monitors and submitting OLES case extensions when necessary (due to unforeseeable factors/resources).

Case Details	Description
Incident Date	05/30/2023
OLES Case Number	2023-00888-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Three officers allegedly used excessive force on a patient, completed inaccurate reports, and conducted an inadequate investigation.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

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

Case Details	Description
Incident Date	06/24/2023
OLES Case Number	2023-00921-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Dishonesty 8. Dishonesty 9. Dishonesty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained 7. Sustained 8. Sustained 9. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatrist and senior psychiatric technician allegedly directed staff to remove a patient from a seclusion room. A psychiatric technician allegedly dragged the patient out of the room by the hair and ankles. The psychiatrist and senior psychiatric technician allegedly failed to intervene. The senior psychiatric technician, and psychiatric technician were also allegedly dishonest during the investigation.

Disposition	The hiring authority sustained dishonesty allegations against the senior psychiatric technician and psychiatric technician, but did not sustain any abuse allegations, and determined letters of instruction were the appropriate penalty. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/27/2023
OLES Case Number	2023-01113-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	Two psychiatric technicians allegedly neglected to adequately monitor a patient on enhanced observation. The patient swallowed two pens. A senior psychiatric technician and a third psychiatric technician allegedly neglected to conduct a full body search of the patient for contraband during their enhanced observation shift.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the senior psychiatric technician and the first psychiatric technician and determined that a letter of warning was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegations

	as to the second and third psychiatric technicians. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/14/2023
OLES Case Number	2023-01185-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pushed a patient, causing him to fall and strike his head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/14/2023
OLES Case Number	2023-01185-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 pushed a patient, causing the patient to fall and strike his head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/01/2023
OLES Case Number	2023-01226-2A
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, assigned to enhanced observation of a patient, allegedly failed to activate an alarm and intervene when two other patients allegedly 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/10/2023
OLES Case Number	2023-01295-1C

Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	A psychiatric technician allegedly 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.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/23/2023
OLES Case Number	2023-01487-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was found unresponsive with a ligature around his neck. Level of care staff initiated life-saving measures. Outside emergency medical staff responded, taking over life-saving efforts; however, the patient remained unresponsive, and was pronounced dead. The medical

	examiner determined the manner of death to be suicide and the cause of death to be hanging.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The Department of Protective Services officers who responded to the scene did not secure nor search the patient's dormitory room for possible evidence. The officer maintaining the crime did not observe the medical examiner remove the ligature from the restroom stall and did not document its chain of custody. Officers did not notify the Office of Special Investigations, who were present on the unit, that the medical examiner had arrived, conducted its investigation and left with the decedent's body.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Office of Protective Services officers did not cordon off nor search the patient's dorm room; relevant writings were recovered during a later search. The officer securing the crime scene did not notice that the medical examiner had taken the ligature from the restroom stall. The officers did not notify the Office of Special Investigations investigators, who were present on the unit, that the medical examiner had arrived, conducted its investigation, and left with the decedent's body. 2. Was the incident properly documented? • No The officer securing the crime scene did not properly document the chain of custody of the ligature. 3. Were all of the interviews thorough and appropriately conducted? • No The Office of Special Investigations did not interview a patient/witness, who was discharged a day after the suicide, until 100 days after the death.

Department Corrective Action Plan	DPS will be trained during briefings to conduct interviews as soon as they identify the involved parties, to include scenario training in securing crime scenes and major incident response will dramatically assist with insufficiencies that occurred in events similar to this one. A Field Sergeant will be dispatched to assist Officers in major incidents and will ensure that if Officers need guidance, a supervisor will be on scene. Scenario training with Office of Special Investigation will give an insight to Officers what investigators need or might be looking for during their investigation.

Case Details	Description
Incident Date	11/13/2023
OLES Case Number	2023-01578-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly used excessive force.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/11/2023
OLES Case Number	2023-01586-1A
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	Three psychiatric technicians allegedly failed to medically assess a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/07/2023
OLES Case Number	2023-01588-1C
Case Type	Monitored
Incident Types	1. Drugs
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly brought narcotics into the facility and provided the narcotics to 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/15/2023
OLES Case Number	2023-01601-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pulled a patient's hair, and a staff member pushed 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	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/14/2023
OLES Case Number	2023-01604-2A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1

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 allegedly inappropriately touched 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/18/2023
OLES Case Number	2023-01638-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician assigned to continuously monitor a patient, allegedly failed to prevent the patient from swallowing batteries.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 147 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 147 days from the date of discovery.
Department Corrective Action Plan	The investigator will strive to schedule and conduct interviews between high priority cases. He will coordinate with unit supervisors to have subject staff members available for interviews, which caused slight delays in this case. The investigator will be reminded of due dates on OLES case files.

Case Details	Description
Incident Date	11/20/2023
OLES Case Number	2023-01639-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained

	2. Sustained 3. Not Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician allegedly failed to properly secure a patient's wheelchair inside a bus and the automotive equipment operator allegedly drove the bus at excessive speeds, causing the patient's wheelchair to fall backwards.
Disposition	The hiring authority sustained allegations against the psychiatric technician and the automotive equipment operator and determined a letter of warning was the appropriate penalty for both employees. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/29/2023
OLES Case Number	2023-01670-3A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct 2. Peace Officer Misconduct
Allegations	1. Misuse of state property 2. Dishonesty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	An officer allegedly misused his state-issued vehicle and was dishonest with a supervisor.
Disposition	The hiring authority sustained the allegation that the

	officer misused the state-issued vehicle and issued a letter of instruction. The hiring authority found insufficient evidence to sustain the dishonesty allegation.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/29/2023
OLES Case Number	2023-01670-4A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct 2. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A law enforcement supervisor allegedly violated an officer's right under the Public Safety Officers Procedural Bill of Rights Act.
Disposition	The hiring authority sustained the allegation and determined a letter of instruction and training was appropriate. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/17/2023
OLES Case Number	2023-01692-1A
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 registered nurse allegedly improperly changed a patient's catheter.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/15/2023
OLES Case Number	2023-01749-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Staff members allegedly twisted a patient's knee while restraining the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	12/26/2023
OLES Case Number	2023-01767-2A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician was allegedly involved in an overly familiar relationship 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/26/2023
OLES Case Number	2023-01786-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin) 2. Head/Neck Injury
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Sustained

Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	An unsupervised patient fell and sustained a fractured foot. A psychiatric technician allegedly failed to conduct thorough periodic safety checks of the patient, and a pre-licensed psychiatric technician allegedly failed to appropriately document those checks as required by policy.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the pre-licensed psychiatric technician. The hiring authority determined corrective action was appropriate and issued a Letter of Instruction. The hiring authority determined there was insufficient evidence to sustain the allegations against the psychiatric technician. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigator did not address a related potential policy violation discovered during the course of the investigation.
Pre-Disciplinary Assessment	1. Was the investigation thorough and appropriately conducted? • No The investigator did not address a related potential policy violation discovered during the course of the investigation.
Department Corrective Action Plan	Investigators will evaluate their case file to correctly identify specific violation policies during the initial review. The investigator shall research all A.D.'s that may be relevant to the allegations. This will help formulate their interview strategies, questions and complete a thorough Statement of Facts for submission to the OLES, and Incident Review Committee.

Case Details	Description

Incident Date	01/05/2024
OLES Case Number	2024-00053-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 allegedly grabbed and chased a patient. Additionally, a registered nurse allegedly pushed and prevented the patient from using a microwave. A second psychiatric technician allegedly refused to empty the patient's urinal.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/12/2024
OLES Case Number	2024-00079-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Applicable
Penalty	**Initial:**

	Final:
Incident Summary	A patient was found without a pulse or respiration. Level of care staff provided life saving measures; however, the patient died unexpectedly from cardiopulmonary arrest.
Disposition	The Office of Protective Services completed the required post-death investigation and determined there was no evidence of a crime nor policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/21/2024
OLES Case Number	2024-00099-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/26/2024
OLES Case Number	2024-00122-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly engaged in an overly familiar sexual relationship with a patient during and after his treatment at the state hospital.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The interviews of the alleged patient victim and suspect were not conducted until nearly six months after the date of discovery, and the department did not provide a copy of the draft investigative report to the OLES monitor prior to closing the investigation.
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 provide a copy of the draft investigative report to the OLES monitor prior to closing the investigation. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The interviews of the alleged patient victim and suspect were not completed until nearly six months after discovery of alleged crime.
Department Corrective Action Plan	The Supervising Special Investigator will take steps to ensure the criminal cases are completed in a timely manner. If an investigator is assigned a criminal case and the investigation reaches 90 days, a case consultation shall be completed with the Supervising Special

	Investigator and the assigned investigator. Afterwards, the AIM shall be notified of the case disposition with reasons for the delay. If warranted, an OLES Monitored Case Request for Extension form will be completed. Furthermore, if an assigned investigator is going to be on an extended leave, the Supervising Special Investigator shall reassign the case to ensure the criminal investigation is completed in a timely manner.

Case Details	Description
Incident Date	01/27/2024
OLES Case Number	2024-00152-1A
Case Type	Monitored
Incident Types	1. Neglect
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 patient reported to two psychologists that she had been sexually assaulted at an outside mental health facility. Both psychologists allegedly failed to report the patient's sexual assault allegations as required as mandated reporters.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/29/2024
OLES Case Number	2024-00176-1C

Case Type	Monitored
Incident Types	1. Head/Neck Injury 2. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Two nurses and a psychiatric technician allegedly failed to medically assess a patient who had fallen and sustained a head injury.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/25/2024
OLES Case Number	2024-00193-1A
Case Type	Monitored
Incident Types	1. Drugs
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 senior psychiatric technician allegedly placed an envelope of suspected narcotics on a patient's 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	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/02/2024
OLES Case Number	2024-00218-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly hit a patient on the face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not assigned to an investigator until 169 days after the date of discovery. The investigation was not completed until 171 days after the date of discovery. Although the Office of Special Investigations conducted a necessary follow-up interview, the interview was documented in an initial case plan and not in a supplemental report.
Pre-Disciplinary Assessment	1. Was the final investigative report thorough and appropriately drafted? • No Although the Office of Special Investigations conducted a necessary follow-up interview, the interview was documented in an initial case plan and

	not in a final supplemental report. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not assigned to an investigator until 169 days after the date of discovery. The investigation was not completed until 171 days after the date of discovery.
Department Corrective Action Plan	The Office of Special Investigations (OSI) has hired a Staff Service Analyst (SSA) to assist in the creation and assignment of OLES monitored cases. After the Department of Protective Services (DPS) forwards new cases to OSI, the SSA will assist in ensuring OLES monitored cases are created, tracked, and assigned to investigators. Moving forward OSI has established a procedure to obtain timely updates from the investigators on all OLES monitored investigations. The procedure consists of a binder containing forms (printed spreadsheets) that require the investigators to provide updates every 60, 90, and 110 days on their assigned OLES monitored investigations. This procedure has assisted with updates and has maintained accountability on the progress of the OLES monitored investigations.

Case Details	Description
Incident Date	02/06/2024
OLES Case Number	2024-00235-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 on the

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

Case Details	Description
Incident Date	02/08/2024
OLES Case Number	2024-00242-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two registered nurses and four psychiatric technicians allegedly hit a patient in the face while placing him into restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/31/2024
OLES Case Number	2024-00255-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Sustained
Incident Summary	A patient sustained a broken elbow while being stabilized by staff.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/12/2024
OLES Case Number	2024-00264-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was found unresponsive in his bed and emergency life saving measures were initiated; however, the patient was declared dead. An autopsy revealed the cause of death was atherosclerosis with hypertensive cardiovascular disease.

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

Case Details	Description
Incident Date	02/12/2024
OLES Case Number	2024-00265-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A custodian allegedly inappropriately touched a patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation because the custodian resigned prior to completion of the criminal case.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/13/2024
OLES Case Number	2024-00268-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical

Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A nurse allegedly slapped a patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/02/2024
OLES Case Number	2024-00281-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly grabbed a patient by the shoulders and improperly administered medication.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.

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

Case Details	Description
Incident Date	02/25/2024
OLES Case Number	2024-00303-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/17/2024
OLES Case Number	2024-00305-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly hit a patient multiple times.
Disposition	The case was not referred to the district attorney's office

	due to a lack of probable cause. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/20/2024
OLES Case Number	2024-00312-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical 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	A psychiatric technician allegedly fractured a patient's ribs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/26/2024
OLES Case Number	2024-00313-1A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An unidentified staff member allegedly inappropriately touched a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/28/2024
OLES Case Number	2024-00326-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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's wrist, causing injury.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process when the investigator conducted the subject interview prior to the agreed upon time for the interview when the assigned monitor was unavailable, thereby precluding the monitor from providing real-time feedback.
Pre-Disciplinary	1. Did OPS cooperate with and provide continued real-

Assessment	time consultation with OLES? • No The investigator conducted the subject interview prior to the agreed upon time for the interview when the assigned monitor was unavailable, thereby precluding the monitor from providing real-time feedback.
Department Corrective Action Plan	A corrective action plan was not provided.

Case Details	Description
Incident Date	03/06/2024
OLES Case Number	2024-00354-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly used excessive force while restraining 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description

Incident Date	03/15/2024
OLES Case Number	2024-00357-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Referred 2. Not Referred
Incident Summary	A senior psychiatric technician allegedly assaulted a patient as the patient tried to diffuse an altercation between two other patients. A psychiatric technician allegedly was aware the first patient was trying to resolve the conflict; however, failed to intervene when responding staff restrained and treated the first patient as an aggressor.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/05/2024
OLES Case Number	2024-00358-2C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred

Incident Summary	Two officers allegedly picked up a restrained patient off the floor, carried the patient in the prone position to the restraint room, and placed the patient face down on the restraint bed.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to the officers having received correspondence from the department clearing them of any potential misconduct prior to the conclusion of the criminal investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 229 days from the date of discovery, and the department failed to notify OLES that the officers were issued correspondence clearing them of any potential misconduct prior to the conclusion of the criminal investigation.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The department issued correspondence to the officers clearing them of any potential misconduct prior to the conclusion of the criminal investigation. 2. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? • No The department did not notify OLES that the officers were issued correspondence clearing them of any potential misconduct prior to the conclusion of the criminal investigation. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 229 days after the incident was discovered.
Department	SAC OPS will identify case timelines and be sure to

Corrective Action Plan	receive approval for OLES extensions when confronted with mitigating circumstances that prevent timely completion of case investigations.

Case Details	Description
Incident Date	03/03/2024
OLES Case Number	2024-00361-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 allegedly hit a patient on the face, head and back.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/06/2024
OLES Case Number	2024-00369-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A registered nurse entered a patient's room and allegedly hit the patient and pulled on the patient's fingers.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/11/2024
OLES Case Number	2024-00393-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly threw 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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/08/2024
OLES Case Number	2024-00405-1C

Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	Three psychiatric technicians allegedly grabbed a patient's arms and dragged the patient to a seclusion room, causing bruising.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/14/2024
OLES Case Number	2024-00406-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit and kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The office of protective services did not open an administrative

	investigation.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The initial interviews were not recorded and were unverifiable. Regardless, the investigator did not interview any witnesses and therefore the investigation was not thorough. The investigator failed to cooperate and provide real-time consultation with OLES.
Pre-Disciplinary Assessment	1. Was the incident properly documented? • No The initial report contained cursory summaries of the witness interviews. Because those interviews were not recorded, there was no way of knowing whether the summaries captured all of the information that was addressed in the interviews. 2. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator refused to interview any witnesses and relied only on the initial reports. 3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The investigator attached the wrong initial report that involved a different patient/victim, creating a HIPPA violation. 4. Was the final investigative report thorough and appropriately drafted? • No The report contained uninvolved patient information; thereby creating privacy concerns. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator did not respond to the monitor's concerns about the initial investigation for over five months.
Department Corrective Action Plan	The Department of Police Services and the Office of Special Investigations (OSI) will continue to work to ensure officers audio record all involved party interviews,

	to include refusals at the outset in their initial criminal report. The investigator will be briefed on the importance of working with OLES regarding their recommendations in a timely manner. OSI will review all interviews for thoroughness in the event interviews are not recorded OSI will evaluate the interviews and reinterview when necessary. Regarding the wrong attachment OSI will stress the importance of checking all attachments for accuracy before submitting the report to a supervisor. The situation of attaching the wrong attachment was addressed with the HIPAA compliance unit, which was considered to be a low-level privacy incident.

Case Details	Description
Incident Date	03/18/2024
OLES Case Number	2024-00410-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff members allegedly sexually assaulted a restrained 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/08/2024
OLES Case Number	2024-00418-1C

Case Type	Monitored
Incident Types	1. Drugs
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Unfounded
Incident Summary	A psychiatric technician was allegedly sexually inappropriate and discourteous to patients. A senior psychiatric technician allegedly provided narcotics to 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/16/2024
OLES Case Number	2024-00433-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
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 rehabilitation therapist allegedly engaged in an overly

	familiar relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/21/2024
OLES Case Number	2024-00449-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly told a disabled patient to walk faster, and pulled the patient's walker, causing injury to the patient's knee.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/28/2024
OLES Case Number	2024-00468-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient struggled to breathe, then became unresponsive. Level of care staff confirmed the patient had a pulse and transported the patient to the urgent care room. Life-saving measures were initiated, but the patient could not be resuscitated. A doctor pronounced the patient dead.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/26/2024
OLES Case Number	2024-00495-1A
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 playing video games with one patient while assigned to an enhanced observation of another patient.

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

Case Details	Description
Incident Date	03/31/2024
OLES Case Number	2024-00497-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient became unresponsive while sitting in his wheelchair. Level of care staff confirmed the patient had a pulse and transported the patient to the urgent care room. The patient's condition declined. Life-saving measures were initiated, but the patient could not be resuscitated. A doctor pronounced the patient dead.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	
OLES Case Number	2024-00500-1A
Case Type	Monitored

Incident Types	1. Abuse - Physical
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 inappropriately touched 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/03/2024
OLES Case Number	2024-00505-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychologist allegedly improperly increased a patient's medication.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/02/2024
OLES Case Number	2024-00506-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 allegedly grabbed a phone from a patient, hit the patient with the phone, then shoved the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/03/2024
OLES Case Number	2024-00517-1C
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 metatarsal bone.

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

Case Details	Description
Incident Date	04/08/2024
OLES Case Number	2024-00549-1C
Case Type	Monitored
Incident Types	1. 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 psychiatric technician allegedly brought controlled substances into the facility to distribute to patients approximately two years ago. A second psychiatric technician allegedly brought controlled substances into the facility earlier this year. A third 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. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/12/2024
OLES Case Number	2024-00553-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician and a psychiatric technician allegedly forced a patient to the floor. The patient sustained a cut to his eyelid and hand and reportedly lost a tooth.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/10/2024
OLES Case Number	2024-00558-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly offered to provide sexual favors to 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	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The investigation was not completed in a timely manner.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 223 days after the incident was discovered.
Department Corrective Action Plan	The Supervising Special Investigator will take steps to ensure the criminal cases are completed in a timely manner to meet OLES Processing Guidelines. If an investigator is assigned a criminal case and the investigation reaches 90 days, a case consultation shall be completed with the Supervising Special Investigator and the assigned investigator. Afterwards, the AIM shall be notified of the case disposition with reasons for the delay. If warranted, an OLES Monitored Case Request for Extension form will be completed.

Case Details	Description
Incident Date	03/05/2024
OLES Case Number	2024-00560-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two officers allegedly violated DSH policy by not

	recording staff members' declination of recordings.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/18/2024
OLES Case Number	2024-00598-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Referred
Incident Summary	A doctor allegedly inappropriately touched a patient during a medical examination.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/22/2024
OLES Case Number	2024-00602-1A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
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	Unidentified staff members, patients and therapy dogs allegedly sexually assaulted a patient. Unidentified staff allegedly killed the patient's parole officers.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/25/2024
OLES Case Number	2024-00617-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly inappropriately touched a patient on three occasions.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/26/2024
OLES Case Number	2024-00625-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A unit supervisor allegedly refused to release a patient from restraints for the purpose of retaliating against the patient.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/30/2024
OLES Case Number	2024-00628-1C
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 ankle and vertebrae. The cause was undetermined,
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.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/22/2024
OLES Case Number	2024-00641-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly fell asleep while assigned to continuously monitor a patient. The patient committed self-harm while the nurse was allegedly sleeping.
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	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The investigation was not completed in a timely manner.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 230 days after the incident was discovered.
Department Corrective Action	The Supervising Special Investigator will take steps to ensure the criminal cases are completed in a timely

Plan	manner to meet OLES Processing Guidelines. If an investigator is assigned a criminal case and the investigation reaches 90 days, a case consultation shall be completed with the Supervising Special Investigator and the assigned investigator. Afterwards, the AIM shall be notified of the case disposition with reasons for the delay. If warranted, an OLES Monitored Case Request for Extension form will be completed.

Case Details	Description
Incident Date	05/02/2024
OLES Case Number	2024-00660-2A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly was overly familiar with a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/02/2024
OLES Case Number	2024-00661-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Over-Familiarity
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant allegedly kissed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/06/2024
OLES Case Number	2024-00672-2C
Case Type	Monitored
Incident Types	1. Head/Neck Injury
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was found on the floor with a forehead injury and an altered level of consciousness.
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 due to lack of evidence.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	
OLES Case Number	2024-00679-1A

Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty 9. Inexcusable neglect of duty 10. Inexcusable neglect of duty 11. Inexcusable neglect of duty 12. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained 7. Not Sustained 8. Not Sustained 9. Not Sustained 10. Not Sustained 11. Not Sustained 12. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Three psychiatric technicians were allegedly overly familiar with a patient and provided the patient with coffee and drugs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/05/2024
OLES Case Number	2024-00687-1A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Unidentified staff allegedly sexually assaulted a sleeping patient on multiple occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/09/2024
OLES Case Number	2024-00688-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 allegedly hit a wheelchair a patient was seated in, causing neck and back pain to the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/12/2024
OLES Case Number	2024-00697-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Applicable
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was found without a pulse or respiration. The patient was transported to an outside hospital where he was pronounced dead. The death was due to cardiac arrest.
Disposition	The Office of Protective Services completed the required post-death investigation and determined there was no evidence of a crime nor policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/10/2024
OLES Case Number	2024-00708-1A

Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly pinched a patient after administering an injection.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/17/2024
OLES Case Number	2024-00713-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff members allegedly repeatedly beat and sexually assaulted a patient.

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

Case Details	Description
Incident Date	05/15/2024
OLES Case Number	2024-00720-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
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	An officer allegedly sexually harassed 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/17/2024
OLES Case Number	2024-00733-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 psychiatrist allegedly assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/20/2024
OLES Case Number	2024-00734-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Unidentified staff allegedly starved a patient by refusing to let him go to the cafeteria for meals. The unidentified staff also allegedly sexually abused 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	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	05/17/2024
OLES Case Number	2024-00741-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly hit a patient in the face, threw the patient against a wall, and knelt on the patient's neck.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/21/2024
OLES Case Number	2024-00763-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed, hit, and threatened 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/23/2024
OLES Case Number	2024-00765-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 twisted a patient's arm and stabbed the patient in the shin. A second psychiatric technician allegedly hit the patient's toe and nose, allegedly breaking both.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against both psychiatric technicians. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/30/2024
OLES Case Number	2024-00784-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior 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 Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/29/2024
OLES Case Number	2024-00785-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly repeatedly hit a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/04/2024
OLES Case Number	2024-00811-2C
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 pressure sores.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/05/2024
OLES Case Number	2024-00820-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A supervising psychiatric technician allegedly hit a patient multiple times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.

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

Case Details	Description
Incident Date	06/07/2024
OLES Case Number	2024-00843-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A law enforcement supervisor allegedly failed to take appropriate action when they discovered a law enforcement officer appeared to be impaired while on duty.
Disposition	The hiring authority sustained the allegations and determined a letter of instruction was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/11/2024
OLES Case Number	2024-00856-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	An unidentified "soul" allegedly raped a patient while she was asleep.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/04/2024
OLES Case Number	2024-00864-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Multiple unidentified staff allegedly placed a patient in seclusion without justification.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/13/2024
OLES Case Number	2024-00866-1C

Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified person 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. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/14/2024
OLES Case Number	2024-00872-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient recently discharged from an outside medical facility, complained of shortness of breath and became unresponsive. Level of care staff initiated life-saving measures. Outside emergency medical staff responded, taking over lifesaving efforts; however, the patient remained unresponsive, and was pronounced dead. An autopsy determined the patient died from congestive heart failure and cardiomyopathy.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/15/2024
OLES Case Number	2024-00873-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly put his knees on both sides of a patient's neck while providing treatment.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/17/2024
OLES Case Number	2024-00882-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	An unidentified staff member twisted a patient's arm and hit him on the back of the head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/19/2024
OLES Case Number	2024-00889-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient's nose with her identification badge.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/19/2024
OLES Case Number	2024-00893-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical

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 by the arms and dropped the patient on the floor of his bedroom.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/23/2024
OLES Case Number	2024-00914-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Discourteous treatment 2. Other failure of good behavior
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	An officer was arrested by local police for an off-duty domestic violence incident.
Disposition	The hiring authority found insufficient evidence to sustain the allegation of domestic violence but determined the officer engaged in discourteous behavior and issued a letter of instruction. The OLES concurred with the hiring

	authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/30/2024
OLES Case Number	2024-00938-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed a patient's by the collar.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/27/2024
OLES Case Number	2024-00939-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A psychiatric technician allegedly hit a patient on the back of the head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/27/2024
OLES Case Number	2024-00940-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient on the back of the head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/02/2024
OLES Case Number	2024-00946-1C
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 femur.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The investigation was not completed until 134 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 134 days after the incident was discovered.
Department Corrective Action Plan	The SSI has established a procedure where the Office of Special Investigations (OSI) professional staff reviews the cases submitted by the investigators and advises the SSI when an OLES monitored case is ready for review.

Case Details	Description
Incident Date	07/01/2024
OLES Case Number	2024-00952-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly hit a patient

	multiple times on the face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/14/2024
OLES Case Number	2024-00958-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed, choked and kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/05/2024
OLES Case Number	2024-00960-1A
Case Type	Monitored

Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychologist was allegedly overly familiar and inappropriately touched 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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/05/2024
OLES Case Number	2024-00969-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Known 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. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/03/2024
OLES Case Number	2024-00974-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A social worker allegedly gave outside food to a patient and inappropriately provided the patient with his medication prior to his discharge.
Disposition	The hiring authority found sufficient evidence to sustain the allegation that the social worker provided outside food to the patient but found insufficient evidence to sustain the allegation she inappropriately provided the patient medication prior to his discharge. The hiring authority was legally unable to impose adverse action against the social worker because her supervisor had previously counseled the social worker regarding the incident. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigatory process. The social worker's supervisor provided verbal counseling prior to the completion of the investigation, thereby preventing the hiring authority from imposing any additional adverse action.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The social worker's immediate supervisor provided a verbal counseling prior to the completion of the investigation, thereby preventing the hiring authority from imposing any additional adverse action.

Department Corrective Action Plan	OPS provided education to the social worker's immediate supervisor to not counsel employees and to reach out to the local Employee Relations Office for guidance on what steps should be taken. OPS has also implemented a process to work with local Employee Relation Office prior to informing supervisors of their employee conduct. This will ensure OPS follows the recommendations so the hiring authority will be able to impose adverse action if warranted.

Case Details	Description
Incident Date	07/05/2024
OLES Case Number	2024-00991-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Incident Summary	An unidentified staff allegedly strangled a patient and placed his knee on the patient's neck. A second unidentified staff allegedly placed his knee on the patient's cheek. A third unidentified staff allegedly placed his knee on the patient's head. A registered nurse allegedly failed to act after the patient reported he was going to have a seizure.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.

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

Case Details	Description
Incident Date	07/01/2024
OLES Case Number	2024-01000-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Multiple unidentified staff members forcibly medicated a patient on multiple occasions.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/18/2024
OLES Case Number	2024-01030-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was found unresponsive in his room and ultimately died from cardiac arrest. The death was

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

Case Details	Description
Incident Date	07/17/2024
OLES Case Number	2024-01031-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Four unidentified staff members allegedly repeatedly hit a patient in the back, head, and face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/19/2024
OLES Case Number	2024-01035-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Sexual Assault: Priority 1

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff allegedly tried to break a patient's arm. A second unidentified staff tried to break the patient's leg, and a third unidentified staff allegedly sexually assaulted 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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/24/2024
OLES Case Number	2024-01065-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	During a floor containment procedure, an unidentified staff member allegedly hit a patient multiple times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/26/2024
OLES Case Number	2024-01084-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unknown staff allegedly failed to assist a patient who was recovering from back surgery, which allegedly led to the patient sustaining a fractured vertebra.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/12/2024
OLES Case Number	2024-01098-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred

	3. Not Referred 4. Not Referred
Incident Summary	A psychiatric technician allegedly sexually assaulted a sleeping patient. The psychiatric technician, a registered nurse, a second psychiatric technician, and a fourth unidentified staff allegedly hit the patient multiple times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2024
OLES Case Number	2024-01104-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified person allegedly sat on a patient, fracturing the patient's hip.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description

Incident Date	08/12/2024
OLES Case Number	2024-01124-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Two psychiatric technicians allegedly grabbed and hit a patient on the arms.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/18/2024
OLES Case Number	2024-01158-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly grabbed a patient by the neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative

	investigation due to lack of evidence.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/02/2024
OLES Case Number	2024-01211-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient choked while eating. Staff and paramedics provided life-saving measures, however, the patient died. An autopsy determined the death was accidental.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/04/2024
OLES Case Number	2024-01230-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient on the arm.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/02/2024
OLES Case Number	2024-01232-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	Two unidentified staff members allegedly pulled a patient by his wrist. A psychiatric technician allegedly struck the patient on the back of the neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/08/2024
OLES Case Number	2024-01254-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff allegedly forced a patient to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/09/2024
OLES Case Number	2024-01263-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly forced a patient's head into a wall causing a laceration to 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 accepted for monitoring.

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

Case Details	Description
Incident Date	09/26/2024
OLES Case Number	2024-01346-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient collapsed and became unresponsive. Life saving measures were unsuccessful and the patient died from a pulmonary embolism. The death was unexpected.
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	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/01/2023
OLES Case Number	2023-01425-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Referred

Incident Summary	A food services technician allegedly engaged in an overly familiar relationship with a patient, took inappropriate pictures of the patient, and attempted to extort the patient.
Disposition	The Office of Protective Services found there was probable cause to believe a crime was committed and referred the case to the district attorney's office. The OLES concurred with the probable cause determination.
Investigative Assessment	**Overall 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	11/12/2020
OLES Case Number	2021-00348-3A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** No Penalty Imposed
Incident Summary	An officer allegedly was dishonest during a deposition.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the dismissal was revoked and the officer was reinstated based on credibility determinations.

Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	01/07/2022
OLES Case Number	2022-00031-3A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly placed his hand on a patient's throat while attempting to restrain the patient.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 10 percent for ten months was the appropriate penalty. The OLES concurred. The senior psychiatric technician filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board revoked the action after making credibility determinations and ruled the evidence was insufficient to counter the senior psychiatric technician's credible denial that he placed his hands on the patient's throat.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	10/26/2022
OLES Case Number	2022-01381-1A
Case Type	Monitored
Incident Types	1. Significant Interest
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Demotion **Final:** No Penalty Imposed
Incident Summary	A fire department manager allegedly failed to report that a fire suppression system in one of the hospital buildings had failed a safety inspection and failed to implement a corrective action plan to address the issues identified by the inspection. The hospital only became aware of the failure when the building failed a second consecutive inspection.
Disposition	The hiring authority sustained the allegations and determined a demotion was the appropriate penalty. The OLES concurred. Disciplinary action was not served because the time period in which to take disciplinary action had expired.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation and disposition conference were not completed in a timely manner.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The hiring authority did not consult with OLES regarding the case disposition until 94 days after receiving the report. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No

	OLES referred the matter back for further investigation to the Office of Protective Services on November 3, 2022; however, the Investigation was not completed until 224 days later.
Disciplinary Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The disciplinary action was not completed in a timely manner and the time period in which to take disciplinary action expired.
Disciplinary Assessment Questions	1. Did the deadline for taking disciplinary action expire before the department completed its findings and served appropriate disciplinary action? • Yes The disciplinary action was not drafted until 118 days after the statute of limitations expired: thereby, precluding disciplinary action.
Department Corrective Action Plan	During this time period, SAC OPS was in flux and did not have a Supervising Investigator position in place, to assist with monitoring cases and meeting investigative case timeframes/guidelines. SAC OPS has created the limited term SI position as of February 2024 to assist with meeting those guidelines – periodic consulting with OLES monitors and submitting OLES case extensions when necessary (due to unforeseeable factors/resources). Employee relations will monitor submitted case files and notify OLES in a timely manner. Should issues arise that will prevent timely completion of actions, employee relations will notify the Hospital Executive Director to contact OLES.

Case Details	Description
Incident Date	12/04/2022
OLES Case Number	2022-01518-2A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A psychiatric technician allegedly sexually assaulted a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The hiring authority failed to consult with OLES regarding the disposition meeting and relied on the criminal report to make its findings regarding administrative violations.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The hiring authority failed to consult with OLES regarding the sufficiency of the investigation or investigative findings.

Disciplinary Assessment	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the disciplinary process. The hiring authority failed to consult with OLES regarding disciplinary determinations prior to the hiring authority making a final decision.
Disciplinary Assessment Questions	1. Did the hiring authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision? • No The hiring authority failed to consult with OLES regarding disciplinary determinations.
Department Corrective Action Plan	DSH will communicate in real time with OLES in each step of procedures governing the investigative process. DSH will ensure each step is completed and OLES is advised and allowed to comment and verify the step is complete before moving on to the next step.

Case Details	Description
Incident Date	12/30/2022
OLES Case Number	2023-00014-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty 2. Inexcusable neglect of duty 3. Other failure of good behavior 4. Willful disobedience
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Dismissal **Final:** Suspension

Incident Summary	An officer allegedly left his assigned post without providing proper supervisor notification and was allegedly dishonest during the investigative process.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board concluded the officer failed to properly notify a supervisor that he had left his assigned post; however, the allegation of dishonesty was dismissed. The State Personnel Board modified the penalty to a two-week suspension.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	01/24/2023
OLES Case Number	2023-00117-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior 3. Discourteous treatment 4. Willful disobedience
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A psychiatric technician, assigned to monitor a patient

	receiving medical care at an outside medical facility, was allegedly unprofessional toward staff and discourteous to the patient.
Disposition	The hiring authority sustained all allegations against the psychiatric technician and determined a 10 percent salary reduction for 12 months was the appropriate penalty. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board upheld the psychiatric technician's salary reduction.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	07/30/2022
OLES Case Number	2023-00160-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior 2. Dishonesty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Suspension
Incident Summary	An off-duty officer allegedly did not properly secure a firearm in a personal vehicle and failed to report the firearm was stolen. The officer was allegedly dishonest during the investigation.

Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board modified the penalty to a 60-working-day-suspension.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	08/01/2022
OLES Case Number	2023-00596-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Discourteous treatment 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** No Penalty Imposed
Incident Summary	An officer allegedly created a hostile work environment by the use of inappropriate language. The officer was allegedly dishonest during the investigation.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. Following a Skelly hearing, the disciplinary action was rescinded based on new factors learned during the Skelly.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with policies and

	procedures governing the investigative process. The disposition conference was not timely conducted.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The investigation was delivered to the hiring authority on February 13, 2024; however, the disposition conference was not held until June 27, 2024.
Disciplinary Assessment	**Overall Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	DSH will ensure that all investigations received are logged and monitored for timeliness compliance the same day received. This will ensure that in the event of staffing changes or vacancies, the case can be reassigned as needed. DSH Employee Relations Analyst and Employee Relations Officer will be trained on this process.

Case Details	Description
Incident Date	05/16/2023
OLES Case Number	2023-00706-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained

	3. Sustained 4. Sustained 5. Not Sustained 6. Not Sustained 7. Not Sustained 8. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A patient was found unresponsive in bed and was pronounced deceased. A psychiatric technician and a nurse allegedly failed to conduct proper checks during the night, causing a delay in finding the patient unresponsive and in medical distress.
Disposition	The hiring authority sustained the allegations against the psychiatric technician and determined a salary reduction of 10 percent for 20 months was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the nurse. The OLES concurred with these determinations. The psychiatric technician filed an appeal with the State Personnel Board. At the pre-hearing settlement conference prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the senior psychiatric technician wherein the penalty was reduced to a salary reduction of 10 percent for seven months in exchange for withdrawing his appeal. The OLES concurred because the settlement was reasonable.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	05/15/2023
OLES Case Number	2023-00709-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	Two nurses, a senior psychiatric technician, and a psychiatric technician allegedly allowed a patient to remain in urine-soaked clothing for approximately five hours.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the nurses and psychiatric technician; however, the hiring authority sustained the allegation against the senior psychiatric technician and determined a salary reduction of 5 percent for seven months was the appropriate penalty. The OLES concurred. The senior psychiatric technician filed an appeal with the State Personnel Board. At the pre-hearing settlement conference prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the senior psychiatric technician wherein the penalty was reduced to a salary reduction of 5 percent for four months in exchange for withdrawing his appeal. The OLES concurred because the settlement was reasonable.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The

	administrative case was completed 219 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 219 days after the case was initiated.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The Supervising Special Investigator shall ensure the assigned Investigator is completes the case extension form when additional investigation is recommended by the assigned AIM and completion of those recommendations will take longer than investigative guideline timeframes (120 days). The Supervising Special Investigator shall monitor these cases to ensure follow up is completed in a timely manner.

Case Details	Description
Incident Date	07/14/2023
OLES Case Number	2023-01027-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment 3. Dishonesty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Not Sustained

Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A psychiatric technician allegedly failed to adequately monitor a patient, was discourteous to his peers, and was dishonest during the investigation.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 10 percent for six months was the appropriate penalty. The OLES concurred with the hiring authority's determination. Following a Skelly hearing, the hiring authority entered into a settlement agreement with the psychiatric technician, wherein the penalty was reduced to a 5 percent salary reduction for three months. The OLES did not concur with the settlement because it was inconsistent with department guidelines and was not adequate based on the seriousness of the misconduct.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the disciplinary process. The hiring authority did not notify OLES of the Skelly hearing, thereby preventing contemporaneous monitoring. Additionally, the hiring authority did not consult with OLES regarding the settlement agreement.
Disciplinary Assessment Questions	1. If there was a Skelly hearing, was it conducted properly? • No The department did not notify OLES of the Skelly hearing 2. Did the hiring authority consult with OLES and the department attorney (if applicable) before modifying the penalty or agreeing to a settlement? • No The hiring authority did not consult with OLES prior to entering into a settlement agreement. 3. If the penalty was modified by department action or a settlement agreement, did OLES concur with the

	modification? • No The OLES was not informed of the settlement agreement until after it was finalized. The OLES did not concur with the settlement terms. 4. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? • No The discipline officer did not consult with OLES regarding the Skelly hearing or settlement agreement. 5. Did the hiring authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? • No The hiring authority did not consult with OLES before entering into a settlement agreement.
Department Corrective Action Plan	The DSH Employee Relations Analyst and Employee Relations Officer will be trained by February 28, 2025, on Policy Directive 5332 Office of Law Enforcement Support Investigation Process Timelines to ensure OLES is notified regarding Skelly and internal settlements during the notice of adverse action process.

Case Details	Description
Incident Date	07/22/2023
OLES Case Number	2023-01050-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction

Incident Summary	An off-duty officer was arrested for allegedly driving while intoxicated.
Disposition	The hiring authority sustained the allegation and determined the appropriate penalty was a salary reduction of 5 percent for 12 months. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	08/01/2023
OLES Case Number	2023-01116-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	A nurse allegedly failed to change a patient's urine-soaked clothing.
Disposition	The hiring authority sustained the allegation and determined a letter of reprimand was the appropriate penalty. The OLES concurred. The nurse did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary	**Overall Rating:** Sufficient

Assessment	The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	09/20/2023
OLES Case Number	2023-01345-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Incompetency 3. Insubordination 4. Discourteous treatment 5. Willful disobedience 6. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A psychiatric technician was allegedly overly familiar with a recently released patient and their family in violation of policy.
Disposition	The hiring authority sustained the allegations and determined that a salary reduction of 10 percent for six months was the appropriate penalty. OLES concurred with the hiring authority's determinations. The psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and

	procedures governing the disciplinary process. The department did not provide OLES with a copy of the draft disciplinary action and did not consult with OLES regarding the draft action prior to service. The disciplinary action was not served on the psychiatric technician until 127 days after disciplinary determinations were made.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? • No The department did not provide OLES with a copy of the draft disciplinary action and did not consult with OLES regarding the draft action prior to service. 2. Was the disciplinary phase conducted with due diligence by the department? • No The disciplinary action was not served on the psychiatric technician until 127 days after disciplinary determinations were made.
Department Corrective Action Plan	DSH will request e-mail confirmation from DSH-Legal that the notice of adverse action has been reviewed by OLES prior to service of the NOAA. DSH Employee Relations Analyst and Employee Relations Officer will be trained by February 28, 2025, on Policy Directive 5332 Office of Law Enforcement Support Investigation Process Timelines to ensure policy timelines are met.

Case Details	Description
Incident Date	10/21/2023
OLES Case Number	2023-01490-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Other 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty

Findings	1. Not Applicable 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	An officer allegedly confronted a registered nurse and accused her of spreading rumors. The officer allegedly brought a subordinate officer to accompany him during the confrontation.
Disposition	The hiring authority sustained the allegations and determined a salary reduction for 5 percent for six months was the appropriate penalty; however, the officer left the department before disciplinary action could be taken. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	11/05/2023
OLES Case Number	2023-01600-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inefficiency 3. Incompetency 4. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained

Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A senior psychiatric technician allegedly fell asleep while monitoring a restrained patient.
Disposition	The hiring authority sustained the allegation and determined a 5 percent salary reduction for seven months was the appropriate penalty. OLES concurred with the hiring authority's determinations. The senior psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	12/11/2023
OLES Case Number	2023-01708-1A
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:** Suspension **Final:** Suspension
Incident Summary	An officer allegedly brought and used his personal mobile phone inside the facility's secure treatment area.
Disposition	The hiring authority sustained the allegation and determined a 10-day suspension was the appropriate penalty. The OLES concurred.

Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The disciplinary action was not served in a timely manner.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The hiring authority decided to take disciplinary action against the officer on April 26, 2024; however, the disciplinary action was not served until August 2, 2024, 98 days later.
Department Corrective Action Plan	While the department understands the OLES cases take priority, other factors contributed during the Executive Director transition and unfortunately caused delay. The department takes responsibility for the untimeliness and will continue to strive to meet expected deadlines.

Case Details	Description
Incident Date	
OLES Case Number	2024-00076-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Suspension **Final:** Suspension
Incident Summary	A senior psychologist allegedly communicated with a former patient following his discharge from a state hospital. A psychologist allegedly knew of and failed to report the communications by the senior psychologist

	with the former patient.
Disposition	The hiring authority sustained the allegation against the senior psychologist and determined a five-day suspension was the appropriate penalty. The hiring authority also determined there was insufficient evidence to sustain the allegation against the psychologist. The OLES concurred with the hiring authority's determinations. The senior psychologist did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	02/19/2024
OLES Case Number	2024-00315-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	An officer allegedly did not properly secure a canine resulting in the death of the canine. A second officer allegedly did not properly board the canine. Two law enforcement supervisors allegedly did not properly

	supervise the canine unit.
Disposition	The hiring authority sustained the allegations against the first officer and the supervisors. The hiring authority determined the appropriate penalty for the first officer was a salary reduction of 5 percent for three months. The hiring authority issued letters of expectation and training for the supervisors. The hiring authority found insufficient evidence to sustain the allegation against the second officer. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	07/21/2024
OLES Case Number	2024-01051-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Fraud in securing employment 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	An officer allegedly sent a photograph of their officer identification badge to a prison inmate. The officer was allegedly dishonest during the background investigation process.
Disposition	The hiring authority sustained the allegations and rejected the officer during probation. The OLES

	concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Appendix D: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

(a) The Office of Law Enforcement Support shall be responsible for contemporaneous oversight of investigations that (1) are conducted by the State Department of State Hospitals and involve an incident that meets the criteria of section 4023, and (2) are conducted by the State Department of Developmental Services and involve an incident that meets the criteria of section 4427.5.

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

(3) The reports required by paragraph (1) shall be in a form that does not identify the agency employees involved in the alleged misconduct.

(4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise

made available to the public upon their release to the Governor and the Legislature.

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

California Welfare and Institutions Code 4427.5

4427.5.

(a) (1) A developmental center shall immediately report the following incidents involving a resident to the local law enforcement agency having jurisdiction over the city or county in which the developmental center is located, regardless of whether the Office of Protective Services has investigated the facts and circumstances relating to the incident:

(A) A death.

(B) A sexual assault, as defined in section 15610.63.

(C) An assault with a deadly weapon, as described in section 245 of the Penal Code, by a nonresident of the developmental center.

(D) An assault with force likely to produce great bodily injury, as described in section 245 of the Penal Code.

(E) An injury to the genitals when the cause of the injury is undetermined.

(F) A broken bone, when the cause of the break is undetermined.

(2) If the incident is reported to the law enforcement agency by telephone, a written report of the incident shall also be submitted to the agency, within two working days.

(3) The reporting requirements of this subdivision are in addition to, and do not substitute for, the reporting requirements of mandated reporters, and any other reporting and investigative duties of the developmental center and the department as required by law.

(4) Nothing in this subdivision shall be interpreted to prevent the developmental center from reporting any other criminal act constituting a danger to the health or safety of the residents of the developmental center to the local law enforcement agency.

(b) (1) The department shall report to the agency described in subdivision (i) of section 4900 any of the following incidents involving a resident of a developmental center:

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

(B) Any allegation of sexual assault, as defined in section 15610.63, in which the alleged perpetrator is a developmental center or department employee or contractor.

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

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

California Welfare and Institutions Code 4023

4023

(a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of section 4900 the following incidents involving a resident of a state mental hospital:
  (1) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
  (2) Any allegation of sexual assault, as defined in section 15610.63, in which the alleged perpetrator is an employee or contractor of a state mental hospital or of the Department of Corrections and Rehabilitation.
  (3) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in section 15610.63, in which a staff member is implicated.

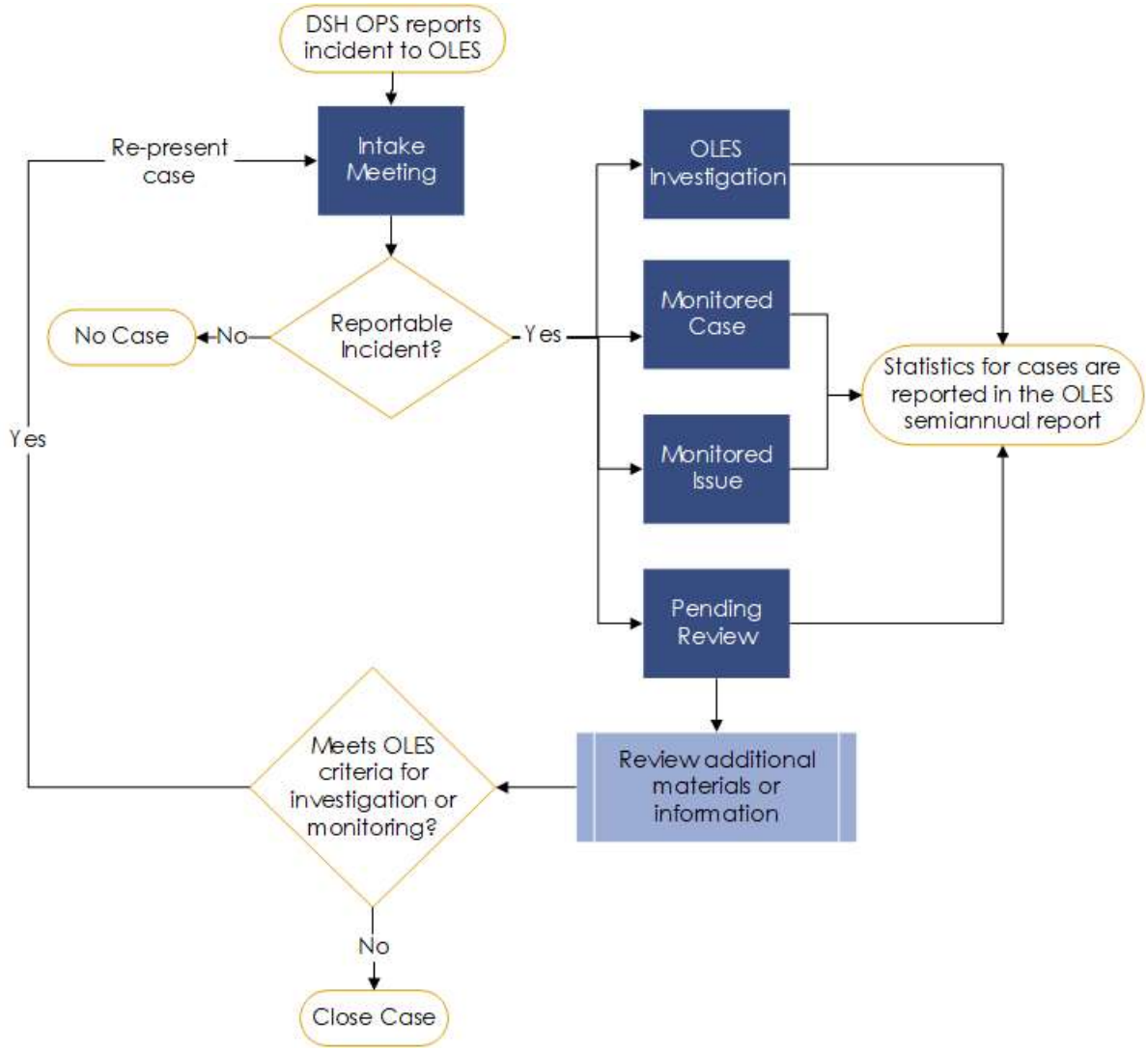
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

(a) Assault, as defined in section 240 of the Penal Code.
(b) Battery, as defined in section 242 of the Penal Code.
(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in section 245 of the Penal Code.
(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
(e) Sexual assault, that means any of the following:
  (1) Sexual battery, as defined in section 243.4 of the Penal Code.
  (2) Rape, as defined in section 261 of the Penal Code.
  (3) Rape in concert, as described in section 264.1 of the Penal Code.
  (4) Spousal rape, as defined in section 262 of the Penal Code. (5) Incest, as defined in section 285 of the Penal Code.
  (6) Sodomy, as defined in section 286 of the Penal Code.
  (7) Oral copulation, as defined in section 288a of the Penal Code.
  (8) Sexual penetration, as defined in section 289 of the Penal Code.
  (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of section 288 of the Penal Code.
(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
  (1) For punishment.
  (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
  (3) For any purpose not authorized by the physician and surgeon.

Appendix E: OLES Intake Flow Chart



Outline Description

1. OLES receives a notification of an incident and discusses the incident during an intake meeting
2. The disposition of the incident case may be assigned to any of the following:
    a. No Case
    b. Pending review
        i. If the disposition is pending review, the case is reviewed for sufficient information and is represented at an intake meeting. From there, the case may be investigated, become a monitored issue, be monitored, be investigated or be rejected.
    c. OLES Investigation Case
    d. Monitored Case
    e. Monitored Issue

Appendix F: Guidelines for OLES Processes

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

If, instead, an incident is investigated by DSH but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH investigator and the department attorney, if one is designated[6], 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. 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

[6] 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[7]. 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. 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.

[7] *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.