



Office of Law Enforcement Support

Semiannual Report

July 1, 2025 – December 31, 2025

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
<i>Incident Types Meeting OLES Criteria</i>	10
<i>Most Frequent Incident Types</i>	11
<i>Patient Deaths</i>	11
<i>Patient Arrests</i>	12
<i>Results of Completed OLES Investigations of DSH Law Enforcement</i>	12
<i>Results of Completed OLES Monitored Cases</i>	13
Incidents and Incident Types	14
<i>Increase in Reported Incident Types</i>	14
<i>Most Frequent Incident Types Reported</i>	14
<i>Incident Types by Reporting Period</i>	16
<i>Distribution of Incident Types</i>	18
<i>Sexual Assault Allegations</i>	19
<i>Patient Deaths</i>	20
<i>Reports of Head or Neck Injuries</i>	21
<i>Reports of Patients Absent Without Leave</i>	21
Notification of Incident Types	22
<i>Priority 1 Incident Type Descriptions</i>	22
<i>Priority 2 Incident Type Descriptions</i>	23
<i>Timeliness of Notifications</i>	25
Intake	26
Completed Investigations and Monitored Cases	27
<i>OLEs Investigations</i>	28
<i>OLEs Monitored Cases</i>	29
DSH Tracking of Law Enforcement Compliance with Training Requirements	30
<i>Self-Reported Compliance Rates for Mandated Training</i>	30

Methods Used to Track Training.....	31
DSH Law Enforcement Training Advisory Committee	31
Additional Mandated Data.....	32
Adverse Actions against Employees.....	32
Criminal Cases against Employees	33
Reports of Employee Misconduct to Licensing Boards.....	33
Patient Criminal Cases	34
Monitored Issues	35
Underutilization of Blue Team/IAPro	35
Use of Force Reports, Reviews and Tracking at DSH.....	36
Delayed Reporting by Other Mandated Reporters.....	37
Appendix A: Completed OLES Investigations	40
Appendix B: Pre-Disciplinary Cases Monitored by OLES.....	47
Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases.....	150
Appendix D: Statutes	165
California Welfare and Institutions Code 4023.6 et seq.	165
California Welfare and Institutions Code 4427.5.....	167
California Welfare and Institutions Code 4023	168
California Welfare and Institutions Code 15610.63 (Physical Abuse)	168
Appendix E: OLES Intake Flow Chart.....	169
Appendix F: Guidelines for OLES Processes.....	170
Administrative Investigation Process.....	170

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, 2025.

In this report, OLES provides details on 617 reported incidents and the results of completed investigations and monitored cases.

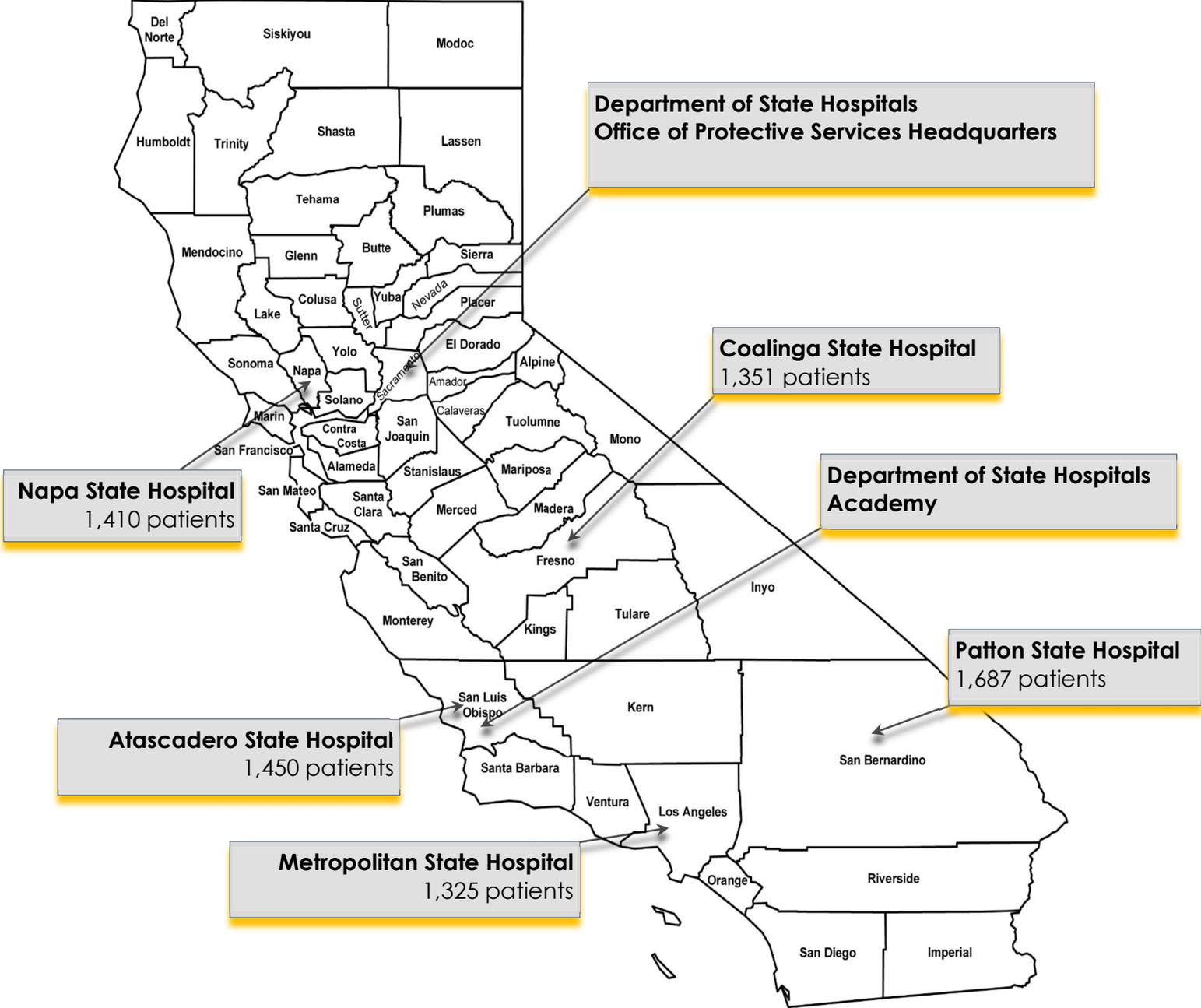
OLES provides updates on previous monitored issues regarding the use of the department's early intervention system, use of force reporting and documentation, and ongoing deficiencies in mandated reporting as required by Welfare and Institutions Code section 15630, et.al.

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
Director
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, 2025, and were provided by the department.



Total Patients Served by Facility July 1 through December 31, 2025

DSH Facility	Total Number of Patients
Atascadero	1,450
Coalinga	1,351
Metropolitan	1,325
Napa	1,410
Patton	1,687
Total	7,223

The total number of patients served by DSH from July 1 through December 31, 2025, increased 1.72 percent, from 7,101 during the prior reporting period to 7,223 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.

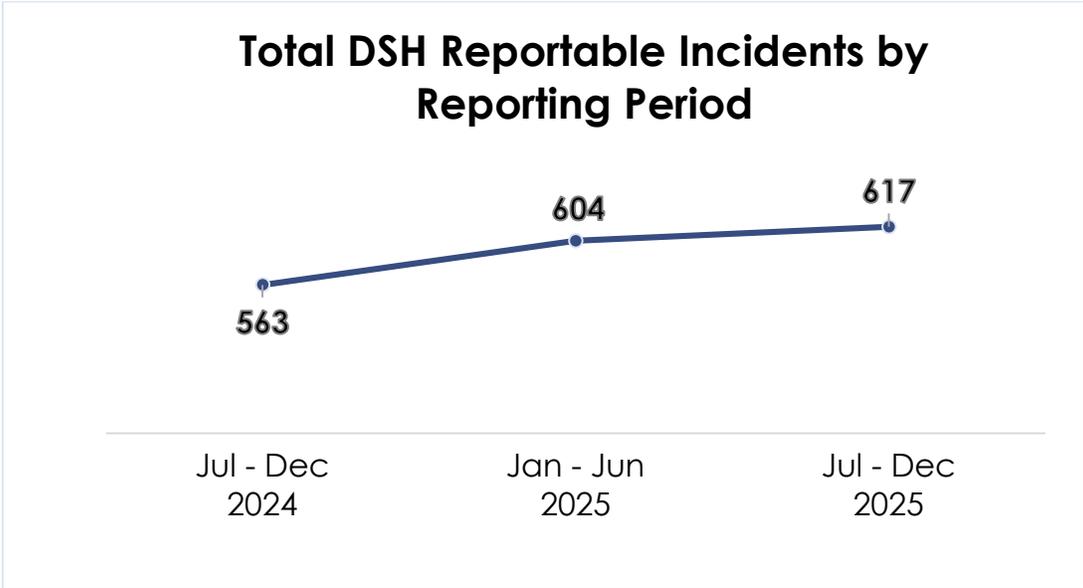
The following table provides the commitment type of patients served during the reporting period.

Commitment Type	Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST	366	0	1,029	735	746
PC 1026 NGI	296	<11	***	444	471
PC 2962/2964a OMD	406	0	0	<11	***
PC 2972 OMD	***	279	<11	***	200
WIC 6316 MDSO	0	<11	0	<11	<11
PC 2684 CDCR	224	***	0	0	***
WIC 6602/6604 SVP	0	976	0	0	0
WIC 5358 LPS	***	<11	275	191	157

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, 2025, the Office of Law Enforcement Support (OLES) received and processed 617 reportable incidents¹ 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 an increase of 13 incident reports compared to the prior reporting period which had 604 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior two reporting periods.

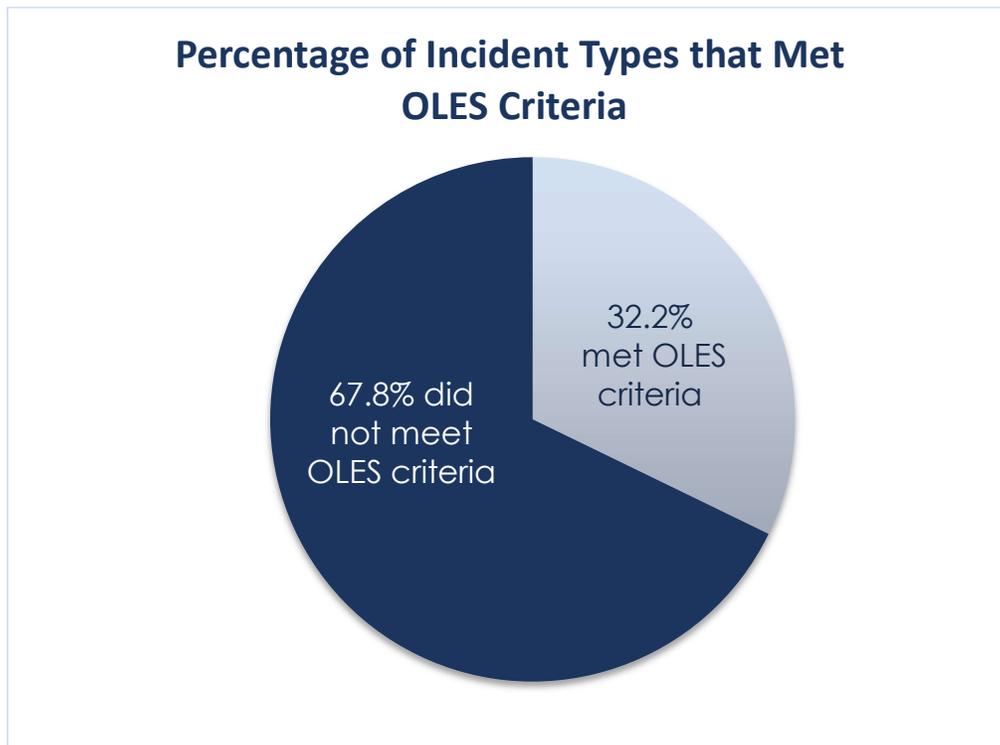


Numbers are unadjusted and are provided as they were previously published.

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.

Incident Types Meeting OLES Criteria

The DSH reports to OLES any incidents and associated reportable incident types² listed in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. An incident type meeting criteria is an occurrence OLES has determined meets OLES criteria for investigation, monitoring, or consideration for research as a potential departmental systemic issue. Out of the 617 reported incidents, OLES identified 32 incidents with two or more incident types. The DSH reported a total of 653 incident types during this reporting period. Two hundred and ten, or 32.2 percent of the 653 incident types reported by DSH met OLES criteria.



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.

Most Frequent Incident Types

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

Allegations of abuse were the most reported incident type, with 113 allegations reported, compared to 98 in the prior reporting period. Allegations of abuse accounted for 17.3 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 86 reports of use of force, which accounted for 13.2 percent of all reported incident types by DSH. Five of the 86 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 list 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 81 incidents reported, compared to 83 in the prior reporting period.

Patient Deaths

The number of patient deaths decreased 3 percent, from 33 deaths to 32 deaths during this reporting period. Four of the reported death incident types met OLES criteria for monitoring. Twenty-five of the 32 patient deaths were expected due to existing medical conditions. Seven 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 11 deaths and Patton State Hospital (PSH) with 8 deaths.

Patient Arrests

OLES works collaboratively with DSH to ensure patients receive the best possible treatment and care at the local jurisdiction holding facilities. OLES also reviews each patient arrest to safeguard patient rights and make certain there is strict compliance with 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 were two less arrests 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, two patients at MSH, two 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 594	Vandalism
Penal Code Section 245(a)	Assault by means of force likely to cause GBI
Penal Code Section 314(1)	Indecent exposure
Penal Code Section 242/243(a)	Simple battery

Results of Completed OLES Investigations of 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 19 investigations that OLES completed during this reporting period. As of December 31, 2025, there were approximately 805 DSH sworn staff.

OLES submitted 17 out of 17 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process in 8 of those cases. 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 conducted two criminal investigations; none of which were referred to the 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.

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

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 61 monitored administrative cases and 79 monitored criminal cases that, by December 31, 2025, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These monitored cases included allegations against psychiatric technicians, psychiatric technician assistants, officers, registered nurses, unit supervisors and several other types of staff members.

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

OLES monitored 140 pre-disciplinary phase cases; 131 of the pre-disciplinary phase cases are listed in Appendix B and 9 are listed in Appendix C. OLES rated 24 of the 140 pre-disciplinary phase cases insufficient. Deficiencies found in insufficient cases include, but are not limited to, incomplete or missing interviews, failure to cooperate with OLES, hiring authority failing to make timely findings on completed investigations, and delayed investigations.

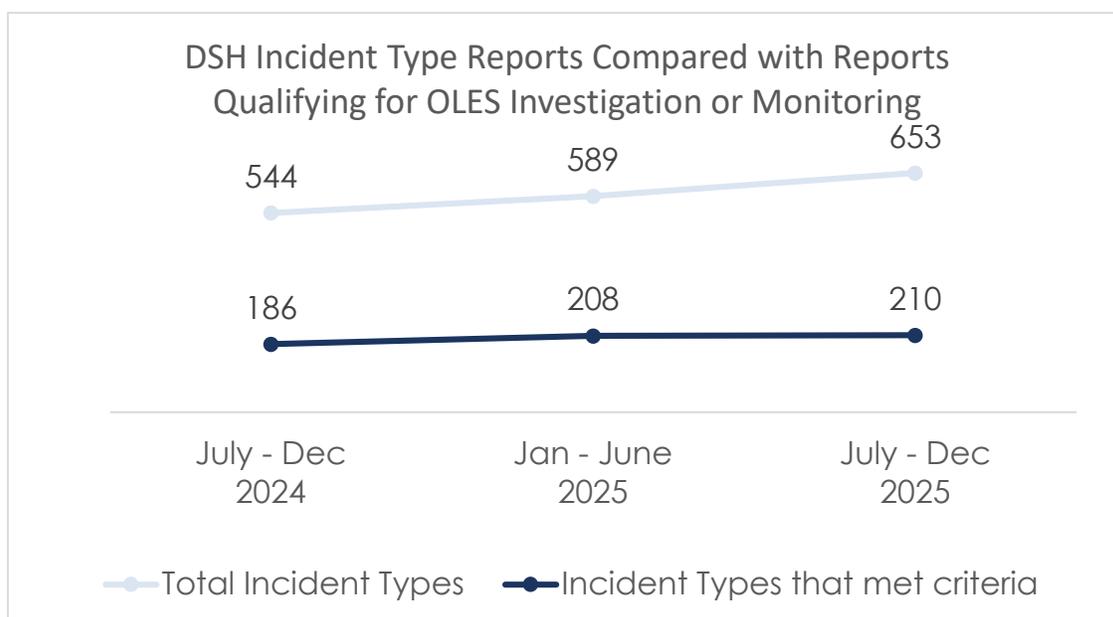
OLES monitored the disciplinary actions, Skelly hearings, settlements and State Personnel Board proceedings in 9 administrative cases listed in Appendix C. Five of the 9 disciplinary phase cases were rated insufficient due to, among other things, untimeliness, failure to provide OLES with required documentation and notice of hearings, and a delay in serving a disciplinary action.

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, most incident reports came from the facilities.

Increase in Reported Incident Types

The number of DSH incidents reported to OLES from July 1 through December 31, 2025, increased 7 percent, from 589 during the prior reporting period to 617 in this reporting period. From the 617 reported incidents, OLES identified 653 incident types, as 32 of the incidents featured two or more incident types. Two hundred ten of the 653 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, then broken bone (unknown origin). These four incident type categories accounted for 344 or 52.7 percent of all incident types reported by DSH. Of the 344 incident types, 160 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was allegations of abuse with 113 reports. The number of abuse allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period was 113. The 113 reports of abuse accounted for 17.3 percent of the reported incident types.

The DSH's second most frequent report to OLES was use of force by law enforcement. The 86 reports of use of force accounted for 13.2 percent of the reported incident types, and up 4.9 percent from the last period's 82 reports.

Allegations of sexual assault were the third most frequently reported incident type by DSH, with 81 incidents reported. Allegations of sexual assault accounted for 12.4 percent of all incident types reported. Of the 81 sexual assault allegations reported in this period, 41 allegations or 50.6 percent qualified for investigation or monitoring.

Allegations of broken bones of unknown origin were the fourth most frequently reported incident type by DSH, with 64 incidents reported. The 64 reports of broken bones of unknown origin accounted for 9.8 percent of the reported incident types.

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

Most Frequent Incident Types July 1 through December 31, 2025

Incident Type Category	Prior Period Incident Type Total January 1 through June 30, 2025	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Abuse	98	113	+15.3%	110
OPS Use of Force ¹	82	86	+4.88%	1
Sexual Assault ²	83	81	-2.41%	41
Drugs	35	65	+85.71	1
Broken Bone (Unknown Origin)	71	64	-9.86%	5

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, 2024 (Reported)	Prior Period July 1 - December 31, 2024 (Meets Criteria)	Prior Period January 1 - June 30, 2025 (Reported)	Prior Period January 1 - June 30, 2025 (Meets Criteria)	Current Period July 1 - December 31, 2025 (Reported)	Current Period July 1 - December 31, 2025 (Meets Criteria)
Abuse	101	98	98	95	113	110
AWOL	5	0	1	0	5	0
Broken Bone (Known Origin)	24	0	27	0	28	0
Broken Bone (Unknown Origin)	52	5	71	6	64	5
Burn	3	0	5	0	7	0
Child Sexual Abuse Material	4	0	1	0	5	0
Contraband (CCR Title 9 section 4350) 1	1	0	2	0	1	0
Contraband Phones 1	2	0	6	0	15	0
Death	34	6	33	3	32	4
Drugs 2	19	0	35	1	65	1
Genital Injury (Known Origin)	9	0	10	0	20	3
Genital Injury (Unknown Origin)	5	0	10	5	9	3
Head/Neck Injury	47	1	51	0	44	1
Misconduct 3	22	22	24	24	20	20
Neglect	17	13	17	13	11	9
Non-patient assault/GBI on Patient	0	0	0	0	1	1

Incident Categories	Prior Period July 1 - December 31, 2024 (Reported)	Prior Period July 1 - December 31, 2024 (Meets Criteria)	Prior Period January 1 - June 30, 2025 (Reported)	Prior Period January 1 - June 30, 2025 (Meets Criteria)	Current Period July 1 - December 31, 2025 (Reported)	Current Period July 1 - December 31, 2025 (Meets Criteria)
OPS Use of Force ⁴	92	0	82	0	86	1
Over-Familiarity	10	10	14	14	14	11
Patient Arrest	7	0	9	0	7	0
Patient-on-Patient Assault/GBI	10	0	5	1	23	0
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Sexual Assault	79	31	83	45	81	41
Significant Interest ⁵	1	0	2	0	0	0
Suicide (Attempted)	0	0	3	1	2	0
Total	544	186	589	208	653	210

¹ 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.

² 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.

³ The misconduct statistics include five allegations of excessive force by law enforcement. These incidents are included in the total count for all incident types reported.

⁴ Eighty-five of the 86 use of force incidents were assigned a pending review. Five of the 86 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.

⁵ Significant Interest is an incident that may draw media attention.

Distribution of Incident Types

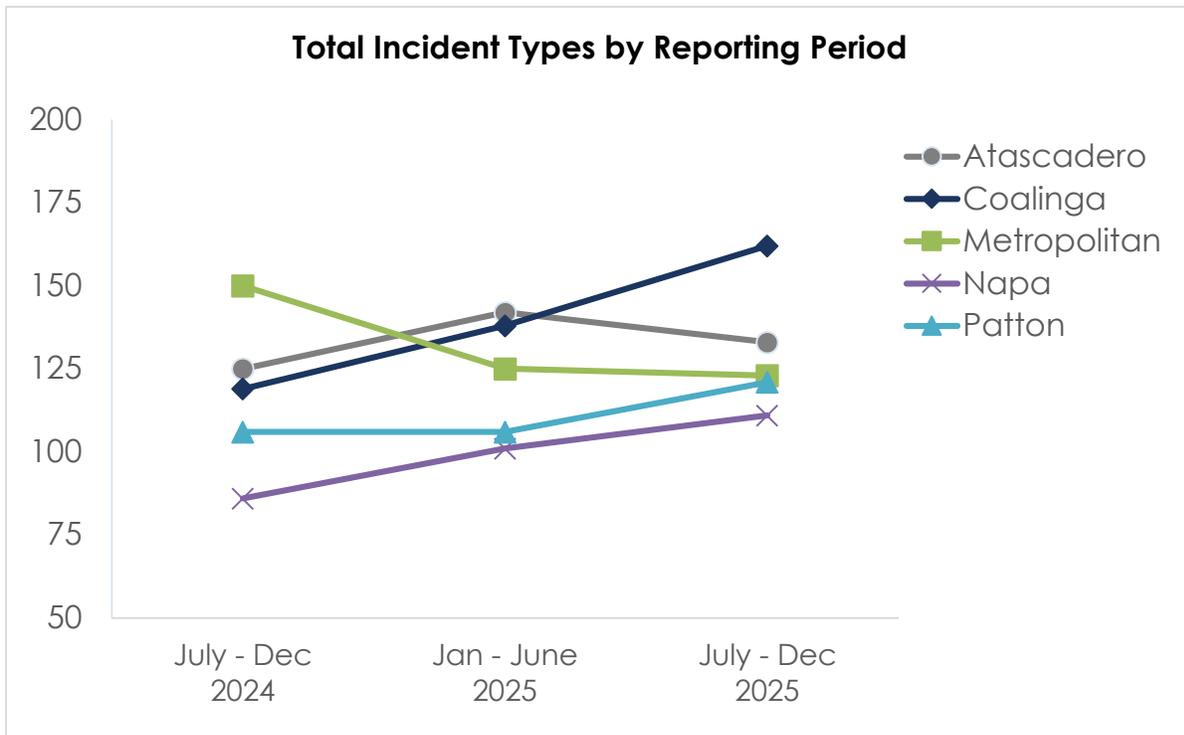
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

DSH Population and Total Incident Types

DSH Facility	Number of Patients Served	Total Incident Types
Atascadero	1,450	133
Coalinga	1,351	162
Metropolitan	1,325	123
Napa	1,410	111
OPS Academy	0	3
Patton	1,687	121
Total	7,223	653

The department provided population served from July 1 through December 31, 2025.

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 third most frequently reported incident type from July 1 through December 31, 2025. The 81 alleged sexual assault incident types reported in this reporting period accounted for 12.4 percent of all reported incident types from DSH. Forty-one of the 81 reported incident types of alleged sexual assault, or 50.6 percent, met OLES criteria for investigation or monitoring.

Of the five DSH facilities, NSH (30), PSH (20) and CSH (12) 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 non-law enforcement staff on a patient, with 29 incident types or 35.8 percent of the 81 alleged sexual assault incident types. Patients assaulting another patient was the most frequently reported, with a total of 37 incident types, or 45.7 percent of the alleged 81 sexual assault incident types. There were fourteen allegations of sexual assault involving an unknown assailant on a patient.

Sexual Assault Allegations Reported July 1 through December 31, 2025

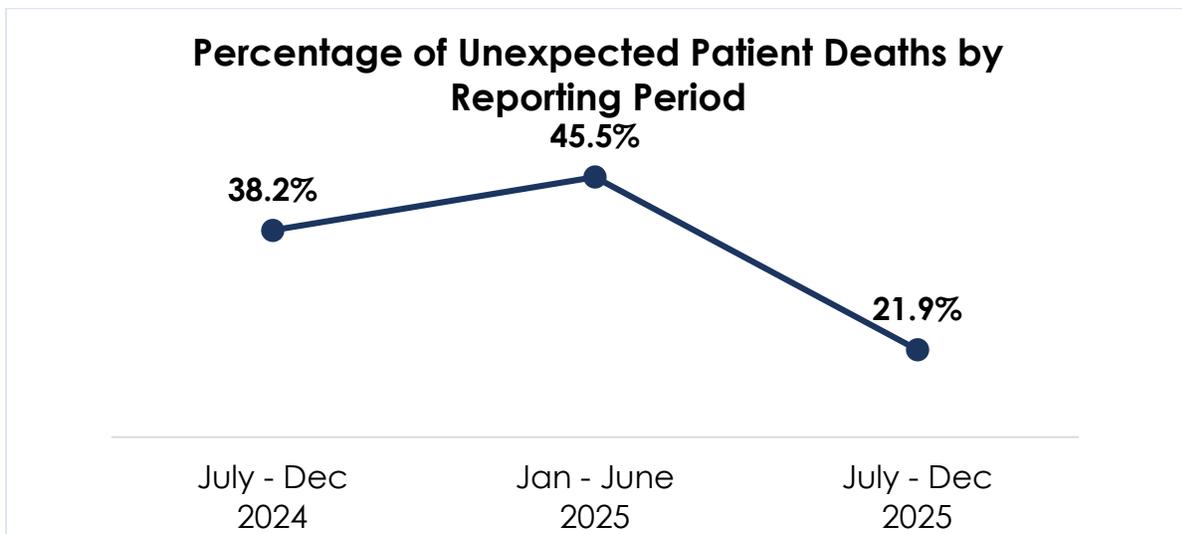
Allegation Type	Total
Non-Law Enforcement Staff-on-Patient	29
Patient-on-Patient	37
Law Enforcement Staff-on-Patient	1
Unknown Person-on-Patient	14
Total	81

Patient Deaths

The DSH reported 32 patient deaths to OLES during this reporting period. This number decreased 3.03 percent from the 33 patient deaths reported in the prior reporting period of January 1 through June 30, 2025.

Twenty-five of the patient deaths were classified as expected primarily due to underlying health conditions, such as cardiac or respiratory issues and cancer. Seven deaths were classified as unexpected. Each unexpected patient death receives two levels of review within DSH, per department policy. OLES monitored three 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 among patients during this reporting period.

Cause of Patient Deaths

Cause	Total
Cancer	6
Cardiac/Respiratory	23
Sepsis	2
Suicide	1
Total	32

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	11
Metropolitan	6
Napa	6
Patton	8
Total	32

Reports of Head or Neck Injuries

The DSH reported 44 head or neck injuries during this reporting period. These head or neck injuries were the result of patient-on-patient altercations, a patient fall or a self-inflicted injury by the patient. Patient-on-patient altercations accounted for 14 of the 44 reported head or neck injuries.

Reports of Patients Absent Without Leave

A patient is Absent Without Leave (AWOL) when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in police intervention to recover the patient. In this reporting period, DSH reported five AWOL incident types. All patients were safely returned to their assigned areas.

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 became a Priority 2 notification. Priority 1 and 2 incident types are listed in the tables below.

Priority 1 Incident Type Descriptions

Incident	Description
Abuse - Physical	Any report of physical abuse of a patient implicating staff.
Assault with a Deadly Weapon by a Non-Patient	Any assault with a deadly weapon (ADW) against a patient by a non-patient. A non-patient is any person who is not a patient in the DSH facility. This can be a staff member, hospital police officer, visitor, custodian or contracted employee.
Broken Bone (Unknown Origin)	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 , or a death that occurs up to 30 days from patient discharge from the DSH facility.
Genital Injury (Unknown Origin)	An injury to the genitals of a patient when the cause of injury is undetermined and was not witnessed by staff.
Sexual Assault: Priority 1	Any allegation of sexual assault of a patient against staff or unidentified person(s).

Priority 2 Incident Type Descriptions

Incident	Description
Absent Without Leave (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.
Assault with GBI	A patient on patient assault with force likely to produce great bodily injury (GBI), including but not limited to, loss of consciousness, concussion, bone fracture, protracted loss of impairment of function of any bodily member or organ; a wound requiring suture or serious disfigurement
Attempted Patient Suicide	Requires treatment beyond first aid.
Broken Bone (Known Origin)	A broken bone of a patient when the cause of the break is known by a doctor or witnessed by staff.
Burn	Any burn of a patient. This does not include sunburns or mouth burns caused by consuming hot food or liquid unless blistering occurs.
Child Sexual Abuse Material	Discovered in any facility.
Drugs	Includes allegations of use, trafficking or smuggling by patients, staff or visitors. When reporting recovered drugs or patient use, a field presumptive positive or lab positive test is required.
Genital Injury (Known Origin)	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, regardless of whether the patient refuses treatment. This includes physical trauma resulting in an altered level of consciousness (ALOC) or loss of consciousness (LOC). Any tooth injury, including but not limited to, chipped, cracked, broken, loosened or displaced teeth that resulted from a forceful impact, regardless of treatment. Treatment beyond first aid includes the use of skin adhesive such as DERMABOND®, 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.
Over-Familiarity	Conduct between a staff member and patient that extends beyond authorized treatment or is contrary to the treatment plan and treatment success of the patient.
Patient Arrest	Any patient arrest by warrant or probable cause.
Peace Officer Misconduct	Any allegations of peace officer misconduct, whether on or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties.
Pregnancy	A patient pregnancy.

Incident	Description
Riot	For the purposes of reporting to OLES, a riot disrupts normal operations; has the potential of expansion and requires a response outside normal resources.
Sexual Assault: Priority 2	Any allegation of sexual assault between two patients.
Use of Force	Any OPS staff member within DSH or DDS that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a patient, regardless of whether an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a patient if no resistance is offered by the patient to the officer or officers.
Significant Interest	An incident of significant interest to the public, including but not limited to commission of serious crimes by patient(s) or staff, or any incident which may potentially draw media attention.

Timeliness of Notifications

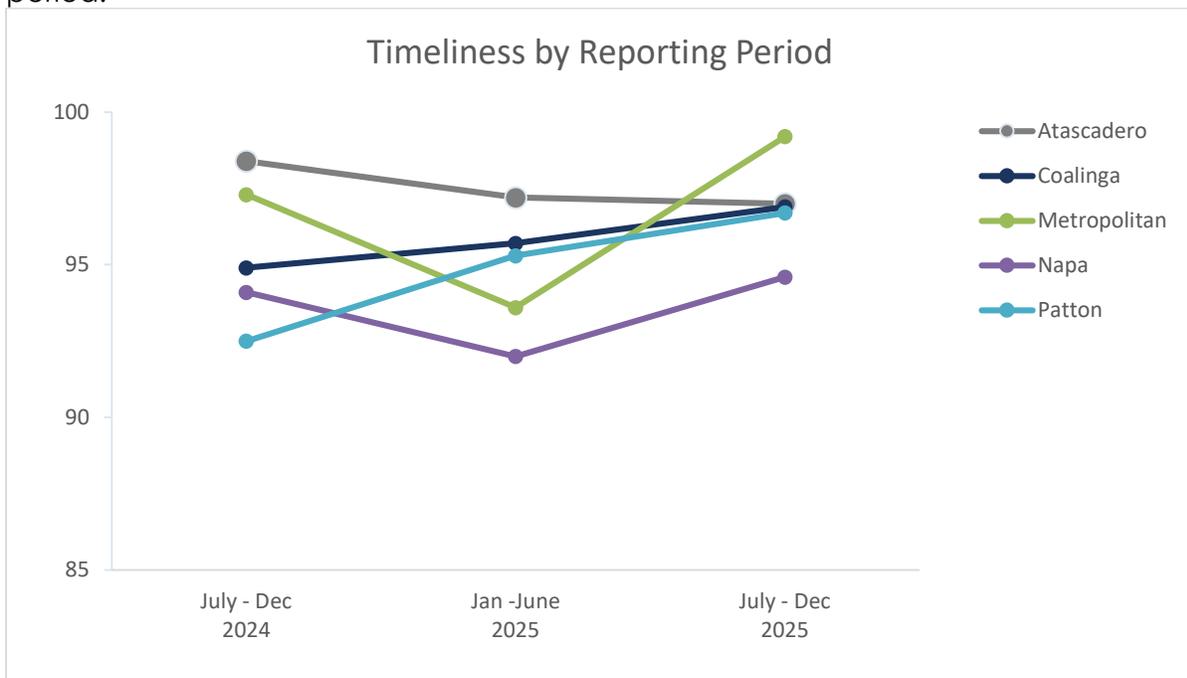
The DSH timely reported incident types 96.9 percent compared to the prior reporting period, which had 94.8 percent timely reports.

Of the 653 incident types evaluated for timeliness, 633 were reported timely and 20 incident types were not timely.

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	133	129	4	97%
Coalinga	162	157	5	96.9%
Metropolitan	123	122	1	99.2%
Napa	111	105	6	94.6%
OPS Academy	3	3	0	100%
Patton	121	117	4	96.7%
Total	653	633	20	96.9%

The following chart compares the percentage of timely facility 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 criteria⁴ 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, 2025, reporting period, 444 of the total 669 cases opened for DSH incident types that occurred within DSH's jurisdiction or 66.4 percent were assigned a pending review. OLES opened 26 administrative investigations and 4 criminal investigations. OLES opened 151 monitored criminal cases and 44 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.

Incident Types Opened in the Current Reporting Period

OLES Case Assignments	July 1 – December 31, 2025	Percentage of Opened Cases
Pending Review	444	66.4%
Monitored, Criminal	151	22.6%
Monitored, Administrative	44	6.6%
OLES Investigations, Criminal	4	0.6%
OLES Investigations, Administrative	26	3.9%
Totals	669	100%

⁴ Welfare and Institutions Code section 4023.6 et. seq. (see Appendix D).

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 19 investigations. 17 of the investigations were administrative. Two of the 19 investigations were criminal.

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 17 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, 2025	Referred to Prosecuting agency	Referred to facility management
Administrative	17	N/A	17
Criminal	2	0	N/A
Total	19	0	17

OLEs Monitored Cases

In this report OLES provides information on 140 completed monitored cases. Seventy-nine of the 140 cases were criminal cases, three of the 79 cases were referred to a district attorney's office.

There were 61 completed monitored pre-disciplinary administrative cases during this reporting period. Nineteen of the 61 cases had sustained allegations; 42 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	3
3Criminal-Not Referred	76
Total Criminal	79
Administrative-With Sustained Allegations	19
Administrative-Without Sustained Allegations	42
42Total Administrative	61
Grand Total	140

Pre-Disciplinary Phase Cases

Of the 61 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 24 cases insufficient. Deficiencies found in insufficient cases include, but are not limited to, incomplete or missing interviews, failure to cooperate with OLES, hiring authority failing to make timely findings on completed investigations, 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 9 administrative cases. Five cases were insufficient due to, among other things, untimeliness, failure to provide OLES with required documentation and notice of hearings, and delays in serving the disciplinary action. Details regarding the monitoring of these cases are in Appendix C of this report.

DSH Tracking of Law Enforcement Compliance with Training Requirements

The DSH OPS Training Plan was revised and approved by the DSH chief of law enforcement and executive staff in June 2025, identifies and prioritizes the training requirements for law enforcement personnel. The training plan categorizes courses for each rank or position into the following categories:

- **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.
- **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.
- **Upward Mobility:** Upon completion of the mandatory and essential courses, an employee may pursue additional interests in their law enforcement training.
- **Career Related:** 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, 2025.

DSH Facility	Percentage of Compliance
Atascadero	97.5%
Coalinga	95.3%
Metropolitan	94.6%
Napa	88.5%
Patton	97%

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 was not enforced. The Chief or the Deputy Chief of OPS attend these meetings and if a hospital is missing, they will contact the hospital police chief to ensure representation from all DSH sites.

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	38	11	23	4	0
Coalinga	52	0	29	21	2
Metropolitan	18	2	15	1	0
Napa	3	0	0	3	0
Patton	50	9	35	6	0
Total	161	22	102	35	2

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	35	0	35	0
Coalinga	13	0	10	0
Metropolitan	49	1	48	1
Napa	11	0	11	0
Patton	5	5	0	0
Total	113	6	104	1

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	0	2	0
Coalinga	0	0	0	0
Metropolitan	0	0	0	0
Napa	0	0	0	0
Patton	0	0	2	0
Total	0	0	2	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	403	75	328	92
Coalinga	360	58	302	63
Metropolitan	81	12	69	16
Napa	14	0	14	0
Patton	134	39	95	18
Total	992	184	808	189

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 director 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.

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.

In February 2025, DSH adopted a supervisor-centric model, with compliance verified through audits conducted by DSH-HQ. At the same time, the Office of Protective Services (OPS) delegated daily management of Blue Team/IAPro to local hospital administrators while retaining overall oversight of its use by hospital police departments. Training for both local administrators and supervisors was completed in 2025.

OPS conducted four audits in 2025 to ensure that the supervisors who were trained to review the Blue Team Entries were doing so and processing the documentation in Blue Team so it could be transferred into IAPRO. The data is collected in Blue Team and then sent to IAPRO where the data can be tabulated and put into reports. A special investigator from OPS Sacramento was assigned to oversee the Blue Team/IAPRO

process. OPS is now able to generate reports in IAPRo from the data collected in Blue Team. This has allowed DSH OPS to identify trends, such as use-of-force effectiveness. For example, the data reviewed in 2025 showed that all incidents of use of OC pepper spray were effective. Control holds had a 95% effective rate. The department is also able to compile statistics on the reason force is used and injuries sustained by patients sworn staff and non-sworn staff. The department is continuing to refine its processes to produce more accurate data and learn from the data collected. OLES commends DSH on its continuing work to improve the Blue Team/IAPRo process and will continue monitoring the department's use of the software.

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.

On July 10, 2025, DSH provided OLES with 11 updated use-of-force forms for review, which together comprise the Use of Force Packet. The packet is designed to provide a comprehensive, transparent, and standardized record of any force used by OPS officers, ensuring accountability and compliance with state law and departmental policy. Its purpose is to capture the facts, evidence, and reasoning behind a force incident in a manner that is complete, accurate, and unbiased, while enabling a multi-layered review process. This process evaluates not only the actions of officers but also the adequacy of supervisory oversight, the integrity of documentation, and adherence to established procedures.

At its core, the UOF packet contains incident reports written by officers that detail their roles, observations, and justification for the level of force applied. Supervisors then expand on this record through formal critiques, including patient interviews conducted by uninvolved OPS officers. These patient interviews must be video recorded when serious bodily injury or allegations of excessive force are involved, with refusals documented. The packet also includes photographs of injuries and pre-existing conditions, along with medical documentation following the incident.

The packet then moves through a deliberately structured successive level of review, with each level of leadership contributing oversight and verification. A sergeant initiates the supervisory review, which is followed by a lieutenant's evaluation and findings. The Chief of Police then scrutinizes the packet for completeness and compliance. From there, the Executive Director and, when appropriate, the Facility Executive Committee review the packet, with further independent oversight provided by OLES and the DSH Chief of Law Enforcement. Thus, the packet serves not merely as an administrative requirement but as a safeguard that preserves the integrity of the investigative process, protects the rights of patients and staff, and reinforces public trust.

Following the DSH submission, OLES reviewed the updated forms and on August 26, 2025, returned them to DSH with suggestions and recommendations for consideration. DSH is continuing to work on updated forms and will be consulting with OLES before finalization. OLES will continue to oversee the department's adherence to the use-of-force policy and its review process to ensure consistency, accountability, and continuous improvement.

Delayed Reporting by Other Mandated Reporters

In December 2021, 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. 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 notifications to OPS. However, continued efforts to ensure thorough knowledge of reporting requirements are needed.

In the last reporting period of January 1, 2025, through June 30, 2025, OLES identified 11 incidents that were not timely reported by Other Mandated Reporters to OPS. During the current reporting period of July 1, 2025, through December 31, 2025, this number decreased to four incidents of delayed reporting by Other Mandated Reporters. However, there continues to be occasional egregious deficiencies, including a physical abuse allegation that was not reported to OPS until more than a day after the allegation was discovered. The four incidents are listed below:

Incident Type	Estimated Delayed Reporting to OPS
Physical abuse	Over 7 hours
Sexual assault (unknown person/non-patient)	Almost 4 hours
Physical abuse	Over 1 day and 1.55 hours
Genital Injury (unknown origin)	Over 4.4 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.

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 recommends that DSH provide additional statewide training to ensure all DSH mandated reporters are made aware of and comply with their obligations 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. OLES will continue to work with the department and monitor the department's progress on this issue.

In response to OLES' recommendations, DSH drafted a new Policy Directive for Mandated Reporting. OPS and SQI have worked collaboratively to incorporate all the various reporting requirements including reporting to outside law enforcement. DSH anticipates the policy will be finalized by the end of March 2026 with training immediately following.

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, 2025. 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	05/12/2024
OLES Case Number	2024-00722-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer was arrested for allegedly engaging in an act of off-duty domestic violence.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	05/26/2024
OLES Case Number	2024-00950-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly "texted" another law enforcement officer that they were about to "fight" a patient.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	09/02/2024

OLES Case Number	2024-01224-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly shoved a psychiatric technician.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	11/06/2024
OLES Case Number	2024-01524-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	Law enforcement officers allegedly slept during their shift.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	11/25/2024
OLES Case Number	2024-01570-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly misrepresented hours worked.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	01/01/2025
OLES Case Number	2025-00005-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct

Incident Summary	An off-duty law enforcement officer was allegedly involved in a public altercation and fled from police. The law enforcement officer was arrested for public intoxication and driving under the influence.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	03/08/2025
OLES Case Number	2025-00289-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	Two law enforcement officers conducted a traffic stop and vehicle search on a hospital employee. One of the officers allegedly yanked the employee's arms behind her back, kicked the employee's car seat, and threw the employee's belongings all over the vehicle.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	03/21/2025
OLES Case Number	2025-00361-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	Several Department of State Hospital police cadets allegedly consumed alcoholic beverages while on the grounds of the Office of Protective Services Academy and while in a state vehicle.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/11/2024

OLES Case Number	2025-00418-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	Two law enforcement officers allegedly refused to remove a patient's restraints, causing the patient to fall and fracture his elbow.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	04/14/2025
OLES Case Number	2025-00463-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly harassed and intimidated a state hospital employee.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	04/21/2025
OLES Case Number	2025-00497-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	It is alleged that a law enforcement officer was involved a single vehicle traffic accident while intoxicated.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	04/21/2025

OLES Case Number	2025-00498-1C
Case Type	Investigative
Incident Types	1. Abuse - Physical 2. Peace Officer Misconduct 3. Sexual Assault: Priority 1
Incident Summary	Three law enforcement officers and one psychiatric technician allegedly used excessive force to make a patient consume crushed up medication mixed with saliva. The psychiatric technician allegedly inappropriately touched the patient. The law enforcement officers and psychiatric technician allegedly tied the patient to a bed and abused the patient both sexually and physically.
Disposition	The case was not referred to the district attorney's due to a lack of probable casue. A summary of the investigation was provided to the department.

Case Details	Description
Incident Date	05/08/2025
OLES Case Number	2025-00603-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly referred to patients as "monkeys."
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	05/14/2025
OLES Case Number	2025-00613-1C
Case Type	Investigative
Incident Types	1. Abuse - Physical 2. Peace Officer Misconduct 3. Sexual Assault: Priority 1

Incident Summary	Law enforcement officers and unidentified staff members allegedly assaulted a patient multiple times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. A summary of the investigation was provided to the department.

Case Details	Description
Incident Date	05/20/2025
OLES Case Number	2025-00629-1A
Case Type	Investigative
Incident Types	1. Abuse - Physical 2. Peace Officer Misconduct
Incident Summary	Multiple unidentified law enforcement officers allegedly interfered with a licensed vocational nurse's treatment of a patient, and unlawfully handcuffed and intimidated the nurse. The unidentified law enforcement officers also allegedly failed to protect the patient from unidentified abusive staff members
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition. OLES monitored the disposition process.

Case Details	Description
Incident Date	06/13/2025
OLES Case Number	2025-00738-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly disclosed confidential investigative information about a suspect to individuals outside of the state hospital.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/16/2025

OLES Case Number	2025-00852-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement supervisor allegedly gave preferential treatment to their spouse in assigning overtime in violation of the nepotism policy.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/19/2025
OLES Case Number	2025-00887-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer was allegedly told by a law enforcement supervisor that he could not return to work until the date listed on a doctor's note. The officer allegedly was insubordinate when he contacted a different law enforcement supervisor requesting to be put back on the schedule early and returned to work before the return date on the doctor's note.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	08/28/2025
OLES Case Number	2025-01049-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A hospital academy cadet was allegedly dishonest to an officer when asked about his out-of-date uniform patches.
Disposition	The investigation was completed by 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 December 31, 2025, 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	11/15/2022
OLES Case Number	2022-01479-1A
Case Type	Monitored
Incident Types	1. Significant Interest
Allegations	1. Inexcusable neglect of duty 2. Willful disobedience
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: Training Final: Training
Incident Summary	A staff psychiatrist allegedly physically abused a patient when he ordered the patient placed in wrist-to-waist restraints without proper justification.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative	Overall Rating: Insufficient

<p>Assessment</p>	<p>The department did not comply with the policies and procedures governing the investigative process. When the Office of Special Investigations asked for an appropriate subject matter expert, the medical director identified himself as one of the two experts to be interviewed, despite the fact it was the medical director's approval for the use of the restraints that the doctor failed to obtain and that the medical director had conducted an initial review of the incident and requested an investigation be conducted and reviewed by the Incident Review Committee. The medical director requested an investigation be completed for review by the internal review committee 60 days after the alleged misconduct. The Office of Special Investigations did not open an administrative investigation until over a year after the medical director's request. The case was transferred to a second investigator who completed the investigation 2 years and 9 months after the investigation was requested.</p>
<p>Pre-Disciplinary Assessment</p>	<p>1. Were all of the interviews thorough and appropriately conducted? • No When the Office of Special Investigations asked for an appropriate subject matter expert, the medical director identified himself as one of the two experts to be interviewed, despite the fact it was the medical director's approval for the use of the restraints that the doctor failed to obtain and that the medical director had conducted an initial review of the incident and requested an investigation be conducted and reviewed by the Incident Review Committee.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The medical director requested an investigation be completed for review by the internal review committee 60 days after the alleged misconduct. The Office of Special Investigations did not open an administrative investigation until over a year after the medical director's request. The case was transferred to a second investigator who completed the investigation 2 years and 9 months after the investigation was requested.</p>

Department Corrective Action Plan	<p>The Supervising Special Investigator (SSI) will ensure all cases are reassigned as soon as possible when staffing changes occur to ensure timely investigations. The Office of Special Investigations (OSI) will be requested to provide timely updates to OPS Headquarters to ensure investigations of high interest are reported to Headquarters. When the medical director identified himself as one of the two experts to be interviewed, this became a conflict-of-interest. When conflict-of-interest concerns arise regarding a Subject Matter Expert (SME), the SSI will ensure consultation with a monitor and discuss the appropriate use of an independent SME to ensure adherence to DSH Policy 3104. In addition, the SSI will provide time management concepts training to all investigators at the next internal training. The SSI will ensure administrative investigations are opened as soon as possible to ensure there are no delays in the completion of investigations.</p>
------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	08/30/2023
OLES Case Number	2023-01288-2A
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 unidentified staff member allegedly assaulted a restrained 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: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation, which lacked appropriate subject matter

	<p>experts, was not completed until 294 days from the date of discovery and the initial review took 91 day to complete.</p>
<p>Pre-Disciplinary Assessment</p>	<p>1. Was the investigation thorough and appropriately conducted? • No No, the investigation did not include an expert to discuss appropriate therapeutic strategies and interventions techniques.</p> <p>2. 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 final report was completed May 6, 2025, however the initial review of the case did not take place until August 5, 2025; 91 days later.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 294 days from the date of discovery.</p>
<p>Department Corrective Action Plan</p>	<p>The Supervising Special Investigator (SSI) will ensure the investigator is reminded and expected to coordinate with Subject Matter Experts (SME), when related to clarification pertaining to strategies and techniques related to case. The SSI will provide training to the investigator on policies related to investigations and requesting a SME. Time management concepts will be discussed and taught at the next internal training. Further, the SSI will monitor the investigator's caseload to ensure OLES monitored cases are tracked for progress at 30, 60, and 90 days to meet deadlines with the help of support staff. The SSI will ensure the investigator submits a case status report to the support staff on cases that have reached 90 days. This will include investigative activity to date; including what investigative steps have been taken, what interviews have been conducted, what interviews are outstanding and estimate completion date to ensure case is completed 120 days before. The SSI will review administrative cases to ensure compelled subject interviews and independent investigative steps are</p>

	conducted for policy violations. The investigator will be reminded of the expectations to fully collaborate and consult with the monitor during investigations. The SSI will review and ensure an OLES monitored case request for extension is completed with the adequate justification for cases that will exceed the 120 days.
--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	12/07/2023
OLES Case Number	2023-01728-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Sustained 2. Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Penalty	<p>Initial: Salary Reduction</p> <p>Final: Letter of Instruction</p>
Incident Summary	Two psychiatric technicians allegedly failed to adequately monitor a patient on an enhanced level of observation; the patient was able to obtain razor blades from her electric razor without being noticed. A third psychiatric technician allegedly failed to adequately monitor the patient who cut her wrists with the razor blades.
Disposition	The hiring authority sustained the allegations against the third psychiatric technician and determined a 5 percent

	<p>salary reduction for seven months was the appropriate penalty. Prior to the disciplinary action being served, the hiring authority reduced the penalty to a letter of instruction because the policy regarding enhanced observation while a patient is shaving was not clear. OLES concurred. The hiring authority determined there was insufficient evidence to sustain the allegations against the other two psychiatric technicians. OLES concurred with the hiring authority's determinations.</p>
Investigative Assessment	<p>Overall Rating: Insufficient</p> <p>The department did not comply with policies and procedures governing the investigative process. A subject matter expert on policy should have been interviewed as part of the investigation. The investigation was not completed until 223 days from the date of discovery.</p>
Pre-Disciplinary Assessment	<p>1. Was the investigation thorough and appropriately conducted? • No A policy subject matter expert should have been interviewed as part of the investigation.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 223 days from the date of discovery</p>
Disciplinary Assessment	<p>Overall Rating: Sufficient</p> <p>The department complied with policies and procedures governing the disciplinary process.</p>
Department Corrective Action Plan	<p>The Supervising Special Investigators will ensure investigators are communicating with OLES monitors regarding the status of the investigations. The investigators will be reminded to thoroughly review the investigative case plan with the monitor prior to moving forward with the interviews to ensure all aspects of the investigation are completed. Should a question arise whether a Subject Matter Expert (SME) should be used, this would be the time frame for the investigator to discuss this with the monitor to determine consulting with a SME.</p>

Case Details	Description
Incident Date	12/14/2023
OLES Case Number	2023-01741-2A
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 registered nurse and senior psychiatric technician allegedly forced a patient's head against a wall and forced the patient to the ground while restraining 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: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 124 days after discovery of the incident. The investigation was approved on October 9, 2024; however, the hiring authority did not conduct an initial review conference until August 5, 2025; 301 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The investigation and report were completed October 9, 2024, and the initial review of the case was not until August 5, 2025; 301 days. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No No. The investigation was not completed until 124 days

	after discovery of the incident.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will remind all investigators and provide training on Lexipol Policy 607 – Office of Law Enforcement Support, for timely completion of monitored cases. Investigators will continue to include the SSI and support staff in all email communications with monitors to identify critical junctures and ensure timely and sufficient investigations. The SSI will request regular case updates from investigators and ensure investigations with pressing deadlines are prioritized. This will ensure cases are completed within the 120-day requirements, as required by policy or an extension request is submitted. OPS Headquarters will follow-up with the hospital and request documentation confirming the internal training was provided.

Case Details	Description
Incident Date	02/23/2024
OLES Case Number	2024-00307-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician assistant allegedly threw or pinned an elderly medically fragile patient to the floor, resulting in fractured ribs and a collapsed lung.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which OLES accepted for monitoring.
Investigative	Overall Rating: Insufficient

<p>Assessment</p>	<p>The department did not comply with the policies and procedures governing the investigative process. Although the patient told the Department of Protective Services on the day of injuries that he was pushed by a staff member, whom he described, and sustained serious injuries, the Office of Special Investigations delayed in commencing its investigation, prematurely concluded the patient fell because of a past history of falls, informed a witness that the patient was "pinned to the floor" when the patient had told the Department of Protective Services that he was pushed, did not present a photographic line-up to the patient despite the fact that an on-duty employee matched the description the patient provided, and did not interview the patient until 197 days after the incident and completed their investigation 293 days after the incident.</p>
<p>Pre-Disciplinary Assessment</p>	<p>1. Did the department adequately respond to the incident? • No Despite an OLES recommendation that the Office of Special Investigations commence their investigation immediately, including interviewing the patient, the assigned investigator did not conduct the first interview of staff members until 102 days after the incident. The investigator did not interview the patient until 195 days after the incident.</p> <p>2. Did the investigator adequately prepare for all aspects of the investigation? • No Although the patient had told the Department of Protective Services that he had been pushed to the floor by a staff member, the investigator initially concluded that the patient was injured when he fell because he had a documented history of falls, limiting and delaying the interviews of other potential staff witnesses.</p> <p>3. Were all of the interviews thorough and appropriately conducted? • No When initially interviewing the patient's primary physician, the investigator asked if the injuries could have occurred if the patient fell or was pinned to the floor, despite the fact the patient told the Department of Protective Services that a staff member had pushed him. &#x0D;</p>

	<p>4. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No Although the investigator had identified several staff witnesses and agreed to interview the patient, the initial draft investigative report was provided without the interviews of two staff witnesses and the patient.</p> <p>5. Was the final investigative report thorough and appropriately drafted? • No Although the supervising special investigator had agreed to presenting the patient with a photographic lineup, the final investigative report did not document that step was completed.</p> <p>6. Was the investigation thorough and appropriately conducted? • No The Office of Special Investigations did not present the patient with a photographic line-up to give the patient the opportunity to identify a possible suspect matching a description the patient provided.</p> <p>7. Was the pre-disciplinary/investigative phase conducted with due diligence? • No Although the patient described a suspect who matched the description of an on-duty employee and sustained serious injuries, the Office of Special Investigation did not conduct its first interview of staff witnesses until 102 days had lapsed, did not interview the patient until 197 days had lapsed, and did not submit a final draft report until 293 days after the incident.</p>
<p>Department Corrective Action Plan</p>	<p>The Supervising Special Investigator will ensure investigators are being more proactive and are following up with Human Resources to check on subject availability for interviews. The department will ensure investigators are communicating with the monitors regularly to confirm the status of subject availability. The investigator will be reminded to provide regular updates to the Supervising Special Investigator on monitored cases. This will include investigative tasks such as scheduling and completion of</p>

	pending interviews for subjects/witnesses. The Supervising Special Investigator will be expected to hold regular meetings with investigators to receive investigative status updates and will closely monitor case progress to ensure time completion of investigations.
--	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	03/11/2024
OLES Case Number	2024-00393-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
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 threw a patient against a wall.
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	03/08/2024
OLES Case Number	2024-00405-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<p>Initial: No Penalty Imposed</p> <p>Final: No Penalty Imposed</p>
Incident Summary	Three psychiatric technicians allegedly grabbed a patient's arms and dragged the patient to a seclusion room, causing bruising.
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	10/03/2023
OLES Case Number	2024-00891-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement supervisor allegedly made unprofessional comments to a subordinate officer.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. 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 274 days from the date of discovery, and the hiring authority did not consult with OLES regarding the case disposition until 112 days after receiving the report.
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 112 days after receiving the report.  2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No

	The investigation was not completed until 274 days after the department discovered the alleged misconduct. 
Department Corrective Action Plan	The Supervising Special Investigator will identify case timelines and ensure regular communication updates are provided to OLES. Further, the Supervising Special Investigator will reaffirm and reinforce investigative standards to ensure strict adherence to established procedures for completing investigations within the 120-day requirement by providing training. The training will be provided to investigators on timeliness of investigations. If the assigned investigator is unable to complete a case within the 120-day requirement, the Supervising Special Investigator will ensure a request for case extension is completed and submitted as soon as possible. The monitor will be notified of the reason for the delay. The Department will ensure to meet with Labor Relations upon receipt of investigative reports to review matters and coordinate the initiation of disposition meetings with OLES.

Case Details	Description
Incident Date	08/13/2024
OLES Case Number	2024-01138-2A
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
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 slammed a patient against a wall, threw the patient on the ground, stomped on the patient's right hand, and put a knee on the patient's 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	08/13/2024
OLES Case Number	2024-01145-1A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement supervisor allegedly accessed a restricted law enforcement report.
Disposition	The hiring authority sustained the allegation; however, no disciplinary action could be imposed because the time period in which to take disciplinary action expired. OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with policies and procedures governing the disciplinary process. The investigation was not completed until 275 days after discovery of the alleged misconduct, and the hiring authority did not consult with OLES regarding the case

	disposition until 55 days after receiving the report. Moreover, no disciplinary action could be imposed because the time period in which to take disciplinary action expired.
Pre-Disciplinary Assessment	<p>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 55 days after receiving the report.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 275 days from the date of discovery.</p>
Department Corrective Action Plan	The Supervising Special Investigator will identify case complexity and time constraints and ensure regular communication updates are provided to OLES. The department will ensure investigators are completing investigations within the 120-day requirement. Department management conducts weekly management reviews focused on investigative practices, training deficiencies, process performance, and corrective action tracking. The Department will also be meeting with Labor Relations upon receipt of investigative reports to review matters and coordinate the initiation of disposition meetings with OLES, as appropriate.

Case Details	Description
Incident Date	09/02/2024
OLES Case Number	2024-01235-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician was allegedly negligent while monitoring a patient who was on an enhanced level of observation. The patient swallowed batteries.
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: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 365 days from the date of discovery. Also, the investigation was approved on September 9, 2025; however, the findings and penalty conference meeting with the hiring authority did not take place until November 10, 2025, 62 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The investigation was approved on September 9, 2025; however, the findings and penalty conference meeting with the hiring authority did not take place until November 10, 2025, 62 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 365 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will remind the investigator that a notification shall be sent to the monitor when scheduling conflicts arise. The SSI will ensure the investigator provides the reasons affecting the completion of the investigation within the 120 -day timeframe requirement. The Investigators will be instructed to include the SSI and support staff in all email communications with monitors to ensure timely and

	sufficient investigations. The SSI will coordinate with the Hiring Authority and the Labor Relations Division to hold more meetings in order to review and adjudicate the pending administrative cases. This will ensure the department has a review process to stay within the threshold guidelines.
--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	08/28/2024
OLES Case Number	2024-01245-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Sexual Assault: Priority 1
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 senior psychiatric technician and a psychiatric technician allegedly threw a patient into the seclusion room, then threw the patient against a wall. The senior psychiatric technician also allegedly pulled the patient's pants down, and groped and slapped the patient's buttocks.
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	09/05/2024
OLES Case Number	2024-01248-1A

Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	Initial: Letter of Reprimand Final: Letter of Reprimand
Incident Summary	A psychiatric technician allegedly hit a patient in the stomach and derided the patient for being overweight.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation of inappropriate personal interaction, but found insufficient evidence to sustain the allegation of patient abuse. The hiring authority issued a letter of warning. 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 hiring authority did not hold a disposition meeting until 60 days after the investigation was completed.
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 concluded on February 2, 2025; however, the findings conference was not conducted until April 14th, 2025, 60 days later.
Department Corrective Action Plan	The Office of Special Investigations (OSI) will work with the Hiring Authority to schedule findings and penalty conferences as soon as possible to meet the 20-day threshold review guidelines. The Supervising Special Investigators will follow this process for each completed case to be sent to Incident Review Committee (IRC) for adjudication. The department has filled the analyst position who will be tasked with sending a reminder email

	to the Hiring Authority to schedule another meeting to review and adjudicate the pending administrative cases. This will ensure the department has a review process to stay within the threshold guidelines.
--	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	10/01/2024
OLES Case Number	2024-01365-2A
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 psychiatric technician allegedly had sexual intercourse with a patient on at least two occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. 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	10/08/2024
OLES Case Number	2024-01397-2A
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	While assigned to maintain enhanced observation over a patient, a psychiatric technician allegedly pulled down that patient's clothes, and sexually assaulted 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	11/25/2024
OLES Case Number	2024-01570-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty
Findings	1. Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement officer allegedly falsified timesheets on multiple dates.
Disposition	The hiring authority sustained the allegations and determined dismissal would be the appropriate penalty. However, the officer resigned during the investigation; therefore, no disciplinary action was taken. A letter indicating the officer resigned under unfavorable circumstances was placed in the official personnel file. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures

	governing the investigative phase.
--	------------------------------------

Case Details	Description
Incident Date	11/24/2024
OLES Case Number	2024-01584-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly kicked a patient's left hip and called the patient a derogatory name.
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	11/27/2024
OLES Case Number	2024-01598-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Penalty Imposed
Incident Summary	A law enforcement officer allegedly fled from an outside law enforcement agency when they attempted to enforce a traffic stop on the officer's vehicle. The officer failed to report his contact with outside law enforcement to his law enforcement supervisor.
Disposition	The hiring authority sustained the allegations and determined dismissal would be the appropriate penalty. However, the officer resigned during the investigation; therefore, no disciplinary action was taken. A letter indicating the officer resigned under unfavorable circumstances was placed in the official personnel file. 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	12/03/2024
OLES Case Number	2024-01602-2A
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
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 nurse allegedly made sexual gestures and sexually suggestive comments towards a patient. The nurse also allegedly gave the patient gifts, including superglue, lipstick, and a bracelet. A second nurse allegedly joined the first nurse in making inappropriate suggestive comments to the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the nurses. However, the hiring authority ordered additional training for the first nurse due to comments made to another staff member. 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	12/09/2024
OLES Case Number	2024-01627-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	After a patient assaulted a staff member, a psychiatric technician allegedly yelled, cursed, and threatened the patient, slammed doors, and threw his keys. The psychiatric technician allegedly poked the patient in the ear with his thumb.
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 department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with the policies and procedures governing the investigative process. The

	<p>investigator sought to interview the psychiatric technician first without interviewing other identified witnesses and the patient, delayed scheduling the patient interview until he was released into the community, told the OLES monitor and two witnesses he was not investigating the psychiatric technician's alleged agitated behavior despite its relevance to the suspect's state of mind; failed to notify the OLES monitor of scheduled interviews and provide collected documents despite a standing request that he do so, submitted an unapproved extension request without prior consultation, and did not complete the investigation until 244 days after the incident was discovered.</p>
<p>Pre-Disciplinary Assessment</p>	<p>1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No</p> <p>Although the investigator's investigative plan identified two witnesses, the patient, and the psychiatric technician to be interviewed, the investigator repeatedly told the OLES monitor he wanted to interview the psychiatric technician first, without benefit of the full statements of the witnesses and the patient.</p> <p>2. Did the investigator adequately prepare for all aspects of the investigation? • No</p> <p>The investigator told the OLES monitor and witnesses he was not investigating the psychiatric technician's alleged agitated behavior because it was not a crime, despite its relevance to the suspect's state of mind during the incident.</p> <p>3. Did OPS cooperate with and provide continued real-time consultation with OLES? • No</p> <p>The investigator scheduled interviews with either no notice or inadequate notice to the OLES Monitor, limiting real-time monitoring, including his first attempt to schedule an interview with the psychiatric technician. Although the OLES monitor requested timely copies of documents that the investigator obtained, the investigator repeatedly failed to do so.</p> <p>4. Was the investigation thorough and appropriately conducted? • No</p>

	<p>The investigator stated he wanted to interview the psychiatric technician before interviewing the other witnesses until reminded by the OLES monitor of what was in his investigative plan and best practices. Although the patient was released from the state hospital to a nearby county jail, the investigator did not schedule the interview in a timely manner and learned that the patient had been released into the community, making him more difficult to locate.</p> <p>5. Was the pre-disciplinary/investigative phase conducted with due diligence? • No</p> <p>The investigator submitted a second extension request to the OLES monitor just before going on approved leave, without proper approval and without prior consultation. The investigation was not completed until 244 days after the incident was discovered.</p>
<p>Department Corrective Action Plan</p>	<p>The Supervising Special Investigator (SSI) will remind all investigators and provide them with training on Lexipol policy for OLES guidelines related to timely completion of monitored cases. The SSI will meet with the investigator and provide expectations outlining their responsibilities to contact the monitor to request extensions and prior to going on leave. The investigator will be reminded of the importance of providing all documentation related to an investigation without delay when requested by a monitor. Further, the SSI will direct support staff to establish a tracking system for completed and submitted cases that are sent back by the hiring authority for further follow-up based on the recommendations by the OLES monitor. The SSI will ensure an OLES case extension is completed and submitted if the case exceeds 120 days due to further follow-up at the request of the monitor. Additionally, the SSI will ensure all Investigators identify all individuals to be interviewed in the Investigative Case Plan (ICP). The SSI will ensure the investigator promptly informs the monitor if a new individual was identified to allow the monitor to be part of the interview. Internal training will be completed in the month of March 2026, addressing these concepts. Investigators will be instructed to include the SSI and support staff in all email communications with monitors to</p>

	ensure timely and sufficient investigations. OPS Headquarters will follow-up with the hospital and request documentation confirming the internal training was provided.
--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	12/28/2024
OLES Case Number	2025-00017-2A
Case Type	Monitored
Incident Types	1. 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 abandoned his assigned post to host a social gathering.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative phase.

Case Details	Description
Incident Date	01/15/2025
OLES Case Number	2025-00071-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly had sex with a patient,

	impregnating her.
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 department did not open an administrative investigation.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/16/2025
OLES Case Number	2025-00096-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician and other unknown staff allegedly failed to properly move a patient with mobility issues, resulting injury.
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	01/25/2025
OLES Case Number	2025-00103-1A
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 registered nurse allegedly threw a patient into his room, punched him three times in the face, and placed him in a chokehold.
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	01/27/2025
OLES Case Number	2025-00104-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A doctor allegedly grabbed a patient's genitals over the patient's clothing during a medical assessment.
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	01/28/2025

OLES Case Number	2025-00114-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	When a patient did not report for lunch call, a psychiatric technician discovered the patient alone in his room on his bed unresponsive. Hospital staff initiated emergency life-saving measures; however, the patient was declared dead. An autopsy determined the patient's death was natural due to influenza infection.
Disposition	The Office of Protective Services conducted an investigation, and determined there was no evidence that a crime caused or contributed to the patient's death; therefore, the case was not referred to the district attorney's office. OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with the policies and procedures governing the investigative process. The Office of Special Investigations decided to conduct all of the interviews of staff who were present when the patient was discovered, without delegating or utilizing Department of Protective Services personnel assigned to the incident, resulting in prolonged delays and unnecessary overtime for some staff witnesses. The investigator left the scene prior to the arrival of the medical examiner, leaving a less knowledgeable Department of Protective Services officer to brief the coroner staff.
Pre-Disciplinary Assessment	1. Was the investigation thorough and appropriately conducted? • No The department did not comply with the policies and procedures governing the investigative process. The Office of Special Investigations decided to conduct all of the interviews of staff who were present when the patient was discovered, without delegating or utilizing Department of Protective Services personnel assigned to the incident, resulting in prolonged delays. The

	investigator left the scene prior to the arrival of the medical examiner, leaving a less knowledgeable Department of Protective Services officer to brief the coroner staff.
Department Corrective Action Plan	DPS personnel will be trained on Lexipol policy 327 to conduct criminal investigations, including death investigations, and when it is appropriate to request an investigator respond to the scene. The Supervising Special Investigator (SSI) will remind all investigators and provide continued training on OPS policies and OLES guidelines for timely completion of death cases. The continued training will be added to the OSI internal monthly training beginning February 2026. Investigators will be instructed to include the SSI and support staff in all email communications with monitors to ensure timely and sufficient investigations. Investigators will be reminded of the importance to brief or obtain information from the coroner investigators/staff on all death cases at the next internal training.

Case Details	Description
Incident Date	01/22/2025
OLES Case Number	2025-00119-1C
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 hit a patient in the face during an escort to the seclusion room.
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	01/30/2025
OLES Case Number	2025-00125-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly escorted a patient into a room alone and hit the patient in the back.
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 department 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	02/11/2025
OLES Case Number	2025-00179-1A
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 psychiatric technician and a registered nurse who were on enhanced observation allegedly neglected a patient who then physically assaulted 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	02/04/2025
OLES Case Number	2025-00202-1A
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 poked a patient in the neck with a restraint key.
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: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was completed on July 2, 2025, 129 days after the investigation was initially opened.
Pre-Disciplinary	1. Was the pre-disciplinary/investigative phase

Assessment	<p>conducted with due diligence? • No</p> <p>The investigation was completed on July 2, 2025, 129 days after the investigation was initially opened.</p>
Department Corrective Action Plan	<p>The Supervising Special Investigator will hold regular meetings with investigators to receive investigative status updates and will closely monitor investigative tracking mechanisms. The Investigator will be reminded to be more proactive and communicate any challenges affecting the completion of an investigation. The Supervising Special Investigator will identify case complexity and time constraints and ensure regular communication updates are provided to OLES by the investigator. The department will ensure investigators are completing case extensions and communicating with the monitors when additional research and documentation is required. The Supervising Special Investigator will hold regular meetings with investigators to receive investigative status updates and will closely monitor case progress.</p>

Case Details	Description
Incident Date	02/19/2025
OLES Case Number	2025-00205-1A
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 allegedly retaliated against a patient because the patient previously reported staff for being overly familiar with patients.
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	02/19/2025
OLES Case Number	2025-00206-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A non-verbal patient was discovered with bruising on his body.
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	02/12/2025
OLES Case Number	2025-00209-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly had an overfamiliar

	relationship with a patient, including once kissing the patient while on the unit.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. 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: Insufficient The department failed to comply with policies and procedures governing the investigative process. The final investigative report contained language contrary to the intent needed to prove the underlying criminal act despite the recommendation by the OLES monitor that the language be removed. The investigator failed to inform the monitor that the erroneous language would remain in the report that was filed with the district attorney.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No No. The draft investigative report contained language contrary to the intent needed to prove the underlying criminal act. 2. Was the final investigative report thorough and appropriately drafted? • No No. The final investigative report contained language contrary to the intent needed to prove the underlying criminal act despite the OLES' monitors recommendation that the incorrect language be removed. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? • No No. OPS did not discuss with OLES the decision to retain the inaccurate language in the final investigative report that was filed with the district attorney's office.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will ensure to review investigative reports and return the reports back to the investigator when language contrary to the intent

	needed to prove a criminal act is present. The SSI will ensure reports contain recommendations from the monitors and will verify the recommendations have been incorporated in the reports. The investigator will be reminded of the importance of incorporating and discussing the recommendations/feedback from a monitor before the investigation is finalized. Further, the investigator will be reminded to adhere to the report writing policy for cases filed with the District Attorney's Office for review and filing consideration.
--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	02/12/2025
OLES Case Number	2025-00209-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	A psychiatric technician allegedly had an overfamiliar relationship with a patient, including once kissing the patient while on the unit.
Disposition	The hiring authority sustained the allegation and intended to impose the penalty of dismissal against the psychiatric technician. However, the psychiatric technician resigned before discipline could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file and the state licensing board was notified of the misconduct findings.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/23/2025
OLES Case Number	2025-00228-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly entered a patient's room, spat in the patient's face, threw her breakfast tray on the floor, and danced in front of the patient, moving her buttocks.
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	03/08/2025
OLES Case Number	2025-00287-1A
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	Four psychiatric technicians allegedly pulled a patient's hair in retaliation for the patient pulling a psychiatric technician's hair.
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	03/11/2025
OLES Case Number	2025-00288-2C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Unidentified staff members allegedly neglected a patient by failing to change the patient's soiled diapers, shower the patient, and withheld food. A psychiatric technician allegedly roughly picked the patient up off the floor and put her in her wheelchair.
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	03/08/2025
OLES Case Number	2025-00289-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	Initial: Training Final: Training
Incident Summary	Two law enforcement officers conducted a traffic stop and vehicle search on a hospital employee. One of the officers allegedly yanked the employee's arms behind her back, kicked the employee's car seat, and threw the employee's belongings all over the vehicle. The officers allegedly failed to properly document the incident.
Disposition	The hiring authority sustained the allegation that the incident was not properly documented. The remaining allegations were not sustained. Training was provided. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative phase.

Case Details	Description
Incident Date	03/11/2025
OLES Case Number	2025-00296-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	After complaining of back pain, a patient was diagnosed with an age indeterminate wedge compression fracture of the lower vertebrae of unknown origin.
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	07/17/2024
OLES Case Number	2025-00299-1A
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 medical doctor allegedly failed to provide adequate medical care by overmedicating and/or poisoning 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: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The initial draft report was not provided to the OLES monitor for review before it was forwarded to the hiring authority. The hiring authority did not timely consult with OLES regarding the sufficiency of the investigation and

	investigative findings.
Pre-Disciplinary Assessment	<p>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 OLES was not provided with a copy of the draft report prior to forwarding it to the hiring authority.</p> <p>2. Did OPS cooperate with and provide continued real-time consultation with OLES? • No After the initial subject interview the investigator did not coordinate with OLES.</p> <p>3. 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 until 46 days after receiving the completed investigation.</p>
Department Corrective Action Plan	The Supervising Special Investigators will ensure case file notes are reviewed to verify the OLES monitors are kept apprised of the final investigative report. The investigators will be reminded to provide a draft copy of the report to the monitor to allow the monitor an opportunity to make recommendations. The department will ensure this process is followed prior to forwarding the final report to the Hiring Authority/Incident Review Committee for adjudication.

Case Details	Description
Incident Date	03/17/2025
OLES Case Number	2025-00317-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A senior psychiatric technician allegedly threw a patient to the floor and used his foot to step on the patient's ribs.
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	03/19/2025
OLES Case Number	2025-00325-1C
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 senior psychiatric technicians allegedly grabbed a patient and pulled the patient's arm behind his back, causing pain to the patient's shoulder. The two senior psychiatric technicians also allegedly placed the patient in seclusion for no reason.
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	
OLES Case Number	2025-00334-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly intentionally threw water onto a patient in front of the medication room, splashing her face, chest, and lap.
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	03/13/2025
OLES Case Number	2025-00343-1A
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	Two psychiatric technicians allegedly hit and tackled 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	01/07/2025
OLES Case Number	2025-00350-1A
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 registered nurse allegedly hit a patient on the buttocks with a tourniquet.
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: Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely consult with OLES regarding the sufficiency of the investigation and investigative findings. The OSI investigation was finalized on August 22, 2025; however, the disposition meeting was not held until October 13, 2025, 53 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No No, the OSI investigation was finalized on August 22, 2025; however, the disposition meeting was not held until

	October 13, 2025, 53 days later. 
Department Corrective Action Plan	The Office of Special Investigations (OSI) will work with the Hiring Authority to schedule disposition meetings to adjudicate cases as soon as investigations are finalized. The Hiring Authority will ensure to consult with the monitor regarding the sufficiency of an investigation and investigative findings upon receiving monitored cases. The Supervising Special Investigators will follow this process for each completed case to be sent to Incident Review Committee (IRC). The department has filled the analyst position who will be tasked with sending a reminder email to the Hiring Authority to schedule another meeting to review and adjudicate the pending administrative cases. This will ensure the department has a review process to stay within the threshold guidelines.

Case Details	Description
Incident Date	03/03/2025
OLES Case Number	2025-00351-1A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Two psychiatric technicians allegedly gave a patient a shot to make her sleep and then raped her.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative	Overall Rating: Insufficient

Assessment	The department did not sufficiently comply with policies and procedures governing the investigative process, the findings and penalty conference did not take place until 59 days after completion of the investigation and report.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was approved on July 11, 2025; however, the findings and penalty conference with the hiring authority did not take place until September 8, 2025, 59 days later.
Department Corrective Action Plan	The Office of Special Investigations (OSI) will work with the Hiring Authority to schedule findings and penalty conferences as soon as possible to meet the 20-day threshold review guidelines. The Supervising Special Investigators will follow this process for each complete case sent to Incident Review Committee (IRC) for adjudication. OSI will work with HR when forwarding the IRC case files to be screened within the time frames. The department has now hired a second Supervising Special Investigator. This will allow OSI to work with the Hiring Authority and the Labor Relations Division to hold more meetings in order to review and adjudicate the pending administrative cases.

Case Details	Description
Incident Date	03/26/2025
OLES Case Number	2025-00367-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly punched a patient once in the nose after the patient punched the senior psychiatric technician.
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	02/28/2025
OLES Case Number	2025-00376-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly engaged in a sexual relationship with 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 due to lack of evidence. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/01/2025
OLES Case Number	2025-00379-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	During a patient's clothing change, staff discovered abrasions of an unknown origin on the patient's genitals.
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	03/29/2025
OLES Case Number	2025-00380-1C
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	Two psychiatric technicians and a registered nurse allegedly raped a male 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	03/31/2025
OLES Case Number	2025-00382-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A female staff member allegedly pushed a patient onto the floor of a restroom, causing him to hit his head and back.
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	03/26/2025
OLES Case Number	2025-00389-1C
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	While placing a patient in a floor containment, a senior psychiatric technician allegedly choked the patient, and

	a program director allegedly pulled the patient's arm behind the patient's back. Additionally, a psychiatric technician allegedly landed with all his weight on the patient during the floor containment.
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	04/01/2025
OLES Case Number	2025-00394-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	During a full body assessment, a patient was discovered with significant bruising on his left buttock and left thigh.
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	04/02/2025
OLES Case Number	2025-00399-1A
Case Type	Monitored

Incident Types	1. Over-Familiarity
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 food services worker was allegedly overly familiar with a patient and a psychiatric technician allegedly failed to report the overfamiliarity.
Disposition	The hiring authority sustained the allegations against the food service worker and the psychiatric technician and determined letters of expectation were the appropriate penalty. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/03/2025
OLES Case Number	2025-00403-1C
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	A senior psychiatric technician allegedly persuaded a patient to attack a second patient. A second senior

	psychiatric technician assigned to enhanced observation of the second patient was allegedly overly aggressive toward the second patient and along with a registered nurse, allegedly slammed the second patient's head against a wall. The second senior psychiatric technician also allegedly hit and kicked the second patient multiple times. A pre-licensed psychiatric technician was also allegedly involved in causing injury to the second 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	03/31/2025
OLES Case Number	2025-00406-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient who allegedly fell from his bed onto his left shoulder, sustained a fractured left clavicle.
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 Department of Protective Services preliminary report was

	not complete because the responding officer did not interview the patient about the cause of the broken bone.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The Department of Protective Services preliminary report was not complete because the officer who responded to the scene did not interview the patient about the cause of the broken bone.
Department Corrective Action Plan	The Department is taking proactive steps to reinforce compliance with investigative and reporting requirements by providing refresher training through roll-call briefings and practical scenario-based applications. In addition, Lieutenants are working directly with Sergeants to identify specific training needs observed during report review, ensuring that deficiencies are addressed in real time and that additional areas for improvement are captured, documented, and incorporated into ongoing training and supervisory oversight.

Case Details	Description
Incident Date	06/11/2024
OLES Case Number	2025-00418-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Two law enforcement officers allegedly refused to remove a patient's restraints, causing the patient to fall and fracture his elbow.

Disposition	The hiring authority determined the allegations were unfounded. 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	04/06/2025
OLES Case Number	2025-00426-1A
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 gave a patient an injection in retaliation for calling the staff member a name.
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	04/08/2025
OLES Case Number	2025-00427-1A
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 allegedly was overly familiar with 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 sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/07/2025
OLES Case Number	2025-00434-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly grabbed a patient's arm and choked the patient's throat, then slammed the patient to the floor. The nurse also allegedly argued with the patient, and used profanity.
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	04/09/2025

OLES Case Number	2025-00435-1C
Case Type	Monitored
Incident Types	1. Assault with GBI
Allegations	
Findings	
Incident Summary	After a psychiatrist ordered enhanced observation of a newly admitted patient as a danger to self, a registered nurse initially assigned to the observation entered the dormitory room and stopped the patient as he was choking another patient, necessitating life-saving measures to resuscitate the victim.
Disposition	The Office of Protective Services completed the required criminal investigation, determining there was no evidence of a crime or policy violation by staff that contributed to the attempted murder of the victim-patient. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/08/2025
OLES Case Number	2025-00438-1A
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 registered nurse and a psychiatric technician allegedly hit a patient once on the back of his head
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	04/10/2025
OLES Case Number	2025-00441-1A
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 psychiatrist and a registered nurse allegedly hit a patient in the face with a shoe and hit the patient in the stomach on multiple occasions.
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	03/24/2025
OLES Case Number	2025-00451-1A
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 registered nurse allegedly forcefully grabbed a patient from behind and dragged him from the hallway into a side room.
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	03/24/2025
OLES Case Number	2025-00462-1A
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 improperly placed his knee on a patient's leg during a containment in violation of policy.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. 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 161 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 161 days after the incident was discovered.
Department Corrective Action Plan	The Department of Police Services will ensure prompt screening of incidents. This will include a review of investigative reports, evidence, and any related video surveillance. The Lieutenants will continue to closely monitor reports that require further clarification and corrections. This will ensure adherence to investigative time frames to improve efficiency and timely completion of investigations. The department will ensure reports and investigations are being tracked when pressing deadlines are present. Lieutenants will be tasked with creating specific tabletop/roll call training for officers and sergeants on the importance of completing reports in a timely manner. The training will be completed in the next 30 to 60 days. The department will update OPS Headquarters when once this training has been completed.

Case Details	Description
Incident Date	03/18/2025
OLEs Case Number	2025-00487-1A
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 pulled a chair out from under a patient, causing her to fall. The psychiatric technician also allegedly slammed the patient's head

	against a wall and threw the patient onto a restraint bed.
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	04/20/2025
OLES Case Number	2025-00492-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly used his open hand to strike a patient's left bicep twice.
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	04/01/2025
OLES Case Number	2025-00501-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act

Findings	1. Not Referred 2. Not Referred
Incident Summary	A senior psychiatric technician allegedly touched a patient in a sexual manner during multiple contraband searches.
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	04/05/2025
OLES Case Number	2025-00507-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A licensed vocational nurse, assigned to maintain enhanced observation over a patient, allegedly undressed from the waist down, and engaged in sexual acts with that 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 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	04/26/2025
OLES Case Number	2025-00515-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician was allegedly negligent while monitoring a patient who was on an enhanced level of observation. The patient swallowed a pen.
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: Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely consult with OLES regarding the sufficiency of the investigation and investigative findings.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No No, the OSI investigation was finalized on August 22nd, the disposition meeting was not held until October 13th; a 55 day time period.
Department Corrective Action Plan	The Hiring Authority will ensure to consult with the monitor regarding the sufficiency of an investigation and investigative findings upon receiving monitored cases. The Office of Special Investigations (OSI) has proposed to the Human Resources Director to hold an additional disposition hearing in order review and adjudicate administrative cases. The proposal will be discussed with the Hiring Authority for consideration. This review process

	will aim to stay within the threshold guidelines for monitored cases.
--	-----------------------------------------------------------------------

Case Details	Description
Incident Date	04/26/2025
OLES Case Number	2025-00524-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A licensed vocational nurse assigned to an enhanced observation of a patient was allegedly negligent when they left the patient alone in his room. An unidentified patient went into the room and hit the patient on the mouth causing a laceration.
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	04/28/2025
OLES Case Number	2025-00528-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician was allegedly negligent while monitoring a patient who was on an enhanced level of observation. The patient fell out of his wheelchair and sustained a fractured finger.
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	01/01/2025
OLES Case Number	2025-00538-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Three unidentified staff members allegedly sexually assaulted 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 due to lack of evidence. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/01/2025
OLES Case Number	2025-00540-1A

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. 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 was allegedly negligent while monitoring a patient who was on an enhanced level of observation. The patient fell and sustained an injury to the patient's ankle. Further, the psychiatric technician allegedly failed to report or document the patient fall, which delayed a medical assessment. Further, a registered nurse allegedly failed to medically assess the patient in a timely manner. Additionally, a senior psychiatric technician allegedly failed to properly inform the registered nurse the patient required an assessment.
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: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was completed on September 30, 2025; however, the findings and penalty conference meeting with the hiring authority did not take place until November 10, 2025, 41 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The investigation was completed on September 30, 2025; however, the findings and penalty conference

	meeting with the hiring authority did not take place until November 10, 2025, 44 days later.
Department Corrective Action Plan	The Office of Special Investigations (OSI) has now hired a second Supervising Special Investigator and will ensure to coordinate with the Human Resources Department in an effort to meet the threshold guidelines for the completion/approval date of investigations. The Supervising Special Investigators will work with HR to schedule a findings and penalty conference meeting with the hiring authority within the required time-frames. The investigator will be reminded to schedule interviews as soon as possible and be cognizant of employees' vacation in relation to due dates.

Case Details	Description
Incident Date	05/03/2025
OLES Case Number	2025-00547-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Incident Summary	A psychiatric technician and licensed vocational nurse attempted to wake a sleeping patient for a regular medical examination and found him to be unresponsive. Emergency life saving measures were initiated; however, the patient was declared dead. An autopsy revealed the cause of death was arteriosclerotic cardiovascular disease.
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. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/08/2025
OLES Case Number	2025-00566-1C
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 unidentified male staff members allegedly entered a patient's room on multiple days and hit the patient in 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	05/06/2025
OLES Case Number	2025-00570-1C
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 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	05/13/2025
OLES Case Number	2025-00586-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pushed or tripped a patient, causing the patient to fall to the floor, sustaining a head laceration requiring stitches.
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	05/11/2025
OLES Case Number	2025-00589-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly intentionally kicked a patient's foot.
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	05/16/2025
OLES Case Number	2025-00605-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was discovered with a pressure wound on his buttocks.
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	05/11/2025

OLES Case Number	2025-00626-1C
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 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 department 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	05/11/2025
OLES Case Number	2025-00626-2A
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 hit a patient on the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. 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	05/20/2025
OLES Case Number	2025-00628-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	
Findings	
Incident Summary	Two unidentified male staff members and an unidentified female patient allegedly raped, sodomized, and sexually battered a second patient several 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	05/14/2025
OLES Case Number	2025-00632-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified female staff member allegedly rammed a large wheeled trash can into a patient's shins.
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	05/07/2025
OLES Case Number	2025-00633-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified male staff member allegedly entered a patient's bedroom and hit the patient multiple times in 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	05/21/2025
OLES Case Number	2025-00636-1C
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	An unidentified male staff member allegedly raped and sodomized 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	05/25/2025
OLES Case Number	2025-00644-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed his knee into the back of a patient's wheelchair.
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	05/24/2025

OLES Case Number	2025-00646-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act 6. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred 6. Not Referred
Incident Summary	A senior psychiatric technician and five unidentified staff members allegedly threw a patient onto the floor, held him there before escorting him to a seclusion room, where they threw him onto the restraint bed, and restrained him, injuring his torso.
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	05/24/2025
OLES Case Number	2025-00647-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act

	2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly raped a patient who was on a two to one enhanced observation.
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 department will not open an administrative investigation.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/14/2025
OLES Case Number	2025-00658-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly slapped a patient's 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	05/31/2025

OLES Case Number	2025-00674-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly entered a patient's room, punched and kicked the patient multiple times and pulled the patient's hair.
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	05/30/2025
OLES Case Number	2025-00677-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A registered nurse was allegedly negligent while monitoring a patient who was on an enhanced level of observation when the registered nurse fell asleep. A psychiatric technician allegedly sexually assaulted the patient while the registered nurse slept.
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	06/02/2025
OLES Case Number	2025-00684-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	After a patient allegedly assaulted a registered nurse, a psychiatric technician allegedly struck the patient twice in 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	06/04/2025
OLES Case Number	2025-00691-1C
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 psychiatric technician allegedly punched a patient's head multiple times while at least two other staff members allegedly witnessed the abuse. Several unidentified staff also allegedly punched the 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 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	05/06/2025
OLES Case Number	2025-00697-1A
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 senior psychiatric technician allegedly pushed a patient and then sexually assaulted her.
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	06/07/2025
OLES Case Number	2025-00708-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly struck a patient once in the face while reapplying the patient's restraints.
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	06/22/2025
OLES Case Number	2025-00761-1A
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 harassed and physically attacked 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	06/24/2025
OLES Case Number	2025-00770-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified female staff allegedly approached a female patient washing her hands in the restroom, digitally penetrated the female patient with a finger and rubbed her private area against the 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	06/26/2025
OLES Case Number	2025-00778-1C
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 in the face two 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	05/28/2025
OLES Case Number	2025-00779-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was readmitted to the State Hospital after a month long stay at an outside medical facility. During the re-admission medical assessment, a doctor discovered two pressure sores on the patient's buttocks.
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 responding hospital police officer did not obtain information as to whether the pressure sores pre-dated the patient's transfer to an outside hospital, whether the patient had a prior history of pressure sores, the stage of the pressure sores, or a doctor's opinion as to the cause of the injuries. Although OLES notified OPS of its monitoring

	<p>and specifically requested an initial case conference, the investigator did not contact the monitor until 125 days after the date of discovery to advise that the investigation was untimely. The investigator did not interview the patient's physician to obtain an expert opinion as to the cause of the injury. The investigative report did not include the treating physician's opinion as to the cause of the injuries. The investigation was not completed until 131 days from the date of discovery.</p>
<p>Pre-Disciplinary Assessment</p>	<p>1. Did the department adequately respond to the incident? • No The responding hospital police officer did not obtain information as to whether the pressure sores pre-dated the patient's transfer to an outside hospital, whether the patient had a prior history of pressure sores, the stage of the pressure sores, or a doctor's opinion as to the cause of the injuries.</p> <p>2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No Although OLES notified OPS of its monitoring and specifically requested an initial case conference, the investigator did not contact the monitor until 125 days after the date of discovery to advise that the investigation was untimely.</p> <p>3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The investigative report did not include the treating physician's opinion as to the cause of the injuries.</p> <p>4. Was the investigation thorough and appropriately conducted? • No The investigator did not interview the patient's physician to obtain an expert opinion as to the cause of the injury.</p> <p>5. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 131 days from the date of discovery.</p>

Department Corrective Action Plan	<p>DPS personnel will be trained to conduct criminal investigations to include exhausting all efforts to determine if an injury is result of a criminal act, Lexipol Policy 600, Investigation and Prosecution will be briefed to all DPS personnel. Additionally, supervisory review protocols will be reinforced to ensure that investigations involving medical injuries are reviewed for completeness prior to report finalization, including confirmation that relevant medical history, staging injury, and provider opinions have been obtained and documented. The Supervising Special Investigator (SSI) will provide time/case management training to the Office of Special Investigations (OSI) personnel, to ensure OLES's oversight and investigative functions to receive full access to information. The investigator will coordinate interviews within a timely manner with witnesses (staff and/or patient) and OLES to ensure significate time does not lapse. Further, the SSI shall ensure OLES monitors are updated, consulted, and notified throughout the pre-disciplinary and investigative process to ensure the monitor has an opportunity to provide recommendations. This will ensure the monitors are consulted to achieve a timely and collaborative resolution.</p>
------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Case Details	Description
Incident Date	07/05/2025
OLES Case Number	2025-00803-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	<p>A senior psychiatric technician allegedly used his fingers to push a patient on the forehead 4-5 times. The senior psychiatric technician moved the patient's wheelchair out of his reach, causing the patient to lose his balance, fall, and strike his head. When the patient reported the</p>

	fall, the senior psychiatric technician and a registered nurse verbally abused the 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	07/07/2025
OLES Case Number	2025-00809-1A
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 registered nurse allegedly hit a patient in the jaw.
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	07/05/2025
OLES Case Number	2025-00820-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly sodomized 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 department will not open an administrative investigation.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/10/2025
OLES Case Number	2025-00826-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified level of care staff are allegedly contaminating a patient's toothpaste. Additionally, unidentified food service workers are allegedly poisoning the patient's food.
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 due to lack of evidence. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/11/2025

OLES Case Number	2025-00833-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient swallowed a pen. He and a second patient allegedly reported the incident to a psychiatric technician, who did nothing.
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 department 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	07/07/2025
OLES Case Number	2025-00839-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A unidentified male staff member allegedly entered a dormitory, penetrated a patient with a foreign object and sodomized the 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	07/15/2025
OLES Case Number	2025-00844-1C
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	Unknown individuals allegedly raped 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	07/15/2025
OLES Case Number	2025-00849-1A
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 choked and hit 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	07/18/2025
OLES Case Number	2025-00885-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: Final:
Incident Summary	An unidentified staff member 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	07/18/2025
OLES Case Number	2025-00891-1C
Case Type	Monitored

Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unknown persons allegedly raped a sleeping patient in her bedroom on two separate nights.
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	07/25/2025
OLES Case Number	2025-00903-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	While a patient was in bed, a psychiatric technician allegedly grabbed the patient's head and forced it once against the bed's guard rail.
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	07/28/2025
OLES Case Number	2025-00907-1C
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 psychiatric technician allegedly lifted a patient's left arm too high and hyper-extended the arm while assisting with transferring the patient from her bed to her wheelchair. In a prior incident, the psychiatric technician caused the patient to fall out of her wheelchair to the ground and the chair fell on top of her, spreading and hyperextending the patient's legs.
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	07/29/2025
OLES Case Number	2025-00923-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	An unidentified male staff member allegedly was overfamiliar with a patient when he kissed her on the forehead.
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	07/28/2025
OLES Case Number	2025-00927-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assigned to an enhanced observation of a patient was less than attentive when he was seen sleeping.
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 department 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	08/01/2025
OLES Case Number	2025-00942-1C

Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Four psychiatric technicians, two nurses, and a senior psychiatric technician allegedly abused a patient while placing him in restraints.
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 department 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	08/04/2025
OLES Case Number	2025-00948-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly hit a patient in the face in excess of ten 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	08/05/2025
OLES Case Number	2025-00950-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed a urinating patient in the restroom by both arms, escorted him to his bedroom, sat him on his bed, grabbed both of the patient's arms, and threw him to the ground, causing the patient's head to strike his roommate's bed frame.
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 department 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	08/05/2025
OLES Case Number	2025-00953-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient sustained a large pressure sore on her buttocks

	while receiving treatment at an outside hospital.
Disposition	The case was referred to the law enforcement agency whose jurisdiction included the outside hospital. OLES concurred with the outside law enforcement referral. 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	08/11/2025
OLES Case Number	2025-00969-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient with multiple medical conditions was on comfort care at an outside hospital when he died from chronic obstructive pulmonary disease. The death was expected.
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. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/14/2025
OLES Case Number	2025-00980-1A
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	Two psychiatric technicians allegedly kicked and hit a patient in the head and body.
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	08/19/2025
OLES Case Number	2025-01002-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Assault with GBI
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly directed a patient to strangle another 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 due to lack of evidence. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/18/2025
OLES Case Number	2025-01007-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	After staff placed a patient in a floor containment procedure, a registered nurse allegedly hit the patient on the ribs and kicked him once on the forehead.
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	08/21/2025
OLES Case Number	2025-01013-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	An unidentified male staff member hit a patient while a second unidentified staff member placed a knee on the

	patient's ribs.
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	<p>Overall Rating: Insufficient</p> <p>The department did not comply with the policies and procedures governing the investigative process. Although the investigating Hospital Police Officers identified a critical witness, they did not interview the witness. Although the investigating Hospital Police Officers wrote in their police report they would interview the critical witness at a later time, their report does not include the interview nor document their attempts to contact the witness. The investigator did not interview the critical witness until 112 days after the incident, during which the witness said she had no recall of the date. The investigator conducted the interview of the critical witness without notifying the OLES monitor in advance.</p>
Pre-Disciplinary Assessment	<p>1. Did the department adequately respond to the incident? • No Although they determined that the patient was on enhanced observation by a psychiatric technician during the alleged abuse, the two investigating Hospital Police Officers did not interview the psychiatric technician.</p> <p>2. Was the incident properly documented? • No Although two investigating Hospital Police Officers wrote that they would interview the enhanced observing psychiatric technician at a later time, their police report does not include the interview nor document their attempts to contact the witness.</p> <p>3. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator did not notify OLES of the interview of the enhanced observer psychiatric technician, a critical witness, in advance.</p> <p>4. Was the investigation thorough and appropriately conducted? • No</p>

	<p>Although the investigator listed the interview of the enhanced observer psychiatric technician in the investigative plan, the interview did not occur until 112 days after the date of the alleged abuse, during which the psychiatric technician said she did not recall what happened that day.</p>
<p>Department Corrective Action Plan</p>	<p>DPS personnel will be trained to conduct criminal investigations to include identifying critical witnesses and conducting an interview as soon as possible. Lexipol Policy 600, Investigation and Prosecution will be briefed to all DPS personnel. This will include the supervisors reviewing investigative reports and ensuring all parties identified in an investigation are interviewed. The hospital police officers will be reminded of the importance of interviewing critical witnesses or documenting in the report any efforts to conduct the interview if their attempts were unsuccessful. The Supervising Special Investigator (SSI) will provide time/case management training to the Office of Special Investigations (OSI) personnel, to ensure OLES's oversight and investigative functions to receive full access to information. The investigator will coordinate interviews within a timely manner with witnesses (staff and/or patient) and OLES to ensure significant time does not lapse. Time management concepts will be discussed and taught at the next OSI internal training. Further, the SSI will monitor the investigator's caseload to ensure OLES monitored cases are tracked for progress at 30, 60, and 90 days to meet deadlines with the help of support staff. The SSI will ensure the investigator submits a case status report to the support staff on cases that have reached 90 days. This will include investigative activity to date; including what investigative steps have been taken, what interviews have been conducted, what interviews are outstanding and estimate completion date to ensure case is completed 120 days before. Further, the SSI shall ensure OLES monitors are updated, consulted, and notified throughout the pre-disciplinary and investigative process to ensure the monitor has an opportunity to provide recommendations. This will ensure the monitors are consulted to achieve a timely and collaborative</p>

	resolution.
--	-------------

Case Details	Description
Incident Date	08/24/2025
OLES Case Number	2025-01025-1C
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 once 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	08/28/2025
OLES Case Number	2025-01049-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty
Findings	1. Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A hospital academy cadet was allegedly dishonest to a law enforcement officer when asked about his out-of-

	date uniform patches.
Disposition	The hiring authority sustained the allegation; however, the cadet resigned during the investigation. A letter indicating the cadet resigned under unfavorable circumstances was placed in his official personnel file. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative phase.

Case Details	Description
Incident Date	09/03/2025
OLES Case Number	2025-01070-1C
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 allegedly choked 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	09/08/2025
OLES Case Number	2025-01091-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	After a floor containment procedure, a registered nurse allegedly hit a patient in the face and pulled the patient's hair. While being placed in five point restraints, a psychiatric technician allegedly pinched the patient's nose to inhibit normal breathing.
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	09/17/2025
OLES Case Number	2025-01131-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unknown female staff member allegedly hit a patient on the back of the head.

Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. 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	08/29/2025
OLES Case Number	2025-01145-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly raped a patient in the middle of the night.
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.
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	01/14/2021
OLES Case Number	2021-00138-1A
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. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
Incident Summary	A nurse allegedly failed to medically assess a patient's

	injury and was allegedly dishonest during the investigative interview.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 10 percent for 13 months was the appropriate penalty. OLES concurred. The nurse filed an appeal with the State Personnel Board. The State Personnel Board upheld the penalty. The nurse filed a writ in superior court appealing the State Personnel Board's decision. The superior court ruled in favor of the department, again upholding the penalty.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently 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 disciplinary action was not timely served.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The disciplinary action was not served on the nurse until 211 days after the hiring authority made disciplinary findings.
Department Corrective Action Plan	The Human Resources Department hired a new Employee Relations Officer in the month of June 2024. The department has taken proactive steps and has provided training beginning February 2025 for all current and new staff. The department provided training to all staff on 2/24/2025, reviewing DSH Policy Directive 6001 and 5332 (Oversight-Investigation Review Process and Timelines). Established plans of correction have been put into place, specifically, staff were notified of the investigation/disciplinary process and expectations of notifying monitors throughout the process were shared. The department will ensure this process is followed for all monitored cases to comply with DSH policies and ensure the monitor is able to attend Skelly hearings. The department will ensure to draft and serve the NOAA as soon as possible to comply with the requirements established in policy.

Case Details	Description
Incident Date	02/11/2023
OLES Case Number	2023-00229-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: Suspension
Incident Summary	A psychiatric technician allegedly repeatedly hit a patient in the face after the patient grabbed extra food during meal time.
Disposition	The hiring authority sustained the allegation and determined dismissal of the psychiatric technician was the appropriate penalty. OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the evidentiary hearing, the department entered into a settlement agreement with the psychiatric technician, reducing the penalty from a dismissal to a 90-day suspension. OLES concurred with the department's decision because it was a substantial penalty and there were evidentiary issues with establishing the psychiatric technician initiated the physical contact with the patient.
Investigative Assessment	Overall Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 405 days after the district attorney declined to file criminal charges against the psychiatric technician, and a key eye witness was not interviewed prior to drafting the investigative report.
Pre-Disciplinary Assessment	1. Was the investigation thorough and appropriately conducted? • No A key witness was not interviewed prior to the investigator completing the draft report. 2. Was the pre-disciplinary/investigative phase

	<p>conducted with due diligence? • No</p> <p>The investigation was not completed until 405 days after the district attorney declined to file criminal charges against the psychiatric technician.</p>
Disciplinary Assessment	<p>Overall Rating: Insufficient</p> <p>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.</p>
Disciplinary Assessment Questions	<p>1. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? • No</p> <p>The department did not notify the OLES monitor of the Skelly hearing.</p>
Department Corrective Action Plan	<p>The Department has initiated proactive corrective actions to strengthen investigative processes and supervisory oversight. Management has reaffirmed and reinforced investigative standards, emphasizing thorough fact-gathering, complete documentation, and strict adherence to established investigative requirements to ensure consistent application across the Department. In response to the identified delay following the District Attorney's declination and the omission of a key eyewitness interview prior to report finalization, the Department has reinforced requirements that administrative investigations proceed without unnecessary delay once criminal review has concluded and that all known material witnesses be interviewed and documented prior to drafting investigative findings. The Department has also taken steps to formalize regular monthly meetings with OLES to enhance consultation, ensure clarity of expectations, and maintain alignment with applicable oversight standards. Department management conducts weekly management reviews focused on investigative practices, training deficiencies,</p>

process performance, and corrective action tracking. The Department will also be meeting with Labor Relations upon receipt of investigative reports to review matters and coordinate the initiation of disposition meetings with OLES, as appropriate. Information derived from supervisory oversight and consultation, including OLES input, is actively applied to strengthen accountability, refine processes, and mitigate the risk of future deficiencies. OPS Headquarters will request documentation confirming the implementation of this plan.

Case Details	Description
Incident Date	01/29/2024
OLES Case Number	2024-00176-2A
Case Type	Monitored
Incident Types	1. Head/Neck Injury 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
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 hiring authority determined there was insufficient evidence to sustain the allegations against the first nurse and the psychiatric technician, but found sufficient evidence to sustain the allegation against the second

	nurse for failing to assess the patient, and imposed a salary reduction of 10 percent for six months. 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 318 days after the investigator was assigned to conduct the administrative investigation.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 318 days after the investigator was assigned to conduct the administrative investigation.
Disciplinary Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The Supervising Special Investigator will ensure investigators are being more proactive and are following up with Human Resources to check on subject availability for interviews. The department will ensure investigators are communicating with the monitors regularly to confirm the status of subject availability. The investigator will be reminded to provide regular updates to the Supervising Special Investigator on monitored cases. This will include investigative tasks such as scheduling and completion of pending interviews for subjects/witnesses. The Supervising Special Investigator will be expected to hold regular meetings with investigators to receive investigative status updates and will closely monitor case progress to ensure time completion of investigations.

Case Details	Description
Incident Date	03/05/2024
OLES Case Number	2024-00358-3A
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
Incident Summary	A psychiatric technician allegedly forced a patient to the floor after evading the patient's attempted attack.
Disposition	The hiring authority determined there was insufficient evidence the psychiatric technician abused the patient, but did find sufficient evidence to sustain the allegation the psychiatric technician had utilized improper restraint techniques, and imposed a salary reduction of 10 percent for 12 months as an appropriate penalty. 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	03/05/2024
OLES Case Number	2024-00395-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inefficiency 2. Other failure of good behavior 3. Insubordination 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty

Findings	<ol style="list-style-type: none"> 1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained
Penalty	<p>Initial: Salary Reduction</p> <p>Final: Salary Reduction</p>
Incident Summary	A psychiatric technician assigned to an enhanced observation of a patient left the patient unsupervised sitting in the dayroom, entered an inaccurate entry when leaving the unit, and made false statements to the Office of Special Investigations during his interview.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 5 percent for seven months was the appropriate penalty. OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a salary reduction of 5 percent for five months. The psychiatric technician agreed to withdraw his appeal. OLES agreed with the terms of the settlement.
Investigative Assessment	<p>Overall Rating: Sufficient</p> <p>The department complied with policies and procedures governing the investigative process.</p>
Disciplinary Assessment	<p>Overall Rating: Sufficient</p> <p>The department sufficiently complied with policies and procedures governing the disciplinary process.</p>

Case Details	Description
Incident Date	04/22/2024
OLES Case Number	2024-00641-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Inexcusable neglect of duty

Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Salary Reduction Final: Modified Salary Reduction
Incident Summary	A nurse allegedly fell asleep while assigned to continuously monitor a patient, who allegedly committed self-harm due to nurse's lack of attention.
Disposition	The hiring authority determined there was insufficient evidence to sustain the abuse allegation against the nurse, but found sufficient evidence the nurse was less than alert and imposed a salary reduction of 10% for three months. OLES concurred. The nurse 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 psychiatric technician wherein the penalty was reduced to a salary reduction of 10 percent for two months in exchange for the withdrawing her appeal. 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: Insufficient The department failed to comply with policies and procedures governing the disciplinary process. The department did not provide OLES with a draft of pre-hearing settlement conference statement prior to it being filed with the SPB.
Disciplinary Assessment Questions	1. Was OLES provided with a draft of the pre-hearing settlement conference statement prior to it being filed? • No The department did not provide OLES with a draft of pre-hearing settlement conference statement prior to it being filed with the SPB. 2. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase,

	<p>until all proceedings were completed, except for those related to a writ? • No</p> <p>The department did not provide OLES with a draft of pre-hearing settlement conference statement prior to it being filed with the SPB.</p>
Department Corrective Action Plan	<p>In this case there was a typographical error on the OLES monitor's email address when this document was provided and the monitor did not receive it. The department has provided internal training to department attorneys on when OLES is to be provided with a copy of the pre-hearing settlement conference statement. Additionally, OLES monitored cases are flagged and department attorneys are tracking timelines. Department attorneys are proactively confirming whether the OLES monitor would like a copy of the prehearing settlement conference statement prior to filing.</p>

Case Details	Description
Incident Date	05/18/2024
OLES Case Number	2024-00796-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Not Sustained 3. Sustained 4. Not Sustained 5. Sustained 6. Sustained 7. Sustained

Penalty	Initial: Salary Reduction Final: Modified Salary Reduction
Incident Summary	A psychiatric technician assigned to an enhanced observation allegedly fell asleep and left a patient unattended. A second psychiatric technician, a pre-licensed psychiatric technician, a third psychiatric technician, an acting unit supervisor, and a custodian supervisor I all failed to report the first psychiatric technician for leaving the enhanced monitored patient unattended. Further, a custodian allegedly called a psychiatric technician a profane name and then was allegedly dishonest about having done it. A second custodian was also allegedly dishonest about the first custodian's use of profanity.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the first psychiatric technician for leaving the patient on enhanced monitoring unattended, however found insufficient evidence the first psychiatric technician slept during the monitoring. The hiring authority imposed a penalty of 10 percent salary reduction for 24 months. OLES concurred with the hiring authority's determinations. After a Skelly hearing, the hiring authority entered into a settlement agreement with the first psychiatric technician wherein the penalty was reduced to a 10 percent salary reduction for 12 months. OLES concurred with the settlement because it achieved a deterrent effect and secured finality of the matter. The hiring authority sustained the allegations of failing to report the alleged patient neglect by the first psychiatric technician against the second psychiatric technician and the acting unit supervisor. The hiring authority issued letters of warning to both staff. The hiring authority determined there was insufficient evidence to sustain the failure to report the neglect by the first psychiatric technician against the pre-licensed psychiatric technician and custodian supervisor I. The hiring authority sustained the allegations against the first custodian for using profanity toward a co-worker and being dishonest about it and issued a letter of warning. The hiring authority found sufficient evidence to sustain the allegations against the second custodian for dishonesty and issued a letter of expectation. 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.
Disciplinary Assessment	Overall Rating: Insufficient The department failed to comply with policies and procedures governing the disciplinary process. Although a Skelly hearing was held, OLES was not notified of the hearing. Also, the discipline process took 124 days from disposition meeting to service of the adverse action on the first psychiatric technician.
Disciplinary Assessment Questions	1. If there was a Skelly hearing, was it conducted properly? • No The department did not notify OLES of the scheduling of the Skelly hearing, thereby preventing the monitor from attending the hearing. 2. Was the disciplinary phase conducted with due diligence by the department? • No The disposition meeting was completed January 24, 2025. However, the NOAA was not drafted and served until May 28, 2024; 124 days later.
Department Corrective Action Plan	The department provided training to all staff on 2/24/2025, reviewing DSH Policy Directive 6001 and 5332 (Oversight-Investigation Review Process and Timelines). Established plans of correction have been put into place, specifically, staff were notified of the investigation/disciplinary process and expectations of notifying monitors throughout the process shared. The department will ensure this process is followed for all monitored cases to comply with DSH policies and ensure the monitor is able to attend Skelly hearings. The department will ensure to draft and serve the NOAA as soon as possible to comply with the requirements established in policy.

Case Details	Description
Incident Date	01/01/2024
OLES Case Number	2024-01176-1A
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
Findings	1. Not Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: Dismissal
Incident Summary	A psychiatric technician allegedly kissed a patient on the cheek and asked to see private body parts in exchange for doughnuts. The psychiatric technician allegedly failed to properly document this incident. The psychiatric technician allegedly provided false statements during an investigative interview. The psychiatric technician allegedly violated HIPPA by recording patient information and keeping this information in a personal file. The psychiatric technician also allegedly engaged in unprofessional and threatening behavior with fellow staff members.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation of sexual abuse. However, the hiring authority sustained the remainder of the allegations and determined dismissal was the appropriate penalty. OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board upheld the dismissal of the psychiatric technician.
Investigative Assessment	Overall Rating: Sufficient The department 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. Although a Skelly hearing and a pre-hearing settlement conference were held, OLES was not notified of either

	proceeding nor was OLES provided with a draft of the pre-hearing settlement conference statement.
Disciplinary Assessment Questions	<p>1. Was OLES provided with a draft of the pre-hearing settlement conference statement prior to it being filed? • No OLES was not provided a draft of the pre-hearing settlement conference statement.</p> <p>2. 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 department did not notify OLES of the scheduling of the prehearing settlement conference thereby preventing the monitor from attending the settlement conference.</p> <p>3. 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 department did not notify OLES of the scheduling of the Skelly hearing thereby preventing the monitor from attending the hearing.</p>
Department Corrective Action Plan	The department provided training to all staff on 2/24/2025, reviewing DSH Policy Directive 6001 and 5332 (Oversight-Investigation Review Process and Timelines). Established plans of correction have been put into place, specifically, staff were notified of the investigation/disciplinary process and expectations of notifying monitors throughout the process shared. The department will ensure this process is followed for all monitored cases to comply with DSH policies and ensure the monitor is able to attend Skelly hearings.

Case Details	Description
Incident Date	03/21/2025
OLES Case Number	2025-00361-2A

Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Reprimand Final: Letter of Reprimand
Incident Summary	Several officers allegedly consumed alcoholic beverages while on the grounds of the Office of Protective Services Academy.
Disposition	The hiring authority sustained the allegations and issued letters of reprimand. OLES concurred with the hiring authority's determinations. The officers 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

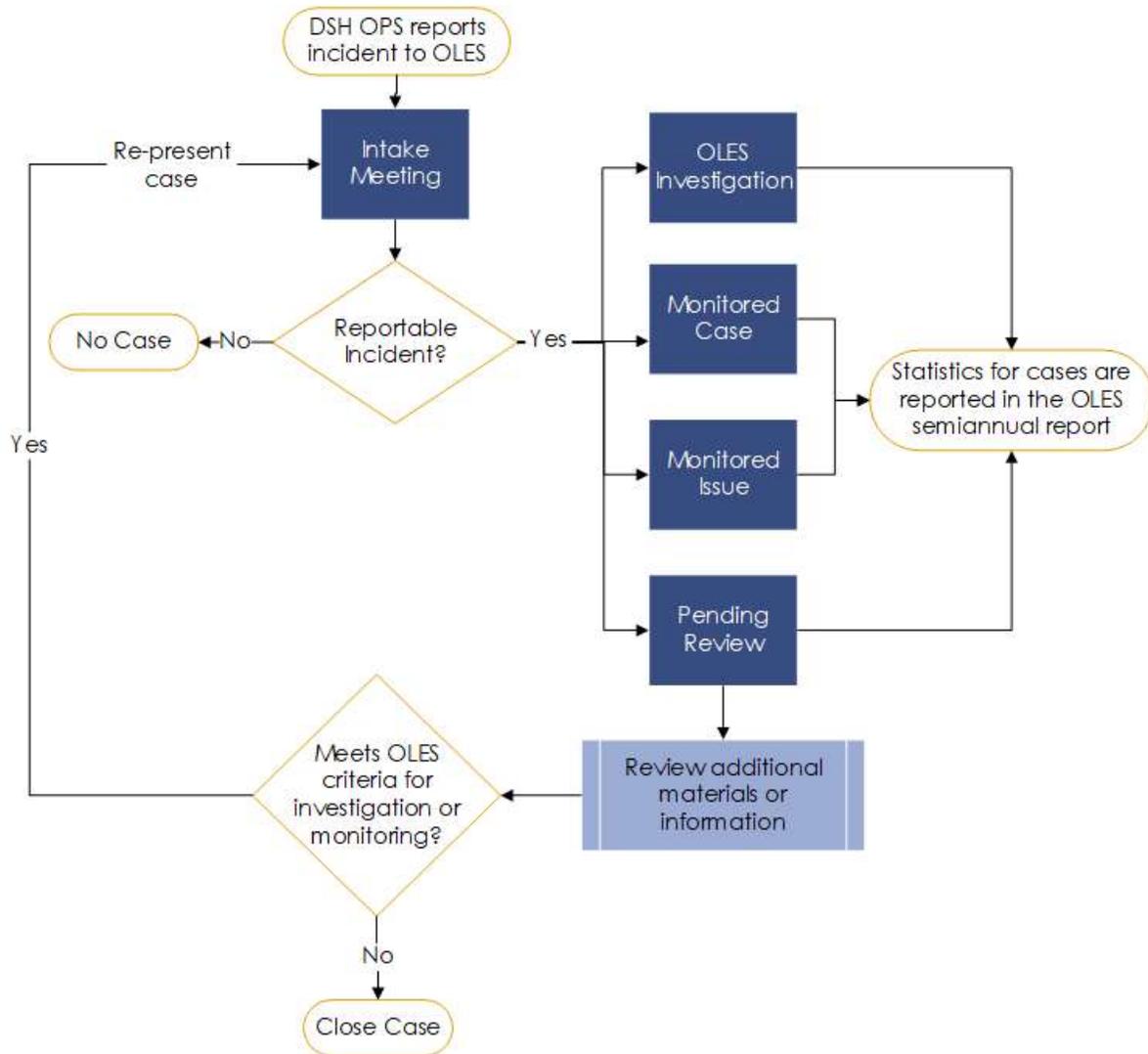
- (a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of section 4900 the following incidents involving a resident of a state mental hospital:
 - (1) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
 - (2) Any allegation 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,⁵ throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

1. Department notifies OLES of an incident that meets OLES reporting criteria.
2. OLES reviews the incident and makes a case determination.
3. If the case is monitored by OLES, the OLES AIM meets with the OPS administrative investigator and identifies critical junctures.
4. DSH law enforcement completes investigation and submits final report.

Critical Junctures

- Site visit
- Initial case conference
 - Develop investigation plan
 - Determine statute of limitations
- Critical witness interviews
- Draft investigation report

It is recommended that within 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority must consult with the AIM attorney on the discipline decision, including 1) the allegations for which the employee should be exonerated, the allegations for which the evidence is insufficient and the allegations should not be sustained, or the allegations

⁵ The best practice is to have an employment law attorney from the department involved from the outset to guide investigators, assist with interviews and gathering of evidence, and to give advice and counsel to the facility management (also known as the hiring authority) where the employee who is the subject of the incident works.

that should be sustained; and 2) the appropriate discipline for sustained allegations, if any. If the AIM believes the hiring authority's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.

45 Days

1. The AIM attends the disposition conference, discusses and analyzes the case with the appropriate department representative.
2. Additional investigation may be required.
3. The AIM meets with executive director at the facility to finalize disciplinary determinations.
4. The process for resolving disagreements may be enacted.

Once a final determination is reached regarding the appropriate allegations and discipline in a case, it is recommended that a Notice of Adverse Action (NOAA) be finalized and served upon the employee within 60 days.

60 Days

1. The department's human resources unit completes the NOAA and provides it to AIM for review.
2. The approved NOAA is provided to the executive director for service to the employee.

State employees subject to discipline have a due process right to have the matter reviewed in a *Skelly* hearing by an uninvolved supervisor who, in turn, makes a recommendation to the hiring authority, that is, whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee.⁶ It is recommended that the *Skelly* due process meeting be completed within 30 days.

30 Days

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

State employees who receive discipline have a right to challenge the decision by filing an appeal with the State Personnel Board (SPB), which is an independent state agency. OLES continues monitoring through this appeal process. During an appeal, a case can be concluded by settlement (a mutual agreement between the department(s) and the employee), a unilateral action by one party withdrawing the appeal or disciplinary action, or an SPB decision after a contested hearing. In cases where the SPB decision is subsequently appealed to a Superior Court, OLES continues to monitor the case until final resolution.

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

Conclusion

1. The department attorney notifies AIM of any SPB hearing dates. The AIM monitors all hearings.
2. The department attorney or hiring authority 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.