



Office of Law Enforcement Support

Semiannual Report

January 1, 2026 – June 30, 2026

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.

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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 January 1 through June 30, 2026.

In this report, OLES provides details on 628 reported incidents and the results of completed investigations and monitored cases.

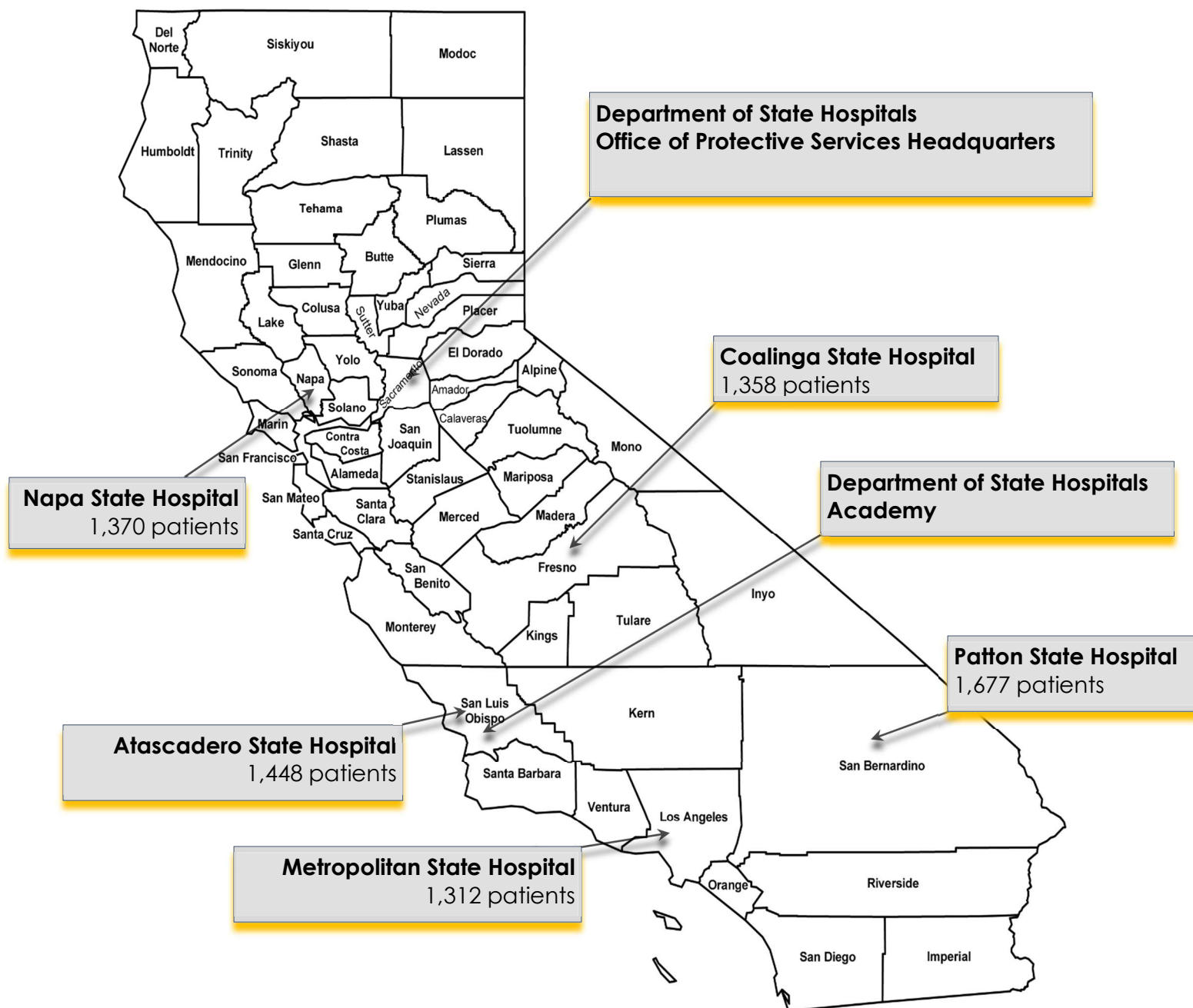
OLES provides updates on previous monitored issues regarding the use of the department's early intervention system, use of force reporting and documentation, and ongoing deficiencies in mandated reporting as required by Welfare and Institutions Code section 15630, et.al.

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 January 1 through June 30, 2026, and were provided by the department.



Total Patients Served by Facility January 1 through June 30, 2026

DSH Facility	Total Number of Patients
Atascadero	1,448
Coalinga	1,358
Metropolitan	1,312
Napa	1,370
Patton	1,677
Total	7,165

The total number of patients served by DSH from January 1 through June 30, 2026, decreased 0.803 percent, from 7,223 during the prior reporting period to 7,165 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.

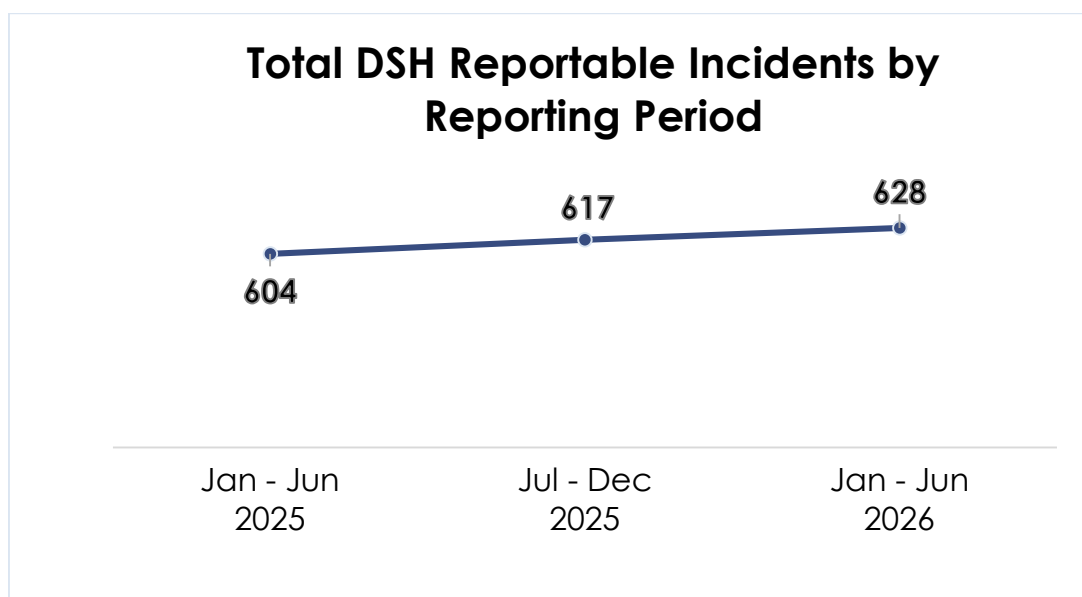
The following table provides the commitment type of patients served during the reporting period.

Commitment Type	Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST	414	0	970	690	779
PC 1026 NGI	296	<11	***	445	456
PC 2962/2964a OMD	391	0	0	<11	***
PC 2972 OMD	***	286	<11	***	178
WIC 6316 MDSO	0	<11	0	<11	<11
PC 2684 CDCR	221	***	0	0	***
WIC 6602/6604 SVP	0	972	0	0	0
WIC 5358 LPS	***	<11	285	***	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 January 1, through June 30, 2026, the Office of Law Enforcement Support (OLES) received and processed 628 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 11 incident reports compared to the prior reporting period which had 617 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior two reporting periods.

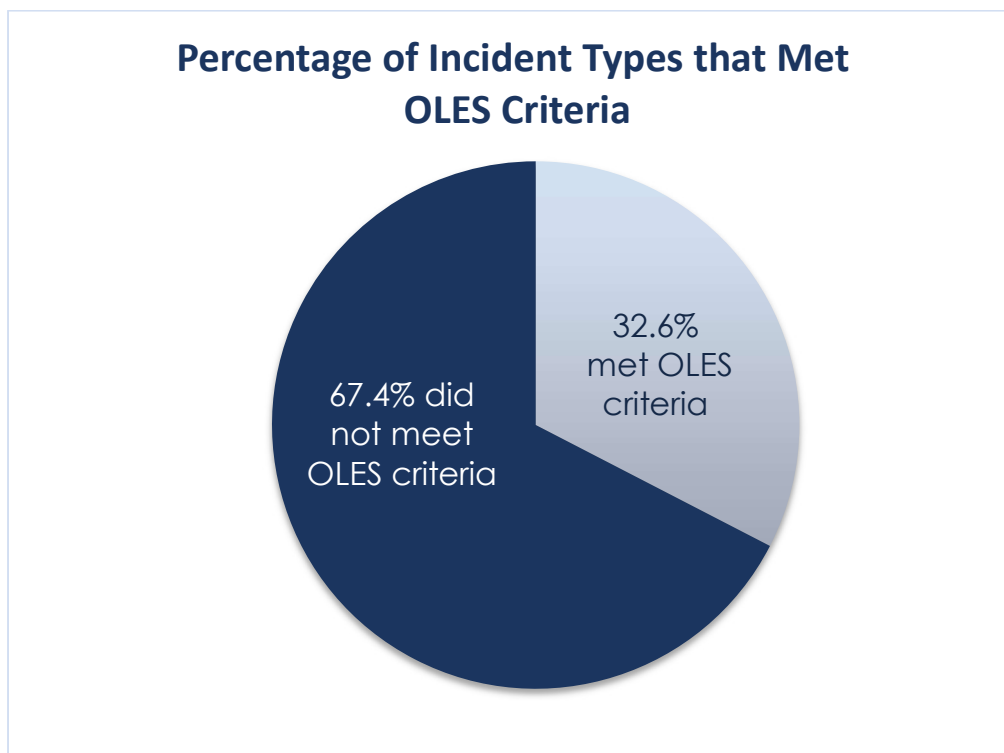


Numbers are unadjusted and are provided as they were previously published.

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 628 reported incidents, OLES identified 34 incidents with two or more incident types. The DSH reported a total of 671 incident types during this reporting period. Two hundred and nineteen, or 32.6 percent of the 672 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 sexual assault, use of force by law enforcement, and abuse.

Allegations of sexual assault were the most reported incident type, with 111 allegations reported, compared to 81 in the prior reporting period. Allegations of abuse accounted for 16.54 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 94 reports of use of force, which accounted for 14.01 percent of all reported incident types by DSH. Five of the 94 use of force reports included an allegation of excessive force, which is included in the Abuse total and was 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 abuse were the third most reported incident type, with 91 incidents reported, compared to 113 in the prior reporting period.

Patient Deaths

The number of patient deaths increased 34.4 percent, from 32 deaths to 43 deaths during this reporting period. One of the reported death incident types met OLES criteria for monitoring. Twenty-eight of the 43 patient deaths were expected due to existing medical conditions. Fifteen 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 Napa State Hospital (NSH) with 16 deaths and Patton State Hospital (PSH) with 9 deaths.

Patient Arrests

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

Statute	Description
Penal Code Section 69	Resisting executive officer with force or violence
Penal Code Section 148	Resisting
Penal Code Section 166(a)	Disobedience of a court order
Penal Code Section 242/243(a)	Simple battery
Penal Code Section 243(b)	Battery on a peace officer
Penal Code Section 243(d)	Battery with force likely to cause great bodily injury (GBI)
Penal Code Section 243(e)	Domestic battery
Penal Code Section 245(a)	Assault by means of force likely to cause GBI
Penal Code Section 422	Criminal threats
Penal Code Section 4501.5	Battery by a prisoner
Penal Code Section 12022.7	Causing GBI or substantial injury during the commission of a felony

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 11 administrative investigations that OLES completed during this reporting period. As of June 30, 2026, there were approximately 805 DSH sworn staff.

OLES submitted all of the 11 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process in every case. Administrative investigations are initiated in response to alleged policy violations such as excessive force, dishonesty, discourteous treatment, failure to report misconduct or sleeping on duty. OLES did not complete any criminal investigations during this SAR period.

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 65 monitored administrative cases and 72 monitored criminal cases that, by June 30, 2026, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These monitored cases included allegations against psychiatric technicians, psychiatric technician assistants, officers, registered nurses, unit supervisors and several other types of staff members.

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

OLES monitored 137 pre-disciplinary phase cases; 125 of the pre-disciplinary phase cases are listed in Appendix B and 12 are listed in Appendix C. OLES rated 28 of the 137 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 12 administrative cases listed in Appendix C. Four of the 12 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.

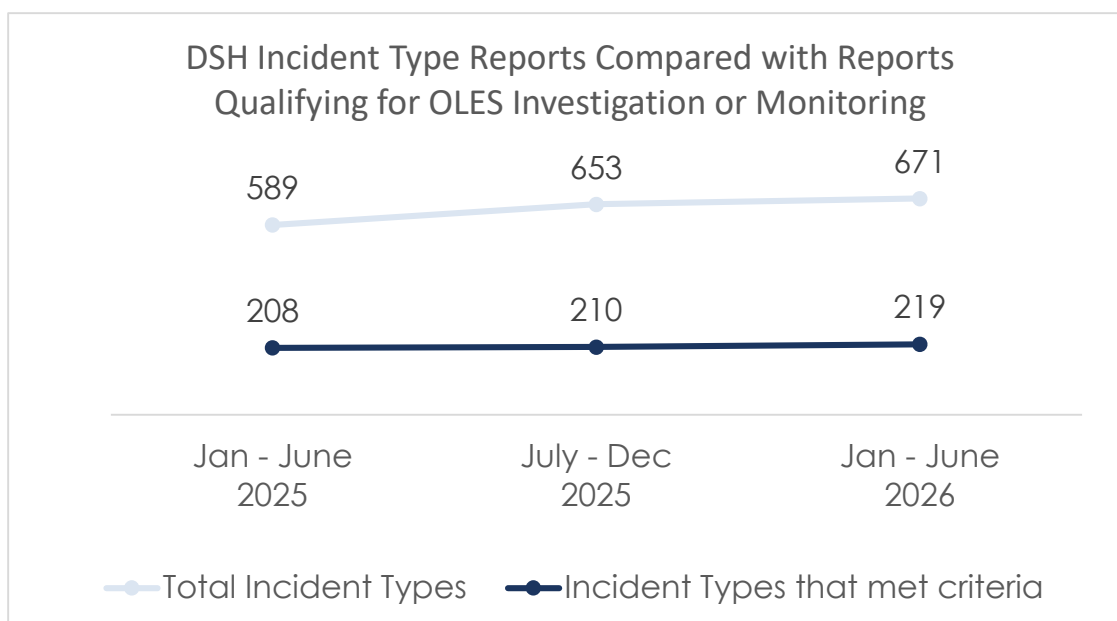
³ Welfare and Institutions Code sections 4023, 4023.6, and 4427.5. (See Appendix D).

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 January 1 through June 30, 2026, increased 1.78 percent, from 617 during the prior reporting period to 628 in this reporting period. From the 628 reported incidents, OLES identified 671 incident types, as 34 of the incidents featured two or more incident types. Two hundred nineteen of the 671 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic issue.



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

Most Frequent Incident Types Reported

The most frequent incident types reported were allegations of sexual assault, use of force by law enforcement, abuse, then broken bone (unknown origin). These four incident type categories accounted for 346 or 51.56 percent of all incident types reported by DSH. Of the 346 incident types, 149 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was allegations of sexual assault with 111 incidents reported. Allegations of sexual assault accounted for 16.54 percent of all incident types reported. Of the 111 sexual assault allegations reported in this period, 57 allegations or 51.35 percent qualified for investigation or monitoring.

The DSH's second most frequent report to OLES was use of force by law enforcement. The 94 reports of use of force accounted for 14.01 percent of the reported incident types, an increase of 9.30 percent from the last period's 86 reports.

The DSH's third most frequent report to OLES was allegations of abuse with 91 reports. The number of abuse allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period was 89. The 91 reports of abuse accounted for 13.56 percent of the reported incident types.

Allegations of broken bones of unknown origin were the fourth most frequently reported incident type by DSH, with 50 incidents reported. The 50 reports of broken bones of unknown origin accounted for 7.45 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 January 1 through June 30, 2026

Incident Type Category	Prior Period Incident Type Total July 1 through December 31, 2025	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Sexual Assault ¹	81	111	+37.04%	57
OPS Use of Force ²	86	94	+9.30%	0
Abuse	113	91	-19.47%	89
Broken Bone (Unknown Origin)	64	50	-21.87%	3

¹ These statistics do not include sexual assaults alleged to have occurred to patients before they were admitted to a state hospital.

² Five use of force reports included allegations of excessive force by law enforcement and are also included in the total count for the abuse incident type category.

Incident Types by Reporting Period

The following table compares the total count of reported incident types during this reporting period to the total count from the two prior reporting periods. Numbers in these columns are unadjusted and provided as they were previously published.

Incident Categories	Prior Period January 1 - June 30, 2025 (Reported)	Prior Period January 1 - June 30, 2025 (Meets Criteria)	Prior Period July 1 - December 31, 2025 (Reported)	Prior Period July 1 - December 31, 2025 (Meets Criteria)	Current Period January 1 - June 30, 2026 (Reported)	Current Period January 1 - June 30, 2026 (Meets Criteria)
Abuse	98	95	113	110	91	89
AWOL	1	0	5	0	4	0
Broken Bone (Known Origin)	27	0	28	0	41	2
Broken Bone (Unknown Origin)	71	6	64	5	50	3
Burn	5	0	7	0	7	0
Child Sexual Abuse Material	1	0	5	0	2	0
Contraband (CCR Title 9 section 4350) 1	2	0	1	0	1	0
Contraband Phones 1	6	0	15	0	12	2
Death	33	3	32	4	43	1
Drugs 2	35	1	65	1	46	1
Genital Injury (Known Origin)	10	0	20	3	11	0
Genital Injury (Unknown Origin)	10	5	9	3	6	1
Head/Neck Injury	51	0	44	1	43	0
Misconduct 3	24	24	20	20	32	31
Neglect	17	13	11	9	26	17
Non-patient assault/GBI on Patient	0	0	1	1	0	0

Incident Categories	Prior Period January 1 - June 30, 2025 (Reported)	Prior Period January 1 - June 30, 2025 (Meets Criteria)	Prior Period July 1 - December 31, 2025 (Reported)	Prior Period July 1 - December 31, 2025 (Meets Criteria)	Current Period January 1 - June 30, 2026 (Reported)	Current Period January 1 - June 30, 2026 (Meets Criteria)
OPS Use of Force ⁴	82	0	86	1	94	0
Over-Familiarity	14	14	14	11	14	13
Patient Arrest	9	0	7	0	10	0
Patient-on-Patient Assault/GBI	5	1	23	0	20	1
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Sexual Assault	83	45	81	41	111	57
Significant Interest ⁵	2	0	0	0	7	1
Suicide (Attempted)	3	1	2	0	0	0
Total	589	208	653	210	671	219

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 All 94 use of force incidents were assigned a pending review. One of the 94 incidents of use of force included allegations of excessive force and was assigned an investigation. This incident is included in the allegations of abuse meeting criteria.

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

Distribution of Incident Types

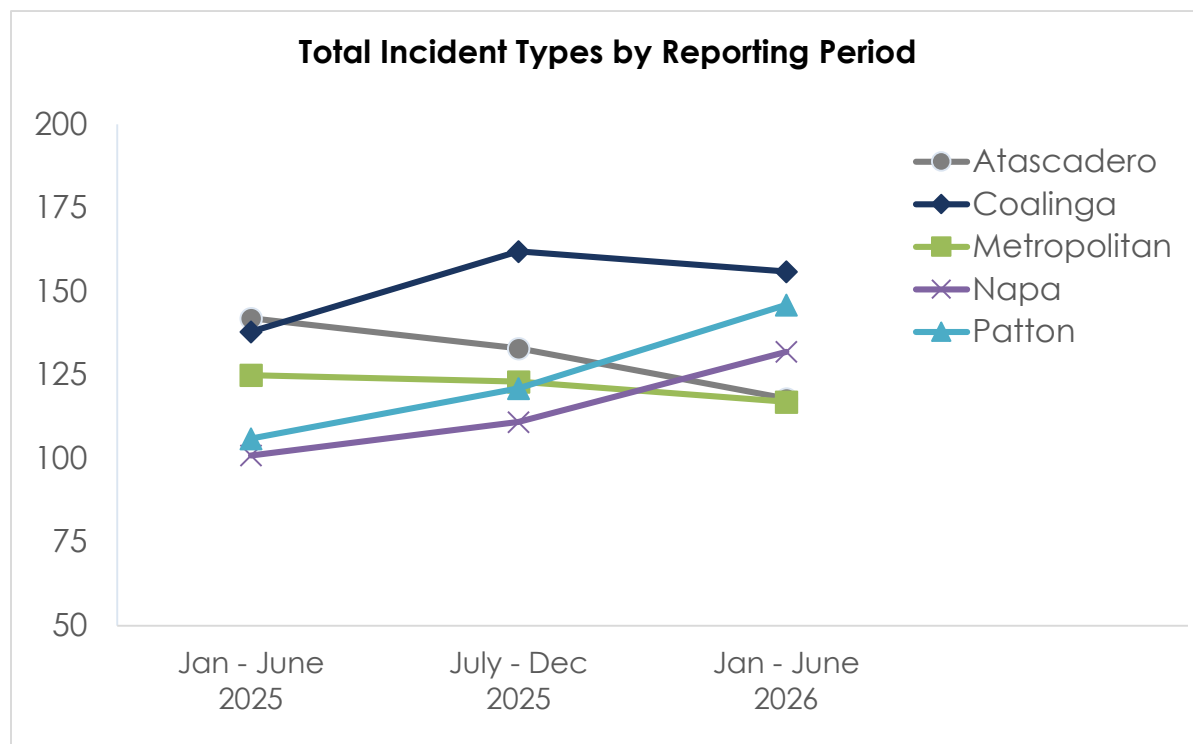
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

DSH Population and Total Incident Types

DSH Facility	Number of Patients Served	Total Incident Types
Atascadero	1,448	118
Coalinga	1,358	156
Metropolitan	1,312	117
Napa	1,370	132
OPS Academy	0	2
Patton	1,677	146
Total	7,165	671

The department provided population served from January 1 through June 30, 2026.

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 most frequently reported incident type from January 1 through June 30, 2026. The 111 alleged sexual assault incident types reported in this reporting period accounted for 16.54 percent of all reported incident types from DSH. Fifty-seven of the 111 reported incident types of alleged sexual assault, or 51.35 percent, met OLES criteria for investigation or monitoring.

Of the five DSH facilities, NSH (45), PSH (21) and CSH (17) 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 49 incident types or 41.14 percent of the 111 alleged sexual assault incident types. Patients assaulting another patient was the most frequently reported, with a total of 47 incident types, or 42.34 percent of the alleged 111 sexual assault incident types. There were fourteen allegations of sexual assault involving an unknown assailant on a patient.

Sexual Assault Allegations Reported January 1 through June 30, 2026

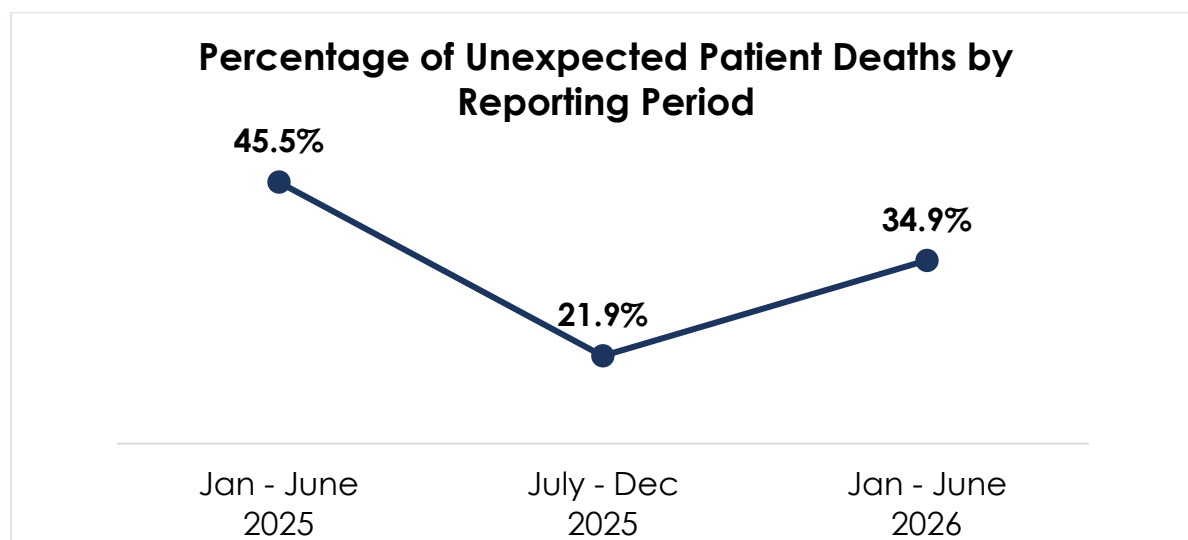
Allegation Type	Total
Non-Law Enforcement Staff-on-Patient	49
Patient-on-Patient	47
Law Enforcement Staff-on-Patient	1
Unknown Person-on-Patient	14
Total	111

Patient Deaths

The DSH reported 43 patient deaths to OLES during this reporting period. This number increased 34.38 percent from the 32 patient deaths reported in the prior reporting period of July 1 through December 31, 2025.

Twenty-eight of the patient deaths were classified as expected primarily due to underlying health conditions, such as cardiac or respiratory issues and cancer. Fifteen deaths were classified as unexpected. Each unexpected patient death receives two levels of review within DSH, per department policy. OLES monitored one 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	7
Cardiac/Respiratory	33
Sepsis	1
Pending Toxicology Results	1
Unknown (Former Patient)	1
Total	43

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

Patient Deaths by Facility

DSH Facility	Total Number of Deaths
Atascadero	2
Coalinga	7
Metropolitan	9
Napa	16
Patton	9
Total	43

Reports of Head or Neck Injuries

The DSH reported 43 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 12 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 four 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

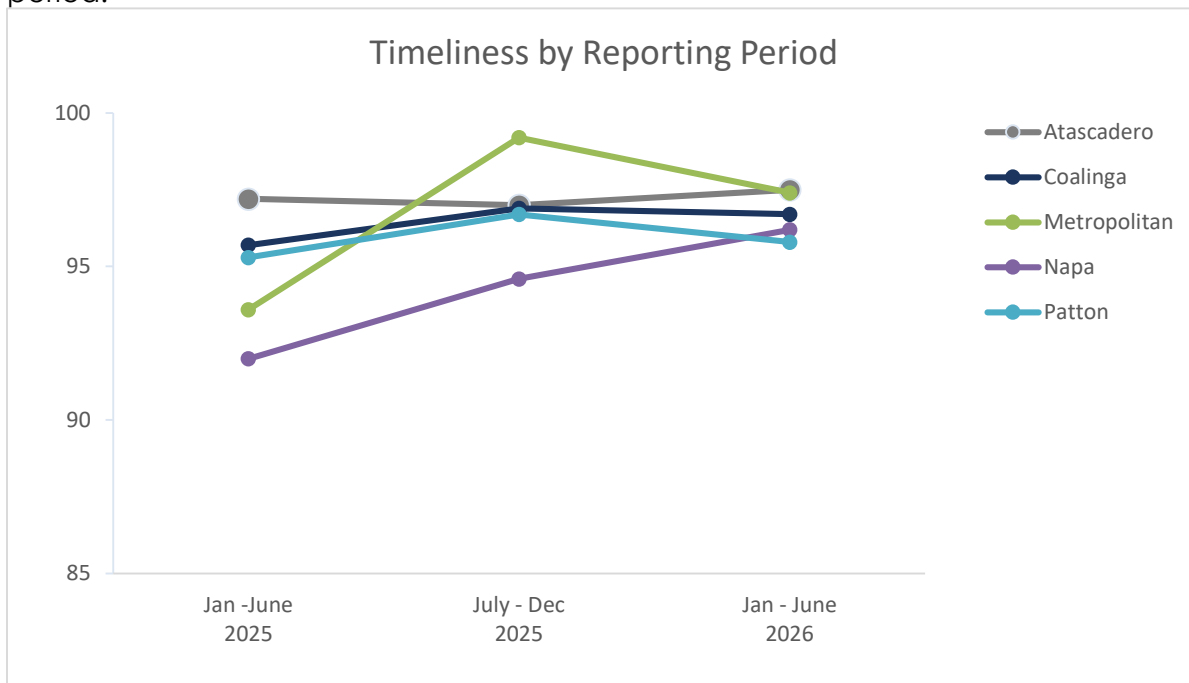
The DSH timely reported incident types 96.7 percent compared to the prior reporting period, which had 96.9 percent timely reports.

Of the 665 incident types evaluated for timeliness, 643 were reported timely and 22 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	118	115	3	97.5%
Coalinga	153	148	5	96.7%
Metropolitan	116	113	3	97.4%
Napa	132	127	5	96.2%
OPS Academy	2	2	0	100%
Patton	144	138	6	95.8%
Total	665	643	22	96.7%

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 January 1 through June 30, 2026, reporting period, 427 of the total 633 cases opened for DSH incident types that occurred within DSH's jurisdiction or 67.5 percent were assigned a pending review. OLES opened 32 administrative investigations and 3 criminal investigations. OLES opened 124 monitored criminal cases and 47 monitored administrative cases.

The following table provides the case assignments for incidents received by OLES during the reporting period.

Incident Types Opened in the Current Reporting Period

OLES Case Assignments	January 1 – June 30, 2026	Percentage of Opened Cases
Pending Review	427	67.5%
Monitored, Criminal	124	19.6%
Monitored, Administrative	47	7.4%
OLES Investigations, Criminal	3	0.5%
OLES Investigations, Administrative	32	5.1%
Totals	633	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 11 investigations. All of the investigations were administrative. There were no criminal investigations completed during this SAR period.

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 11 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 January 1 - June 30, 2026	Referred to Prosecuting agency	Referred to facility management
Administrative	11	N/A	11
Criminal	0	0	N/A
Total	11	0	11

OLES Monitored Cases

In this report OLES provides information on 137 completed monitored cases. Seventy-two of the 137 cases were criminal cases, four of the 72 cases were referred to a district attorney's office.

There were 65 completed monitored pre-disciplinary administrative cases during this reporting period. Twenty-four of the 65 cases had sustained allegations; 41 cases did not have sustained allegations. Results of OLES monitored cases are provided in the table below.

Type of Case/Result	DSH
Criminal-Referred to Prosecuting Agency	4
Criminal-Not Referred	68
Total Criminal	72
Administrative-With Sustained Allegations	24
Administrative-Without Sustained Allegations	41
Total Administrative	65
Grand Total	137

Pre-Disciplinary Phase Cases

Of the 137 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 28 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 24 administrative cases. Four 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 June 30, 2026.

DSH Facility	Percentage of Compliance
Atascadero	97%
Coalinga	96.3%
Metropolitan	97%
Napa	84%
Patton	98.8%

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	44	4	28	10	2
Coalinga	39	0	21	18	0
Metropolitan	38	0	28	3	1
Napa	10	5	0	5	0
Patton	69	24	30	15	0
Total	200	33	107	51	3

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	37	0	37	0
Coalinga	21	0	21	0
Metropolitan	67	2	65	0
Napa	20	0	20	0
Patton	2	2	0	1
Total	147	4	143	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	4	0
Coalinga	0	0	0	0
Metropolitan	0	0	1	0
Napa	0	0	0	0
Patton	0	0	2	0
Total	0	0	7	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	406	37	369	78
Coalinga	336	69	267	35
Metropolitan	97	7	90	7
Napa	33	3	30	0
Patton	275	131	144	89
Total	1147	247	900	209

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 ongoing monitored issues are provided below.

Underutilization of Blue Team/IAPro

In 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.

In September 2026, DSH reported that the training provided for the supervisors on Blue Team entries was successful. There were no hospital police officers over the threshold for use of force incidents for January through March of 2026. A threshold is a pre-designated level that when reached will trigger an intervention advisory. One of the reasons for a zero threshold is the routine checks are being made by supervisors on assigned officers and entries are cleared as required after review.

The IAPro HR integration was put in place on May 6, 2026. This has implemented an automated process to maintain employee information within the IAPro database. The system will automatically:

- Add new employees
- Remove employees who are no longer with the department
- Update employee changes such as promotions or demotions

This automation will improve the accuracy of our reporting, enhance IAPro functionality, and ensure our records are up to date on a continuous ongoing basis. Is also important for security reasons to ensure only those who should have access to Blue Team have access.

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

In 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. A use of force report documents an operational incident and does not necessarily indicate misconduct or excessive force by an officer. DSH acknowledged there were opportunities for improvement in its use of force 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. In July 2024, DSH completed a policy update and produced a training video. By 2025, all OPS staff had received the training.

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 use of force 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 returned them to DSH with suggestions and recommendations for consideration. In August of 2026, DSH finalized and implemented the new forms as part of its use of force policy. 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 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 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 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. However, continued efforts to ensure thorough knowledge of reporting requirements are needed.

In the last reporting period of July 1, 2025, through December 31, 2025, OLES identified four incidents that were not timely reported by Other Mandated Reporters to OPS. During the current reporting period of January 1, 2026, through June 30, 2026, this number increased to ten incidents of delayed reporting by Other Mandated Reporters. The ten incidents are listed below:

Incident Type	Estimated Delayed Reporting to OPS
Physical Abuse	3 days and 21.5 hours
Sexual Assault	3 days and 7 hours
Physical Abuse	2 hours and 45 minutes
Genital Injury (unknown origin)	4 hours and 20 minutes
Physical Abuse	3 hours and 25 minutes
Sexual Assault	14 hours
Sexual Assault	13 hours and 10 minutes
Broken Bone	4 hours and 45 minutes
Broken Bone	17 hours and 30 minutes
Broken Bone	23 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.

In response to OLES' recommendations, DSH drafted a new Policy Directive for Mandated Reporting. OPS and SQL have worked collaboratively to incorporate all of the various reporting requirements, including reporting to outside law enforcement. The policy has not yet been implemented. OLES will continue to work with the department and monitor the department's progress on this issue.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2026. 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	10/25/2024
OLES Case Number	2024-01483-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An off-duty law enforcement officer was arrested for allegedly driving under the influence causing injury and fleeing the scene of an automobile accident.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	05/12/2025
OLES Case Number	2025-00600-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	Two law enforcement officers assigned to monitor a patient at an outside hospital allegedly left the patient unattended and were instead located in the hospital parking lot.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/17/2025
OLES Case Number	2025-00859-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A cadet allegedly sexually harassed another cadet.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	08/06/2025
OLES Case Number	2025-00955-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A supervisor allegedly used homemade wine to drug or poison a female he met on a dating app.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	10/08/2025
OLES Case Number	2025-01264-2A
Case Type	Investigative
Incident Types	1. Over-Familiarity 2. Over-Familiarity 3. Over-Familiarity
Incident Summary	A state hospital employee allegedly made multiple purchases for a patient and engaged in phone calls with him.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
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Incident Date	10/20/2025
OLES Case Number	2025-01276-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement cadet was driving a state vehicle and allegedly caused a vehicle accident due to driving at an unsafe speed.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	08/25/2025
OLES Case Number	2025-01283-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An academy cadet allegedly did not possess the proper law enforcement certification and was also allegedly dishonest in two separate interviews during the course of the investigation.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	10/24/2025
OLES Case Number	2025-01334-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement supervisor allegedly threatened to give a level of care staff member a ticket for parking in the electric vehicle charging spot the law enforcement supervisor was going to park in.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	10/26/2025
OLES Case Number	2025-01348-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	It is alleged a hospital police cadet operated a state vehicle while intoxicated.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	10/30/2025
OLES Case Number	2025-01349-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An academy cadet allegedly threatened another cadet.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/19/2025
OLES Case Number	2025-01550-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A supervisor allegedly gave conflicting orders to an officer by allowing the officer to return to work early after the officer had been told he could not return early by another supervisor.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Appendix B: Pre-Disciplinary Cases Monitored by OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2026, 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	04/03/2020
OLEs Case Number	2020-00335-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A licensed clinical social worker allegedly engaged in sexual contact with numerous female patients over a period of years.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The social worker was convicted of Sex with an Inmate, a felony, in violation of PC 289.6. He was sentenced to three years in state prison.
Investigative	Overall Rating: Sufficient

Assessment	The department sufficiently complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	04/05/2024
OLES Case Number	2024-00544-1C
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. Referred 3. Not Referred
Incident Summary	A senior psychiatric technician, and two psychiatric technicians allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	05/12/2024
OLES Case Number	2024-00722-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained

Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	A law enforcement officer allegedly engaged in an act of off-duty domestic violence.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/26/2024
OLES Case Number	2024-00950-2A
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 officer allegedly text messaged another law enforcement officer that they were about to fight a patient as staff was preparing to administer involuntary medication.
Disposition	The hiring authority found insufficient evidence to sustain the allegations; however, facility wide training was provided regarding proper usage of personal cell phones in the secure treatment area. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/04/2024

OLES Case Number	2024-01307-2A
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
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	When a patient refused to submit to a mouth check for medication and began to walk away, a psychiatric technician allegedly grabbed the patient's shirt and hand, then attempted a wall containment. The patient sustained a broken left pinky finger.
Disposition	The hiring authority sustained the allegations and determined a letter of instruction and training were the appropriate penalty. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/31/2024
OLES Case Number	2024-01376-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty

Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	One licensed vocational nurse, two psychiatric technicians and law enforcement staff allegedly forced a patient's head into a mattress and then hit the patient and cut his lip with keys.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 311 days from the date of discovery. Also, the hiring authority did not 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 The hiring authority did not consult with OLES regarding the sufficiency of the investigation and investigative findings. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 311 days from the date of discovery
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will ensure to compare OLES daily intake log and OLES AIM's report to confirm report is a monitored case. Currently the newly appointed Analyst has been assigned to implement an excel spreadsheet to track the due dates for all monitored cases. All three systems will be used to ensure

	the department is tracking monitored cases. Prior to sending report to the Incident Review Committee the SSI will ensure the report is noted as a monitored case so that the monitor is allowed to provide feedback to ensure OLES provides real time monitoring of the case.
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Case Details	Description
Incident Date	11/01/2024
OLES Case Number	2024-01511-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	A psychiatric technician allegedly provided a patient with the wrong medication.
Disposition	The hiring authority sustained the allegation and determined a letter of expectation was the appropriate action. The OLES concurred.
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 199 days from the date of discovery. Also, the investigation was approved on May 23, 2025; however, the disposition conference meeting with the hiring authority did not take place until February 18, 2026, 272 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 May 23, 2025; however, the disposition conference with the hiring authority did not take place until February 18, 2026, 272 days later.

	2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 199 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators strive to schedule and conduct interviews between high-priority cases. The SSI will meet with the investigator on a weekly basis to obtain case updates, investigative steps, and feedback from the monitor. The SSI will check the status of scheduled interviews, and any issues encountered that may delay the timely submission of the investigation. A log is being implemented with filters that track the time frames for all monitored cases. A case extension will continue to be utilized if there are issues with staff members that need to be interviewed impacting scheduling resulting from vacations, injuries, or issues such as registry staff members.

Case Details	Description
Incident Date	11/06/2024
OLES Case Number	2024-01524-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Applicable
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Two law enforcement officers allegedly slept during their shift.
Disposition	The hiring authority did not sustain the allegations. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies

	and procedures governing the disciplinary process.
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Case Details	Description
Incident Date	01/20/2025
OLES Case Number	2025-00076-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant allegedly grabbed a patient's hoodie from behind, causing the patient to fall to the floor on her 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 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 investigator scheduled interviews with little to no notice to the OLES monitor. After the suspect invoked her right to remain silent, the investigator continued to speak with the suspect to "refresh her memory". The investigation was not completed until 203 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? • No After the psychiatric technician assistant, who was the suspect, told the investigator that she wished to remain silent, the investigator continued to speak with her to "refresh her memory", after which she told the investigator she did not want to make a statement. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator scheduled interviews with no notice or

	little notice to the OLES monitor, limiting real-time monitoring. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 203 days after the incident was discovered.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will provide training on scheduling interviews with OLES, to include providing sufficient time prior to the interview. The SSI will brief in reoccurring monthly meetings and train investigators on methods of setting a date that is favorable to all parties. The SSI will conduct in-house training sessions beyond the police academy and meeting discussions that cover the Miranda rule and case law. The SSI will continue to train and brief on Miranda case law in monthly meetings and in upcoming September scheduled training. The SSI have trained and facilitated in-house discussions in meetings about the OLES monitored investigative time frames. Training will be provided on the existence and availability of obtaining an extension through the use of appropriate documentation. The department has created a real time investigator monthly case status update on Teams to track and monitor an investigator's caseload accessible to the SSI.

Case Details	Description
Incident Date	01/16/2025
OLES Case Number	2025-00096-2A
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 psychiatric technician allegedly repositioned a patient's leg in a rough, careless manner as the patient sat in a wheelchair. The rough handling allegedly fractured the patient's hip.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/10/2025
OLES Case Number	2025-00173-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly showed her buttocks to a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
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 311 days after the incident was discovered. The investigator did not attempt to make any contact with former patients who possibly had knowledge of the incident, and did not

	consider social media content as possible evidence corroborating a patient's allegations.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator would not travel nor make arrangements to contact two former discharged patients who possibly had knowledge of the psychiatric technician's inappropriate behavior. 2. Was the investigation thorough and appropriately conducted? • No The investigator disregarded possible evidence from social media corroborating a patient's statement on the basis that the patient could have accessed the psychiatric technician's social media account. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 311 days after the incident was discovered.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will ensure investigators will document all reasonable efforts to locate and interview potential witnesses, including discharged patients when appropriate. If circumstances prevent an interview from being completed, the investigative report will clearly document those efforts and the rationale for proceeding without the interview. The investigators and OLES discussed social media content in this case. The assigned AIM concluded that the information warranted additional investigative consideration. To correct this issue, investigators will document the evaluation of all potentially relevant electronic and social media evidence, including the basis for its inclusion or exclusion from the investigation. Supervisory review will ensure all reasonably available evidence has been considered and appropriately documented prior to finalizing the investigative case findings. The investigation exceeded the expected completion timeframe. The Office of Special Investigations recognizes

	the importance of completing investigations within established timeframes. The SSI will closely monitor pending investigations and evaluate the impact of issues that may affect case completions to ensure cases are submitted in a timely manner. The SSI has expressed the supervisory expectation that criminal cases should be completed within four months. The Investigators have been advised that any case outside of that deadline should be briefed with the SSI, who will brief the case with assigned AIM.
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Case Details	Description
Incident Date	04/07/2025
OLES Case Number	2025-00434-2A
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 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 hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/08/2025
OLES Case Number	2025-00448-1C

Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly used his knees to pin down a patient's arm during a containment.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 285 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 285 days after the incident was discovered.
Department Corrective Action Plan	There was a delay in reporting this incident as the allegation was not made until a member of the executive staff watched the video of the incident. This happened a month and a half after the incident occurred. The executive team member felt policies may have been violated; therefore, an SOC was initiated. Moving forward, reports shall be reviewed daily by the Supervising Special Investigator (SSI) and Investigators. The SSI will conduct routine case status reviews daily, monitor investigative timelines, and address potential delays as they arise. Investigators will promptly communicate any anticipated delays to supervisory staff to ensure appropriate oversight and timely completion of future investigations.

Case Details	Description
Incident Date	03/08/2025
OLES Case Number	2025-00448-2A
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 used his knees to pin down a patient's arm during a containment.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/23/2025
OLES Case Number	2025-00532-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Conviction of a crime
Findings	1. Not Referred
Incident Summary	A pre-licensed psychiatric technician allegedly provided a bottle of chemical cleaner to a patient, which the patient utilized in an attempt to commit suicide.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred

	with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with policies and procedures governing the investigative process. Interviews were not completed of the patient's doctors regarding any possible mental health injury resulting from the failed suicide attempt, and the unit shift lead was not questioned regarding the staff's knowledge of the patient's suicidal ideations. The investigator continued questioning a witness without the OLES monitor present on the telephone. The investigator submitted a draft investigative report containing an incorrect legal opinion of the mens rea required for the crime of dependent adult abuse. The investigation was not completed until 327 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Responding police officers failed to question level of care staff regarding any possible mental health injuries resulting from the patient's failed suicide attempt. 2. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator failed to interview the unit shift lead regarding the staff's knowledge of the patient's suicidal ideations and question the patient's doctors regarding any possible mental health injuries resulting from the patient's failed suicide attempt. 3. Were all of the interviews thorough and appropriately conducted? • No The investigator ended a phone call with the OLES monitor, who was monitoring a witness interview via telephone, and then asked the witness follow-up questions without the OLES monitor present. 4. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The draft investigative report included references to an irrelevant and inapplicable penal code section and

	contained the investigator's incorrect legal opinions regarding the mental state required for the crime of dependent adult abuse. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator continued asking a witness questions after ending a telephone call with the OLES monitor. 6. Was the investigation thorough and appropriately conducted? • No Throughout the investigation, the investigator repeatedly relied upon an incorrect legal opinion regarding the mental state required from the crime of dependent adult abuse. In addition, despite the OLES monitor's repeated recommendations, the investigator failed to interview the unit shift lead regarding the staff's knowledge of the patient's suicidal ideations and question the patient's doctors regarding any possible mental health injuries resulting from the patient's failed suicide attempt. 7. Was the pre-disciplinary/investigative phase conducted with due diligence? • No No. The investigation was not completed until 327 days from the date of discovery,
Department Corrective Action Plan	Hospital police officers will ensure all appropriate witnesses, including treatment staff, are interviewed regarding any physical or mental health injuries relevant to the allegations. Supervisory review will ensure all necessary investigative steps have been completed prior to finalizing the investigation. Moving forward, investigators will ensure all potentially relevant witnesses are identified and interviewed, or the rationale for not conducting an interview is discussed with the Supervising Special Investigator (SSI) and the monitor. The completion of these duties will be monitored daily by the SSI. Investigators will ensure monitored interviews are completed in their entirety with the assigned OLES monitor present unless otherwise authorized. The SSI has

	made this a topic during a unit meeting. This expectation was understood by all the investigators in attendance. Moving forward, investigators will ensure legal analyses are supported by the applicable statutes and established legal standards. Supervisory review will verify the accuracy of legal references and investigative conclusions before draft reports are submitted. Investigators will maintain communication with assigned OLES monitors during monitored interviews and ensure all substantive questioning occurs while the monitor is present unless otherwise directed. Moving forward, investigators will ensure all recommended investigative steps are completed or appropriately documented, and legal analyses will be reviewed for accuracy through supervisory oversight prior to finalizing investigative findings. Supervisory staff will conduct routine case status reviews, monitor investigative timelines, and address potential delays as they arise. Investigators will promptly communicate any anticipated delays to supervisory staff to ensure appropriate oversight and timely completion of investigations.
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Case Details	Description
Incident Date	05/11/2025
OLES Case Number	2025-00569-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly aggressively scrubbed a patient's face with a soapy washcloth, getting the soapy cloth in the patient's mouth. When the patient told the psychiatric technician he hurt the patient's face, the psychiatric technician allegedly continued scrubbing the patient's face, and responded to the patient with profanity and a raised fist.
Disposition	The Office of Protective Services conducted an

	investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	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	2025-00603-2A
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 officer allegedly made inappropriate comments regarding patients.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction and training. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/16/2025
OLES Case Number	2025-00604-1C
Case Type	Monitored
Incident Types	1. Attempted Patient Suicide

Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician and unidentified level of care staff allegedly made discourteous statements to a patient who had recently been on suicide precautions. A second psychiatric technician allegedly failed to adequately account for patients, and secure the unit quiet room where the patient was later found after injuring himself.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/18/2025
OLES Case Number	2025-00618-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Insubordination
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained

Penalty	Initial: Other Final: Other
Incident Summary	A licensed vocational nurse allegedly refused multiple direct orders to be reassigned from an enhanced observation over a patient. The licensed vocational nurse became agitated and then allegedly refused multiple direct orders from supervisors and law enforcement to leave the facility. The licensed vocational nurse also allegedly yelled at several staff members, and pushed a sergeant and an officer.
Disposition	The hiring authority sustained the allegations; however, the licensed vocational nurse was registry staff, not a facility employee. Therefore, the licensed vocational nurse's contract was canceled. No further action could be taken. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed in a timely manner.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation commenced on July 29, 2025; however, the investigation was not completed until January 20, 2026, 175 days later.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will remind investigators of the expectations specified in policy regarding the completion of OLES monitored investigations, and the importance of adhering to specified timeframes. The SSI will also hold monthly meetings with the investigators for continual assessment of each investigator's caseload to identify critical junctures and ensure monitored investigations are completed within 120 days.

Case Details	Description
Incident Date	05/20/2025
OLES Case Number	2025-00629-2A
Case Type	Monitored

Incident Types	1. Abuse - Physical 2. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
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 hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/24/2025
OLES Case Number	2025-00655-1A
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 licensed vocational nurse and a psychiatric technician allegedly neglected a patient by failing to keep the patient within line of sight while the patient was on

	enhanced observation. During the lapse in observation, the patient was allegedly raped.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/25/2025
OLES Case Number	2025-00665-1A
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 forcefully grabbed a patient's legs and feet in an attempt to force the patient to take a shower.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 152 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 152 days from the date of discovery.

Department Corrective Action Plan	The Supervising Special Investigators (SSI) will meet with the investigator on a weekly basis to obtain updates on monitored cases. The SSI will ensure the investigators provide information regarding meetings and feedback from the OLES monitor. This will include the status of pending interviews, and any issues encountered that may delay the timely submission of the investigation. The OLES monitor has also discussed with the SSI that if a case review is requested for a possible case rejection, the request should come from the SSI. A log is being implemented with filters that track the time frames in conjunction with a board that is updated on a weekly basis by the SSI. Investigators will be afforded overtime if additional time is needed to complete investigations or to allow for accommodation of staff members that work PM or NOC shifts. A case extension will continue to be utilized if it is determined the investigation will be delayed as a result of issues with scheduling interviews due to vacations, injuries, or unavailability of registry staff members.
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Case Details	Description
Incident Date	06/13/2025
OLES Case Number	2025-00738-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement officer allegedly disclosed confidential investigative information about a suspect to individuals outside of the state hospital.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.

Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	06/29/2025
OLES Case Number	2025-00793-1A
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 punched the patient in the chest.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 162 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 162 days from the date of discovery
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators schedule and conduct interviews between high priority cases to meet deadlines. The SSI will meet with the investigators on a weekly basis to obtain updates on meetings and feedback from the OLES monitors. The SSI will verify investigators are scheduling interviews, and any

	issues encountered that may delay the timely submission of the investigation, will be discussed with the monitor. A Microsoft Excel tracking log is being implemented with filters that track the time frames. A case extension will continue to be utilized if the problem lies with staff scheduling due to vacations, injuries, or issues such as registry staff members.
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Case Details	Description
Incident Date	07/02/2025
OLES Case Number	2025-00799-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly struck the head of a patient who was trying to de-escalate an agitated patient. The psychiatric technician also allegedly attempted to strike the agitated patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/07/2025
OLES Case Number	2025-00818-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity

Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	A psychiatric technician assistant allegedly shared photos on her cell phone with a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a Letter of Instruction. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/16/2025
OLES Case Number	2025-00852-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Insubordination
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement supervisor allegedly gave preferential treatment to their law enforcement officer spouse in assigning overtime in violation of the nepotism policy.
Disposition	The hiring authority determined that there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/16/2025
OLES Case Number	2025-00855-1C
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 and a second unidentified staff allegedly physically abused a patient as they and hospital police officers prevented the patient from escaping from a housing unit.
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. A Department of Protective Services supervisor did not interview three Hospital Police Officers present during the alleged abuse about their observations, requiring the Office of Special Investigations to conduct the interviews. The supervisor improperly saved the draft incident report on a desktop computer instead of the Records Management System without approval, preventing its review.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No A Department of Protective Services supervisor did not interview three Hospital Police Officers present during the alleged abuse about their observations, requiring the Office of Special Investigations to conduct the interviews. 2. Was the incident properly documented? • No

	The supervisor improperly saved the draft incident report on a desktop computer instead of the Records Management System without approval, preventing its review.
Department Corrective Action Plan	The Training Division will provide in-house training to officers and Supervisors utilizing POST Learning Domain 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. The Training Division will integrate OPS Policies #322 – Report Preparation and 600 – Investigation and Prosecution within the training. Supervisors will receive additional training in Peace Officer Bill of Rights, Policy 300 – Use of Force, and Policy 1008 – Personnel Complaints. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.

Case Details	Description
Incident Date	07/18/2025
OLES Case Number	2025-00870-1A
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 targeted a patient during a game, striking him in the groin with a foam ball.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/13/2025
OLES Case Number	2025-00871-1C
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	A nurse allegedly refused to treat a patient's injured finger. A senior psychiatric technician then allegedly failed to ensure the patient's finger was treated. The senior psychiatric technician and a psychiatric technician allegedly placed the patient in the seclusion room for no reason, and also refused to let the patient speak with a sergeant.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/27/2025
OLES Case Number	2025-00920-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly punched 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	08/01/2025
OLES Case Number	2025-00942-2A
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 abused a patient while placing him in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred

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

Case Details	Description
Incident Date	08/06/2025
OLES Case Number	2025-00955-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Criminal Act
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A civilian alleged that an officer drugged her with an unknown substance while on a date off duty.
Disposition	The hiring authority determined that 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	08/06/2025
OLES Case Number	2025-00958-1A
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	An unidentified staff member allegedly inappropriately touched a patient's middle finger and left ring finger.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was approved on December 8, 2025; however, the findings and penalty conference meeting with the hiring authority did not take place until March 9, 2026, 91 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was approved on December 8, 2025; however, the findings and penalty conference meeting with the hiring authority did not take place until March 9, 2026, 91 days later.
Department Corrective Action Plan	The Office of Special Investigations (OSI) had a procedure in which investigator□ held onto case files after the monitors had approved the draft reports. In order to correct this, the Supervising Special Investigators (SSI) established a new process in which case files are not returned to the investigator pending the OLES review. To avoid any delays, files are now kept in the main office area for SSI access once the monitor has approved the report. The reports are then prepared for the hiring authority disposition meetings within the 20-day guidelines. The SSI will continue to monitor case files to be submitted to the hiring authority for adjudication.

Case Details	Description
Incident Date	08/22/2025
OLES Case Number	2025-01019-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly hit a patient on the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 144 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 144 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators will continue to strive to schedule and conduct interviews between high-priority cases. The investigator will be directed to coordinate with unit supervisors to have subject staff members available for interviews in order to avoid any delays. The SSI Supervising Special Investigator will assist if an investigator is met with staff members being uncooperative that may result in delayed investigations. The SSI will meet with the investigator on a weekly basis to obtain updates on meetings and feedback from the OLES monitor on the status of AIM, scheduled interviews, and/or any issues encountered that may delay the timely submission of the investigation, such as staff members delaying interviews. A tracking log is being implemented with filters that track the time frames for monitored cases. A case extension will continue to be utilized if there are issues scheduling interviews resulting from subjects or witnesses being unavailable staff scheduling due to

	vacations, injuries, or issues such as registry staff members.
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Case Details	Description
Incident Date	08/22/2025
OLES Case Number	2025-01020-1A
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 registered nurse and a psychiatric technician were allegedly negligent while monitoring a patient who was on an enhanced level of observation. The patient swallowed part of a whiteboard.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/25/2025
OLES Case Number	2025-01026-2C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

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

Case Details	Description
Incident Date	08/25/2025
OLES Case Number	2025-01028-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A senior psychiatric technician allegedly yanked and pulled on the injured leg of a patient who was lying on a table, refusing to get up. The senior psychiatric technician allegedly continued to pull on the patient's leg even though the patient told the senior psychiatric technician his leg was injured.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services will open an administrative investigation after the district attorney's review. The OLES will monitor the administrative investigation.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures

	governing the investigative process.
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Case Details	Description
Incident Date	07/27/2025
OLES Case Number	2025-01038-1A
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: Training Final: Training
Incident Summary	A registered nurse allegedly kicked a patient and allegedly failed to properly perform her rounds.
Disposition	The hiring authority determined there was insufficient evidence to sustain the abuse allegation. The OLES concurred with the hiring authority's determination. However, the hiring authority sustained the allegation of improperly performing rounds and determined additional training was the appropriate penalty. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with the policies and procedures governing the investigative process as the investigative report was completed on November 26, 2025, and the disposition meeting with OLES took place on February 6, 2026, 73 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 hiring authority did not timely consult with OLES regarding the sufficiency of the investigation and the investigative findings, as the investigative report was completed on November 26, 2025 and the consultation

	with OLES took place on February 6, 2026, 73 days later.
Department Corrective Action Plan	The case report was sent to the Executive Director from on December 15, 2026. The Hiring Authority inadvertently missed noting this investigation as a monitored case in the investigation tracking log. This resulted in OLES not having an opportunity to review the case and make recommendations on the level of action. The Hiring Authority has since updated their investigation tracking log to ensure all fields are completed, which now identifies cases that are OLES monitored and highlights the need for OLES review. The Hiring Authority will continue to track monitored cases and document when the disposition meeting with OLES has occurred.

Case Details	Description
Incident Date	08/27/2025
OLES Case Number	2025-01040-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Neglect 3. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Unidentified staff and law enforcement officers allegedly assaulted a patient. Unidentified staff and doctors allegedly raped the patient. Unidentified staff allegedly denied providing the patient with medication for his illnesses.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	Overall Rating: Sufficient

Assessment	The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	08/27/2025
OLES Case Number	2025-01046-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A patient alleged he witnessed unidentified staff grab a patient by the shirt and lift him off a toilet seat. The same patient also alleged he witnessed unidentified staff grab a different patient by the shirt and push him against the wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/02/2025
OLES Case Number	2025-01065-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A senior psychiatric technician allegedly battered a patient, causing the patient to batter the senior psychiatric technician.
Disposition	The case as to the senior psychiatric technician 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 officer investigating the battery on staff interviewed the senior psychiatric technician, four staff witnesses and the patient. When investigating the patient's physical abuse allegation, the officer did not interview three of the staff witnesses and only documented a spontaneous comment made by the fourth staff member. The officer wrote and submitted separate reports, even though the report regarding staff assault documented the statements of four staff witnesses and the report regarding the patient's physical abuse allegation documented only a spontaneous comment made by one of the staff witnesses.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The officer investigating the battery committed by the patient interviewed the senior psychiatric technician, four staff witnesses, and the patient. When the patient alleged that the senior psychiatric technician had battered him, the officer did not interview three of the four staff witnesses and noted only a spontaneous comment from the fourth staff member that he did not witness anything. 2. Was the incident properly documented? • No The officer's report documenting the battery committed by the patient contained statements by the senior psychiatric technician, four staff witnesses, and the patient. The officer's report documenting the patient's physical abuse allegation did not include statements

	from the patient, three of the previously interviewed staff witnesses and noted only a spontaneous comment from the fourth staff member that he did not witness anything. The senior psychiatric technician was unavailable for interview regarding the physical abuse allegation.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.

Case Details	Description
Incident Date	09/09/2025
OLES Case Number	2025-01092-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient found another patient unresponsive in a restroom stall with a ligature around his neck. Level of care staff initiated life-saving measures. Outside emergency medical staff responded, taking over lifesaving efforts; however, the patient remained unresponsive, and was pronounced dead. The medical examiner determined the manner of death to be suicide

	and the cause of death to be asphyxia due to hanging.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime that contributed to the patient's death. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with the policies and procedures governing the investigative process. Although told by a psychiatric technician assistant that the patient was found unresponsive with a ligature around his neck, the reporting officer did not recall this until almost two hours later, resulting in a delay in recognizing a possible suicide and resulting in incomplete notifications to the facility's executive director, the Office of Special Investigations, and OLES.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Although told by a psychiatric technician assistant that the patient was found unresponsive with a ligature around his neck, the reporting officer did not recall this until almost two hours later, resulting in a delay in recognizing a possible suicide and resulting in incomplete notifications to the facility's executive director, the Office of Special Investigations, and OLES.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing POST Learning Domain 18, Investigative Report Writing implementing policies #322 – Report Writing, #327 – Death Investigation, and #600 – Investigation and Prosecution within the training. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant.

Case Details	Description
Incident Date	09/09/2025
OLES Case Number	2025-01100-1A

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 doctor allegedly sexually assaulted a patient during a medical examination.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/09/2025
OLES Case Number	2025-01101-1A
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 demanded money from a patient and when the patient refused, the psychiatric technicians picked the patient up by his collar and took him to the side room causing the patient to hit his leg on the bed.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 156 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 156 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators will continue to strive to schedule and conduct interviews between high-priority cases. The investigator will be directed to coordinate with unit supervisors to have subject staff members available for interviews in order to avoid any delays. The SSI will assist if an investigator is met with staff members being uncooperative that may result in delayed investigations. The SSI will meet with the investigator on a weekly basis to obtain updates on meetings and feedback from the OLES monitor on the status of AIM, scheduled interviews, and/or any issues encountered that may delay the timely submission of the investigation, such as staff members delaying interviews. A tracking log is being implemented with filters that track the time frames for monitored cases. A case extension will continue to be utilized if there are any problems scheduling interviews resulting from subjects or witnesses being unavailable due to vacations, injuries, or other issues.

Case Details	Description
Incident Date	09/12/2025
OLES Case Number	2025-01114-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical

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

Case Details	Description
Incident Date	09/15/2025
OLES Case Number	2025-01125-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
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 172 days from the date of discovery.
Pre-Disciplinary	1. Was the pre-disciplinary/investigative phase

Assessment	conducted with due diligence? • No The investigation was not completed until 172 days from the date of discovery.
Department Corrective Action Plan	The Supervising Investigator conduct routine case status reviews, monitor investigative timelines, and address potential delays as they arise. Investigators will promptly communicate any anticipated delays and document circumstances outside of their control that may affect investigative timelines to ensure appropriate oversight and timely completion of investigations.

Case Details	Description
Incident Date	09/22/2025
OLES Case Number	2025-01157-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly pushed a patient to the floor.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/24/2025
OLES Case Number	2025-01165-1A

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

Case Details	Description
Incident Date	09/28/2025
OLES Case Number	2025-01175-1A
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 physically assaulted a patient by forcefully grabbing the patient's left arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/29/2025
OLES Case Number	2025-01181-1A
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 nurse allegedly touched a patient's genitals.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/27/2025
OLES Case Number	2025-01183-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly hit a patient in the mouth and temple and stabbed the patient with a pen in her right cheek.
Disposition	The hiring authority determined there was insufficient

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

Case Details	Description
Incident Date	10/01/2025
OLES Case Number	2025-01193-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient returned from a prolonged stay at an outside hospital with twenty-seven pressure sores on his upper and lower body.
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	10/01/2025
OLES Case Number	2025-01202-1A
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 psychiatric technician allegedly grabbed a patient's genitals.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/09/2025
OLES Case Number	2025-01224-1A
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 senior psychiatric technician allegedly forced a patient to take "as needed" medication when it was not necessary and an unidentified staff member grabbed the patient's right arm and twisted it behind the patient's back.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures

	governing the investigative process.
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Case Details	Description
Incident Date	10/13/2025
OLES Case Number	2025-01236-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified male staff member allegedly hit a patient multiple times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/13/2025
OLES Case Number	2025-01240-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient returned from a 14 day stay at an outside hospital with a deep tissue genital pressure injury.
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	10/12/2025
OLES Case Number	2025-01243-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly asked a patient in a wheelchair what her race was, raised her right leg over the patient's lap and sat down on the patient's knees, facing the patient, remaining there until the patient told the the senior psychiatric technician to get off.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department did not adequately respond to nor properly document the incident. Although his incident report stated there were no attachments, the reporting officer collected and attached several documents, including observation notes written by staff members assigned to enhanced observation of the patient. The officer did not identify that the records identified the staff member assigned to watch the patient during the alleged abuse. The officer did not document efforts to identify potential staff witnesses, did not document his review of the collected documents, and did not identify

	nor attempt to interview the staff member who was watching the patient during the time of the alleged abuse. Despite these issues, a sergeant approved the incident report.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Although his incident report stated there were no attachments, the reporting hospital police officer collected and attached multiple documents, including observation notes written by staff members assigned to enhanced observation of the patient. The officer did not identify that the records identified the staff member assigned to watch the patient during the alleged abuse. The officer did not document efforts to identify potential staff witnesses, did not document his review of the collected documents, and did not identify nor attempt to interview the staff member who was watching the patient during the time of the alleged abuse. Despite these issues, a sergeant approved the incident report. 2. Was the incident properly documented? • No Although he wrote in the incident report there were no attachments, the reporting officer collected multiple documents and attached them to the case in the records management system. Among these were observation notes written by a staff member assigned to watch the patient during the time of the alleged abuse. However, the reporting officer's incident report did not document the officers' efforts to identify potential staff witnesses, did not document his review of the collected documents, and did not identify nor attempt to interview the staff member who was watching the patient during the time of the alleged abuse.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing POST Learning Domain 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers, and Officers attend the training. Training in the appropriate state laws and OPS policies #322 -Report Preparation, #327 Death Investigation and #600 Investigation and Prosecution, will be in within the in-

	house training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Division, will assess the quality of the reports and provide training for personnel who do not meet department expectations.
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Case Details	Description
Incident Date	10/13/2025
OLES Case Number	2025-01244-1A
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 punched a patient several times in the back of the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/14/2025
OLES Case Number	2025-01245-1C
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	A senior psychiatric technician and two unidentified male staff members allegedly hit a patient in the day hall multiple times in the head, stomach, and groin, escorted him to a seclusion room, and continued to hit him in the head, stomach, and groin.
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	10/15/2025
OLES Case Number	2025-01254-2C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient returned from a five-day stay at an outside hospital with discoloration in his genitals consistent with developing pressure wounds
Disposition	The Office of Protective Services conducted an investigation, found insufficient evidence that the outside

	hospital neglected the patient while under their care, and did not refer the matter to the law enforcement agency whose jurisdiction included the outside hospital. 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	10/08/2025
OLES Case Number	2025-01264-3A
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Over-Familiarity 3. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: No Penalty Imposed
Incident Summary	A communications operator purchased items for a patient and deposited money into the patient's trust account, in violation of ethics policy.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations. The communications operator resigned prior to the imposition of penalty. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/18/2025
OLES Case Number	2025-01268-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pinched a patient's back and also pulled at the hair on the patient's back as the psychiatric technician tried to remove the patient from the shower area.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/20/2025
OLES Case Number	2025-01278-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant allegedly hit a patient in the chest.
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	10/20/2025
OLES Case Number	2025-01279-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly dragged a patient into a bathroom and gave the patient drugs or medication.
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. Although level of care staff physically escorted an agitated patient to the seclusion room, the reporting officers (a field training officer and a trainee) reported their actions as "Therapeutic Strategies and Interventions (TSI)", instead of describing how the level of care staff actually controlled the patient. A sergeant approved the report.
Pre-Disciplinary Assessment	1. Was the incident properly documented? • No Although level of care staff physically escorted an agitated patient to the seclusion room, the reporting hospital police officers (a field training officer and a trainee) reported their actions as "Therapeutic Strategies and Interventions (TSI)", instead of describing how the level of care staff actually controlled the patient. A sergeant approved the report.
Department Corrective Action	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing.

Plan	Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.
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Case Details	Description
Incident Date	08/25/2025
OLES Case Number	2025-01283-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: Dismissal
Incident Summary	An academy cadet was allegedly dishonest and acted in bad faith when she submitted an invalid Penal Code section 832 certificate to human resources.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and voided the cadet's appointment. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/28/2025
OLES Case Number	2025-01314-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	A patient and "everyone" 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	10/28/2025
OLES Case Number	2025-01317-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed and verbally threatened a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred

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

Case Details	Description
Incident Date	10/24/2025
OLES Case Number	2025-01334-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A hospital staff member claimed that a law enforcement officer was aggressive and threatening towards her in the staff parking lot.
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	05/05/2024
OLES Case Number	2025-01339-1A
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 made one patient physically abuse another patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process, the investigation took 159 days from the date of discovery to complete the report.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 159 days from the date of discovery
Department Corrective Action Plan	The Supervising Special Investigators will contact the Operations Lieutenant to ensure timely approval of OLES monitored cases to be forwarded to Office of Special Investigations (OSI) allow timely assignments to an investigator. The SSI will meet with the investigator on a weekly basis to obtain updates on meetings and feedback from the OLES monitor on the status of scheduled interviews, and/or any issues encountered that may delay the timely submission of the investigation. A tracking log is being implemented with filters that track the time frames for monitored cases. This will be utilized in conjunction with the tracking board that is updated on a weekly basis by the SSI. Investigators may be afforded overtime if additional time is needed to complete their reports or to allow for accommodation of staff members that work PM or NOC shifts. A case extension will be utilized if there are any issues scheduling interviews resulting from subjects or witnesses being unavailable due to vacations, injuries, or issues such as registry staff members.

Case Details	Description
Incident Date	10/30/2025
OLES Case Number	2025-01345-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician and a pre-licensed psychiatric technician allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The investigation was not completed until 147 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 147 days from the date of discovery.
Department Corrective Action Plan	The investigation was not completed within the expected timeframe. During the investigative period, the assigned investigator was absent from work for approximately five weeks, which contributed to the overall delay in completing the investigation. Upon the investigator's return, efforts were made to complete the remaining investigative tasks; however, the case ultimately exceeded the expected completion timeline. The Supervising Special Investigator

	will continue to monitor investigative caseloads on a weekly basis, conduct periodic case status reviews, and promptly reassign or otherwise address cases when extended employee absences may impact investigative timelines. Investigators will also provide notification of circumstances that may delay case completion to ensure appropriate oversight and timely completion of assigned investigations.
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Case Details	Description
Incident Date	10/29/2025
OLES Case Number	2025-01346-1C
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.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/29/2025
OLES Case Number	2025-01347-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A patient returned from a 15 day stay at an outside hospital with a deep tissue genital pressure injury.
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	11/04/2025
OLES Case Number	2025-01378-1A
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 assistant was allegedly overly familiar with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/06/2025
OLES Case Number	2025-01381-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly placed a patient in a chokehold as the patient attempted to leave a unit without permission.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/07/2025
OLES Case Number	2025-01389-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An identified male staff member allegedly grabbed a patient by both sides of the head, lifted the patient from a wheelchair, and slammed the patient's face on a table.
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.
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Case Details	Description
Incident Date	11/07/2025
OLES Case Number	2025-01390-1C
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 registered nurse allegedly kicked a patient twice while the patient was being contained on the floor. A health records technician who witnessed the alleged abuse did not timely report the abuse to the Office of Protective Services.
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 adequately respond to the incident nor properly document the incident in the incident report. A staff witness not assigned to the unit but in the nurses' station reported witnessing a physical abuse in the day hall. The responding officers (a field training officer and a trainee) did not determine where in the nurses' station the reporting staff member was, where in the day hall the alleged abuse occurred, and whether there were obstructions or distractions affecting the reporting staff witness' ability to observe. The officers did not explain how they identified the involved patient or the alleged suspect. Although they obtained relevant unit documents, the officers did not identify significant information within those documents, including the notations of the registered nurse who was assigned as the

	enhanced observer of the patient during the time of the alleged abuse. The incident report contained numerous errors, including misidentifying staff members or classifications of those contacted as witnesses and not identifying significant information in unit documents the officers had collected, including the notations of the patient's enhanced observer for the relevant time period in the Observation Record for Behavioral or Restraint. A sergeant approved the report.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No A staff witness not assigned to the unit but in the nurses' station reported witnessing a physical abuse in the day hall. The responding officers (a field training officer and a trainee) did not determine where in the nurses' station the reporting staff member was, where in the day hall the alleged abuse occurred, and whether there were obstructions or distractions affecting the reporting staff witness' ability to observe. The officers did not explain how they identified the involved patient or the alleged suspect. Although they obtained relevant unit documents, the officers did not identify significant information within those documents, including the notations of the registered nurse who was assigned as the enhanced observer of the patient during the time of the alleged abuse. 2. Was the incident properly documented? • No The incident report prepared by the responding officers (a field training officer and a trainee) contained numerous errors, including misidentifying staff members or classifications of those contacted as witnesses and not identifying significant information in unit documents the officers had collected, including the notations of the Patient's enhanced observer for the relevant time period in the Observation Record for Behavioral or Restraint. A sergeant approved the report.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations

	Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. Additional training for Field Training Officers and Sergeant will be allocated for the proper report review process. The Operations Lieutenants will track reviewed OLES reports Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.
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Case Details	Description
Incident Date	11/04/2025
OLES Case Number	2025-01391-1A
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 physically attacked a patient and took the patient's vending card and bought chips with it.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/10/2025

OLES Case Number	2025-01393-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred
Incident Summary	Five unidentified staff members allegedly verbally demeaned and pushed 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	11/08/2025
OLES Case Number	2025-01396-1C
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 pre-licensed psychiatric technician allegedly threw a patient to the ground, causing a head injury.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. Unit staff cleaned the crime scene before the officer could take photographs and collect evidence.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Unit staff directly disobeyed an officer's order not to clean the crime scene, thereby resulting in the loss of potential evidence.
Department Corrective Action Plan	Both law enforcement and therapeutic supervisory staff will reinforce expectations with hospital personnel regarding crime scene preservation and the requirement to comply with law enforcement directives during active investigations. Staff will be reminded that potential crime scenes are not to be disturbed until they have been released by the responding investigator or hospital police officer.

Case Details	Description
Incident Date	11/11/2025
OLES Case Number	2025-01412-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	An unidentified male staff member allegedly punched a patient through the open medication room door as the patient was walking by.
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	11/13/2025
OLES Case Number	2025-01427-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician observing a patient on enhanced observation in wrist-to-waist restraints allegedly used inappropriate language and then slammed the patient to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/13/2025

OLES Case Number	2025-01433-1C
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 allegedly hit a patient in the face causing a fractured orbital bone.
Disposition	The case was referred to the district attorney's office. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/15/2025
OLES Case Number	2025-01437-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly tackled a patient, throwing him to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative	Overall Rating: Sufficient

Assessment	The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	11/15/2025
OLES Case Number	2025-01437-2A
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 tackled a patient, throwing him to the ground.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. The department repeatedly refused to interview the responding officers regarding their perception of the patient's movements when the psychiatric technician initiated a containment on the patient, and the issue was not resolved until after the first draft investigative report was written and a meeting occurred between the Department of Protective Services and OLES.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The department initially refused to interview the responding officers regarding their perception of the patient's movements when the psychiatric technician initiated a containment on the patient. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No

	Because the department initially refused to interview the responding officers regarding their perception of the patient's movements when the psychiatric technician initiated a containment on the patient, the initial draft did not contain these critical interviews.
Department Corrective Action Plan	Investigators will ensure all witnesses identified as having potentially relevant information are interviewed during the investigative process, or that the rationale for not conducting an interview is discussed with the Supervising Special Investigator and the monitor. Supervisory review will ensure all necessary investigative steps have been completed prior to finalizing the investigation. Moving forward, investigators and supervisory staff will ensure all identified witnesses are interviewed, or the rationale for not conducting an interview is documented, prior to submission of draft investigative reports. This will help ensure draft reports contain all relevant investigative information before being forwarded for review.

Case Details	Description
Incident Date	11/16/2025
OLES Case Number	2025-01438-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	While being placed in restraints in a seclusion room, a registered nurse allegedly punched a patient once in the nose and spat on the patient's left eye.
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 officer observed the uncooperative patient yelling and disobeying staff, observed multiple staff members use Therapeutic Strategies and Interventions (TSI) techniques to place the patient in restraints, observed the patient spit at and strike or attempt to strike staff after slipping his restraints. The officer did not conduct recorded interviews with the involved and witnessing staff members and did not write an incident report regarding the staff assaults because the victim staff members did not desire prosecution. Instead, following facility practice, the officer documented cursory notes in the computer aided dispatch record. When the patient alleged that a staff member had struck him on the nose and spat in his left eye, the officer initiated an investigation of the patient's abuse allegation. Although the officer observed much of the incident between staff and the patient, the officer only interviewed the patient. The officer's incident report regarding the patient's physical abuse allegation only included the officer's observations and the patient's interview and did not document interviews of the other staff members present. A sergeant approved the report. Although the Office of Special Investigations requested that the officer identify and interview the involved staff members regarding the alleged abuse, the officer conducted cursory interviews of three staff members, did not document the Therapeutic Strategies and Interventions (TSI) techniques used by staff, did not determine how the patient received his nose injury, did not commence interviews until 97 days after the incident, and did not complete a supplemental report until 107 days after the incident. Because of this, the Office of Special Investigations was required to identify witnesses, conduct interviews, and complete its report in a short period of time in order to comply with the 120-day investigative time-frame.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The responding officer observed the uncooperative

	patient yelling and disobeying staff, observed multiple staff members use Therapeutic Strategies and Interventions (TSI) techniques to place the patient in restraints, observed the patient spit at and strike or attempt to strike staff after slipping his restraints. The officer did not conduct recorded interviews with the involved and witnessing staff members and did not write an incident report regarding the staff assaults because the victim staff members did not desire prosecution. Instead, following facility practice, the officer documented cursory notes in the computer aided dispatch record. When the patient alleged that a male staff member had struck him on the nose and spat in his left eye, the officer initiated an investigation of the patient's abuse allegation. Although the officer observed much of the incident between staff and the patient, the officer only interviewed the patient. 2. Was the incident properly documented? • No The officer's incident report regarding the patient's physical abuse allegation only included the officer's observations and the patient's interview and did not document interviews of the other staff members present. A sergeant approved the report. Although the Office of Special Investigations requested that the officer identify and interview the involved staff members regarding the alleged abuse, the officer conducted cursory interviews of three staff members, did not document the Therapeutic Strategies and Interventions (TSI) techniques used by staff, did not determine how the patient received his nose injury, did not commence interviews until 97 days after the incident, and did not complete a supplemental report until 107 days after the incident. Because of this, the Office of Special Investigations was required to identify witnesses and conduct interviews in a short period of time in order to comply with the 120-day investigative timeframe.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations

	Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. State law, and OPS policies will be within the training objectives. Additional training will be allotted for FTOs and Sergeants covering the review process. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.
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Case Details	Description
Incident Date	11/12/2025
OLES Case Number	2025-01453-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly stepped on a patient's neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/13/2025
OLES Case Number	2025-01457-1C
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 with his fists.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/24/2025
OLES Case Number	2025-01477-1C
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 unknown staff member allegedly pulled a patient's arm, injuring the shoulder.
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	11/23/2025
OLES Case Number	2025-01482-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed a patient, put the patient against a wall, then placed the patient in seclusion for no reason. The psychiatric technician also allegedly made discourteous comments towards the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/27/2025
OLES Case Number	2025-01515-1C
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 on the back of his soft helmet to wake him, poured water on the patient's back, pushed the patient's head back, and forced medication down his throat.
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	12/05/2025
OLES Case Number	2025-01520-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Two psychiatric technicians allegedly sexually assaulted a patient, while a third psychiatric technician allegedly watched the assault.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/08/2025
OLES Case Number	2025-01527-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly tortured a patient by placing him in wrist-to-waist restraints for two weeks.
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	12/10/2025
OLES Case Number	2025-01535-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	When a patient tried to grab snacks in the day hall, a psychiatric technician allegedly grabbed the patient's arm, pulled the patient away, yelled at the patient, and called him a derogatory name. On the previous day, unknown staff members forced the patient to take

	medication.
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	07/19/2025
OLES Case Number	2025-01550-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	Initial: Counseling Final: Counseling
Incident Summary	A law enforcement sergeant allegedly gave conflicting orders to a hospital police officer in violation of DSH policy regarding Standards of Conduct.
Disposition	The hiring authority determined that there was sufficient evidence to sustain the allegation and issued the sergeant a counseling memorandum. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/12/2025
OLES Case Number	2025-01552-1C
Case Type	Monitored

Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse was allegedly sexually aroused and rubbed himself against a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/14/2025
OLES Case Number	2025-01553-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pushed a patient and hit the patient's head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/11/2025
OLES Case Number	2025-01569-1A
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 registered nurses allegedly pushed a patient during a fire drill.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/16/2025
OLES Case Number	2025-01575-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Penalty Imposed
Incident Summary	A nurse allegedly failed to medically assess an ill patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation of abuse, but found sufficient evidence to sustain the allegation that the nurse failed to properly document the patient's medical status. However, the nurse resigned before discipline could be imposed. A letter indicating the nurse resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/18/2025
OLES Case Number	2025-01598-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pulled a seated patient by his clothing from his chair in the day hall to the patio against his will.
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	12/05/2025

OLES Case Number	2025-01622-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Multiple staff allegedly denied a patient transfer requests, exposed the patient to violence, provoked the patient, and forced unnecessary medication upon the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/26/2025
OLES Case Number	2025-01628-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff observed numerous pressure wounds on a patient, including a genital pressure wound, after the patient returned from a 57-day stay at an outside medical facility.
Disposition	The Office of Protective Services conducted an investigation, found insufficient evidence that the outside hospital neglected the patient while under their care, and did not refer the matter to the law enforcement

	agency whose jurisdiction included the outside hospital. 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	12/27/2025
OLES Case Number	2025-01642-1C
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	A psychiatric technician allegedly made kissing noises with his mouth a few inches from a patient's face. The psychiatric technician then allegedly followed the patient around the unit, and made discourteous statements to other patients about the first patient. The next day, the psychiatric technician allegedly hit the first patient's arm with a shower door as the patient entered the shower area. A few days later, the psychiatric technician allegedly made discourteous statements to another staff member about the first patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/29/2025
OLES Case Number	2025-01643-1C
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 slammed a patient against a wall three times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/31/2025
OLES Case Number	2026-00001-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	While a patient was being placed in restraints after assaulting staff members, a psychiatric technician

	allegedly struck the patient once in the mouth with the palm of his right hand.
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. Although they interviewed three witnesses in the hour preceding the patient alleging he was punched in the nose, the responding hospital police officers did not recontact the witnesses regarding the abuse claim nor did they document why they were unable to do so. Because of this, the Office of Special Investigations was required to conduct the interviews to complete a thorough investigation.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Although they interviewed three witnesses in the hour preceding the patient alleging he was punched in the nose, the responding hospital police officers did not recontact the witnesses regarding the abuse claim nor did they document why they were unable to do so. Because of this, the Office of Special Investigations was required to conduct the interviews to complete a thorough investigation.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the

	Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.
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Case Details	Description
Incident Date	11/27/2025
OLES Case Number	2026-00053-1A
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 unidentified staff members allegedly hit a patient in the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/10/2025
OLES Case Number	2026-00061-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act

Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred
Incident Summary	After escorting a patient to the seclusion room and placing him in restraints, a psychiatric technician allegedly used a choke hold to choke the patient, after which four other psychiatric technicians joined the first and allegedly repeatedly punched 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 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	01/16/2026
OLES Case Number	2026-00067-1A
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 pushed the patient when she tried to enter the stairwell.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	Overall Rating: Sufficient

Assessment	The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	01/23/2026
OLES Case Number	2026-00098-1A
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 sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/26/2026
OLES Case Number	2026-00104-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	
Findings	
Incident Summary	A senior psychiatric technician allegedly slammed a patient's head against a wall during a wall containment procedure. After escorting the patient to a seclusion room, the senior psychiatric technician allegedly pushed the patient onto the restraint bed.

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	01/16/2026
OLES Case Number	2026-00131-1A
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 assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/28/2026
OLES Case Number	2026-00141-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Discourteous treatment

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement officer allegedly engaged in discourteous treatment of an office assistant.
Disposition	The hiring authority determined that there was not sufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/02/2026
OLES Case Number	2026-00145-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Training Final: Training
Incident Summary	A registered nurse allegedly failed to report possible abuse by a psychiatric technician to the Office of Protective Services.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and ordered additional training on reporting requirements. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/03/2026

OLES Case Number	2026-00146-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	While escorting a patient to a seclusion room, a psychiatric technician allegedly kicked a patient once in the leg.
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	02/09/2026
OLES Case Number	2026-00176-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred
Incident Summary	A patient was allegedly taken to the housing unit

	basement where multiple female patients and multiple unidentified male staff members raped her while the patient's son and husband watched.
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	02/11/2026
OLES Case Number	2026-00195-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly squeezed a patient's left breast during a medical examination.
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	02/13/2026
OLES Case Number	2026-00203-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly struck the wrist of an aggressive patient with a bundle of unit keys
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	03/02/2026
OLES Case Number	2026-00285-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient complained of ongoing back pain. After a recent unwitnessed fall, x-rays were taken, and confirmed the patient had a compression fracture of his lumbar vertebrae.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative	Overall Rating: Sufficient

Assessment	The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	03/05/2026
OLES Case Number	2026-00301-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	During patient grooming, a psychiatric technician assistant allegedly struck a patient on the side of the face with hot white towels.
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	03/05/2026
OLES Case Number	2026-00305-1C
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 once on the back of the head as the patient stood alone

	in the restroom.
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	03/22/2026
OLES Case Number	2026-00308-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Two psychiatric technicians allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	02/23/2026
OLES Case Number	2026-00322-1C
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 bedroom, forcibly removed his blankets, and kicked the patient in the left shin.
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	03/14/2026
OLES Case Number	2026-00352-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly targeted a patient, leading to physical containment and placement in restraints.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/10/2026
OLES Case Number	2026-00376-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	During a floor containment procedure, a 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	04/07/2026
OLES Case Number	2026-00502-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly sexually assaulted a patient on three occasions.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES

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

Case Details	Description
Incident Date	04/03/2020
OLES Case Number	2020-00335-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A licensed clinical social worker allegedly engaged in sexual contact with numerous female patients over a period of years.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The social worker was convicted of Sex with an Inmate, a felony, in violation of PC 289.6. He was sentenced to three years in state prison.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/05/2024
OLES Case Number	2024-00544-1C
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. Referred 3. Not Referred
Incident Summary	A senior psychiatric technician, and two psychiatric technicians allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	05/12/2024
OLES Case Number	2024-00722-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	A law enforcement officer allegedly engaged in an act of off-duty domestic violence.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
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Incident Date	05/26/2024
OLES Case Number	2024-00950-2A
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 officer allegedly text messaged another law enforcement officer that they were about to fight a patient as staff was preparing to administer involuntary medication.
Disposition	The hiring authority found insufficient evidence to sustain the allegations; however, facility wide training was provided regarding proper usage of personal cell phones in the secure treatment area. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/04/2024
OLES Case Number	2024-01307-2A
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
Findings	1. Sustained 2. Sustained 3. Sustained

	4. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	When a patient refused to submit to a mouth check for medication and began to walk away, a psychiatric technician allegedly grabbed the patient's shirt and hand, then attempted a wall containment. The patient sustained a broken left pinky finger.
Disposition	The hiring authority sustained the allegations and determined a letter of instruction and training were the appropriate penalty. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/31/2024
OLES Case Number	2024-01376-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	One licensed vocational nurse, two psychiatric technicians and law enforcement staff allegedly forced a patient's head into a mattress and then hit the patient and cut his lip with keys.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred

	with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 311 days from the date of discovery. Also, the hiring authority did not 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 The hiring authority did not consult with OLES regarding the sufficiency of the investigation and investigative findings. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 311 days from the date of discovery
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will ensure to compare OLES daily intake log and OLES AIM's report to confirm report is a monitored case. Currently the newly appointed Analyst has been assigned to implement an excel spreadsheet to track the due dates for all monitored cases. All three systems will be used to ensure the department is tracking monitored cases. Prior to sending report to the Incident Review Committee the SSI will ensure the report is noted as a monitored case so that the monitor is allowed to provide feedback to ensure OLES provides real time monitoring of the case.

Case Details	Description
Incident Date	11/01/2024
OLES Case Number	2024-01511-1A
Case Type	Monitored
Incident Types	1. Neglect

Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	A psychiatric technician allegedly provided a patient with the wrong medication.
Disposition	The hiring authority sustained the allegation and determined a letter of expectation was the appropriate action. The OLES concurred.
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 199 days from the date of discovery. Also, the investigation was approved on May 23, 2025; however, the disposition conference meeting with the hiring authority did not take place until February 18, 2026, 272 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 May 23, 2025; however, the disposition conference with the hiring authority did not take place until February 18, 2026, 272 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 199 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators strive to schedule and conduct interviews between high-priority cases. The SSI will meet with the investigator on a weekly basis to obtain case updates, investigative steps, and feedback from the monitor. The SSI will check the status of scheduled interviews, and any issues encountered that may delay the timely submission

	of the investigation. A log is being implemented with filters that track the time frames for all monitored cases. A case extension will continue to be utilized if there are issues with staff members that need to be interviewed impacting scheduling resulting from vacations, injuries, or issues such as registry staff members.
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Case Details	Description
Incident Date	11/06/2024
OLES Case Number	2024-01524-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Applicable
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Two law enforcement officers allegedly slept during their shift.
Disposition	The hiring authority did not sustain the allegations. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	01/20/2025
OLES Case Number	2025-00076-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A psychiatric technician assistant allegedly grabbed a patient's hoodie from behind, causing the patient to fall to the floor on her 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 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 investigator scheduled interviews with little to no notice to the OLES monitor. After the suspect invoked her right to remain silent, the investigator continued to speak with the suspect to "refresh her memory". The investigation was not completed until 203 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? • No After the psychiatric technician assistant, who was the suspect, told the investigator that she wished to remain silent, the investigator continued to speak with her to "refresh her memory", after which she told the investigator she did not want to make a statement. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator scheduled interviews with no notice or little notice to the OLES monitor, limiting real-time monitoring. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 203 days after the incident was discovered.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will provide training on scheduling interviews with OLES, to include providing sufficient time prior to the interview. The SSI will brief in reoccurring monthly meetings and train investigators on methods of setting a date that is

	favorable to all parties. The SSI will conduct in-house training sessions beyond the police academy and meeting discussions that cover the Miranda rule and case law. The SSI will continue to train and brief on Miranda case law in monthly meetings and in upcoming September scheduled training. The SSI have trained and facilitated in-house discussions in meetings about the OLES monitored investigative time frames. Training will be provided on the existence and availability of obtaining an extension through the use of appropriate documentation. The department has created a real time investigator monthly case status update on Teams to track and monitor an investigator's caseload accessible to the SSI.
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Case Details	Description
Incident Date	01/16/2025
OLES Case Number	2025-00096-2A
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 psychiatric technician allegedly repositioned a patient's leg in a rough, careless manner as the patient sat in a wheelchair. The rough handling allegedly fractured the patient's hip.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/10/2025
OLES Case Number	2025-00173-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly showed her buttocks to a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
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 311 days after the incident was discovered. The investigator did not attempt to make any contact with former patients who possibly had knowledge of the incident, and did not consider social media content as possible evidence corroborating a patient's allegations.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator would not travel nor make arrangements to contact two former discharged patients who possibly had knowledge of the psychiatric technician's inappropriate behavior. 2. Was the investigation thorough and appropriately conducted? • No The investigator disregarded possible evidence from social media corroborating a patient's statement on the

	basis that the patient could have accessed the psychiatric technician's social media account. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 311 days after the incident was discovered.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will ensure investigators will document all reasonable efforts to locate and interview potential witnesses, including discharged patients when appropriate. If circumstances prevent an interview from being completed, the investigative report will clearly document those efforts and the rationale for proceeding without the interview. The investigators and OLES discussed social media content in this case. The assigned AIM concluded that the information warranted additional investigative consideration. To correct this issue, investigators will document the evaluation of all potentially relevant electronic and social media evidence, including the basis for its inclusion or exclusion from the investigation. Supervisory review will ensure all reasonably available evidence has been considered and appropriately documented prior to finalizing the investigative case findings. The investigation exceeded the expected completion timeframe. The Office of Special Investigations recognizes the importance of completing investigations within established timeframes. The SSI will closely monitor pending investigations and evaluate the impact of issues that may affect case completions to ensure cases are submitted in a timely manner. The SSI has expressed the supervisory expectation that criminal cases should be completed within four months. The Investigators have been advised that any case outside of that deadline should be briefed with the SSI, who will brief the case with assigned AIM.

Case Details	Description
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Incident Date	04/07/2025
OLES Case Number	2025-00434-2A
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 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 hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/08/2025
OLES Case Number	2025-00448-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly used his knees to pin down a patient's arm during a containment.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES

	accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 285 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 285 days after the incident was discovered.
Department Corrective Action Plan	There was a delay in reporting this incident as the allegation was not made until a member of the executive staff watched the video of the incident. This happened a month and a half after the incident occurred. The executive team member felt policies may have been violated; therefore, an SOC was initiated. Moving forward, reports shall be reviewed daily by the Supervising Special Investigator (SSI) and Investigators. The SSI will conduct routine case status reviews daily, monitor investigative timelines, and address potential delays as they arise. Investigators will promptly communicate any anticipated delays to supervisory staff to ensure appropriate oversight and timely completion of future investigations.

Case Details	Description
Incident Date	03/08/2025
OLES Case Number	2025-00448-2A
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 used his knees to pin down a patient's arm during a containment.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/23/2025
OLES Case Number	2025-00532-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Conviction of a crime
Findings	1. Not Referred
Incident Summary	A pre-licensed psychiatric technician allegedly provided a bottle of chemical cleaner to a patient, which the patient utilized in an attempt to commit suicide.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with policies and procedures governing the investigative process. Interviews were not completed of the patient's doctors regarding any possible mental health injury resulting from the failed suicide attempt, and the unit shift lead was not questioned regarding the staff's knowledge of the patient's suicidal ideations. The investigator continued questioning a witness without the OLES monitor present on the telephone. The investigator submitted a draft investigative report containing an incorrect legal opinion

	of the mens rea required for the crime of dependent adult abuse. The investigation was not completed until 327 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Responding police officers failed to question level of care staff regarding any possible mental health injuries resulting from the patient's failed suicide attempt. 2. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator failed to interview the unit shift lead regarding the staff's knowledge of the patient's suicidal ideations and question the patient's doctors regarding any possible mental health injuries resulting from the patient's failed suicide attempt. 3. Were all of the interviews thorough and appropriately conducted? • No The investigator ended a phone call with the OLES monitor, who was monitoring a witness interview via telephone, and then asked the witness follow-up questions without the OLES monitor present. 4. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The draft investigative report included references to an irrelevant and inapplicable penal code section and contained the investigator's incorrect legal opinions regarding the mental state required for the crime of dependent adult abuse. 5. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator continued asking a witness questions after ending a telephone call with the OLES monitor. 6. Was the investigation thorough and appropriately conducted? • No Throughout the investigation, the investigator repeatedly relied upon an incorrect legal opinion regarding the mental state required from the crime of

	dependent adult abuse. In addition, despite the OLES monitor's repeated recommendations, the investigator failed to interview the unit shift lead regarding the staff's knowledge of the patient's suicidal ideations and question the patient's doctors regarding any possible mental health injuries resulting from the patient's failed suicide attempt. 7. Was the pre-disciplinary/investigative phase conducted with due diligence? • No No. The investigation was not completed until 327 days from the date of discovery.
Department Corrective Action Plan	Hospital police officers will ensure all appropriate witnesses, including treatment staff, are interviewed regarding any physical or mental health injuries relevant to the allegations. Supervisory review will ensure all necessary investigative steps have been completed prior to finalizing the investigation. Moving forward, investigators will ensure all potentially relevant witnesses are identified and interviewed, or the rationale for not conducting an interview is discussed with the Supervising Special Investigator (SSI) and the monitor. The completion of these duties will be monitored daily by the SSI. Investigators will ensure monitored interviews are completed in their entirety with the assigned OLES monitor present unless otherwise authorized. The SSI has made this a topic during a unit meeting. This expectation was understood by all the investigators in attendance. Moving forward, investigators will ensure legal analyses are supported by the applicable statutes and established legal standards. Supervisory review will verify the accuracy of legal references and investigative conclusions before draft reports are submitted. Investigators will maintain communication with assigned OLES monitors during monitored interviews and ensure all substantive questioning occurs while the monitor is present unless otherwise directed. Moving forward, investigators will ensure all recommended investigative steps are completed or appropriately documented, and legal analyses will be reviewed for accuracy through

	supervisory oversight prior to finalizing investigative findings. Supervisory staff will conduct routine case status reviews, monitor investigative timelines, and address potential delays as they arise. Investigators will promptly communicate any anticipated delays to supervisory staff to ensure appropriate oversight and timely completion of investigations.
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Case Details	Description
Incident Date	05/11/2025
OLES Case Number	2025-00569-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly aggressively scrubbed a patient's face with a soapy washcloth, getting the soapy cloth in the patient's mouth. When the patient told the psychiatric technician he hurt the patient's face, the psychiatric technician allegedly continued scrubbing the patient's face, and responded to the patient with profanity and a raised fist.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	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	2025-00603-2A

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 officer allegedly made inappropriate comments regarding patients.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction and training. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/16/2025
OLES Case Number	2025-00604-1C
Case Type	Monitored
Incident Types	1. Attempted Patient Suicide
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician and unidentified level of care staff allegedly made discourteous statements to a patient who had recently been on suicide precautions. A second psychiatric technician allegedly failed to adequately account for patients, and secure the unit quiet room where the patient was later found after injuring himself.
Disposition	The case was not referred to the district attorney's office

	due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/18/2025
OLES Case Number	2025-00618-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Insubordination
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	Initial: Other Final: Other
Incident Summary	A licensed vocational nurse allegedly refused multiple direct orders to be reassigned from an enhanced observation over a patient. The licensed vocational nurse became agitated and then allegedly refused multiple direct orders from supervisors and law enforcement to leave the facility. The licensed vocational nurse also allegedly yelled at several staff members, and pushed a sergeant and an officer.
Disposition	The hiring authority sustained the allegations; however, the licensed vocational nurse was registry staff, not a facility employee. Therefore, the licensed vocational nurse's contract was canceled. No further action could

	be taken. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed in a timely manner.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation commenced on July 29, 2025; however, the investigation was not completed until January 20, 2026, 175 days later.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will remind investigators of the expectations specified in policy regarding the completion of OLES monitored investigations, and the importance of adhering to specified timeframes. The SSI will also hold monthly meetings with the investigators for continual assessment of each investigator's caseload to identify critical junctures and ensure monitored investigations are completed within 120 days.
Case Details	Description
Incident Date	05/20/2025
OLES Case Number	2025-00629-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
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 hiring authority found insufficient evidence to sustain

	the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/24/2025
OLES Case Number	2025-00655-1A
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 licensed vocational nurse and a psychiatric technician allegedly neglected a patient by failing to keep the patient within line of sight while the patient was on enhanced observation. During the lapse in observation, the patient was allegedly raped.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/25/2025
OLES Case Number	2025-00665-1A
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 forcefully grabbed a patient's legs and feet in an attempt to force the patient to take a shower.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 152 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 152 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will meet with the investigator on a weekly basis to obtain updates on monitored cases. The SSI will ensure the investigators provide information regarding meetings and feedback from the OLES monitor. This will include the status of pending interviews, and any issues encountered that may delay the timely submission of the investigation. The OLES monitor has also discussed with the SSI that if a case review is requested for a possible case rejection, the request should come from the SSI. A log is being implemented with filters that track the time frames in conjunction with a board that is updated on a weekly basis by the SSI. Investigators will be afforded overtime if additional time is needed to complete investigations or to allow for accommodation of staff members that work PM

	or NOC shifts. A case extension will continue to be utilized if it is determined the investigation will be delayed as a result of issues with scheduling interviews due to vacations, injuries, or unavailability of registry staff members.
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Case Details	Description
Incident Date	06/13/2025
OLES Case Number	2025-00738-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement officer allegedly disclosed confidential investigative information about a suspect to individuals outside of the state hospital.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/29/2025
OLES Case Number	2025-00793-1A
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 punched the patient in the chest.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 162 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 162 days from the date of discovery
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators schedule and conduct interviews between high priority cases to meet deadlines. The SSI will meet with the investigators on a weekly basis to obtain updates on meetings and feedback from the OLES monitors. The SSI will verify investigators are scheduling interviews, and any issues encountered that may delay the timely submission of the investigation, will be discussed with the monitor. A Microsoft Excel tracking log is being implemented with filters that track the time frames. A case extension will continue to be utilized if the problem lies with staff scheduling due to vacations, injuries, or issues such as registry staff members.

Case Details	Description
Incident Date	07/02/2025
OLES Case Number	2025-00799-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly struck the head of a patient who was trying to de-escalate an agitated patient. The psychiatric technician also allegedly attempted to strike the agitated patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/07/2025
OLES Case Number	2025-00818-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	A psychiatric technician assistant allegedly shared photos on her cell phone with a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a Letter of Instruction. The OLES concurred with the hiring authority's determination.
Investigative	Overall Rating: Sufficient

Assessment	The department sufficiently complied with the policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	07/16/2025
OLES Case Number	2025-00852-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Insubordination
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement supervisor allegedly gave preferential treatment to their law enforcement officer spouse in assigning overtime in violation of the nepotism policy.
Disposition	The hiring authority determined that there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/16/2025
OLES Case Number	2025-00855-1C
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 and a second unidentified staff allegedly physically abused a patient as they and hospital police officers prevented the patient from escaping from a housing unit.
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. A Department of Protective Services supervisor did not interview three Hospital Police Officers present during the alleged abuse about their observations, requiring the Office of Special Investigations to conduct the interviews. The supervisor improperly saved the draft incident report on a desktop computer instead of the Records Management System without approval, preventing its review.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No A Department of Protective Services supervisor did not interview three Hospital Police Officers present during the alleged abuse about their observations, requiring the Office of Special Investigations to conduct the interviews. 2. Was the incident properly documented? • No The supervisor improperly saved the draft incident report on a desktop computer instead of the Records Management System without approval, preventing its review.
Department Corrective Action Plan	The Training Division will provide in-house training to officers and Supervisors utilizing POST Learning Domain 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. The Training Division will integrate OPS Policies #322 – Report Preparation and 600 – Investigation and Prosecution within the training. Supervisors will receive additional training in Peace Officer Bill of Rights, Policy

	300 – Use of Force, and Policy 1008 – Personnel Complaints. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.
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Case Details	Description
Incident Date	07/18/2025
OLES Case Number	2025-00870-1A
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 targeted a patient during a game, striking him in the groin with a foam ball.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/13/2025
OLES Case Number	2025-00871-1C

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	A nurse allegedly refused to treat a patient's injured finger. A senior psychiatric technician then allegedly failed to ensure the patient's finger was treated. The senior psychiatric technician and a psychiatric technician allegedly placed the patient in the seclusion room for no reason, and also refused to let the patient speak with a sergeant.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/27/2025
OLES Case Number	2025-00920-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly punched 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	08/01/2025
OLES Case Number	2025-00942-2A
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 abused a patient while placing him in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2025
OLES Case Number	2025-00955-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Criminal Act

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A civilian alleged that an officer drugged her with an unknown substance while on a date off duty.
Disposition	The hiring authority determined that 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	08/06/2025
OLES Case Number	2025-00958-1A
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	An unidentified staff member allegedly inappropriately touched a patient's middle finger and left ring finger.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was approved on December 8, 2025; however, the findings and penalty conference meeting with the hiring authority did not take place until March 9, 2026, 91 days later.

Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was approved on December 8, 2025; however, the findings and penalty conference meeting with the hiring authority did not take place until March 9, 2026, 91 days later.
Department Corrective Action Plan	The Office of Special Investigations (OSI) had a procedure in which investigator□ held onto case files after the monitors had approved the draft reports. In order to correct this, the Supervising Special Investigators (SSI) established a new process in which case files are not returned to the investigator pending the OLES review. To avoid any delays, files are now kept in the main office area for SSI access once the monitor has approved the report. The reports are then prepared for the hiring authority disposition meetings within the 20-day guidelines. The SSI will continue to monitor case files to be submitted to the hiring authority for adjudication.

Case Details	Description
Incident Date	08/22/2025
OLES Case Number	2025-01019-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly hit a patient on the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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 investigation was not completed until 144 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 144 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators will continue to strive to schedule and conduct interviews between high-priority cases. The investigator will be directed to coordinate with unit supervisors to have subject staff members available for interviews in order to avoid any delays. The SSI Supervising Special Investigator will assist if an investigator is met with staff members being uncooperative that may result in delayed investigations. The SSI will meet with the investigator on a weekly basis to obtain updates on meetings and feedback from the OLES monitor on the status of AIM, scheduled interviews, and/or any issues encountered that may delay the timely submission of the investigation, such as staff members delaying interviews. A tracking log is being implemented with filters that track the time frames for monitored cases. A case extension will continue to be utilized if there are issues scheduling interviews resulting from subjects or witnesses being unavailable staff scheduling due to vacations, injuries, or issues such as registry staff members.

Case Details	Description
Incident Date	08/22/2025
OLES Case Number	2025-01020-1A
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 registered nurse and a psychiatric technician were allegedly negligent while monitoring a patient who was on an enhanced level of observation. The patient swallowed part of a whiteboard.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/25/2025
OLES Case Number	2025-01026-2C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly attempted to kick a patient who was having a seizure.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/25/2025
OLES Case Number	2025-01028-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A senior psychiatric technician allegedly yanked and pulled on the injured leg of a patient who was lying on a table, refusing to get up. The senior psychiatric technician allegedly continued to pull on the patient's leg even though the patient told the senior psychiatric technician his leg was injured.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services will open an administrative investigation after the district attorney's review. The OLES will monitor the administrative investigation.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/27/2025
OLES Case Number	2025-01038-1A
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: Training Final: Training
Incident Summary	A registered nurse allegedly kicked a patient and allegedly failed to properly perform her rounds.
Disposition	The hiring authority determined there was insufficient evidence to sustain the abuse allegation. The OLES concurred with the hiring authority's determination. However, the hiring authority sustained the allegation of improperly performing rounds and determined additional training was the appropriate penalty. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with the policies and procedures governing the investigative process as the investigative report was completed on November 26, 2025, and the disposition meeting with OLES took place on February 6, 2026, 73 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 hiring authority did not timely consult with OLES regarding the sufficiency of the investigation and the investigative findings, as the investigative report was completed on November 26, 2025 and the consultation with OLES took place on February 6, 2026, 73 days later.
Department Corrective Action Plan	The case report was sent to the Executive Director from on December 15, 2026. The Hiring Authority inadvertently missed noting this investigation as a monitored case in the investigation tracking log. This resulted in OLES not having an opportunity to review the case and make recommendations on the level of action. The Hiring Authority has since updated their investigation tracking log to ensure all fields are completed, which now identifies cases that are OLES monitored and highlights the need for OLES review. The Hiring Authority will continue to track monitored cases and document when the disposition meeting with OLES has occurred.

Case Details	Description
Incident Date	08/27/2025
OLES Case Number	2025-01040-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Neglect 3. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Unidentified staff and law enforcement officers allegedly assaulted a patient. Unidentified staff and doctors allegedly raped the patient. Unidentified staff allegedly denied providing the patient with medication for his illnesses.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/27/2025
OLES Case Number	2025-01046-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A patient alleged he witnessed unidentified staff grab a patient by the shirt and lift him off a toilet seat. The same patient also alleged he witnessed unidentified staff grab a different patient by the shirt and push him against the wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Case Details	Description
Incident Date	09/02/2025
OLES Case Number	2025-01065-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly battered a patient, causing the patient to batter the senior psychiatric technician.
Disposition	The case as to the senior psychiatric technician 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 officer investigating the battery on staff interviewed the senior psychiatric technician, four staff witnesses and the patient. When investigating the patient's physical abuse allegation, the officer did not interview three of the staff

	witnesses and only documented a spontaneous comment made by the fourth staff member. The officer wrote and submitted separate reports, even though the report regarding staff assault documented the statements of four staff witnesses and the report regarding the patient's physical abuse allegation documented only a spontaneous comment made by one of the staff witnesses.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The officer investigating the battery committed by the patient interviewed the senior psychiatric technician, four staff witnesses, and the patient. When the patient alleged that the senior psychiatric technician had battered him, the officer did not interview three of the four staff witnesses and noted only a spontaneous comment from the fourth staff member that he did not witness anything. 2. Was the incident properly documented? • No The officer's report documenting the battery committed by the patient contained statements by the senior psychiatric technician, four staff witnesses, and the patient. The officer's report documenting the patient's physical abuse allegation did not include statements from the patient, three of the previously interviewed staff witnesses and noted only a spontaneous comment from the fourth staff member that he did not witness anything. The senior psychiatric technician was unavailable for interview regarding the physical abuse allegation.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the

	concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.
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Case Details	Description
Incident Date	09/09/2025
OLES Case Number	2025-01092-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient found another patient unresponsive in a restroom stall with a ligature around his neck. Level of care staff initiated life-saving measures. Outside emergency medical staff responded, taking over lifesaving efforts; however, the patient remained unresponsive, and was pronounced dead. The medical examiner determined the manner of death to be suicide and the cause of death to be asphyxia due to hanging.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime that contributed to the patient's death. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with the policies and procedures governing the investigative process. Although told by a psychiatric technician assistant that the patient was found unresponsive with a ligature around his neck, the reporting officer did not recall this until almost two hours later, resulting in a delay in recognizing a possible suicide and resulting in incomplete notifications to the facility's executive director, the Office of Special Investigations, and OLES.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No

	Although told by a psychiatric technician assistant that the patient was found unresponsive with a ligature around his neck, the reporting officer did not recall this until almost two hours later, resulting in a delay in recognizing a possible suicide and resulting in incomplete notifications to the facility's executive director, the Office of Special Investigations, and OLES.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing POST Learning Domain 18, Investigative Report Writing implementing policies #322 – Report Writing, #327 – Death Investigation, and #600 – Investigation and Prosecution within the training. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant.

Case Details	Description
Incident Date	09/09/2025
OLES Case Number	2025-01100-1A
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 doctor allegedly sexually assaulted a patient during a medical examination.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures

	governing the investigative process.
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Case Details	Description
Incident Date	09/09/2025
OLES Case Number	2025-01101-1A
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 demanded money from a patient and when the patient refused, the psychiatric technicians picked the patient up by his collar and took him to the side room causing the patient to hit his leg on the bed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 156 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 156 days from the date of discovery.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators will continue to strive to schedule and conduct interviews between high-priority cases. The investigator will

	be directed to coordinate with unit supervisors to have subject staff members available for interviews in order to avoid any delays. The SSI will assist if an investigator is met with staff members being uncooperative that may result in delayed investigations. The SSI will meet with the investigator on a weekly basis to obtain updates on meetings and feedback from the OLES monitor on the status of AIM, scheduled interviews, and/or any issues encountered that may delay the timely submission of the investigation, such as staff members delaying interviews. A tracking log is being implemented with filters that track the time frames for monitored cases. A case extension will continue to be utilized if there are any problems scheduling interviews resulting from subjects or witnesses being unavailable due to vacations, injuries, or other issues.
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Case Details	Description
Incident Date	09/12/2025
OLES Case Number	2025-01114-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly physically abused a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
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Incident Date	09/15/2025
OLES Case Number	2025-01125-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
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 172 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 172 days from the date of discovery.
Department Corrective Action Plan	The Supervising Investigator conduct routine case status reviews, monitor investigative timelines, and address potential delays as they arise. Investigators will promptly communicate any anticipated delays and document circumstances outside of their control that may affect investigative timelines to ensure appropriate oversight and timely completion of investigations.

Case Details	Description
Incident Date	09/22/2025

OLES Case Number	2025-01157-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly pushed a patient to the floor.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/24/2025
OLES Case Number	2025-01165-1A
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 pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	09/28/2025
OLES Case Number	2025-01175-1A
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 physically assaulted a patient by forcefully grabbing the patient's left arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/29/2025
OLES Case Number	2025-01181-1A
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 nurse allegedly touched a patient's genitals.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/27/2025
OLES Case Number	2025-01183-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly hit a patient in the mouth and temple and stabbed the patient with a pen in her right cheek.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/01/2025
OLES Case Number	2025-01193-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A patient returned from a prolonged stay at an outside hospital with twenty-seven pressure sores on his upper and lower body.
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	10/01/2025
OLES Case Number	2025-01202-1A
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 psychiatric technician allegedly grabbed a patient's genitals.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/09/2025
OLES Case Number	2025-01224-1A

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 senior psychiatric technician allegedly forced a patient to take "as needed" medication when it was not necessary and an unidentified staff member grabbed the patient's right arm and twisted it behind the patient's back.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/13/2025
OLES Case Number	2025-01236-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified male staff member allegedly hit a patient multiple times.
Disposition	The case was not referred to the district attorney's office

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

Case Details	Description
Incident Date	10/13/2025
OLES Case Number	2025-01240-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient returned from a 14 day stay at an outside hospital with a deep tissue genital pressure injury.
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	10/12/2025
OLES Case Number	2025-01243-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly asked a patient in a wheelchair what her race was, raised her right leg over the patient's lap and sat down on the patient's knees, facing the patient, remaining there until the patient told the the senior psychiatric technician to get off.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department did not adequately respond to nor properly document the incident. Although his incident report stated there were no attachments, the reporting officer collected and attached several documents, including observation notes written by staff members assigned to enhanced observation of the patient. The officer did not identify that the records identified the staff member assigned to watch the patient during the alleged abuse. The officer did not document efforts to identify potential staff witnesses, did not document his review of the collected documents, and did not identify nor attempt to interview the staff member who was watching the patient during the time of the alleged abuse. Despite these issues, a sergeant approved the incident report.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Although his incident report stated there were no attachments, the reporting hospital police officer collected and attached multiple documents, including observation notes written by staff members assigned to enhanced observation of the patient. The officer did not identify that the records identified the staff member assigned to watch the patient during the alleged abuse. The officer did not document efforts to identify potential staff witnesses, did not document his review of the collected documents, and did not identify nor attempt to interview the staff member who was watching the

	patient during the time of the alleged abuse. Despite these issues, a sergeant approved the incident report. 2. Was the incident properly documented? • No Although he wrote in the incident report there were no attachments, the reporting officer collected multiple documents and attached them to the case in the records management system. Among these were observation notes written by a staff member assigned to watch the patient during the time of the alleged abuse. However, the reporting officer's incident report did not document the officers' efforts to identify potential staff witnesses, did not document his review of the collected documents, and did not identify nor attempt to interview the staff member who was watching the patient during the time of the alleged abuse.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing POST Learning Domain 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers, and Officers attend the training. Training in the appropriate state laws and OPS policies #322 -Report Preparation, #327 Death Investigation and #600 Investigation and Prosecution, will be in within the in-house training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Division, will assess the quality of the reports and provide training for personnel who do not meet department expectations.

Case Details	Description
Incident Date	10/13/2025
OLES Case Number	2025-01244-1A

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 punched a patient several times in the back of the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/14/2025
OLES Case Number	2025-01245-1C
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	A senior psychiatric technician and two unidentified male staff members allegedly hit a patient in the day hall multiple times in the head, stomach, and groin, escorted him to a seclusion room, and continued to hit him in the head, stomach, and groin.
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	10/15/2025
OLES Case Number	2025-01254-2C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient returned from a five-day stay at an outside hospital with discoloration in his genitals consistent with developing pressure wounds
Disposition	The Office of Protective Services conducted an investigation, found insufficient evidence that the outside hospital neglected the patient while under their care, and did not refer the matter to the law enforcement agency whose jurisdiction included the outside hospital. 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	10/08/2025
OLES Case Number	2025-01264-3A
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Over-Familiarity

	3. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: No Penalty Imposed
Incident Summary	A communications operator purchased items for a patient and deposited money into the patient's trust account, in violation of ethics policy.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations. The communications operator resigned prior to the imposition of penalty. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/18/2025
OLES Case Number	2025-01268-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pinched a patient's back and also pulled at the hair on the patient's back as the psychiatric technician tried to remove the patient from the shower area.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.

Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	10/20/2025
OLES Case Number	2025-01278-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant allegedly hit a patient in the chest.
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	10/20/2025
OLES Case Number	2025-01279-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly dragged a patient into a bathroom and gave the patient drugs or

	medication.
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. Although level of care staff physically escorted an agitated patient to the seclusion room, the reporting officers (a field training officer and a trainee) reported their actions as "Therapeutic Strategies and Interventions (TSI)", instead of describing how the level of care staff actually controlled the patient. A sergeant approved the report.
Pre-Disciplinary Assessment	1. Was the incident properly documented? • No Although level of care staff physically escorted an agitated patient to the seclusion room, the reporting hospital police officers (a field training officer and a trainee) reported their actions as "Therapeutic Strategies and Interventions (TSI)", instead of describing how the level of care staff actually controlled the patient. A sergeant approved the report.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.

Case Details	Description
Incident Date	08/25/2025
OLES Case Number	2025-01283-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: Dismissal
Incident Summary	An academy cadet was allegedly dishonest and acted in bad faith when she submitted an invalid Penal Code section 832 certificate to human resources.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and voided the cadet's appointment. OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/28/2025
OLES Case Number	2025-01314-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred

Incident Summary	A patient and "everyone" 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	10/28/2025
OLES Case Number	2025-01317-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed and verbally threatened a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/24/2025
OLES Case Number	2025-01334-2A
Case Type	Monitored

Incident Types	1. Peace Officer Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A hospital staff member claimed that a law enforcement officer was aggressive and threatening towards her in the staff parking lot.
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	05/05/2024
OLES Case Number	2025-01339-1A
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 made one patient physically abuse another patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process, the

	investigation took 159 days from the date of discovery to complete the report.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 159 days from the date of discovery
Department Corrective Action Plan	The Supervising Special Investigators will contact the Operations Lieutenant to ensure timely approval of OLES monitored cases to be forwarded to Office of Special Investigations (OSI) allow timely assignments to an investigator. The SSI will meet with the investigator on a weekly basis to obtain updates on meetings and feedback from the OLES monitor on the status of scheduled interviews, and/or any issues encountered that may delay the timely submission of the investigation. A tracking log is being implemented with filters that track the time frames for monitored cases. This will be utilized in conjunction with the tracking board that is updated on a weekly basis by the SSI. Investigators may be afforded overtime if additional time is needed to complete their reports or to allow for accommodation of staff members that work PM or NOC shifts. A case extension will be utilized if there are any issues scheduling interviews resulting from subjects or witnesses being unavailable due to vacations, injuries, or issues such as registry staff members.

Case Details	Description
Incident Date	10/30/2025
OLES Case Number	2025-01345-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician and a pre-licensed

	psychiatric technician allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Insufficient The investigation was not completed until 147 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 147 days from the date of discovery.
Department Corrective Action Plan	The investigation was not completed within the expected timeframe. During the investigative period, the assigned investigator was absent from work for approximately five weeks, which contributed to the overall delay in completing the investigation. Upon the investigator's return, efforts were made to complete the remaining investigative tasks; however, the case ultimately exceeded the expected completion timeline. The Supervising Special Investigator will continue to monitor investigative caseloads on a weekly basis, conduct periodic case status reviews, and promptly reassign or otherwise address cases when extended employee absences may impact investigative timelines. Investigators will also provide notification of circumstances that may delay case completion to ensure appropriate oversight and timely completion of assigned investigations.

Case Details	Description
Incident Date	10/29/2025
OLES Case Number	2025-01346-1C

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

Case Details	Description
Incident Date	10/29/2025
OLES Case Number	2025-01347-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient returned from a 15 day stay at an outside hospital with a deep tissue genital pressure injury.
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	11/04/2025
OLES Case Number	2025-01378-1A
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 assistant was allegedly overly familiar with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/06/2025
OLES Case Number	2025-01381-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly placed a patient in a chokehold as the patient attempted to leave a unit without permission.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of

	Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/07/2025
OLES Case Number	2025-01389-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An identified male staff member allegedly grabbed a patient by both sides of the head, lifted the patient from a wheelchair, and slammed the patient's face on a table.
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	11/07/2025
OLES Case Number	2025-01390-1C
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 registered nurse allegedly kicked a patient twice while the patient was being contained on the floor. A health records technician who witnessed the alleged abuse did not timely report the abuse to the Office of Protective Services.
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 adequately respond to the incident nor properly document the incident in the incident report. A staff witness not assigned to the unit but in the nurses' station reported witnessing a physical abuse in the day hall. The responding officers (a field training officer and a trainee) did not determine where in the nurses' station the reporting staff member was, where in the day hall the alleged abuse occurred, and whether there were obstructions or distractions affecting the reporting staff witness' ability to observe. The officers did not explain how they identified the involved patient or the alleged suspect. Although they obtained relevant unit documents, the officers did not identify significant information within those documents, including the notations of the registered nurse who was assigned as the enhanced observer of the patient during the time of the alleged abuse. The incident report contained numerous errors, including misidentifying staff members or classifications of those contacted as witnesses and not identifying significant information in unit documents the officers had collected, including the notations of the patient's enhanced observer for the relevant time period in the Observation Record for Behavioral or Restraint. A sergeant approved the report.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No A staff witness not assigned to the unit but in the nurses' station reported witnessing a physical abuse in the day

	hall. The responding officers (a field training officer and a trainee) did not determine where in the nurses' station the reporting staff member was, where in the day hall the alleged abuse occurred, and whether there were obstructions or distractions affecting the reporting staff witness' ability to observe. The officers did not explain how they identified the involved patient or the alleged suspect. Although they obtained relevant unit documents, the officers did not identify significant information within those documents, including the notations of the registered nurse who was assigned as the enhanced observer of the patient during the time of the alleged abuse. 2. Was the incident properly documented? • No The incident report prepared by the responding officers (a field training officer and a trainee) contained numerous errors, including misidentifying staff members or classifications of those contacted as witnesses and not identifying significant information in unit documents the officers had collected, including the notations of the Patient's enhanced observer for the relevant time period in the Observation Record for Behavioral or Restraint. A sergeant approved the report.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. Additional training for Field Training Officers and Sergeant will be allocated for the proper report review process. The Operations Lieutenants will track reviewed OLES reports Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.

Case Details	Description
Incident Date	11/04/2025
OLES Case Number	2025-01391-1A
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 physically attacked a patient and took the patient's vending card and bought chips with it.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/10/2025
OLES Case Number	2025-01393-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred

	4. Not Referred 5. Not Referred
Incident Summary	Five unidentified staff members allegedly verbally demeaned and pushed 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	11/08/2025
OLES Case Number	2025-01396-1C
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 pre-licensed psychiatric technician allegedly threw a patient to the ground, causing a head injury.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. Unit staff cleaned the crime scene before the officer could take

	photographs and collect evidence.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Unit staff directly disobeyed an officer's order not to clean the crime scene, thereby resulting in the loss of potential evidence.
Department Corrective Action Plan	Both law enforcement and therapeutic supervisory staff will reinforce expectations with hospital personnel regarding crime scene preservation and the requirement to comply with law enforcement directives during active investigations. Staff will be reminded that potential crime scenes are not to be disturbed until they have been released by the responding investigator or hospital police officer.

Case Details	Description
Incident Date	11/11/2025
OLES Case Number	2025-01412-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified male staff member allegedly punched a patient through the open medication room door as the patient was walking by.
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	11/13/2025
OLES Case Number	2025-01427-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician observing a patient on enhanced observation in wrist-to-waist restraints allegedly used inappropriate language and then slammed the patient to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/13/2025
OLES Case Number	2025-01433-1C
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 allegedly hit a patient in the face causing a fractured orbital bone.

Disposition	The case was referred to the district attorney's office. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/15/2025
OLES Case Number	2025-01437-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly tackled a patient, throwing him to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/15/2025
OLES Case Number	2025-01437-2A
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 tackled a patient, throwing him to the ground.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. The department repeatedly refused to interview the responding officers regarding their perception of the patient's movements when the psychiatric technician initiated a containment on the patient, and the issue was not resolved until after the first draft investigative report was written and a meeting occurred between the Department of Protective Services and OLES.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The department initially refused to interview the responding officers regarding their perception of the patient's movements when the psychiatric technician initiated a containment on the patient. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No Because the department initially refused to interview the responding officers regarding their perception of the patient's movements when the psychiatric technician initiated a containment on the patient, the initial draft did not contain these critical interviews.
Department Corrective Action Plan	Investigators will ensure all witnesses identified as having potentially relevant information are interviewed during the investigative process, or that the rationale for not conducting an interview is discussed with the Supervising Special Investigator and the monitor. Supervisory review will ensure all necessary investigative steps have been completed prior to

	finalizing the investigation. Moving forward, investigators and supervisory staff will ensure all identified witnesses are interviewed, or the rationale for not conducting an interview is documented, prior to submission of draft investigative reports. This will help ensure draft reports contain all relevant investigative information before being forwarded for review.
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Case Details	Description
Incident Date	11/16/2025
OLES Case Number	2025-01438-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	While being placed in restraints in a seclusion room, a registered nurse allegedly punched a patient once in the nose and spat on the patient's left eye.
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 officer observed the uncooperative patient yelling and disobeying staff, observed multiple staff members use Therapeutic Strategies and Interventions (TSI) techniques to place the patient in restraints, observed the patient spit at and strike or attempt to strike staff after slipping his restraints. The officer did not conduct recorded interviews with the involved and witnessing staff members and did not write an incident report regarding the staff assaults because the victim staff members did not desire prosecution. Instead, following facility practice, the officer documented

	cursory notes in the computer aided dispatch record. When the patient alleged that a staff member had struck him on the nose and spat in his left eye, the officer initiated an investigation of the patient's abuse allegation. Although the officer observed much of the incident between staff and the patient, the officer only interviewed the patient. The officer's incident report regarding the patient's physical abuse allegation only included the officer's observations and the patient's interview and did not document interviews of the other staff members present. A sergeant approved the report. Although the Office of Special Investigations requested that the officer identify and interview the involved staff members regarding the alleged abuse, the officer conducted cursory interviews of three staff members, did not document the Therapeutic Strategies and Interventions (TSI) techniques used by staff, did not determine how the patient received his nose injury, did not commence interviews until 97 days after the incident, and did not complete a supplemental report until 107 days after the incident. Because of this, the Office of Special Investigations was required to identify witnesses, conduct interviews, and complete its report in a short period of time in order to comply with the 120-day investigative time-frame.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The responding officer observed the uncooperative patient yelling and disobeying staff, observed multiple staff members use Therapeutic Strategies and Interventions (TSI) techniques to place the patient in restraints, observed the patient spit at and strike or attempt to strike staff after slipping his restraints. The officer did not conduct recorded interviews with the involved and witnessing staff members and did not write an incident report regarding the staff assaults because the victim staff members did not desire prosecution. Instead, following facility practice, the officer documented cursory notes in the computer aided dispatch record. When the patient alleged that a male staff member had struck him on the nose and spat in his left eye, the officer initiated an investigation of the

	patient's abuse allegation. Although the officer observed much of the incident between staff and the patient, the officer only interviewed the patient. 2. Was the incident properly documented? • No The officer's incident report regarding the patient's physical abuse allegation only included the officer's observations and the patient's interview and did not document interviews of the other staff members present. A sergeant approved the report. Although the Office of Special Investigations requested that the officer identify and interview the involved staff members regarding the alleged abuse, the officer conducted cursory interviews of three staff members, did not document the Therapeutic Strategies and Interventions (TSI) techniques used by staff, did not determine how the patient received his nose injury, did not commence interviews until 97 days after the incident, and did not complete a supplemental report until 107 days after the incident. Because of this, the Office of Special Investigations was required to identify witnesses and conduct interviews in a short period of time in order to comply with the 120-day investigative time-frame.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants, Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. State law, and OPS policies will be within the training objectives. Additional training will be allotted for FTOs and Sergeants covering the review process. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. Any incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department

	expectations.
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Case Details	Description
Incident Date	11/12/2025
OLES Case Number	2025-01453-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly stepped on a patient's neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/13/2025
OLES Case Number	2025-01457-1C
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 with his fists.
Disposition	The case was not referred to the district attorney's office

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

Case Details	Description
Incident Date	11/24/2025
OLES Case Number	2025-01477-1C
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 unknown staff member allegedly pulled a patient's arm, injuring the shoulder.
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	11/23/2025
OLES Case Number	2025-01482-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed a patient, put the patient against a wall, then placed the patient in seclusion for no reason. The psychiatric technician also allegedly made discourteous comments towards the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/27/2025
OLES Case Number	2025-01515-1C
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 on the back of his soft helmet to wake him, poured water on the patient's back, pushed the patient's head back, and forced medication down his throat.
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	12/05/2025
OLES Case Number	2025-01520-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Two psychiatric technicians allegedly sexually assaulted a patient, while a third psychiatric technician allegedly watched the assault.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/08/2025
OLES Case Number	2025-01527-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly tortured a patient by placing him in wrist-to-waist restraints for two weeks.
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	12/10/2025
OLES Case Number	2025-01535-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	When a patient tried to grab snacks in the day hall, a psychiatric technician allegedly grabbed the patient's arm, pulled the patient away, yelled at the patient, and called him a derogatory name. On the previous day, unknown staff members forced the patient to take medication.
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	07/19/2025
OLES Case Number	2025-01550-2A
Case Type	Monitored

Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	Initial: Counseling Final: Counseling
Incident Summary	A law enforcement sergeant allegedly gave conflicting orders to a hospital police officer in violation of DSH policy regarding Standards of Conduct.
Disposition	The hiring authority determined that there was sufficient evidence to sustain the allegation and issued the sergeant a counseling memorandum. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/12/2025
OLES Case Number	2025-01552-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse was allegedly sexually aroused and rubbed himself against a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative	Overall Rating: Sufficient

Assessment	The department complied with policies and procedures governing the investigative process.
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Case Details	Description
Incident Date	12/14/2025
OLES Case Number	2025-01553-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pushed a patient and hit the patient's head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/11/2025
OLES Case Number	2025-01569-1A
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 registered nurses allegedly pushed a patient during a fire drill.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/16/2025
OLES Case Number	2025-01575-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A nurse allegedly failed to medically assess an ill patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation of abuse, but found sufficient evidence to sustain the allegation that the nurse failed to properly document the patient's medical status. However, the nurse resigned before discipline could be imposed. A letter indicating the nurse resigned under adverse circumstances was placed in her official personnel file. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/18/2025
OLES Case Number	2025-01598-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pulled a seated patient by his clothing from his chair in the day hall to the patio against his will.
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	12/05/2025
OLES Case Number	2025-01622-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	Multiple staff allegedly denied a patient transfer requests, exposed the patient to violence, provoked the patient, and forced unnecessary medication upon the patient.

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

Case Details	Description
Incident Date	12/26/2025
OLES Case Number	2025-01628-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff observed numerous pressure wounds on a patient, including a genital pressure wound, after the patient returned from a 57-day stay at an outside medical facility.
Disposition	The Office of Protective Services conducted an investigation, found insufficient evidence that the outside hospital neglected the patient while under their care, and did not refer the matter to the law enforcement agency whose jurisdiction included the outside hospital. 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	12/27/2025
OLES Case Number	2025-01642-1C
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	A psychiatric technician allegedly made kissing noises with his mouth a few inches from a patient's face. The psychiatric technician then allegedly followed the patient around the unit, and made discourteous statements to other patients about the first patient. The next day, the psychiatric technician allegedly hit the first patient's arm with a shower door as the patient entered the shower area. A few days later, the psychiatric technician allegedly made discourteous statements to another staff member about the first patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/29/2025
OLES Case Number	2025-01643-1C
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 slammed a patient against a wall three times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/31/2025
OLES Case Number	2026-00001-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	While a patient was being placed in restraints after assaulting staff members, a psychiatric technician allegedly struck the patient once in the mouth with the palm of his right hand.
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. Although they interviewed three witnesses in the hour preceding the patient alleging he was punched in the nose, the responding hospital police officers did not recontact the witnesses regarding the abuse claim nor did they document why they were unable to do so.

	Because of this, the Office of Special Investigations was required to conduct the interviews to complete a thorough investigation.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Although they interviewed three witnesses in the hour preceding the patient alleging he was punched in the nose, the responding hospital police officers did not recontact the witnesses regarding the abuse claim nor did they document why they were unable to do so. Because of this, the Office of Special Investigations was required to conduct the interviews to complete a thorough investigation.
Department Corrective Action Plan	The Training Division will provide in-house training to officers utilizing LD 18, Investigative Report Writing. Command Staff will ensure Sergeants Field Training Officers and Officers attend the training. Operations Lieutenants will be responsible for the review of all OLES monitored reports once approved by the Sergeant. The Operations Lieutenants will track reviewed OLES reports for the Hospital Police Chief and will document concerns. incomplete or inaccurate reports will be returned to the authoring officer and approving Sergeant with the instructions of the changes needed to address the concerns. The Command Staff, in coordination with the Training Unit, will assess the quality of the reports and provide training for personnel who do not meet department expectations.

Case Details	Description
Incident Date	11/27/2025
OLES Case Number	2026-00053-1A
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 unidentified staff members allegedly hit a patient in the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/10/2025
OLES Case Number	2026-00061-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred
Incident Summary	After escorting a patient to the seclusion room and placing him in restraints, a psychiatric technician allegedly used a choke hold to choke the patient, after which four other psychiatric technicians joined the first and allegedly repeatedly punched 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 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	01/16/2026
OLES Case Number	2026-00067-1A
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 pushed the patient when she tried to enter the stairwell.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/23/2026
OLES Case Number	2026-00098-1A
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 sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/26/2026
OLES Case Number	2026-00104-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	
Findings	
Incident Summary	A senior psychiatric technician allegedly slammed a patient's head against a wall during a wall containment procedure. After escorting the patient to a seclusion room, the senior psychiatric technician allegedly pushed the patient onto the restraint bed.
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	01/16/2026
OLES Case Number	2026-00131-1A
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 assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/28/2026
OLES Case Number	2026-00141-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	A law enforcement officer allegedly engaged in discourteous treatment of an office assistant.
Disposition	The hiring authority determined that there was not sufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/02/2026
OLES Case Number	2026-00145-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Training Final: Training
Incident Summary	A registered nurse allegedly failed to report possible abuse by a psychiatric technician to the Office of Protective Services.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and ordered additional training on reporting requirements. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/03/2026
OLES Case Number	2026-00146-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	While escorting a patient to a seclusion room, a psychiatric technician allegedly kicked a patient once in the leg.
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	02/09/2026
OLES Case Number	2026-00176-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred
Incident Summary	A patient was allegedly taken to the housing unit basement where multiple female patients and multiple unidentified male staff members raped her while the patient's son and husband watched.
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	02/11/2026
OLES Case Number	2026-00195-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly squeezed a patient's left breast during a medical examination.
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	02/13/2026
OLES Case Number	2026-00203-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly struck the wrist of an aggressive patient with a bundle of unit keys
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	03/02/2026
OLES Case Number	2026-00285-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient complained of ongoing back pain. After a recent unwitnessed fall, x-rays were taken, and confirmed the patient had a compression fracture of his lumbar vertebrae.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/05/2026
OLES Case Number	2026-00301-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	During patient grooming, a psychiatric technician assistant allegedly struck a patient on the side of the face with hot white towels.
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	03/05/2026
OLES Case Number	2026-00305-1C
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 once on the back of the head as the patient stood alone in the restroom.
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	03/22/2026

OLES Case Number	2026-00308-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Two psychiatric technicians allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	02/23/2026
OLES Case Number	2026-00322-1C
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 bedroom, forcibly removed his blankets, and kicked the patient in the left shin.
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.
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Case Details	Description
Incident Date	03/14/2026
OLES Case Number	2026-00352-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly targeted a patient, leading to physical containment and placement in restraints.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/10/2026
OLES Case Number	2026-00376-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	During a floor containment procedure, a 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	04/07/2026
OLES Case Number	2026-00502-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly sexually assaulted a patient on three occasions.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.

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	07/09/2023
OLES Case Number	2023-00988-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Incompetency 2. Inexcusable neglect of duty 3. Discourteous treatment 4. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	A psychiatric technician allegedly challenged a patient to fight and placed his hands around the patient's neck.

Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. OLES concurred. The psychiatric technician resigned before discipline could be imposed. The department failed to place a letter, indicating the psychiatric technician resigned under adverse circumstances, in his official personnel file.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	05/01/2023
OLES Case Number	2023-01425-2A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Incompetency 3. Discourteous treatment 4. Willful disobedience 5. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	A food services technician allegedly took photographs and video of a patient with her personal cell phone, distributed the photographs and video to the patient's relatives, placed money in the patient's trust account, and had numerous phone conversations with the patient.

Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. OLES concurred. The food services technician filed an appeal with the State Personnel Board. At the pre-hearing settlement conference prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the food services technician resigned, withdrew her appeal with prejudice and agreed to attach the settlement agreement to any application should she reapply for state employment. OLES concurred because the settlement was reasonable.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	01/02/2024
OLES Case Number	2024-00004-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Sustained 4. Not Sustained 5. Not Sustained

	6. Sustained 7. Sustained 8. Sustained
Penalty	Initial: Salary Reduction Final: No Penalty Imposed
Incident Summary	A psychiatric technician allegedly failed to report observed patient abuse. A second psychiatric technician allegedly engaged in sexual activity with a patient and allegedly engaged in an inappropriate relationship with the patient while the patient was in a conditional release program. Two other psychiatric technicians allegedly engaged in sexual activity with the patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain allegations of failing to report the alleged patient abuse against the first psychiatric technician. The hiring authority determined that a 5% pay reduction for 12 pay periods was the appropriate penalty. The first psychiatric technician appealed and ultimately the state withdrew the disciplinary action due to the expiration of the statute of limitations. The OLES concurred. The hiring authority also sustained all allegations against the second psychiatric technician; however, no disciplinary action could be taken against the second psychiatric technician because he resigned before completion of the investigation. A letter indicating the second psychiatric technician resigned under adverse circumstances was placed in the second psychiatric technician's official personnel file. The hiring authority determined there was insufficient evidence to sustain the allegations against the two remaining psychiatric technicians. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Overall Rating: Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was approved on July 15, 2024; however, the findings and penalty conference meeting with the hiring authority did not take place until October 14, 2024, 91 days later.
Pre-Disciplinary	1. Was the pre-disciplinary/investigative phase

Assessment	conducted with due diligence? • No The investigation was approved on July 15, 2024; however, the findings and penalty conference meeting with the hiring authority did not take place until October 14, 2024, 91 days later.
Disciplinary Assessment	Overall Rating: Insufficient The department did not comply with policies and procedures governing the disciplinary process. The penalty conference with the hiring authority took place on January 2, 2025, however, the Notice of Adverse Action was not drafted by the department until June 4, 2025; 153 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The penalty conference with the hiring authority took place on January 2, 2025, however, the Notice of Adverse Action was not drafted by the department until June 4, 2025; 153 days later.
Department Corrective Action Plan	In order to correct this, the Human Resources Department has provided training to all staff on Investigation Process Guideline Threshold Incidents, DSH PD 5332 - Office of Law enforcement Support Investigation Process Timeliness and -□PD 6001 Office of Law Enforcement Support (OLES) Oversight - Investigation Review Process - Disposition Committee. A Microsoft Excel tracking sheet has been created in which OLES monitored cases are highlighted to track due dates. The department has provided expectations for all staff that OLES cases are to be prioritized.

Case Details	Description
Incident Date	05/20/2024
OLES Case Number	2024-00754-2A
Case Type	Monitored
Incident Types	1. Neglect

Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty 9. Inexcusable neglect of duty 10. Inexcusable neglect of duty 11. Inexcusable neglect of duty 12. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained 7. Not Sustained 8. Sustained 9. Sustained 10. Sustained 11. Not Sustained 12. Sustained
Penalty	Initial: Salary Reduction Final: Modified Salary Reduction
Incident Summary	A registered nurse allegedly slept while on enhanced observation of a patient. Additionally, two other registered nurses, a psychiatric technician, and a senior psychiatric technician allegedly failed to timely report they observed the employee sleeping. The psychiatric technician and senior psychiatric technician also allegedly failed to cooperate with the investigation.
Disposition	The hiring authority sustained the allegations against the nurse who was on enhanced observation and determined a 12-working day suspension was the appropriate penalty. The hiring authority sustained allegations against the second nurse for failing to timely report patient neglect and determined a letter of instruction was the appropriate penalty. The hiring

	authority did not sustain allegations against the third registered nurse. The hiring authority also sustained the allegations against both the psychiatric technician and senior psychiatric technician and determined letters of warning were the appropriate penalty. The OLES concurred with all of the findings and penalty determinations. The first registered nurse filed an appeal with the State Personnel Board. Prior to the hearing, the department entered into a settlement agreement with the first registered nurse wherein the penalty was reduced to a 6-working day suspension in exchange for withdrawing the appeal. The OLES concurred because the settlement was reasonable.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the disciplinary process. The notice of adverse action was not served on the senior psychiatric technician until 239 days after the hiring authority made disciplinary findings.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The notice of adverse action was not served on the senior psychiatric technician until 239 days after the hiring authority made disciplinary findings.
Department Corrective Action Plan	The Department will ensure patient notifications are sent at the time Employee Relations sends the Notice of Adverse Action (NOAA) to the DSH Legal team for review. In order to correct this, the Human Resources Department has provided training to all staff on Investigation Process Guideline Threshold Incidents, DSH PD 5332 - Office of Law enforcement Support Investigation Process Timeliness and - PD 6001 Office of Law Enforcement Support (OLES) Oversight - Investigation Review Process - Disposition Committee. A Microsoft Excel tracking sheet has been created in which OLES monitored cases are highlighted

	to track due dates. The department has provided expectations for all staff that OLES cases are to be prioritized.
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Case Details	Description
Incident Date	06/05/2024
OLES Case Number	2024-00822-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Willful disobedience 2. Inexcusable neglect of duty 3. Dishonesty 4. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: Dismissal
Incident Summary	A psychiatric technician was transporting a patient in a state vehicle. The psychiatric technician allegedly drove the vehicle in a reckless manner, resulting in a collision, and causing injury to the patient. The psychiatric technician allegedly failed to report the collision and likewise failed to obtain medical attention for the patient. The psychiatric technician was allegedly dishonest when he was questioned about the incident. Additionally, the psychiatric technician had allegedly failed to maintain a defensive driving certificate as required by policy.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board upheld the dismissal of the psychiatric technician.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures

	governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	09/02/2024
OLES Case Number	2024-01224-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
Incident Summary	A law enforcement officer allegedly shoved a psychiatric technician and allegedly looked up a prior unrelated case involving the psychiatric technician in RMS to show she was dishonest.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation of physical abuse. The OLES concurred with the hiring authority's determination. The hiring authority determined there was sufficient evidence to sustain the allegation of discourteous treatment and imposed a five percent salary reduction for seven months. The OLES concurred with the hiring authority's determination. The law enforcement officer did not file an appeal with the State Personnel Board.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies

	and procedures governing the disciplinary process.
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Case Details	Description
Incident Date	09/03/2024
OLES Case Number	2024-01295-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Salary Reduction Final: Modified Salary Reduction
Incident Summary	A psychiatric technician and a registered nurse allegedly failed to provide medication to a patient in a timely manner. The registered nurse was also allegedly uncooperative, disrespectful, and rude to a hospital investigator during the investigative interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the psychiatric technician and imposed a salary reduction of 5 percent for seven months. The hiring authority also sustained the allegations against the registered nurse and imposed a salary reduction of 10 percent for nine months. OLES concurred with the hiring authority's determinations. The registered nurse filed an appeal with the State Personnel Board. Prior to hearing, the hiring authority entered into a settlement agreement with the registered nurse wherein the penalty was reduced to 10 percent salary reduction for three months. The OLES concurred with the penalty reduction because it still achieved a deterrent effect, and secured finality on the matter. The psychiatric technician did not appeal the decision.
Investigative Assessment	Overall Rating: Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. It took 177 days to complete the investigation from the

	date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 177 days after the date of discovery.
Disciplinary Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The Supervising Special Investigators (SSI) will ensure investigators schedule and conduct interviews between high-priority cases. The investigator will be directed to coordinate with unit supervisors to have subject staff members available for interviews in order to avoid any delays. The SSI will assist an investigator if met with uncooperative staff members that may result in delayed investigations. The SSI will meet with the investigator on a weekly basis to obtain updates on meetings and feedback from the OLES monitor on the status of scheduled interviews, and/or any issues encountered that may delay the timely submission of the investigation. A tracking log is being implemented with filters that track the time frames for monitored cases. A case extension will be utilized if there are any issues scheduling interviews resulting from subjects or witnesses being unavailable due to vacations, injuries, or issues such as registry staff members.

Case Details	Description
Incident Date	12/15/2024
OLES Case Number	2024-01645-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Suspension

	Final: Suspension
Incident Summary	A psychiatric technician allegedly failed to maintain proper supervision of a patient and the patient swallowed a toothbrush.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a suspension for 12 days. The OLES concurred with the hiring authority's determination. The psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Insufficient The disciplinary phase was not conducted with due diligence by the department. The disposition meeting was held on July 8, 2025, and the disciplinary action was not completed until October 6, 2025, 90 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No The disciplinary phase was not conducted with due diligence by the department. The disposition meeting was held on July 8, 2025, and the disciplinary action was not completed until October 6, 2025, 90 days later.
Department Corrective Action Plan	In order to correct this, the Human Resources Department has provided training to all staff on Investigation Process Guideline Threshold Incidents, DSH PD 5332 - Office of Law enforcement Support Investigation Process Timeliness and -PD 6001 Office of Law Enforcement Support (OLES) Oversight- Investigation Review Process - Disposition Committee. A Microsoft Excel tracking sheet has been created in which OLES monitored cases are highlighted to track due dates. The department has provided expectations for all staff that OLES cases are to be prioritized.

Case Details	Description
Incident Date	12/23/2024
OLES Case Number	2024-01681-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Other failure of good behavior 4. Discourteous treatment
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	A psychiatric technician allegedly struck a sight impaired patient once on the back of the head and attempted to dissuade a witness from reporting his actions.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Following the pre-hearing settlement conference, the department entered into a settlement agreement wherein the psychiatric technician resigned and withdrew his appeal with prejudice. OLES concurred because the settlement was reasonable. 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.
Disciplinary Assessment	Overall Rating: Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	01/01/2025
OLES Case Number	2025-00005-2A
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: Salary Reduction Final: Modified Salary Reduction
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 hiring authority sustained the allegations and determined the appropriate penalty was a 10 percent salary reduction for 12 months. The OLES concurred with the hiring authority's determinations. Following a Skelly hearing, the department entered into a settlement agreement wherein the department agreed to reduce the salary reduction to 5 percent for 12 months and the officer agreed to waive his right to appeal. The OLES concurred as the officer expressed remorse for his actions and sought treatment, reducing the likelihood of recurrence.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient Overall, the department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	04/14/2025
OLES Case Number	2025-00463-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: Letter of Reprimand
Incident Summary	A law enforcement officer allegedly harassed and intimidated a state hospital employee.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined a salary reduction for 10 percent for 12 months was the appropriate penalty. The officer filed an appeal with the State Personnel Board. Prior to the evidentiary hearing, the department entered into a settlement agreement with the officer, wherein it was agreed that the penalty would be reduced to a formal letter of reprimand. The OLES concurred.
Investigative Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient The department sufficiently complied with the policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	04/21/2025
OLES Case Number	2025-00497-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior 2. Dishonesty

Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: Dismissal
Incident Summary	An off-duty law enforcement officer was allegedly involved in a single vehicle traffic accident while intoxicated. The officer was also allegedly dishonest to outside law enforcement regarding the incident.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	Overall Rating: Sufficient The department complied with policies and procedures governing the disciplinary process.

Appendix D: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

- (a) The Office of Law Enforcement Support within the California Health and Human Services Agency shall investigate both of the following:
 - (1) Any incident at a developmental center or state hospital that involves developmental center or state hospital law enforcement personnel and that meets the criteria in section 4023 or 4427.5 or alleges serious misconduct by law enforcement personnel.
 - (2) Any incident at a developmental center or state hospital that the Chief of the Office of Law Enforcement Support, the Secretary of the California Health and Human Services Agency, or the Undersecretary of the California Health and Human Services Agency directs the office to investigate.
- (b) All incidents that meet the criteria of section 4023 or 4427.5 shall be reported immediately to the Chief of the Office of Law Enforcement Support by the Chief of the facility's Office of Protective Services.
- (c)
 - (1) Before adopting policies and procedures related to fulfilling the requirements of this section related to the Developmental Centers Division of the State Department of Developmental Services, the Office of Law Enforcement Support shall consult with the executive director of the protection and advocacy agency established by section 4901, or his or her designee; the Executive Director of the Association of Regional Center Agencies, or his or her designee; and other advocates, including persons with developmental disabilities and their family members, on the unique characteristics of the persons residing in the developmental centers and the training needs of the staff who will be assigned to this unit.
 - (2) Before adopting policies and procedures related to fulfilling the requirements of this section related to the State Department of State Hospitals, the Office of Law Enforcement Support shall consult with the executive director of the protection and advocacy agency established by section 4901, or his or her designee, and other advocates, including persons with mental health disabilities, former state hospital residents, and their family members.

4023.7.

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

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

4023.8.

- (a) (1) Commencing October 1, 2016, the Office of Law Enforcement Support shall issue regular reports, no less than semiannually, to the Governor, the appropriate policy and budget committees of the Legislature, and the Joint Legislative Budget Committee, summarizing the investigations it conducted pursuant to section 4023.6 and its oversight of investigations pursuant to section 4023.7. Reports encompassing data from January through June, inclusive, shall be made on October 1 of each year, and reports encompassing data from July to December, inclusive, shall be made on March 1 of each year.
- (2) The reports required by paragraph (1) shall include, but not be limited to, all of the following:
 - (A) The number, type, and disposition of investigations of incidents.
 - (B) A synopsis of each investigation reviewed by the Office of Law Enforcement Support.
 - (C) An assessment of the quality of each investigation, the appropriateness of any disciplinary actions, the Office of Law Enforcement Support's recommendations regarding the disposition in the case and the level of disciplinary action, and the degree to which the agency's authorities agreed with the Office of Law Enforcement Support's recommendations regarding disposition and level of discipline.
 - (D) The report of any settlement and whether the Office of Law Enforcement Support concurred with the settlement.
 - (E) The extent to which any disciplinary action was modified after imposition.
 - (F) Timeliness of investigations and completion of investigation reports.
 - (G) The number of reports made to an individual's licensing board, including, but not limited to, the Medical Board of California, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, or the California State Board of Pharmacy, in cases involving serious or criminal misconduct by the individual.
 - (H) The number of investigations referred for criminal prosecution and employee disciplinary action and the outcomes of those cases.
 - (I) The adequacy of the State Department of State Hospitals' and the Developmental Centers Division of the State Department of Developmental Services' systems for tracking patterns and monitoring investigation outcomes and employee compliance with training requirements.
- (3) The reports required by paragraph (1) shall be in a form that does not identify the agency employees involved in the alleged misconduct.
- (4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise

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

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

California Welfare and Institutions Code 4427.5

4427.5.

- (a) (1) A developmental center shall immediately report the following incidents involving a resident to the local law enforcement agency having jurisdiction over the city or county in which the developmental center is located, regardless of whether the Office of Protective Services has investigated the facts and circumstances relating to the incident:
 - (A) A death.
 - (B) A sexual assault, as defined in section 15610.63.
 - (C) An assault with a deadly weapon, as described in section 245 of the Penal Code, by a nonresident of the developmental center.
 - (D) An assault with force likely to produce great bodily injury, as described in section 245 of the Penal Code.
 - (E) An injury to the genitals when the cause of the injury is undetermined.
 - (F) A broken bone, when the cause of the break is undetermined.
 - (2) If the incident is reported to the law enforcement agency by telephone, a written report of the incident shall also be submitted to the agency, within two working days.
 - (3) The reporting requirements of this subdivision are in addition to, and do not substitute for, the reporting requirements of mandated reporters, and any other reporting and investigative duties of the developmental center and the department as required by law.
 - (4) Nothing in this subdivision shall be interpreted to prevent the developmental center from reporting any other criminal act constituting a danger to the health or safety of the residents of the developmental center to the local law enforcement agency.
- (b) (1) The department shall report to the agency described in subdivision (i) of section 4900 any of the following incidents involving a resident of a developmental center:
 - (A) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
 - (B) Any allegation of sexual assault, as defined in section 15610.63, in which the alleged perpetrator is a developmental center or department employee or contractor.
 - (C) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in section 15610.63, in which a staff member is implicated.
 - (2) A report pursuant to this subdivision shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 4023

4023

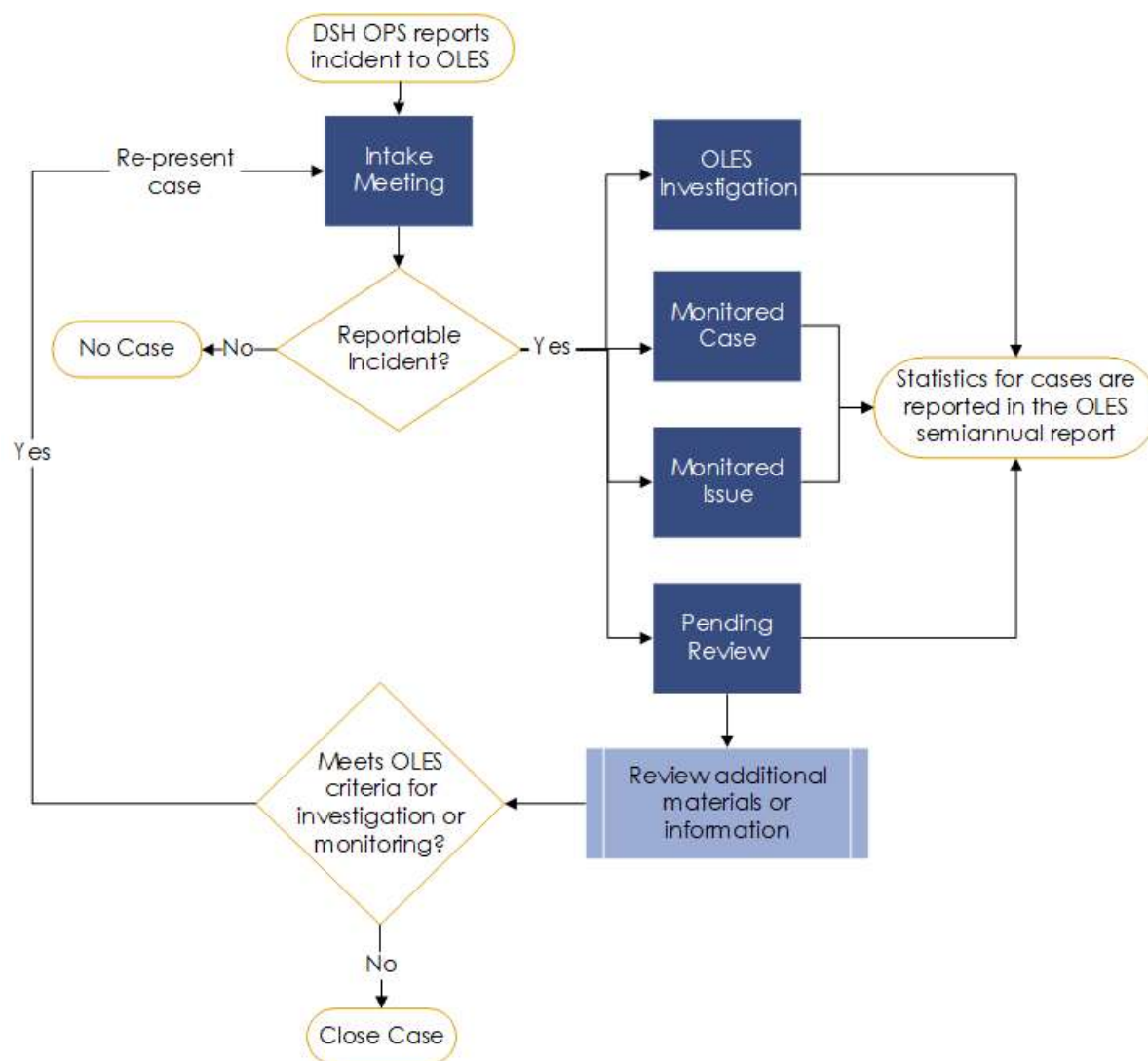
- (a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of section 4900 the following incidents involving a resident of a state mental hospital:
 - (1) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
 - (2) Any allegation of sexual assault, as defined in section 15610.63, in which the alleged perpetrator is an employee or contractor of a state mental hospital or of the Department of Corrections and Rehabilitation.
 - (3) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in section 15610.63, in which a staff member is implicated.
- (b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

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

Appendix E: OLES Intake Flow Chart



Outline Description

1. OLES receives a notification of an incident and discusses the incident during an intake meeting
2. The disposition of the incident case may be assigned to any of the following:
 - a. No Case
 - b. Pending review
 - i. If the disposition is pending review, the case is reviewed for sufficient information and is re-presented at an intake meeting if the additional information meets OLES criteria. From there, the case may be investigated, monitored, or become a monitored issue.
 - 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.