



Office of Law Enforcement Support

Semiannual Report

July 1, 2016–December 31, 2016

Independent review and assessment of law enforcement and employee misconduct at the California state hospitals and developmental centers

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 this report, which completes the first full year that the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency provided oversight and monitoring at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Per its statutory authority, the OLES focused on law enforcement programs and employee misconduct at the departments and conducted internal investigations of DSH and DDS police personnel.

The data in this report stem primarily from activities that occurred from July 1, 2016, through December 31, 2016. The report also incorporates data and insights from the first half of 2016 to provide a full first-year baseline on the departments' reported incidents that impacted the safety and security of patients and clients who are under the state's care.

In addition, this report provides the status, as of December 31, 2016, of the 39 recommendations that the OLES presented to the departments in the first semi-annual report. These recommendations – 19 at DSH and 20 at DDS -- are for best practices in law enforcement, employee discipline processes and the tracking and analyzing of employee misconduct cases. The DSH had complied with the OLES's recommendations regarding standardizing equipment on a statewide basis, such as the baton being issued to police officers, and fully implemented a computerized Early Intervention System that flags potentially problematic behavior among law enforcement employees. DDS had expanded its recruitment efforts.

This reporting period also brings to a close the consulting services of two full-time California Highway Patrol (CHP) law enforcement staff at the OLES. I am grateful for the assistance and subject matter experts that the CHP provided. The OLES continues to leverage the subject matter experts from the California Office of the Inspector General and the California Department of Corrections and Rehabilitation.

Additionally, I am thankful for the contributions and assistance provided by the families, friends and advocates of the patients and clients at DSH and DDS facilities. In the final half of 2016, the OLES continued to build relationships with these stakeholders and incorporate their input. With their help, the OLES is developing into a unique entity that is at the forefront of one of society's most troubling challenges – how to provide a safe, secure environment where the mentally ill and developmentally disabled can receive optimal treatment.

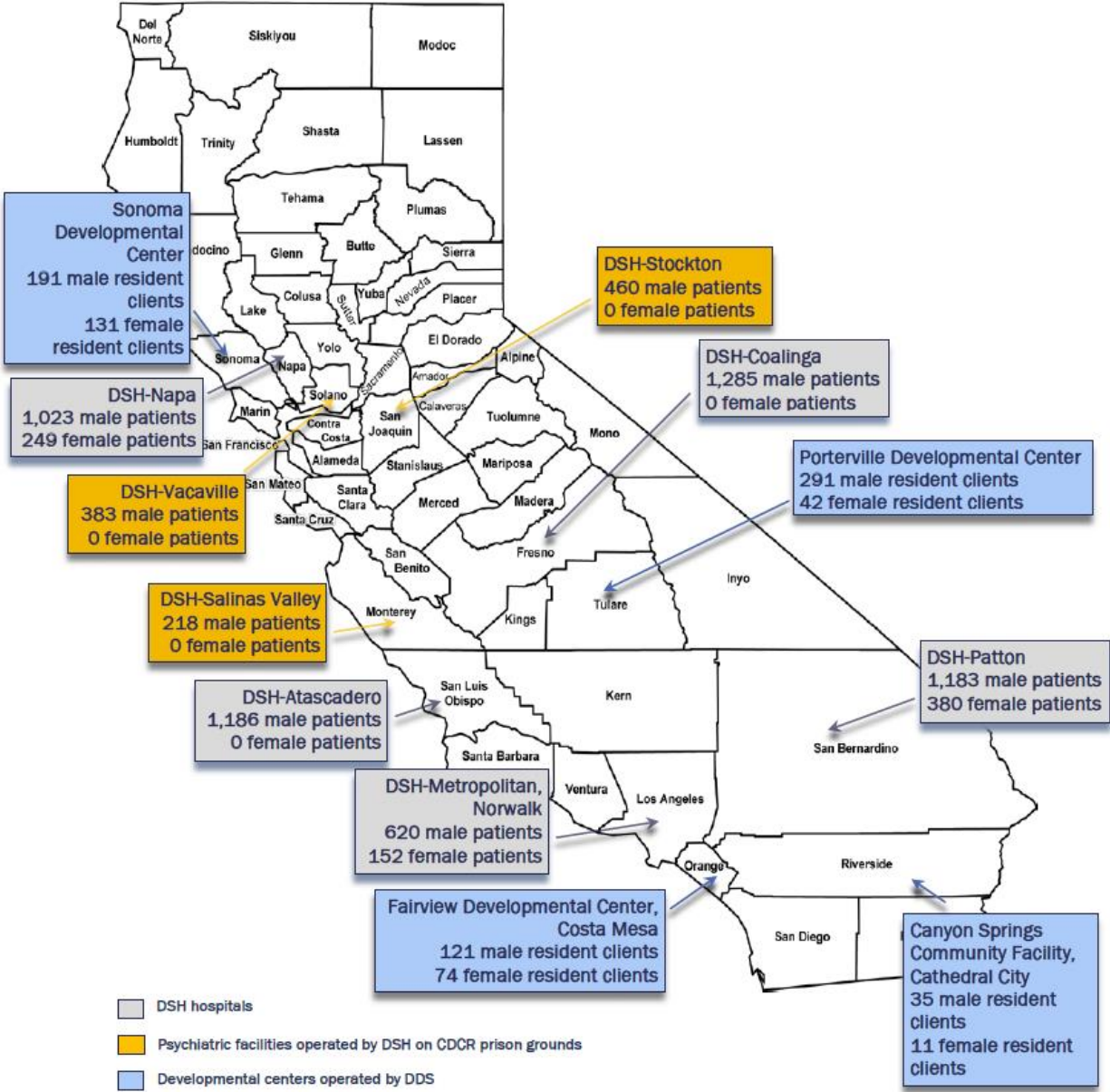
I welcome your comments and questions. Please visit the OLES website at

www.oles.ca.gov to contact us.

*Ken Baird
Chief, Office of Law Enforcement Support*

Facilities

The DSH and DDS facilities where the OLES conducts investigations and provides contemporaneous oversight (monitoring) are shown below.



Note: Population numbers as of December 31, 2016, were provided by the departments. DSH total rose by 155 patients, or 2.2 percent, from June 30, 2016. DDS total declined from June 30, 2016, by 52 clients, or 5.5 percent.

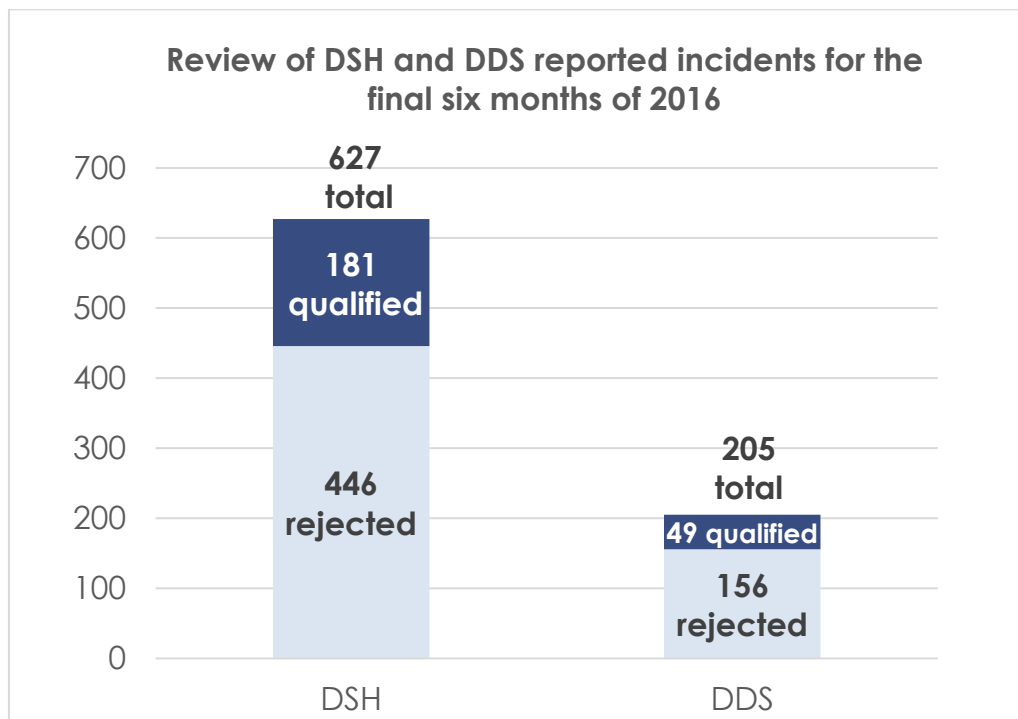
DSH and DDS Facility Population Chart

Facility	Number of Male Residents/Patients	Number of Female Residents/Patients
DSH-Atascadero	1,186	0
DSH-Coalinga	1,285	0
DSH-Metropolitan	620	152
DSH-Napa	1,023	249
DSH-Patton	1,183	380
DSH-Salinas Valley	218	0
DSH-Stockton	460	0
DSH-Vacaville	383	0
Fairview	121	74
Porterville	291	42
Sonoma	191	131
Canyon Springs	35	11

Executive Summary

From July 1, 2016, through December 31, 2016, the Office of Law Enforcement Support (OLES) received and reviewed 832 reports of prescribed incidents¹ at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Prescribed incidents included alleged misconduct by state employees, serious offenses between facility residents and reports of resident pregnancies and deaths, among other occurrences. The 832 reports were on par with the 830 incident reports that the OLES received in the first half of 2016. The number of incidents that met the OLES criteria for investigations and/or monitoring in the final six months of 2016 totaled 230, which is a 19 percent decrease from the 285 in the first half of the year. There also were declines in certain types of incidents reported at the departments. These included use of force, neglect and broken bones.

For the full calendar year, the 1,662 total incidents reported at DSH and DDS averaged more than four a day, seven days a week. This was more than double the number projected for the OLES as it began first-time monitoring of DSH and DDS law enforcement and the departments' investigations in January 2016.



At least three quarters of the reported incidents, as well as the incidents meeting the OLES criteria for investigations and/or monitoring in the last half of 2016, were at DSH. This was not unexpected since DSH had approximately 7.5 times as many patients at

¹ Prescribed incident reports were pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix F)

its eight facilities during the period as DDS had clients in its four state-operated developmental centers.²

As in the first half of 2016, the single largest category of incidents received by the OLES from both departments during the July through December period involved allegations of abuse.³ The total 255 abuse incident reports in the period accounted for 31 percent of all DSH and DDS incidents that were reported to the OLES. Almost half of the 255 abuse incidents in the last half of the year, or 49 percent, met the criteria for the OLES to investigate and/or monitor.

At both DSH and DDS, sexual assault reports increased in the second half of the year. At DSH, they were the second largest category of incidents in the period, and they increased 66.3 percent from the first half of the year – from 89 to 148. Forty of the 148 DSH sexual assault reports in the period, or 27 percent, qualified for OLES investigation and/or monitoring. As in the first reporting period, 41 percent of these DSH incident reports alleged that a patient had sexually assaulted another.

At DDS, reports of alleged sexual assault were far fewer than at DSH and totaled 18 in the last half of 2016. However, this was double the nine incidents reported in the first half of 2016. Twenty-two percent, or four of the 18 incidents, qualified for monitoring by the OLES.

Taking into account that in the first half of 2016, some law enforcement allegations were contained in the OLES's "misconduct" category, the allegations against DSH law enforcement personnel in the last half of the year were generally consistent in number with the first period. At DDS, there were no reported incidents involving law enforcement during the reporting period.

Like DSH, DDS was required to report to the OLES all head and neck injuries of facility residents if they needed treatment beyond first aid. As a result, at DDS, where residents are developmentally disabled, these injuries were the second most prevalent incidents reported in the second half of 2016. Head/neck injury reports totaled 33, for 16 percent of all 205 DDS incidents in the period.

Both departments showed marked improvement in their reporting of incidents to the OLES. At DSH, the overall timely reporting of incidents to the OLES rose from approximately 73 percent to just over 80 percent. DDS law enforcement boosted its timely reporting of incidents from approximately 79 percent in the first half of 2016 to slightly over 90 percent. In fact, all reported incidents at two DDS facilities – Sonoma and Canyon Springs in Cathedral City – met the OLES notification requirements during the period.

² Patient and client population numbers for the period were provided by DSH and DDS.

³ Initial reports were descriptions of allegations. During its intake process, the OLES determined, for the purposes of OLES investigation and monitoring, whether the described allegations met the statutory definitions for physical abuse and sexual assault in Welfare and Institutions Code Section 15610.63.

Results of the OLES investigations

Per the statute,⁴ an OLES investigation commenced after the OLES was notified of an allegation that a DSH or DDS law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents.⁵ From July 1, 2016, through December 31, 2016, the OLES conducted investigations into 29 second-half incidents. Twenty of these investigations were completed by the end of the reporting period, and nine had not concluded. During the last six months of 2016, the OLES also completed 17 investigations that had been opened in the first half of the year. One case from the first half of the year remained open as of December 31, 2016.

During the second half of the year, 14 cases were referred to the hiring authority for disposition. Several of these cases resulted in sustained administrative findings. Nine cases were closed by the OLES after further analysis. None of the 18 OLES criminal cases reported in this document resulted in probable cause referrals to a prosecuting agency.

Results of the OLES monitored cases

In this report's appendices B, C and D, the OLES provides information on the 149 monitored cases that, by December 31, 2016, had reached completion of one type or another. As described on page 28, 21 monitored administrative cases were deemed insufficient by the OLES – 18 were procedurally insufficient only and three were procedurally and substantively insufficient. Another 10 monitored criminal cases also were found to be insufficient – eight were procedurally insufficient only and two were procedurally and substantively insufficient. In addition, during the July through December 2016 period, 27 of 92 monitored cases at DSH and DDS, or 29 percent, had sustained allegations. This compares with 12 of 54 monitored cases at the departments, or 22 percent, in the first half of 2016.

During 2016, the OLES monitored approximately 453 cases. As of December 31, 2016, approximately 253, or approximately 56 percent of these DSH and DDS cases, remained open. Of the 253, approximately 83 dated back to the first half of the year. Results for these continuing OLES monitored cases will be presented in subsequent reports.

Monitored Issues

In the course of its work, the OLES identified systemic issues, such as observed patterns of misconduct and shortcomings in policy, procedures and protocol, at the departments. The OLES labeled these items “monitored issues” and brought them to the attention of the departments along with a request for a response back to the OLES within a specific time. In most instances, the OLES also asked the departments

⁴ Welfare and Institutions Code Section 4023.6 (2). (See Appendix F).

⁵ An OLES investigation also could start when ordered by the California Health and Human Services Secretary, Undersecretary or the OLES Chief.

for corrective action plans. Appendix E contains the monitored issues that were resolved during the July through December 2016 reporting period.

Additional mandated data

The statute⁶ requires the OLES to compile and report statistics on criminal and administrative investigations and notifications to state licensing boards. This information, which had not been publicly released on a regular basis before, is contained in tables starting on page 28.

OLES recommendations for best practices

For this report, the OLES followed up with the departments on 39 recommendations that the OLES had made to them in the first semi-annual report that would bring them in line with best practices in law enforcement and employment discipline. The departments' responses and status reports start on page 35.

⁶ Welfare and Institutions Code Section 4023.8.

Types of incidents

Every OLES case started with a report of an incident. Reports of incidents – alleged, inferred or actually witnessed at the facilities – can arrive at the OLES from many sources 24/7. In the July through December 2016 reporting period, nearly all incident reports came from the departments.

Most frequent DSH incidents reported this period

Overall, the number of DSH incidents reported to the OLES from July 1, 2016, through December 31, 2016, increased 8.5 percent, from 578 in the first half of 2016 to 627. As shown in the chart below, only 181, or 30 percent of the DSH incidents in the last half of the year, qualified for OLES investigation and/or monitoring. This was 8 percent fewer than the 197 incidents that qualified in the first half. Overall, DSH incidents declined in several categories.

DSH reported incidents this period

Incident Categories	Number of Reports July 1 – Dec. 31	Number Meeting OLES Criteria July 1-Dec. 31
Abuse	164	98
Sexual Assault	148	40
Head/Neck Injury	92	2
Law Enforcement	56	5
Neglect	53	16
Death	31	8
Other, Significant	27	5
Use of Force	16	3
Attempted Suicide	10	0
AWOL	9	1
Broken Bone	8	1
Misconduct	7	2
Burns	2	0
Genital Injury	2	0
Non-Resident Assault	1	0
Professional Board Violation	1	0
Pregnancy	0	0
Attack on Staff	0	0
Child Pornography	0	0
Riot	0	0
Totals	627	181

As in the first half of 2016, allegations of abuse⁷ of patients at DSH made up the single largest category of incidents that came to the OLES, and the allegations also accounted for the single largest category that met the OLES criteria for investigation and/or monitoring during the period. As the adjacent chart shows, 26 percent of the DSH incidents – 164 of the 627 total reported incidents – cited abuse of patients that did not involve sexual assault. This number was a decline of 25 percent from the 220 abuse incidents reported to the OLES in the first half of 2016 but still amounted to nearly one abuse report per day in the final six months of the year. More than 59 percent of the abuse incident reports from July through December 2016 met the OLES criteria for investigation and/or monitoring.

Note that while “abuse” was how certain incidents were described when they arrived at the OLES, the determination of whether each incident met the threshold for the OLES’s purposes of investigation and monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.⁸ It also is critical that every incident reported by mental health patients be given thorough and objective review.

The OLES tracked sexual assault⁹ allegations separately, and they accounted for the second largest category of incidents reported at DSH. The OLES received 148 incidents alleging sexual assault, for 24 percent of the DSH total, in the final six months of 2016. This was up 66 percent from the 89 sexual assault incidents reported in the first half of 2016. Of the total 148 incidents reported at DSH, 37 involved allegations against state employees. Forty of the 148 incidents, or 27 percent, met

⁷ Initial incident reports were descriptions of allegations. During its intake process, the OLES determined, for the purposes of OLES investigation and monitoring, whether the described allegations met the statutory definitions for physical abuse and sexual assault in Welfare and Institutions Code Section 15610.63.

⁸ Welfare and Institutions Code 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.

⁹ Allegations of sexual assault included those that did not involve state employees.

the OLES criteria for investigation and/or monitoring.

Taking into account that in the first half of 2016, some law enforcement allegations were contained in the OLES's "misconduct" category, incidents involving law enforcement misconduct at DSH were generally consistent throughout the year. Five of the 56 reported incidents, or 9 percent, met the OLES criteria for investigation and/or monitoring.

The OLES received 92 reports involving head and neck injuries at DSH in the last half of 2016 – 39 percent more than in the first half. Only two reports qualified for OLES investigation and/or monitoring. Because head and neck injuries have the potential for lasting health impairment or death and may be indicative of assault, battery or neglect, the OLES required DSH to report every head and neck injury that required treatment beyond first aid.

There were no reports of pregnancies among DSH patients during the last six months of the year, while there were four reported pregnancies in the first half of 2016. Note that the table on the previous page shows all incidents reported, inclusive of allegations against staff as well as against other patients.

Most frequent DSH incidents reported in 2016

As shown in the chart on the next page, five categories of reported incidents accounted for 82 percent of all 2016 reports at DSH. These categories are abuse, sexual assault, head/neck injuries, allegations against law enforcement and neglect. These same five categories also accounted for 85 percent of all the DSH incidents during the year that met the criteria for the OLES to investigate and/or monitor.

DSH reported incidents in 2016

Incident Categories	Number Reported July 1- Dec. 31	Number Meeting OLES Criteria July 1- Dec. 31	Number Reported Jan. 1- June 30	Number Meeting OLES Criteria Jan.1- June 30	Totals of All 2016 Incident Reports	2016 Totals Meeting OLES Criteria
Abuse	164	98	220	100	384	198
Sexual Assault	148	40	89	22	237	62
Head/Neck Injury	92	2	66	6	158	8
Law Enforcement	56	5	17	8	73	13
Neglect	53	16	57	25	110	41
Death	31	8	32	7	63	15
Significant-	27	5	11	1	38	6

Other						
Use of Force	16	3	19	7	35	10
Attempted Suicide	10	0	3	1	13	1
AWOL	9	1	14	0	23	1
Broken Bone	8	1	11	3	19	4
Misconduct	7	2	25	13	32	15
Burns	2	0	2	0	4	0
Genital Injury	2	0	1	0	3	0
Non-Resident Assault	1	0	0	0	1	0
Professional Board Violation	1	0	1	1	2	1
Pregnancy	0	0	4	3	4	3
Attack on Staff	0	0	3	0	3	0
Child Pornography	0	0	2	0	2	0
Riot	0	0	1	0	1	0
Totals	627	181	578	197	1,205	378

Sexual assault reports at DSH in 2016

As shown in the chart above, the OLES received 237 incident reports alleging sexual assault at DSH facilities during 2016, and 62 of them, or 26 percent, qualified for OLES investigation and/or monitoring. More than 45 percent of the 237 reports, or 107, alleged patients sexually assaulted other patients. Allegations that DSH staff members sexually assaulted patients totaled 65 during the year, for 27 percent of the year's sexual assault incident reports. Another 16 percent of the sexual assault incidents reported during 2016 were defined by the OLES as "unknown" because allegations made by patients did not implicate DSH employees or contactors. This "unknown" category included allegations that implicated family or friends in incidents that occurred when patients were not in a DSH facility. In addition, this category included allegations made by patients that sexual assaults may have occurred but they were unsure if another person was involved. All reports of alleged sexual assaults that the OLES received during the year are shown on the next page. It is important to note that the OLES takes every allegation seriously and closely reviews every case per the statutes, regardless of who is identified as the alleged perpetrator.

Reported incidents of alleged sexual assault at DSH in 2016

Allegations	Number Reported July 1- Dec.31	Number Reported Jan.1 – June 30	Totals for 2016	Percent of Total
Patient on Patient	67	40	107	45.1%
Staff on Patient	37	28	65	27.4%
Unknown on Patient	27	12	39	16.4%
Law Enforcement on Patient	14	6	20	8.4%
Patient on Staff	3	3	6	2.5%
Totals	148	89	237	100%

Deaths of DSH patients reported in 2016

There were 63 deaths – 56 men and seven women – reported at six DSH facilities during the year. Ages ranged from 30 to 90, with 62 the average age of the deceased. Approximately three-quarters of the deaths, or 48 of them, were classified by facility medical directors as “expected”¹⁰ due to underlying health conditions, such as cancer or heart disease. Fifteen other deaths were classified as “unexpected,” and each of these deaths received two levels of reviews within DSH, per department policy. The OLES also reviewed all deaths and monitored departmental investigations into 15 unexpected DSH deaths that occurred in 2016.

Reported causes of death of DSH patients – 2016

Facility	Cancer	Cardiac/Respiratory	Renal/Liver	Cerebral Issue	Other	Totals
DSH-Napa	7	7	2	1	3	20
DSH-Coalinga	7	5	1	0	1	14
DSH-Patton	5	5	0	0	2	12
DSH-Metropolitan	4	5	1	1	0	11
DSH-Atascadero	2	1	0	0	2	5
DSH-Vacaville	0	0	0	0	1	1
Totals	25	23	4	2	9	63

*Other deaths were those that were not accounted for in the top four categories. These included a death that the department attributed to “severe diabetes” and another attributed to “multiple medical problems,” including a seizure disorder.

Most frequent DDS incidents reported this period

Overall, the number of DDS incidents reported to the OLES in the July through

¹⁰ Per department policy, medical directors at DSH facilities made the determination of whether a death was “expected” or “unexpected.” The department also requires staff to follow DSH policy for standardized death investigations and “mortality reviews.”

December 2016 period declined 19 percent, from the 252 in the first half of the year to 205. Forty-nine of the DDS incidents in the last half of the year, or 24 percent, qualified for OLES investigation and/or monitoring. This was 44 percent fewer than the 88 incidents that qualified in the first half of the year. DDS showed declines in the majority of the 17 incident categories including abuse, neglect, use of force and head and neck injuries.

DDS reported incidents this period

Incident Categories	Number Reported July 1- Dec. 31	Number Meeting OLES Criteria July 1-Dec. 31
Abuse	91	27
Head/Neck injury	33	0
Broken Bone	23	9
Sexual Assault	18	4
Death	10	2
Neglect	9	5
Genital Injury	7	2
Other, Significant	7	0
AWOL	5	0
Burns	1	0
Attack on Staff	1	0
Use of Force	0	0
Misconduct	0	0
Attempted Suicide	0	0
Law Enforcement	0	0
Professional Board Violation	0	0
Non-Resident Assault	0	0
Totals	205	49

As in the first half of 2016, allegations of abuse that did not involve sexual assault were the most common type of incident at DDS reported to the OLES during the reporting period. Just over 44 percent, or 91 of the 205 total incidents, alleged abuse during the reporting period.

It is important to note that while “abuse” was how certain incidents were described when they arrived at the OLES, the determination of whether each incident met the threshold for the OLES’s purposes of investigation and monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.¹¹ It is also critical that every incident reported by

¹¹ Welfare and Institutions Code 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.

mental health patients and the developmentally disabled be given thorough and objective review.

At DDS, reports of head and neck injuries constituted the second most frequent incident received by the OLES. However, during the July 1, 2016, through December 31, 2016, reporting period, reports of these injuries decreased to 33 from 38 in the first half of the year, and none met the statutory requirement for the OLES to investigate or monitor. Note that because head and neck injuries have the potential for lasting health impairment or death and may be indicative of assault, battery or neglect, the OLES required DDS to report every head and neck injury that needed treatment beyond first aid.

Incidents involving sexual assault allegations at DDS were tracked separately by the OLES, and they doubled to 18 in the July through December 2016 reporting period. As a result, sexual assault allegations jumped from sixth to fourth in the ranking of the most frequent incidents at DDS reported to the OLES in the recent period. Four of the incidents, or approximately 22 percent of the total, qualified for investigation and/or monitoring by the OLES.

Reports of broken bones totaled 23 during the period compared with 24 in the first half of 2016. Broken bones remained the third most frequent incident reported at DDS, accounting for 11 percent of all incidents, according to the OLES data. Nine of these incidents qualified for OLES investigation and/or monitoring compared with eight in the first half of 2016. The OLES also was notified of 10 client deaths at DDS during the reporting period, which was half as many reports of deaths as in the first half of 2016.

Most frequent DDS incidents reported in 2016

As shown in the chart below, four categories of incidents accounted for 78 percent of all 2016 reports at DDS. These categories are abuse, broken bones, sexual assaults and head/neck injuries. These same four categories also accounted for 79 percent of all the DDS incidents during the year that met the criteria for the OLES to investigate and/or monitor.

(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.

DDS reported incidents in 2016

Incident Categories	Number Reported July 1- Dec. 30	Number Meeting OLES Criteria July 1- Dec. 31	Number Reported Jan. 1- June 30	Number Meeting OLES Criteria Jan.1- June 30	Totals of All 2016 Incident Reports	2016 Totals Meeting OLES Criteria
Abuse	91	27	120	55	211	82
Head/Neck Injury	33	0	38	3	71	3
Broken Bone	23	9	24	8	47	17
Sexual Assault	18	4	9	2	27	7
Death	10	2	20	4	30	6
Neglect	9	5	18	12	27	17
Genital Injury	7	2	4	1	11	3
Other Significant	7	0	1	0	8	0
AWOL	5	0	4	0	9	0
Burns	1	0	3	0	4	0
Attack on Staff	1	0	1	0	2	0
Use of Force	0	0	3	1	3	0
Misconduct	0	0	3	1	3	1
Attempted Suicide	0	0	1	0	1	0
Law Enforcement	0	0	1	1	1	1
Professional Board Violation	0	0	1	1	1	1
Non-Resident Assault	0	0	1	0	1	0
Totals	205	49	252	88	457	138

Sexual assault reports at DDS in 2016

As shown in the chart below, the OLES received 27 incident reports alleging sexual assault at DDS during 2016, which amounted to 6 percent of all incident reports at the department. Approximately two thirds of the sexual assault reports alleged clients assaulted other clients. Allegations that DDS staff members sexually assaulted clients accounted for six of the year's sexual assault incident reports. The OLES categorized the remaining three reported incidents of alleged sexual assaults as "unknown" because allegations made by clients did not implicate DDS employees

or contactors. In addition, the OLES includes in this category allegations made by clients that sexual assaults may have occurred but they were unsure if another person was involved.

Reported incidents of alleged sexual assaults at DDS in 2016

Sexual Assault Reports at DDS	Number Reported July 1-Dec.31	Number Reported Jan.1 – June 30	Totals for 2016
Client on Client	11	7	18
Staff on Client	4	2	6
Unknown on Client	3	0	3
Law Enforcement on Client	0	0	0
Client on Staff	0	0	0
Totals	18	9	27

Deaths of DDS clients reported in 2016

There were 30 deaths of DDS clients at three facilities reported to the OLES during the year – 18 men and 12 women. The deceased ranged in age from 34 to 82, with 58 the average age. Most of the deaths – 25 – were classified by the department as “expected” due to underlying health conditions. The OLES reviewed all deaths that were reported. The OLES reviewed or monitored investigations into the deaths that were classified as “unexpected.”

Reported causes of death of DDS clients - 2016

Facility	Cardiac/Respiratory	Cancer	Renal/Liver	Spinal Issue	Other	Totals
Sonoma	7	2	1	0	3	13
Fairview	8	0	1	1	1	11
Porterville	5	0	0	0	1	6
Totals	20	2	2	1	5	30

*Other deaths were those not accounted for in the top four categories or whose cause was not provided. These included a death attributed to influenza where the client had major underlying health conditions.

Distribution of Incidents

Distribution of incidents at DSH this period

With 627 incidents reported to the OLES in the July 1, 2016, through December 31, 2016, period, DSH accounted for more than 75 percent of the 832 incidents the OLES received. Three of the eight DSH facilities – Napa, Patton and Vacaville -- reported fewer total incidents than in the first six months of the year. Indeed, the Napa hospital reduced its incident count by 37 percent – from 79 in the first half to 50 – resulting in a department-best 3.94 incident rate per 100 patients. Still, the incident rate per 100 patients in DSH overall rose to 8.9 from 8.4 because of increases in incidents reported at other facilities.

DSH-Coalinga, in particular, had a jump in reported incidents in the last half of 2016. The facility had ranked third in the number of incidents reported in the first half of the year. In the second half, Coalinga had the highest number of reports – 123, for a 40 percent increase in incidents per 100 patients– in the department. The charts below show the distribution of reported incidents among the eight DSH facilities.

All Reported Incidents Per DSH Facility – July 1-Dec. 31

Rank	Facility	Number of Patients*	Incidents Reported	Incidents Per 100 Patients
1	DSH-Coalinga	1,277	123	9.63
2	DSH-Metropolitan	752	114	15.16
3	DSH-Patton	1,559	105	6.73
4	DSH- Atascadero	1,166	92	7.89
5	DSH-Vacaville	381	66	17.32
6	DSH-Napa	1,268	50	3.94
7	DSH-Stockton	445	42	9.44
8	DSH-Salinas Valley	222	35	15.77
	Totals	7,070	627	8.87

*DSH average daily census numbers from July 1, 2016, to December 31, 2016.

All Reported Incidents Per DSH Facility – Jan. 1-June 30

Rank	Facility	Number of Patients*	Incidents Reported	Incidents Per 100 Patients
1	DSH-Metropolitan	746	111	14.88
2	DSH-Patton	1,569	109	6.95
3	DSH-Coalinga	1,268	94	7.41
4	DSH-Napa	1,240	79	6.37
5	DSH-Atascadero	1,168	77	6.59
6	DSH-Vacaville	362	69	19.06
7	DSH-Stockton	358	23	6.42
8	DSH-Salinas Valley	198	16	8.08

	Totals	6,909	578	8.37
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*DSH average daily census from January 1, 2016, through June 30, 2016.

Distribution of incidents at DDS this period

Overall, DDS incident reports decreased 19 percent in the six-month reporting period compared with the first half of 2016. Also in the July through December period, the incident rate per 100 patients at the department declined by nearly 15 percent, from 26 in the first half of 2016 to 22. The Sonoma Developmental Center had the largest decline – down 41 percent in the number of reported incidents and 37 percent in incidents per 100 residents. The largest DDS facility, the Porterville Developmental Center in Tulare County, accounted for 38 percent of the DDS incident reports to the OLES in the period. The Canyon Springs Community Facility in Cathedral City had the fewest incident reports in the last half of 2016. However, because there were so few residents at Canyon Springs, the facility still had the highest incident rate in DDS. Details are in the following charts.

All Reported Incidents Per DDS Facility - July 1– Dec. 31

DDS Facility	Number of Residents*	Incidents Reported	Incidents Per 100 Residents
Porterville	338	77	22.78
Fairview	204	74	36.27
Sonoma	334	34	10.18
Canyon Springs	45	20	44.44
Total	921	205	22.26

*DDS average of resident clients July 1, 2016 – December 31, 2016.

**Included general treatment area and Secure Treatment Program.

All Reported Incidents Per DDS Facility – Jan. 1– June 30

DDS Facility	Number of Residents*	Incidents Reported	Incidents Per 100 Residents
Fairview	232	81	34.91
Porterville	349	78	22.35
Sonoma	360	58	16.11
Canyon Springs	47	35	74.47
Total	988	252	25.51

*DDS average of resident clients Jan. 1, 2016 – June 30, 2016.

**Included general treatment area and Secure Treatment Program.

OLES's response to incidents

The OLES response was based upon the timeliness of the notification, the severity of the incident/allegation as reported and the quality of the information that the OLES received. It was key for the OLES to receive appropriate information in order to make suitable responses. To help improve the quality and completeness of initial information coming in, the OLES developed and distributed to the departmental

law enforcement personnel certain report outlines that list pertinent information that should be provided to the OLES at the initial notification. Such information included a description of any injuries suffered, the commitment type of the patient or patients involved and the facility case number for the incident.

Departments’ notifications of incidents

Different types of incidents required different kinds of notification to the OLES. Based on legislative mandates found in Welfare and Institutions Code sections 4023 and 4427.5 et seq. (in Appendix F), and agreements between the OLES and the departments, certain serious incidents were required to be reported to the OLES within two hours of their discovery. Notification of these Priority 1 incidents was deemed to be satisfied by a telephone call to the OLES hotline in the two-hour period and the receipt of a detailed report. Priority 2 threshold incidents required notification within one day and the receipt of a detailed report within two days. The OLES maintained these notification requirements throughout 2016, and in the second half of the year, aided the departments by providing the OLES criteria in detail as defined by statute to the facilities. Priority 1 and 2 threshold incidents are shown in the tables below.

Priority 1 Threshold Incidents

PRIORITY 1 NOTIFICATIONS- 2-HOUR NOTIFICATION
<ul style="list-style-type: none"> • Any death involving in a resident • Any allegation of sexual assault involving a resident • An assault with a deadly weapon or an assault with force likely to produce great bodily injury, involving a resident by a non-resident or, as described in Penal Code section 245 • Any report of physical abuse of a resident implicating a staff member • Any injury to the genitals of a resident when the cause of injury is undetermined • A broken bone of a resident when the cause of the break is undetermined • Any use of deadly force, including any strike to the head or neck, by an employee or contractor occurring within a DSH-or DDS-operated facility or a DSH psychiatric center located within a California Department of Corrections and Rehabilitation institution

Priority 2 Threshold Incidents

PRIORITY 2 NOTIFICATIONS- 1-DAY NOTIFICATION
<ul style="list-style-type: none"> • A pregnancy involving a resident • Any injury to the head or neck of a resident requiring treatment beyond first aid • Any burns of a resident, regardless of whether the cause is known, requiring treatment beyond first aid • Any riot occurring within the jurisdiction of the department and as defined

in Penal Code section 404

- Any incident of significant interest to the public; e.g., escapes, “AWOL”, commission of serious crimes by a resident or patient off facility grounds, attempted suicide (requiring treatment beyond first aid), etc.
- Any incident by a staff member or contractor affecting the health, safety or well-being of a resident that reasonably could have resulted in serious or great bodily injury, abuse or neglect, or death
- Any allegations of DSH/DDS law enforcement personnel misconduct, whether on-duty or off-duty
- Any allied law enforcement contact with DSH/DDS law enforcement personnel, with the exception of routine traffic infractions, that are outside the scope of department policing official duties

Timeliness of incident notifications

Both DSH and DDS improved during the second half of the year in the timeliness¹² of their notifications of incidents to the OLES. The DDS achieved the greatest improvement, going from a department-wide 79 percent rate of timely notifications in the first six months of the year to 90 percent in the final six months of 2016. In fact, at two DDS facilities – the Sonoma Developmental Center and Canyon Springs Community Facility – every incident that was reported to the OLES was timely. The DSH timeliness rating also improved, from nearly 74 percent in the first half of 2016 to 80 percent in the final six months of the year. The following charts show how facilities ranked in the first half and second half of 2016.

Timely Notifications at DSH – July 1-Dec. 31

Rank	DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	DSH-Coalinga	1,277	123	112	89.4%
2	DSH-Atascadero	1,167	92	80	87.0%
3	DSH-Vacaville	381	66	57	86.4%
4	DSH-Napa	1,268	50	43	86.0
5	DSH-Metropolitan	752	114	90	78.9%
6	DSH-Patton	1,559	105	82	78.1%
7	DSH-Salinas Valley	222	35	22	62.9%

¹² Whenever it was reasonably believed that employee misconduct may have occurred, it was the responsibility of the hiring authority (department facility) to report the conduct in a timely manner, per the notification schedules on the previous page, to the OLES for investigation or monitoring. Each reported incident was reviewed by the OLES during a daily intake meeting where it was determined if the report was timely and contained adequate information.

8	DSH-Stockton	445	42	20	47.6
	DSH Totals	7,070	627	502	80.1%

*DSH average daily census July 1, 2016, through December 31, 2016.

Timely Notifications at DSH – Jan. 1– June 30

Rank	DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	DSH-Stockton	358	23	22	95.7%
2	DSH-Atascadero	1,168	77	67	87%
3	DSH-Vacaville	362	69	56	81.2%
4	DSH-Metropolitan	746	111	89	80.2%
5	DSH-Coalinga	1,268	94	64	68.1%
6	DSH-Patton	1,569	109	72	66.1%
7	DSH-Napa	1,249	79	48	60.8%
8	DSH-Salinas Valley	198	16	7	43.8%
	DSH Totals	6,909	578	425	73.5%

*DSH average daily census January through June 2016.

Timely Notifications at DDS- July 1-Dec.31

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported**	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Sonoma	334	34	34	100%
1	Canyon Springs	45	20	20	100%
3	Porterville**	338	77	73	94.8%
4	Fairview	204	74	58	78.4%
	DDS Totals	921	205	185	90.2%

*DDS average of resident clients July 1, 2016, through December 31, 2016.

**Included general treatment area and Secure Treatment Program.

Timely Notifications at DDS- Jan. 1-June 30

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported**	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Canyon Springs	47	35	32	91.4%
2	Sonoma	360	58	51	87.9%

3	Fairview	232	81	60	74.1%
4	Porterville**	349	78	55	70.5%
	DDS Totals	988	252	198	78.6%

*DDS average of resident clients January 1, 2016, through June 30, 2016.

**Included general treatment area and Secure Treatment Program.

Perspective on incident reports

During 2016, the OLES observed that a small number of patients and clients repeatedly reported abuse by staff at DSH and DDS facilities. In fact, four DSH patients and three DDS clients accounted for 94 incidents reported to the OLES during the year, with one DDS client alone responsible for 30 abuse allegations. The DDS client who made the 30 abuse reports recanted approximately 75 percent of them and the other 25 percent received further evaluation or investigation, none of which resulted in sustained allegations.

The OLES takes every allegation of abuse seriously and closely reviews every case per the statutes. This includes reported incidents that may, on their face, appear to be unusual or impossible. These reports are part of the tally of 1,662 incidents for 2016 that received attention from the OLES.

The OLES attorneys and investigators are aware that some patients and clients in the facilities have difficulty communicating. In addition, patients in DSH facilities can suffer from significant mental illnesses ranging from psychosis to anti-social behavior and borderline personality disorders. Making false allegations can be a product of the mental illness, according to the deputy director for clinical operations at DSH.

At DDS, a supervising clinical psychologist at the Porterville Developmental Center acknowledged some clients, for a variety of reasons, have histories of making false reports. Some of the factors that may lead to this behavior are a sense of control over their environment, anger at a staff member and a manifestation of mental illness.

The OLES staff is mindful that patients and clients who frequently make allegations of abuse can become targeted victims when their credibility is questioned following repeat allegations that are not substantiated, making them the proverbial “perfect victims”. Thus, following its policies and procedures, the OLES handles each case individually on its merits and seeks to deter victimization by ensuring that every allegation is thoroughly investigated and not dismissed or disregarded.

These investigations also are required by the California Welfare and Institutions Code Section 15630, which mandates that DSH and DDS facility law enforcement investigate and notify local law enforcement of allegations of abuse and neglect in state mental hospitals and developmental centers. Likewise, the OLES is mandated by the Welfare and Institutions Code Section 4023.6 et. seq.¹³ to monitor all DSH and

¹³ Welfare and Institutions Code 4023.6 et.seq. (See Appendix F).

DDS investigations into allegations of physical and sexual abuse in which a staff member who is not a law enforcement officer is implicated. When a DSH or DDS law enforcement officer is implicated, the OLES is required to conduct the investigation, per the statute.¹⁴

To better understand the circumstances surrounding patients and clients recanting allegations at DSH and DDS, the OLES is gathering information to determine who is present when patients or clients recant and where the interviews with the patients or clients take place.

¹⁴ Welfare and Institutions Code 4023.6 et. seq. (See Appendix F).

Intake

All incidents received by the OLES during the six-month period were reviewed by an OLES panel at a daily intake meeting. Based on statutory requirements, the panel determined whether allegations against law enforcement officers warranted an internal affairs investigation by the OLES. If the allegations were against other DSH or DDS staff members, the panel determined whether the allegations warranted OLES monitoring of the departmental investigation. A flowchart of all the possible OLES outcomes from intake is shown in Appendix G.

Rejections

In the last half of 2016, 446 incidents at DSH were rejected by the OLES because they did not meet the criteria for the OLES to undertake investigation and/or monitoring. This amounted to more than two-thirds of all the DSH incidents received. At DDS, 156 incidents were rejected during the six-month period because they did not meet the criteria for the OLES to undertake investigations and/or monitoring. This amounted to nearly two-thirds of all incidents received that involved DDS. Every incident that was rejected by the OLES received a preliminary review – an extra step to ensure that incidents that initially appeared to not fit the criteria¹⁵ for OLES involvement were being properly rejected. Sometimes, allegations were unclear, and additional information needed to be obtained to finalize an initial intake decision, which could involve significant delays in getting additional information. As an example, an alleged abuse case could require the OLES to review video files or digital recordings of a particular hallway, day room or staff area where a patient or client was located. It could take time for the OLES to get the recordings from a facility and view them. Once the additional material/information was obtained and scrutinized by the OLES staff, the decision to initially reject an incident for not meeting the OLES criteria was reviewed again and could be reversed. The following charts show what happened to all incidents the OLES received in 2016.

Disposition of DSH Reported Incidents – 2016

OLES Categories	July 1 – December 31 Number	Percentage of Reported Incidents	Number	Percentage of reported Incidents	Year Totals
Rejected	446	71.1%	381	65.9%	827
Monitored, Administrative	38	6.1%	117	20.2%	155
Monitored, Criminal	111	17.7	45	7.8%	156
OLES Investigations, Administrative	7	1.1%	21	3.6%	28
Monitored	4	0.6%	8	1.4%	12

¹⁵ Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix F).

Issues					
OLES Investigations, Criminal	21	3.3%	6	1.0%	27
Totals	627	100%	578	100%	1,205

Disposition of DDS Reported Incidents – 2016

OLES Categories	July 1 – December 31 Number	Percentage of Reported Incidents	Number	Percentage of reported Incidents	Year Totals
Rejected	156	76.1%	164	65.1%	320
Monitored, Administrative	6	2.9%	46	18.3%	52
Monitored, Criminal	43	21.0%	38	15.1%	81
Monitored Issues	0	-	3	1.2%	3
OLES Investigations, Administrative	0	-	1	0.4%	1
OLES Investigations, Criminal	0	-	0	0%	0
Totals	205	100%	252	100%	457

Investigations and Monitoring

The OLES has several statutory responsibilities under the California Welfare and Institutions Code Section 4023 et seq. (see Appendix F). These include:

- Investigate allegations of serious misconduct by DSH and DDS law enforcement personnel. These investigations can involve criminal or administrative wrongdoing, or both.
- Monitor investigations conducted by DSH and DDS 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 and DDS.
- Review and assess the appropriateness of disciplinary actions resulting from a case involving an investigation and report the degree to which the OLES and the hiring authority agree on the disciplinary actions, including settlements.
- Monitor that the agreed-upon disciplinary actions are imposed and not modified. Note that this can include monitoring adverse actions against employees all the way through Skelly hearings, State Personnel Board proceedings and lawsuits.

OLES-conducted investigations

During the July through December 2016 period, the OLES conducted investigations into 29 incidents. Of these incidents, 20 were completed and nine were still under investigation. Also, during the second period of the year, the OLES completed 17 investigations that had been opened in the first half of 2016. As of December 31, 2016, one case from the first reporting period remained open.

During the period, 14 cases were referred to the hiring authority for disposition. Several of these cases resulted in sustained administrative findings. Nine cases were closed by the OLES after further analysis. Summaries of the findings were sent to the departments. None of the 18 criminal cases that the OLES closed in the period resulted in probable cause for referral to a prosecuting agency.

An investigation conducted by the OLES is just the start of the process. If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, the OLES submits the investigation to a prosecuting agency. All OLES investigations into cases of administrative wrongdoing/misconduct are forwarded to facility management for review and disposition. If the facility management imposes discipline, the OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if necessary.

Monitored departmental investigations this period

In this report's appendices B, C and D, the OLES provides information on the 149 monitored cases that, by December 31, 2016, had reached completion of one type or another. Of the 149 total, 21 monitored administrative cases were deemed insufficient by the OLES – 18 were procedurally insufficient only and three were procedurally and substantively insufficient. Another 10 monitored criminal cases also were found to be insufficient – eight were procedurally insufficient only and two were procedurally and substantively insufficient. Procedural sufficiency assesses the notifications to the OLES, consultations with the OLES and investigation activities for timeliness, among other things. Substantive sufficiency assesses the quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

In the July through December period, 27 of the 92 DSH and DDS monitored administrative investigations in the period, or 29 percent, were sustained, meaning sufficient evidence was found to exist for discipline to be considered. This compares with 12 of 54 monitored cases at the departments, or 22 percent, in the first half of 2016. In addition, only seven of the 57 criminal investigations that the OLES monitored were referred to a prosecuting agency. The synopses for both administrative and criminal investigations completed by the departments are in Appendix B.

Note that six other cases that the OLES monitored completed both the pre-disciplinary phase (departmental investigation) and the discipline phase. These cases, in Appendix D, have assessments for each phase.

Monitoring the discipline phase

When an administrative investigation – by the department or by the OLES – is completed, an investigation report with facts about the allegations is sent to the facility management where the state employee works. The discipline phase commences as the facility management decides whether to sustain any allegations against the employee or exonerate the employee. This decision is based upon the evidence presented. If the evidence shows the allegations are unfounded, the facility management can determine that the allegations are not sustained or can exonerate the employee. If there is sufficient evidence or a preponderance of evidence showing the allegations are factual, the facility management can sustain the allegations. If one or more allegations are sustained, the facility management must impose an appropriate disciplinary penalty.

Sixteen cases that the OLES monitored during the reporting period have assessments of the discipline phase only, and these can be found in Appendix C.

The OLES assesses every discipline phase case for both procedural and substantive sufficiency. Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and

whether the entire disciplinary process was conducted in a timely fashion. Substantive sufficiency assesses 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.

Additional Mandated Data

The OLES is required by statute to put into its semi-annual reports specific data about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where patients or resident clients are the perpetrators. All the mandated data for the final six months of 2016 came directly from DSH and DDS and are presented in the following tables.

DSH Mandated Data – Adverse Actions Against Employees

DSH Facilities	Formal Administrative investigations completed*	Adverse action taken (Formal Investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/retired pending adverse action****
DSH-Atascadero	31	3	23	5	0
DSH-Coalinga	61	15	31	15	2
DSH-Metropolitan	26	7	12	7	0
DSH-Napa	90	11	73	6	0
DSH-Patton	60	14	34	12	3
DSH-Salinas Valley	19	2	16	1	0
DSH-Stockton	41	3	38	0	0
DSH-Vacaville	4	3	1	0	0
Totals	332	58	228	46	5

DDS Mandated Data – Adverse Actions Against Employees

DDS Facilities	Formal Administrative investigations completed*	Adverse action taken**	No adverse action taken***	Resigned/retired pending adverse action****
Fairview	46	7	35	4
Porterville	34	11	23	0
Sonoma	16	2	12	2
Canyon Springs	12	0	12	0
Totals	108	20	82	6

*Administrative investigations completed includes all formal investigations and direct actions that resulted in or could have resulted in an adverse action. These

numbers do not include background investigations, Equal Employment Opportunity investigations or progressive discipline of minor misconduct that did not result in an adverse action against an employee.

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

***No adverse action taken refers to cases in which a formal administrative investigation was completed and it was determined that no adverse action was warranted or taken against the employees.

****Resigned or retired pending 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 a completed Formal Investigation and DDS reports these as completed investigations.

DSH Mandated Data – Criminal Cases Against Employees*

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
DSH-Atascadero	13	0	13	0
DSH-Coalinga	1	0	1	0
DSH-Metropolitan	8	3	5	0
DSH-Napa	1	0	1	0
DSH-Patton	27	26	1	12
DSH-Salinas Valley	0	0	0	0
DSH-Stockton	0	0	0	0
DSH-Vacaville	0	0	0	0
Totals	50	29	21	12

DDS Mandated Data – Criminal Cases Against Employees*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Fairview	2	0	1	1
Porterville	3	0	3	0
Sonoma	7	2	5	0
Canyon Springs	9	0	9	0
Totals	21	2	18	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.

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

*** Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed with a prosecuting agency.

**** Cases rejected by prosecuting agencies are criminal cases that were submitted to a prosecuting agency and rejected for prosecution by that agency.

DSH Mandated Data – Patient/Client Criminal Cases*

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies***
DSH-Atascadero	332	169	163	127
DSH-Coalinga	263	96	167	3
DSH-Metropolitan	249	41	208	5
DSH-Napa	526	50	476	0
DSH-Patton	490	199	291	169
DSH-Salinas Valley	0	0	0	0
DSH-Stockton	0	0	0	0
DSH-Vacaville	0	0	0	0
Totals	1,860	555	1,305	304

DDS Mandated Data – Patient/Client Criminal Cases*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not Referred***	Rejected by prosecuting agencies***
Fairview	5	1	4	1
Porterville	39	21	9	9
Sonoma	13	0	4	9
Canyon Springs	2	0	2	0
Totals	59	22	19	19

*Patient/client criminal cases include criminal investigations involving patients or resident clients. Numbers are for investigations which were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

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

***Cases rejected by prosecuting agencies are criminal cases that were submitted to prosecuting agencies and rejected for prosecution.

****Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed with prosecuting agencies.

DSH Mandated Data – Reports of Employee Misconduct to Licensing Boards*

DSH Facilities	Registered Nursing	Vocational Nursing	Medical Board	Pharmacy	Public Health	Behavioral Science	Psychology
DSH-Atascadero	0	0	0	0	0	0	0
DSH-Coalinga	0	3	0	0	0	0	0
DSH-Metropolitan	0	1	0	0	0	0	0
DSH-Napa	1	2	0	0	0	0	0
DSH-Patton	2	14	0	0	1	0	0
DSH-Salinas Valley	0	0	0	0	0	0	0
DSH-Stockton	0	3	0	0	0	0	0
DSH-Vacaville	0	0	0	0	0	0	0
Totals	3	23	0	0	1	0	0

*Reports of employee misconduct to California licensing boards include any reports of misconduct made against a state employee.

DDS Mandated Data – Reports of Employee Misconduct to Licensing Boards*

DDS Facilities	Registered Nursing	Vocational Nursing	Medical Board	Pharmacy	Public Health
Fairview	1	2	0	0	20
Porterville	0	0	0	0	9
Sonoma	0	0	0	0	0
Canyon Springs	0	0	0	0	1
Totals	1	2	0	0	30

*Reports of employee misconduct to California licensing boards include any reports of misconduct made against a state employee.

Perspective on mandated data

It is best practice for law enforcement to work directly with prosecuting attorneys in the state to provide investigation reports on criminal acts when probable cause is found. This straightforward process seeks to ensure that criminal cases are evaluated independently and decisions on prosecution are made free of bias.¹⁶ The goal of

¹⁶ This also adheres to California's Constitution Article 5, Section 13, Executive and California Government Code Section 26500 et.seq.

the OLES is not to criminalize the behavior of the mentally ill and developmental center residents or have every instance of state worker misconduct sent to prosecutors. Rather, the OLES wants to make sure the judicial process, which is uniquely situated to fashion remedies for crime victims, has the opportunity to do so.

Generally, DSH law enforcement works with prosecuting agencies. For example, a state hospital that houses Sexually Violent Predators (SVPs) may have child pornography cases while another hospital that houses different categories of forensic commitments may experience more assaults on staff or other patients. To accommodate these differences, some DSH facilities have arrangements with district attorney's offices that low level, non-serious misdemeanors committed by patients/clients will not be referred for prosecution. For example, a patient on patient battery with no injuries may not be referred. However, more serious crimes warrant a higher level of scrutiny and review. On the other hand, some prosecuting agencies review all cases: misdemeanor and felony alike. This is especially true with SVP commitments where there might be advantages to obtaining convictions. For example, it may be beneficial to obtain a child pornography conviction on an SVP commitment and remove the person to prison. On the other hand, it may be of little practical value to prosecute a person who is already deemed incompetent to stand trial, or not guilty by reason of insanity, in another case, for a new crime of battery on staff or another person, while they are still incompetent to stand trial.

DDS, meantime, has a modified practice – an internal review - where a committee of department and facility managers, including DDS clinical personnel and DDS law enforcement, meets and discusses each criminal case and mutually decides whether to forward cases to prosecutors. The OLES sees value in these meetings as clinical personnel can explain a client's developmental history, which can factor into a prosecutor's ability to present viable cases where clients must be shown to have the capability to form the intent to commit a crime. It must be pointed out, however, that prosecutors can obtain this information as they evaluate cases, often by reading the referrals from DDS.

One prosecutor who was contacted by the OLES stated it was inappropriate for clinicians, administrators or managers to decide not to refer a case to a prosecutor when trained police officers and investigators already determined that probable cause exists to believe a crime was committed. Another prosecutor told the OLES the DDS internal review is an efficient method of screening cases prior to referral to a prosecutor.

Just because a criminal case is referred by a facility to a prosecuting agency does not necessarily mean the case will be filed. Many factors go into a filing decision, including the quality of the report and whether additional investigation would be required. But the prosecutors who talked with the OLES said DDS and DSH criminal investigations are adequate for filing purposes. Other factors in whether a case is filed are:

Seriousness of the crime;

- Strength of the case;
- Commitment status of suspect;
- Is suspect a staff member;
- Corroborating witnesses or evidence;
- Can case be proven beyond a reasonable doubt;
- Availability of prosecutorial resources;
- What is to be gained by a prosecution.

It is the prosecutors' prerogative to make filing decisions, and it is a responsibility they take seriously after an objective and considered evaluation of the case. However, they cannot evaluate cases that are not referred to them.

The OLES recommends that DDS work toward a more streamlined and transparent review process for referring cases. One option would be to allow each DDS facility's investigation unit to refer cases directly to the local district attorney. Another option would be to include the local prosecutor or his or her representative in the current internal review at DDS. Alternatively, a Memorandum of Understanding could be entered into between DDS and prosecutors which delineates which cases will be referred. These or other methods would help ensure that the decision of whether to refer a case to the prosecuting agency is transparent and uniform and based on well-established principles of criminal law and make certain the prosecuting agency is included in the decision making process.

Monitored Issues

In the course of its oversight duties, the OLES observed some issues – potential patterns, shortcomings, problematic protocols, etc. -- at the facilities during the six-month period. The chief of the OLES instructed OLES staff to research and document the issues. The issues were then brought to the attention of the departments. In most instances, the OLES asked for corrective plans.

From July 1, 2016, through December 31, 2016, the OLES identified four monitored issues. All four involved DSH. One of the four, plus another monitored issue that arose in the first half of 2016 and had not been resolved at that time, were discussed with DSH, and the department's responses to the OLES were assessed as "sufficient" in how they addressed the matters. This information is in Appendix E.

As of December 31, 2016, nine monitored issues at DSH and one monitored issue at DDS remained open, either because the OLES continued to research them or because the OLES was waiting for responses from the departments.

One of the issues awaiting final departmental response involved the need for medical and psychological expert witnesses for consultation in OLES investigations and monitoring of cases of serious allegations against medical and/or psychological standards of care at DSH. The OLES discussed with DSH in May 2016 the creation of a three-member panel of subject matter experts that would provide objective medical opinions for these cases at DSH. The OLES proposed the panel meet monthly and be composed of department medical directors who had no ties to facilities where the investigations were initiated. The panel would offer professional opinions regarding standard of care issues, death reviews and other reportable issues. If a specialist was required, panel members would select a proxy for the case. If a panelist was associated with the facility where the investigation was initiated, he or she would be replaced by a medical director from another facility.

DDS does not have a standing medical panel of experts, either. The OLES believes such a panel would be beneficial for the department.

Another pending monitored issue called attention to the lack of consistent statewide policies and procedures to prohibit DSH staff from having and using personal electronic devices at their workstations and to screen staff and visitors so they do not bring these devices into DSH facilities. During the reporting period, the OLES found that at most DSH and DDS institutions, employees and contractors can use personal cellular phones and other personal electronic devices while at work. However, these devices can distract staff, thereby compromise the care of residents, and even violate patient privacy.

At DDS, for example, a staff member assigned to provide an enhanced one-on-one client observation became distracted using her personal cellular phone, and the

client removed and ingested the battery from a facility cordless telephone while she looked away. Meantime, at DSH, a staff member used his personal cellular telephone to produce videos of patients, and the videos were posted on social media.

DDS has a policy that restricts the use of personal electronic devices. The OLES has yet to receive final statewide policy, protocol and procedures on the use of personal electronic devices at DSH. In January 2016, the California Department of Public Health (DPH) pointed out the use of personal cellular phones by DSH staff, who violated local facility policy, could affect the supervision of patients and lead to unsafe conditions for patients and staff. Furthermore, other state agencies and some private companies prohibit the use of personal devices in institutional and hospital settings. CDCR screens employees and visitors as they enter institutions to ensure they comply with the department's statewide policy prohibiting personal electronic devices such as cellular telephones and tablets. Kaiser Permanente, which is a consortium of for-profit and non-profit managed health care entities, does not allow its staff to use personal cellular devices while on duty or any time they are in public view at the hospitals.

The OLES will report on the status of the pending monitored issues in subsequent reports.

OLES Recommendations

As required by statute,¹⁷ the OLES in March 2015 provided the Legislature with a report that described the challenges faced by law enforcement at DSH and DDS and the OLES recommendations. Additionally, in the OLES report to the Legislature dated October 1, 2016, the OLES updated the recommendations for best practices in law enforcement and employee discipline that the OLES made to the departments in 2015 and 2016. Below are the recommendations – 19 at DSH and 20 at DDS – and their status at the departments as provided by DSH and DDS as of December 31, 2016.

DSH law enforcement organizational structure

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p style="text-align: center;">A</p> <p>Legislation should be drafted and enacted to consolidate all DSH law enforcement under the department's chief of law enforcement</p>	<p>Upgrades the role of the department chief of law enforcement from consultant to supervisory manager for faster standardization of law enforcement practices. Centralizes fragmented law enforcement authority and the fragmented DSH law enforcement budgeting process</p>	<p>Not yet implemented. No legislation has been enacted to effect this change. DSH has implemented Policy Directive 8000 – DSH Law Enforcement Reporting Structure in December 1, 2015, which clarifies under the existing statute the structure, authority and responsibilities of the DSH Chief of Law Enforcement, Office of Protective Services, and roles and reporting relationships of DSH law enforcement personnel.</p>

OLES response: The OLES continued to recommend that legislation be enacted so all DSH law enforcement can be consolidated under the department's law enforcement chief. Currently, hospital police chiefs at each facility report to the hospital administrators, who are not required to have law enforcement background even though the majority of DSH residents are forensic patients. In addition, while DSH has a departmental chief of law enforcement, he does not have the authority to give directives to the hospital police chiefs at the facilities. This authority is necessary to, among other things, ensure consistency in law enforcement policy and procedures statewide and thereby increase patient and staff safety and reduce the department's exposure to civil liability.

¹⁷ Penal Code Section 830.38(c) and Welfare and Institutions Code Section 4023.5(a).

As an example, during the July through December reporting period, the OLES management met with the executive director, hospital administrator and hospital law enforcement chief at each of five DSH facilities. The OLES was aware that the DSH law enforcement chief sought to implement a statewide program for all law enforcement personnel that clarifies investigative roles. In discussions at these meetings, the OLES learned that four of the facilities had implemented or were implementing the program while one facility demonstrated resistance to implementing the program. As of December 31, 2016, the department had not implemented the program at every facility.

DSH law enforcement policies and procedures

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>B</p> <p>By December 31, 2016, DSH should complete and upload final procedures for all DSH hospitals into its digital policy manual, and the OLES should be notified before any procedure is changed</p>	<p>Written procedures ensure consistent practices in implementing law enforcement policies</p>	<p>Lexipol is currently being utilized by the department. All POST orders were uploaded to Lexipol by June 30, 2016.</p>
<p>C</p> <p>By December 1, 2016, DSH should decide on one police baton statewide, excluding specialized and tactical police teams, and begin to phase out the other baton</p>	<p>Standardized tools reduce on-the-job confusion about which tools to use and when to use them; Use of one baton reduces the complexity of training</p>	<p>DSH has approved the use of the Rapid Containment Baton. Policy is currently being written. An official letter was sent to OLES on October 26, 2016.</p>
<p>D</p> <p>DSH should ensure that all equipment needed for law enforcement personnel is available to staff</p>	<p>Law enforcement personnel must have equipment available if they are to follow policy/procedure that calls for the use of the equipment</p>	<p>Video and audio recording equipment is currently being installed at all facilities. Once installed the equipment will begin to be utilized.</p>
<p>E</p> <p>By December 31, 2016, DSH should have a computerized Early Intervention System in operation at every facility that is sending alerts to</p>	<p>Early intervention systems are designed to help managers pinpoint troubling behavior and address it before serious misconduct occurs</p>	<p>The computerized Early Intervention System (Blue Team) will start on December 31, 2016, at 2359 hours. Training for Blue Team was completed at all facilities</p>

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
management about problematic law enforcement behavior for monthly management action		by December 9, 2016.
<p>F</p> <p>DSH should review and make consistent the law enforcement policies and procedures at the DSH psychiatric facilities that are on CDCR prison grounds</p>	Consistent policies and procedures ensure consistency in law enforcement practices	DSH has created a work group which is addressing policy and procedures at the psychiatric facilities within CDCR prisons grounds.

DSH standardized training

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>G</p> <p>By December 1, 2016, DSH should compile and submit to the OLES standardized lesson plans for statewide training of new law enforcement personnel</p>	The use of standardized lesson plans helps ensure consistency in the initial training of new law enforcement personnel before they are deployed at facilities statewide	In process. DSH is in the process of finalizing lesson plans. Plans will be submitted to the OLES. DSH expects to fully implement for the next law enforcement Academy in 2017.
<p>H</p> <p>By December 31, 2016, DSH should compile and submit to the OLES standardized lesson plans for continued professional training of law enforcement personnel</p>	The use of standardized lesson plans helps ensure consistency in ongoing training of DSH law enforcement personnel at all facilities statewide	Not yet implemented. Once work is completed for the Academy lesson plans for the initial training of new law enforcement personnel, DSH will begin to standardize the continued professional training.
<p>I</p> <p>DSH should include mental health topics in its ongoing professional development training, and mental health professionals should be trainers for new and longstanding law enforcement personnel</p>	The specialized environment at DSH facilities necessitates ongoing professional development training on how staff are to handle DSH patients	In process. Draft lesson plans are under development by DSH mental health professionals. DSH is securing a vendor to help facilitate this training. DSH expects to provide this training for new law enforcement personnel in

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
		the next Academy in 2017. DSH will also provide this training to its existing law enforcement personnel by December 31, 2017.
<p>J</p> <p>DSH should complete and submit to the OLES for approval the policy and procedures for consistent law enforcement field training for newly deployed law enforcement personnel, including objectives, evaluation methods and passing standards, across the department</p>	<p>Consistent training and evaluation in the field, after initial new-hire training, is necessary to ensure that initial standardized training of new hires is retained and reinforced at each facility and that newly deployed law enforcement personnel exhibit competency</p>	<p>In process. DSH is designing a standard officer Field Training Manual that will include general law enforcement training modules, on-duty procedures, site-specific operational training and an evaluation rubric for universal measurement of competency levels. DSH anticipates completing the development of the manual by June 30, 2017. DSH anticipates full implementation by December 31, 2017.</p>
<p>K</p> <p>By December 31, 2017, all current law enforcement staff should complete professional development training on how best to handle patients in mental crises, and this training should be conducted by mental health staff</p>	<p>The specialized environment at DSH facilities necessitates regular professional development training for staff handling patients in mental crises</p>	<p>In process. See item I above on training on mental health topics.</p>
<p>L</p> <p>DSH should centralize law enforcement training records at the department level</p>	<p>Centralized training data can be tracked and analyzed across the department and allows for department-wide budgeting for training</p>	<p>Partially implemented. DSH is manually tracking information via spreadsheets pending implementation of a more robust solution. DSH will be implementing the Envisage software to centralize all DSH law enforcement training data. DSH anticipates full</p>

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
		implementation by October 2017.

DSH standardized assessments of investigations

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p align="center">M</p> <p>By December 1, 2016, DSH should implement written, statewide, standardized policy and procedures for assessing investigation reports in a consistent fashion at all facilities and determine management personnel who should be involved in the evaluations</p>	<p>Provides formalized, consistent, fair and reasoned assessment of the quality of investigations. Strives to equalize how results of investigations are handled across all state facilities so the state's potential legal liability is reduced</p>	<p>In process. In conjunction with the development and implementation of the penalty matrix discussed in OLES recommendation, DSH will develop and implement standardized policy and procedures for assessing investigation reports by April 2017.</p>

DSH standardized discipline process

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p align="center">N</p> <p>By December 1, 2016, DSH should implement comprehensive written, statewide policy and procedures involving standardized penalty matrices for all state employees who are found to be involved in misconduct</p>	<p>Provides formalized, consistent and fair imposition of discipline penalties across all state facilities</p>	<p>In process. DSH has established a work group that is in the process of developing a standardized penalty matrix. This is expected to be completed, finalized and implemented by April 2017.</p>
<p align="center">O</p> <p>By December 1, 2016, DSH should establish a written statewide executive review process to address situations where facility executive directors, labor attorneys and/or the OLES disagree about employee discipline decisions</p>	<p>Provides consistent and formalized review process of discipline penalties across all state facilities; Creates a forum to resolve disagreements</p>	<p>Fully implemented. DSH implemented this recommendation on July 29, 2016, by implementing Police Directive 6001: Office of Law Enforcement Support Oversight Investigation Review Process – Disposition Committee.</p>
<p align="center">P</p>	<p>Helps improve quality</p>	<p>Not yet implemented.</p>

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
By December 31, 2017, DSH should assign departmental attorneys at the beginning of employee misconduct cases to assist in investigations and witness interviews and to provide counsel to facility management about potential employee discipline	of investigations so they can serve as a solid foundation for potential legal proceedings	Due to limited DSH Legal Services Division resources and competing legal priorities, DSH does not currently have the resources to fully implement this recommendation. DSH is evaluating on a case-by-case basis to identify high profile and/or complex cases and will assign legal resources to these cases as needed.

DSH standardized discipline tracking

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>Q</p> <p>DSH should implement department-wide policy and procedures for collecting, organizing, centralizing and keeping consistent records of all employee misconduct reports</p>	Ensures consistent and centralized data collection and record-keeping department-wide	Partially implemented. DSH facilities are now reporting to DSH-Sacramento on a monthly basis all employee discipline cases, including action taken, Skelly hearings, settlements, actions taken by the State Personnel Board and reports made to health professional licensing boards. DSH will develop and implement policies and procedures for the collection, organization and centralization by April 30, 2017.
<p>R</p> <p>DSH should develop a centralized discipline tracking computer system similar to CDCR's</p>	Provides secure, efficient, real-time access to ongoing discipline cases and tracks delays and outcomes so they can	Not yet implemented. DSH will evaluate existing reporting tool and possible solutions and provide a recommendation to DSH

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
	be analyzed. Ensures each discipline case and its disposition are tracked and accounted for in the department	executive management for consideration by April 30, 2017.
<p style="text-align: center;">S</p> <p>DSH should establish department-wide policy and procedures for documenting and recording its analysis of trends and patterns of all DSH employee misconduct</p>	Ensures that centralized data collection and records are used as a management tool to identify and address patterns and trends of employee misconduct on a department-wide basis	In process. DSH has selected the Blue Team software for tracking and analyzing law enforcement misconduct. Additionally, DSH will develop and implement policies and procedures by April 30, 2017, for documenting and recording its analysis of trends and patterns of all DSH employee misconduct data.

DDS standardized investigation reports

OLES Recommendation of best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p style="text-align: center;">A</p> <p>DDS should implement standardized investigation report formats in calendar 2016</p>	Standardized report formats help ensure consistency in reports and investigation facts and in how the facts are presented	DDS has established a committee to standardize investigation formats in conjunction with the configuration of the new Records Management System. DDS anticipates the project to be completed in the spring of 2017.

DDS standardized assessments of investigations

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p style="text-align: center;">B</p> <p>By December 1, 2016, should implement written, statewide, standardized policy and procedures for</p>	Provides formalized, consistent, fair and reasoned assessment of the quality of investigations. Strives to	DDS is preparing an investigation checklist to be used by supervisors and managers to assess the quality of

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>assessing investigation reports in a consistent fashion at all facilities and determine management personnel who should be involved in the evaluations</p>	<p>equalize how results of investigations are handled across all state facilities so the state's potential legal liability is reduced</p>	<p>investigations. The checklist will be similar to the Investigation Assessment Questions used by OLES. Once the checklist is completed and approved by DDS and OLES, DDS will establish policy by June 2017 requiring supervisors and managers to use the checklist during their review of investigations. Additionally, as DDS works with a vendor to configure the Records Management System, DDS will attempt to have the system prompt investigators to provide answers to questions from the checklist. Those answers would then become part of the investigative report.</p>

DDS law enforcement recruitment

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>C DDS should expand its law enforcement outreach and recruitment efforts to more venues and websites, including law enforcement, military and general employment sites, and use social media on a regular basis to publicize job openings</p>	<p>Broader outreach can help boost the number of applicants, thereby helping to address persistently high DDS law enforcement vacancy rates</p>	<p>DDS has expanded recruitment efforts to general employment job fairs and military outlets. DDS has also posted job openings on local developmental center Facebook pages.</p>
<p>D DDS should update and upgrade its law</p>	<p>Modern recruitment materials can improve the department's</p>	<p>DDS is updating its recruitment pamphlets and creating new</p>

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
enforcement recruitment materials	image with applicants and draw more interest, potentially attracting more law enforcement hires	recruitment posters for April 2017. In the meantime, DDS has created a computer-generated update which has been manually inserted into existing recruitment pamphlets.
E DDS should recruit at more POST academies	POST academies provide focused and ready access to the state's newly trained law enforcement personnel and could help boost the number of applicants to DDS	DDS has been providing recruitment presentations at all local law enforcement academies. DDS is scheduled to attend every POST-certified academy in the state (except agency-specific academies such as CHP and LAPD). As a result of recruitment efforts, since July 1, 2016, DDS has placed 16 peace officer I candidates and five investigator candidates into the background investigation stage of the hiring process.
F DDS should incorporate innovative ways that other law enforcement departments use to boost applications and hires, i.e., providing incentives to current staff who bring aboard new hires	Creative recruitment efforts hold the potential to improve hiring of law enforcement at DDS and reduce the persistently high DDS law enforcement vacancy rates	DDS cannot provide financial incentives outside of the collective bargaining process.
G DDS should add a law enforcement cadet job classification similar to CHP's	The cadet class is used at other state departments to provide an additional entry point into law enforcement and allows a redistribution of law enforcement	DDS is in discussion with DSH to allow DDS to use DSH's hospital police officer classification at DDS as a limited-term cadet classification.

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
	duties among cadets and senior staff	
<p>H</p> <p>DDS should work on a transition plan for DDS law enforcement staff who would be interested in moving to DSH law enforcement as the DDS developmental centers close by 2021</p>	<p>Applicants may be more interested in short-term DDS law enforcement jobs if they have information indicating future jobs may be available after the centers close</p>	<p>DDS has been in discussion with DSH on a transition plan for Office of Protective Services staff as DDS developmental centers close and will have a transition plan completed to share with OLES in December 2017.</p>

OLES response: Noting that the four DDS facilities as a whole incurred more than 35,000 hours of law enforcement overtime in 2016, the OLES continued to urge DDS to fill its vacant law enforcement positions as quickly as possible.

DDS standardized training

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>I</p> <p>DDS should develop and submit to the OLES for approval the standardized curriculum for the 24-hour critical incident training course that DDS established at the DSH-Atascadero academy in the first half of 2016</p>	<p>A written, standardized curriculum will ensure standardized training for all DDS law enforcement staff</p>	<p>DDS has developed a standardized curriculum for Critical Incident Training and submitted it to the California Commission on Peace Officers Standards and Training (POST) for POST certification.</p>
<p>J</p> <p>DDS should complete and submit to the OLES the policy and procedures for consistent law enforcement field training for newly deployed law enforcement personnel, including objectives, evaluation methods and passing standards, across the department</p>	<p>Consistent training and evaluation in the field, after initial, new-hire training, is necessary to ensure that initial standardized training of new hires is retained and reinforced at each facility and that newly deployed law enforcement personnel exhibit competency</p>	<p>DDS has developed a Field Training Officer manual that is consistent with POST standards. The manual is in final review by management and will be submitted to OLES for review and recommendations before publishing the manual.</p>
<p>K</p>	<p>The specialized</p>	<p>DDS mental health</p>

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>Ongoing professional development training should include mental health topics, and mental health professionals should be trainers for new and longstanding law enforcement personnel</p>	<p>environment at DDS facilities necessitates ongoing professional development training on how staff are to handle DDS clients</p>	<p>professionals have always provided ongoing professional development training, including mental health topics, to OPS employees. Every new employee receives this training upon hire during New Employee Orientation. All OPS employees attended the POST-certified course "Autism: A Law Enforcement Approach." OPS employees have also attended "Intellectual Disabilities" training from departmental psychologists and crisis intervention training provided by clinical staff at each facility. DDS will continue to seek out and provide training in this arena to OPS employees.</p>

OLES response: In the future, DDS should work collaboratively with the OLES so the OLES can review and provide input to the department's law enforcement training programs. In addition, the OLES recommended that DDS law enforcement add a section in the training database to track all mental health training.

DDS law enforcement policies and procedures

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>L DDS should refrain from instituting verbal policies to law enforcement staff and provide policy changes, in writing, to the OLES in advance</p>	<p>Documented, written policies that are uploaded into the DDS digital policy manual ensure all law enforcement personnel are informed of the latest policies, thus allowing the</p>	<p>DDS agrees with this recommendation and will not institute verbal policies.</p>

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
	department to operate in a standardized fashion	
<p align="center">M</p> <p>By December 31, 2016, DDS should complete and upload final procedures for all DDS facilities into its digital policy manual, and the OLES should be notified before any procedure is changed</p>	Written procedures ensure consistent practices in implementing law enforcement policies	Written procedures were uploaded into Lexipol's Knowledge Management System in October 2016. OPS policies contain a hyperlink to the corresponding procedures. All OPS employees have electronically acknowledged receipt and understanding of the procedures, and employees have 24/7 access to the procedures from any computer or smartphone.
<p align="center">N</p> <p>DDS should ensure that all equipment needed for law enforcement personnel is available to staff</p>	Law enforcement personnel must have equipment available if they are to follow policy/procedure that calls for the use of the equipment	DDS has verified that law enforcement personnel have access to any equipment required by policy/procedure.

DDS standardized discipline tracking

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p align="center">O</p> <p>By December 31, 2016, DDS should have a computerized Early Intervention System in operation in every facility. The system sends alerts to management about problematic law enforcement behavior for monthly management review and action.</p>	Early intervention systems are designed to help managers pinpoint troubling behavior and address it before serious misconduct occurs	DDS conducted a pilot at Porterville Developmental Center to beta test the IA Pro/Blue Team Early Intervention System. During 2016, DDS had only four qualifying incidents. Consequently, it was determined that the IA Pro portion of the Early Intervention System could be used alone at

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
		<p>DDS headquarters rather than having each facility use Blue Team. When a qualifying incident occurs, DDS headquarters will put the information directly into IAPro and the DDS chief of law enforcement will work with law enforcement commanders at the facilities to review the incidents.</p>
<p>P DDS should develop a centralized discipline tracking computer system similar to CDCR's</p>	<p>Provides secure, efficient, real-time access to ongoing discipline cases and tracks delays and outcomes so they can be analyzed. Ensures each discipline case and its disposition are tracked and accounted for in the department</p>	<p>DCD's volume of disciplinary cases is small and will continue to shrink as developmental centers close. Purchase of such a system would not be efficient or cost effective at this point. DCD currently tracks all investigations through disposition and final resolution.</p>
<p>Q DDS should establish department-wide policy and procedures for documenting and recording of its analysis of trends and patterns of all DDS employee misconduct data</p>	<p>Ensures that centralized data collection and records are used as a management tool to identify and address patterns and trends of employee misconduct on a department-wide basis</p>	<p>DCD Policy 323, Governing Body, requires each developmental center to report status of all allegations and investigations to headquarters which is tracked on a standardized report for analysis and trending as part of its risk management system and reviewed quarterly as part of each facility's Governing Body meeting. Each development center has a risk management policy that</p>

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
		tracks and trends all reportable incidents.

DDS standardized discipline process

OLES Recommendation of Best Practice	Benefit of the Best Practice	Status at DSH as of Dec. 31, 2016
<p>R</p> <p>By December 1, 2016, DDS should implement a comprehensive written, statewide policy and procedures involving standardized penalty matrices for all state employees who are found to be involved in misconduct</p>	<p>Provides formalized, consistent and fair imposition of discipline penalties across all state facilities</p>	<p>DCD will write and implement statewide a Case Disposition policy involving review of case facts and justification for level of discipline applied in cases involving staff misconduct. The policy is expected to be drafted by February 1, 2017, and implemented shortly thereafter.</p>
<p>S</p> <p>By December 1, 2016, DDS should establish a written, statewide executive review process to address situations where facility executive directors, labor attorneys and/or OLES disagree about employee discipline decisions</p>	<p>Provides consistent and formalized review process of discipline penalties across all state facilities; Creates a forum to resolve disagreements</p>	<p>The DCD Case Disposition policy (in R above) will include an executive review process to address situations where facility executive directors, labor attorneys and/or OLES disagree about employee discipline decisions.</p>
<p>T</p> <p>By December 31, 2017, DDS should assign departmental attorneys at the beginning of employee misconduct cases to assist in investigations and witness interviews and to provide counsel to facility management about potential employee discipline</p>	<p>Helps improve quality of investigations so they can serve as a solid foundation for potential legal proceedings</p>	<p>Given the closure of three developmental centers currently occurring, DDS will not be requesting the additional staffing needed at this point to provide such representation on every case. Incidents may be evaluated on a case-by-case basis, until DDS can assess the resources that would be needed post-closures.</p>

Perspective on disciplinary process

In 2015, the OLES recommended to executive management at DSH and DDS that they implement a matrix and comprehensive disciplinary policies and procedures to ensure a reasoned assessment of the quality of investigations and imposition of impartial and uniform discipline. Disciplinary policies and procedures provide the foundation for sound and equitable discipline and ensure consistency within each facility and across facilities statewide. Policies and procedures that the OLES advocated include three major areas: 1) Determining if allegations of misconduct by employees are sustained; 2) Instituting a flexible penalty matrix that adjusts for aggravating and mitigating circumstances as it guides the imposition of discipline on state employees, and 3) Establishing a collaborative process that allows for executive review when a consensus on discipline cannot be reached at lower levels of the department.

The OLES recommended that DSH and DDS use the same policy and matrix used for more than 10 years by the California Department of Corrections and Rehabilitation (CDCR). This policy was vetted and approved by a federal court (*Madrid v. Woodford*) and incorporated into Article 22 of the California Code of Regulations in 2005. Its procedures detail every step of the disciplinary process to ensure that decisions are consistent with law. It includes a matrix that is not a rigid tool but a flexible instrument that takes into account the particular circumstances of every case of employee misconduct and ensures fair and uniform selection of discipline by management.

As of December 31, 2016, DSH had informed the OLES that a working group was developing a matrix for the department. The OLES plans to review and evaluate the DSH matrix. Additionally, DSH issued a policy dated July 29, 2016, that establishes an investigation review process and disposition committee. This is an initial step, but DSH needs to work towards a comprehensive discipline policy. The policy should bring statewide consistency in the discipline process and apply to all cases where discipline is contemplated. The OLES recommended that the DSH policy include detailed guidance for DSH executive directors making disciplinary decisions. Specifically, the policy should include guidelines on how executive directors should fully assess administrative investigations, how they should reach disciplinary findings and how they should select the discipline to be imposed.

Meantime, DDS had informed the OLES that as of December 31, 2016, it had no formal disciplinary policy. The DDS also said a draft of a case disposition policy involving review of case facts and justification for level of discipline in employee misconduct cases should be formalized by February 1, 2017, with implementation shortly thereafter. The OLES plans to review and evaluate the DDS policy.

The lack of a comprehensive statewide policy results in inconsistent processes. While some executive directors make findings and penalty decisions on their own, others hold meetings with executive staff and come to a consensus decision. Some executive directors use a particular form to document findings and penalty

decisions, while others do not. In addition to inconsistent processes, each executive director makes disciplinary decisions on a case-by-case basis without reference to standardized factors.

The absence of a uniform disciplinary process can create disparate outcomes in disciplinary case and undesirable consequences. For example, an employee who believes he or she has been unfairly disciplined is more likely to pursue an appeal before the State Personnel Board (SPB) resulting in unnecessary costs to the departments. Further, the SPB may be less likely to uphold a penalty if it can be shown that the penalty is not based on objective and uniform factors. Additionally, lack of consistency in the application of discipline can result in a perception of bias by employees and negatively impact morale as well as the critical relationship between staff and management.

The OLES recommended a matrix because it provides guidelines for making well-reasoned and consistent disciplinary decisions while allowing discretion at every step so executive directors come to thoughtful and appropriate decisions in each case. Application of a matrix gives employees assurance of fair and equitable treatment and can reduce appeals of adverse actions.

Appendix A: OLES Investigations

Investigation Detail	Section Content
Incident Date	12/11/2015
OLES Case Number	2016-00006A
Case Type	Use of Force
Incident Summary	In December 2015, a patient alleged hospital police officers have compromised his safety by reporting false information about him to other patients, and that supervisory staff have failed to take appropriate action when he reported the incident. The patient also alleged hospital police officers subjected him to inappropriate force during a clothed body search.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	12/15/2015
OLES Case Number	2016-00028A
Case Type	Abuse
Incident Summary	On December 15, 2015, a patient alleged a registered nurse made an inappropriate statement to him regarding his transgender sexual orientation.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	01/10/2016
OLES Case Number	2016-00064A
Case Type	Abuse
Incident Summary	On January 10, 2016, a medical technical assistant allegedly used offensive language towards a patient who was threatening to harm himself by banging his head on the wall.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	12/30/2015
OLES Case Number	2016-00089A
Case Type	Misconduct
Incident Summary	On December 27, 2015, an officer allegedly did not proceed with due diligence when evaluating the allegations a client made regarding a genital injury.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	01/08/2016
OLES Case Number	2016-00143A
Case Type	Misconduct
Incident Summary	On January 8, 2016, a patient alleged a hospital police officer had been harassing him and making demeaning remarks towards him every time he sees him since 2007.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	02/09/2016
OLES Case Number	2016-00171A
Case Type	Misconduct
Incident Summary	On February 9, 2016, a patient alleged a medical technical assistant spoke in a sexually inappropriate manner to patients and watched them masturbate.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	01/09/2016
OLES Case Number	2016-00173A
Case Type	Misconduct
Incident Summary	On January 9, 2016, a patient alleged an officer made threatening statements towards him by saying, "he will learn the hard way." The patient further alleged, the officer conducted a search of his living area out of retaliation and was discourteous towards him by calling him by his first name and arguing with him.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority

	for disposition. The OLES monitored the disposition process.
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Investigation Detail	Section Content
Incident Date	03/06/2016
OLEs Case Number	2016-00290A
Case Type	Abuse
Incident Summary	On March 6, 2016, a patient alleged that a medical technical assistant subjected him to verbal abuse when he called him a "pedophile, chomo, and child molester" when providing him his meals and when retrieving his food tray.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined the allegations did not meet the statutory criteria for an investigation by the OLES. The OLES provided a summary of the findings to the department and recommended an investigation in to the allegations of discourteous treatment.

Investigation Detail	Section Content
Incident Date	03/07/2016
OLEs Case Number	2016-00388A
Case Type	Abuse
Incident Summary	On March 7, 2016, a registered nurse allegedly left a patient in the shower for approximately two hours, and then failed to properly document the incident in the patient's interdisciplinary notes. In addition, it was alleged the registered nurse was dishonest in her investigatory interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	03/07/2016
OLEs Case Number	2016-00388A
Case Type	Abuse
Incident Summary	On March 7, 2016, a registered nurse allegedly left a patient in the shower for approximately two hours, and then failed to properly document the incident in the patient's interdisciplinary notes. In addition, it was alleged the registered nurse was dishonest in her investigatory interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	02/24/2016
OLES Case Number	2016-00393A
Case Type	Misconduct
Incident Summary	On February 24, 2016, an investigator alleged an acting supervisor investigator asked her inappropriate questions during a sexual assault investigations training. She further alleged the acting supervisor investigator was discourteous and rude to her because of her gender.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	04/19/2016
OLES Case Number	2016-00492C
Case Type	Abuse
Incident Summary	On April 19, 2016, a patient alleged that medical technical assistants were verbally abusing him. He also alleged that the medical technical assistants' were retaliating against him for filing a complaint, and one of them slammed the food port shut on his hand.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	04/22/2016
OLES Case Number	2016-00499A
Case Type	Abuse
Incident Summary	On April 22, 2016, a patient alleged that a medical technical assistant pulled on his handcuffs while removing them, injuring his left wrist.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined the allegations did not meet the statutory criteria for an investigation by the OLES. The OLES provided a summary of the findings to the department.

Investigation Detail	Section Content
Incident Date	06/08/2016
OLES Case Number	2016-00727A

Case Type	Broken Bone
Incident Summary	On June 8, 2016, two patients were involved in a physical altercation and officers used pepper spray and physical force to subdue one of the patients. The patient sustained broken fingers and a broken cheekbone. It was alleged that officers did not give a warning prior to using pepper spray, the patient was cooperative, and the patient sustained his injuries because of excessive force.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/04/2016
OLEs Case Number	2016-00742A
Case Type	Misconduct
Incident Summary	On June 4, 2016, a registered nurse was allegedly falsifying interdisciplinary notes in patients' medical charts.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/12/2016
OLEs Case Number	2016-00752A
Case Type	Abuse
Incident Summary	On June 12, 2016, a patient alleged that departmental staff failed to properly review and address the complaints he submitted over the past three years.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/15/2016
OLEs Case Number	2016-00768A
Case Type	Use of Force
Incident Summary	On June 15, 2016, a patient alleged three officers used excessive physical force on him during a containment.

	Allegedly, the patient was upset, agitated, and yelling at nursing staff. The nursing staff requested the patient to walk outside of his bedroom, but he refused. Three officers responded to assist in escorting the patient out of his room, when the patient allegedly punched one officer in the face. All three officers then attempted to restrain the patient, who continued to resist. The patient was restrained and removed from his bedroom.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/03/2016
OLES Case Number	2016-00841A
Case Type	Misconduct
Incident Summary	On June 3, 2016, an acting sergeant allegedly engaged in an on-duty sexual relationship with another employee, on facility grounds, in an area accessible to employees only. It was further alleged the acting sergeant utilized departmental email and instant messaging, while on duty to engage in a personal relationship with another employee. In addition, the acting sergeant allegedly discussed the investigation with another employee after being admonished not to do so. Additionally, the acting sergeant was allegedly dishonest in his investigatory interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for a disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	06/20/2016
OLES Case Number	2016-00924C
Case Type	Misconduct
Incident Summary	On June 20, 2016, a patient alleged that an officer threatened to kill him and sexually assault him with brainwaves.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the

	department.
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Investigation Detail	Section Content
Incident Date	07/25/2016
OLES Case Number	2016-00940C
Case Type	Sexual Assault
Incident Summary	On July 25, 2016, a patient alleged an officer inappropriately touched his genitals and buttocks during a search.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	07/30/2016
OLES Case Number	2016-00973C
Case Type	Use of Force
Incident Summary	On July 30, 2016, patient alleged medical technical assistants used excessive force during a cell extraction. Allegedly, a medical technical assistant was twisting the patient's right leg from side to side, injuring his knee.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	07/30/2016
OLES Case Number	2016-00974C
Case Type	Use of Force
Incident Summary	On July 30, 2016, a patient alleged that several medical technical assistants used excessive force on him during a cell extraction. Specifically, the patient alleged when medical technical assistants entered his cell, they threw him to the ground and began kicking and punching him.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the

	department.
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Investigation Detail	Section Content
Incident Date	07/28/2016
OLES Case Number	2016-00976A
Case Type	Abuse
Incident Summary	On July 28, 2016, an officer allegedly abused a patient by pushing him into a closed door.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	08/04/2016
OLES Case Number	2016-00988C
Case Type	Sexual Assault
Incident Summary	On August 4, 2016, a patient alleged a medical technical assistant sexually assaulted him during two clothed body searches. Specifically, the patient stated on both occasions, while he was being patted down, the medical technical assistant's stomach rubbed against his buttocks.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/03/2016
OLES Case Number	2016-01031A
Case Type	Misconduct
Incident Summary	On June 3, 2016, a psychiatric technician allegedly engaged in an on-duty sexual relationship, with another employee on facility grounds, in an area accessible to employees only. It was further alleged the psychiatric technician utilized departmental email and instant messaging, while on duty, to engage in a personal relationship with another employee. Also, the psychiatric technician was allegedly dishonest in her investigatory interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority

	for disposition. The OLES monitored the disposition process.
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Investigation Detail	Section Content
Incident Date	08/04/2016
OLES Case Number	2016-01086C
Case Type	Abuse
Incident Summary	On August 4, 2016, a patient alleged a medical technical assistant used excessive force on him by closing a cell door food port on his right arm.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	03/07/2016
OLES Case Number	2016-01141A
Case Type	Abuse
Incident Summary	On March 7, 2016, a medical technical assistant allegedly left a patient in the shower for approximately two hours, and then failed to properly document the incident in the patient observation record.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	03/07/2016
OLES Case Number	2016-01142A
Case Type	Abuse
Incident Summary	On March 7, 2016, a medical technical assistant allegedly left a patient in the shower for approximately two hours, and then failed to properly document the incident in the patient observation record.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	08/02/2016
OLES Case Number	2016-01169C
Case Type	Abuse
Incident Summary	On September 12, 2016, a patient alleged a senior medical

	technical assistant assaulted another patient on August 2, 2016. The reporting patient alleged that the senior medical technical assistant punched, kicked and threw the patient into a wall. The patient, who was allegedly abused, refuted the reporting patient's allegations.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	09/14/2016
OLES Case Number	2016-01200A
Case Type	Significant Interest - AWOL
Incident Summary	On September 14, 2016, a patient was allegedly allowed to walk around a secured facility without being discovered. Allegedly, the patient accessed a number of unlocked doors and walked into the receiving and release area of the facility before officers detained him.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	05/01/2016
OLES Case Number	2016-01242C
Case Type	Abuse
Incident Summary	A patient alleged that in May or June 2016, an unidentified medical technical assistant used excessive force on him by applying handcuffs to his wrists to tight.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	08/01/2016
OLES Case Number	2016-01282C
Case Type	Abuse

Incident Summary	On August 1, 2016, a patient alleged a medical technical assistant used excessive force on him by grabbing the bottom of his shirt through an open food port.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	02/24/2016
OLES Case Number	2016-01304A
Case Type	Misconduct
Incident Summary	On February 24, 2016, an investigator alleged a commander failed to take appropriate action when an acting supervisor investigator asked her inappropriate questions during a sexual assault investigations training. She further alleged the commander was discourteous and rude to her because of her gender.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	10/04/2016
OLES Case Number	2016-01317C
Case Type	Sexual Assault
Incident Summary	On October 4, 2016, a patient alleged a medical technical assistant sexually assaulted him by grabbing his penis and scrotum during a cursory search.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the finding was provided to the department.

Investigation Detail	Section Content
Incident Date	09/16/2016
OLES Case Number	2016-01328C
Case Type	Sexual Assault
Incident Summary	On September 16, 2016, a patient alleged a medical technical assistant sexually assaulted him by aggressively fondling his chest and other parts of his body.

Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.
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Investigation Detail	Section Content
Incident Date	09/13/2016
OLES Case Number	2016-01344A
Case Type	Misconduct
Incident Summary	On September 13, 2016, a patient allegedly had a behavioral incident, which required him to be restrained in handcuffs and escorted back to his cell. The patient allegedly refused to follow orders to relinquish handcuffs, slipped the handcuffs to the front of his body, and removed one of his hands from the restraint. A senior medical technical assistant and three medical technical assistants allegedly entered into a patient's cell to retrieve handcuffs without seeking approval from management to do so without the assistance of correctional officers.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was sufficient evidence to investigate a potential policy violation. However, the allegations did not meet the statutory mandate of the OLES; therefore, a summary of the findings was provided to the department for further investigation.

Investigation Detail	Section Content
Incident Date	10/30/2016
OLES Case Number	2016-01412C
Case Type	Sexual Assault
Incident Summary	On October 30, 2016, a patient alleged an officer sexually assaulted him by forcefully grabbing his penis during a cursory search.
Disposition	The office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	11/03/2016
OLES Case Number	2016-01435C

Case Type	Sexual Assault
Incident Summary	On November 3, 2016, a patient alleged an officer sexually assaulted him by grabbing his genitals during a cursory search.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	08/01/2016
OLES Case Number	2016-01451C
Case Type	Abuse
Incident Summary	On July 30, 2016, patient alleged medical technical assistants used excessive force during a cell extraction. Allegedly, a medical technical assistant was twisting the patient's right leg from side to side, injuring his knee.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	10/16/2016
OLES Case Number	2016-01455C
Case Type	Sexual Assault
Incident Summary	On October 16, 2016, a patient alleged a medical technical assistant was involved in a romantic relationship with him. The patient further alleged the medical technical assistant provided him with a mobile phone so that she could send him sexually explicit photographs.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	11/07/2016
OLES Case Number	2016-01459C

Case Type	Abuse
Incident Summary	On November 7, 2016, a patient alleged an officer used excessive force on her when he restrained her. The officer allegedly twisted the patient's right arm while applying handcuffs.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	11/30/2016
OLES Case Number	2016-01581C
Case Type	Abuse
Incident Summary	On November 30, 2016, a patient alleged a medical technical assistant kicked his cell door causing the cell door to hit him in the right cheek.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Appendix B: Pre-disciplinary Cases Monitored by the OLES

On the following pages are the departmental investigations that the OLES monitored for both procedural and substantive sufficiency.

- Procedural sufficiency is assessing the notifications to the OLES, consultations with the OLES and investigation activities for timeliness, among other things.
- Substantive sufficiency is assessing the quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

Case Table Section	Section Content
Incident Date	12/27/2015
OLES Case Number	2016-00003MA
Allegations	1. Incompetency
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 27, 2015, a client alleged that a psychiatric technician pulled on her vaginal "vocal cord," causing pain to her genital area.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department's pre-disciplinary process did not sufficiently comply with policies and procedures because the investigation was not completed in a timely manner, nor did the department adequately consult with the OLES.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not timely notify the OLES of the incident. 2. Did the Hiring Authority properly characterize the nature and scope of the incident during his/her notification to OLES? No. The hiring authority did not properly characterize the nature and scope of the incident during the notification to the OLES. 3. Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames

	<p>required by law?</p> <p>No. The hiring authority did not notify outside law enforcement of the incident.</p> <p>4. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>5. Did OPS adequately consult with OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation?</p> <p>No. The OPS did not adequately consult with the OLES to determine if an administrative investigation should be conducted concurrently with the criminal investigation.</p> <p>6. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. A draft copy of the investigative report was not forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority.</p> <p>7. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The pre-disciplinary/investigative phase was not conducted with due diligence because the investigation was not completed within 75 days.</p>
Disposition	The hiring authority determined the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Department Corrective Action Plan	This case began during the pilot period before January 1, 2016. OPS was still learning the reporting requirements that would go into effect January 1, 2016. Investigators have since been provided training and have a better understanding of the process.

Case Table Section	Section Content
Incident Date	01/06/2016
OLES Case Number	2016-00056MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 6, 2016, a registered nurse allegedly locked a patient in a seclusion room. Additionally, it was alleged that another registered nurse was dishonest during the investigatory interview.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation against the registered nurse who allegedly locked the patient in the room. The OLES concurred. The other registered nurse retired prior to the completion of the investigation.

Case Table Section	Section Content
Incident Date	01/11/2016
OLES Case Number	2016-00058MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On January 11, 2016, a psychiatric technician allegedly sexually assaulted a patient while she slept.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with this determination. An administrative case was not opened.

Case Table Section	Section Content
Incident Date	01/18/2016

OLES Case Number	2016-00066MA
Allegations	<ol style="list-style-type: none"> 1. Inefficiency 2. Inexcusable neglect of duty 3. Discourteous treatment 4. Willful disobedience 5. Other failure of good behavior
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	<p>Initial: Salary Reduction</p> <p>Final: No Change</p>
Incident Summary	On January 18, 2016, a psychiatric technician allegedly walked away from a patient he was assigned to monitor, without notifying his supervisor that he was leaving his post.
Overall Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department's pre-disciplinary process sufficiently complied with policies and procedures.</p>
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the psychiatric technician and imposed a 5 percent salary reduction for six months. The OLES concurred.

Case Table Section	Section Content
Incident Date	01/27/2016
OLES Case Number	2016-00107MA
Allegations	<ol style="list-style-type: none"> 1. Discourteous treatment
Findings	<ol style="list-style-type: none"> 1. Unfounded
Penalty	<p>Initial: No Penalty Imposed</p> <p>Final: No Change</p>
Incident Summary	On January 27, 2016, a patient alleged that three psychiatric technicians threatened to forcefully medicate him, pulled him from his room, and threw him to the ground.
Overall Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120 days from the date of the incident.</p>
Disposition	The hiring authority determined that the investigation proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	01/23/2016
OLES Case Number	2016-00116MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On January 23, 2016, it was alleged that a psychiatric technician failed to watch a client who was on a constant supervision behavior plan, during which time she hid a foreign object in her sock. It was further alleged, that another psychiatric technician failed to watch the client during the nighttime hours and the client swallowed the foreign object resulting in emergency medical treatment.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The Office of Protective Services failed to comply with the department's policies and procedures governing the investigative process of notifications and consultations with the OLES.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The incident was not reported to the OLES. 2. Did the Hiring Authority timely notify the department's legal office of the incident? No. A notification was not made to the legal department. 3. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The OPS did not conduct an initial case conference with the OLES. 4. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The OPS did not consult with the OLES during critical junctures of the investigation.
Disposition	The Office of Special Investigations conducted an

	investigation and found sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The district attorney declined to file charges. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
Department Corrective Action Plan	Initially, no abuse was alleged and there was no indication of abuse. This incident was initially being handled as a PICA incident and did not meet the criteria of reporting to OLES. On January 29, 2016, based on the preliminary investigation, OPS became aware of additional information and assigned the case to an investigator to investigate possible criminal neglect. OPS did make notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

Case Table Section	Section Content
Incident Date	02/01/2016
OLES Case Number	2016-00127MA
Allegations	1. Incompetency
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 1, 2016, a psychiatric technician allegedly did not properly supervise a client who was on a one-to-one level of supervision. The psychiatric technician allegedly did not respond appropriately to the client's threats to swallow items.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	01/30/2016
OLES Case Number	2016-00135MA
Allegations	1. Incompetency
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 30, 2016, a psychiatric technician was allegedly neglectful in monitoring a client who swallowed two needles while on a direct level of supervision.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	02/04/2016
OLES Case Number	2016-00137MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On February 4, 2016, a patient alleged that while he was in restraints, several unidentified staff members entered his room, placed a blanket over his head and punched in him in the face and head.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120 days from the date of the incident.
Disposition	The Office of Special Investigations 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 district attorney's office did not file criminal charges. The Office of Protective Services opened an administrative

	investigation, which the OLES accepted for monitoring.
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Case Table Section	Section Content
Incident Date	02/03/2016
OLES Case Number	2016-00139MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 3, 2016, a patient alleged a psychiatric technician kicked him in the buttocks while he was drinking from the toilet.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigative report was not completed until approximately 150 days from the date of the incident and the disposition meeting was not held until 60 days later.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.

Case Table Section	Section Content
Incident Date	02/07/2016
OLES Case Number	2016-00153MA
Allegations	1. Discourteous treatment
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 7, 2016, a patient alleged that a registered nurse hit and kicked him in the ribs.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 150 days from the date of the incident.
Disposition	The hiring authority determined the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	02/08/2016

OLES Case Number	2016-00159MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 8, 2016, a patient alleged he was "chest bumped" and pinned against a door by a psychiatric technician.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The OPS did not provide the OLES with a draft copy of the investigative report prior to closure of the investigation. The investigation was not completed until approximately 203 days from the date of the incident.
Pre-Disciplinary Assessment	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OPS failed to provide the OLES with a draft copy of the investigative report before the investigation was closed.</p> <p>3. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS failed to appropriately provide the OLES with a copy of the draft investigative report prior to closing the case.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered by OPS on February 8, 2016, however the investigation was not completed until August 29, 2016, 203 days later.</p>
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Department Corrective Action Plan	The department utilizes a multitude of factors to determine how we prioritize investigations. Some of these factors include severity of the crime, assessment of the evidence, likelihood of prosecution, and the possibility of a collateral administrative investigation. The 75-day timeline is only one of the factors considered. Although this investigation was completed 128 days beyond that timeline, it was well within the statute established in the Penal Code. Also, the department has established a process that requires written justification for any case exceeding the timeframe be approved by a supervisor and the chief of police. The time extension process was implemented by the department on November 10, 2016.

Case Table Section	Section Content
Incident Date	02/10/2016
OLES Case Number	2016-00167MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	From 2013 to February 2016, a unit supervisor allegedly harassed patients by unnecessarily changing patient bed assignments, and unnecessarily turning on lights. Additionally, the unit supervisor allegedly encouraged staff members to be aggressive toward patients and failed to take action when staff abused patients.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	02/16/2016
OLES Case Number	2016-00192MC
Allegations	1. Criminal Act
Findings	1. Not Referred

Penalty	Initial: Other Final: No Change
Incident Summary	On February 16, 2016, a psychiatric technician allegedly fractured a client's thumb during a containment procedure.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. A copy of the draft report was not provided in a timely manner. Also, the draft report was completed approximately 105 days after the last interview was concluded.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not timely notify the OLES of the incident 2. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The draft copy of the investigative report was not provided to the OLES in a timely manner; the draft report was completed approximately 105 days after the last interview was completed.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Department Corrective Action Plan	OPS did notify OLES, but the notification was 75 minutes late per policy. OPS has provided additional training to supervisors to ensure notifications are timely. In regards to the timeliness, the command was experiencing a severe staffing shortage and the assigned investigator was carrying a large caseload, many of which carried a higher priority than this case. The command has since addressed the staffing shortage.

Case Table Section	Section Content
Incident Date	02/18/2016
OLES Case Number	2016-00204MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On February 18, 2016, it was alleged that a psychiatric technician assistant kicked a client on the back of his left leg.
Overall Assessment	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The Office of Protective Services failed to comply with the department's policies and procedures governing the investigative process of notifications and consultations with OLES. Upon case initiation, a supervisor discussed the matter with the OLES and advised the matter would be referred the district attorney, with some possible follow-up interviews. The OPS then had minimal contact with the OLES regarding critical witnesses that were interviewed. Also, the OLES was not given an opportunity to review the investigative report before it was final.</p>
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the legal department. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The OPS did not confer with the OLES regarding an investigative plan. 3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The OLES was not provided a draft report to review. The OLES was provided a final copy. 4. Did OPS cooperate with and provide continued real-time consultation with OLES?

	<p>No. The OPS did not provide continued real-time consultation with the OLES. Although the OLES was notified of a potential suspect interview, the final report revealed a number of witness interviews that were conducted without notice to the OLES.</p> <p>5. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident occurred February 18, 2016; however, the investigation was not completed until May 31, 2016.</p>
Disposition	The Office of Special Investigations conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The district attorney declined to file charges. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
Department Corrective Action Plan	OPS did make notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately." OPS believes the investigative phase was conducted with due diligence. The assigned investigator in this case was a retired annuitant who works limited hours and carries multiple cases. However, OPS is continuing its recruitment efforts to address staffing shortages, which will in turn help address timeliness of closing cases.

Case Table Section	Section Content
Incident Date	02/21/2016
OLES Case Number	2016-00207MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 21, 2016, a doctor and a psychiatric technician allegedly failed to call for an immediate on-site emergency

	medical response for a patient who was suffering chest pains.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigative report was not completed until approximately 180 days from the date of the incident and the disposition meeting was not held until approximately 60 days after the case was complete.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.

Case Table Section	Section Content
Incident Date	02/19/2016
OLES Case Number	2016-00208MA
Allegations	1. Incompetency
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 19, 2016, a medical examination revealed that a client suffered a bilateral hip fracture of undetermined origin.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's pre-disciplinary process sufficiently complied with policies and procedures.
Disposition	The hiring authority determined that the investigation conclusively proved misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	02/20/2016
OLES Case Number	2016-00258MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 20, 2016, a patient alleged that a staff member improperly moved her from her bed to a wheelchair, which resulted in a scratch on her back.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigative report was not completed until approximately 240 days from the date of the incident.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	03/06/2016
OLES Case Number	2016-00278MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On March 6, 2016, a psychiatric technician allegedly pushed a client too fast in his wheelchair, which hit a door-jam, causing the client to fall out of his wheelchair.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The department did not open an administrative investigation due to lack of evidence. The OLES concurred.

Case Table Section	Section Content
Incident Date	02/03/2016
OLES Case Number	2016-00286MA
Allegations	1. Incompetency
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 3, 2016, a psychiatric technician allegedly conducted a medical examination of a client beyond the scope of her license.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's pre-disciplinary process sufficiently comply with policies and procedures.

Disposition	The hiring authority determined that the investigation conclusively proved misconduct did not occur. The OLES concurred with the hiring authority's determination.
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Case Table Section	Section Content
Incident Date	03/15/2016
OLES Case Number	2016-00308MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 15, 2016, a patient alleged a senior staff psychiatrist grabbed his penis during the new patient admitting process. The patient further alleged a senior medical technical assistant grabbed his penis the same day, while he was in his cell. On March 18, 2016, the patient alleged a registered nurse threatened to sexually assault him. Finally, on March 21, 2016, the patient alleged that a staff psychiatrist rubbed his buttocks in a sexual manner, after administering a inter-muscular injection.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 150 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.

Case Table Section	Section Content
Incident Date	01/23/2016
OLES Case Number	2016-00326MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On January 23, 2016, it was alleged that a psychiatric technician failed to watch a client who was on a constant supervision behavior plan, during which time the client hid a foreign object in her sock. It was further alleged, that another psychiatric technician failed to watch the client during the nighttime hours and the client swallowed the foreign object resulting in emergency medical treatment.
Overall Assessment	Procedural Rating: Insufficient

	<p>Substantive Rating: Insufficient</p> <p>Overall, the department failed to sufficiently comply with policies and procedures governing the pre-disciplinary/investigative process. The hiring authority failed to consult with the OLES during the pre-disciplinary/investigative phase. Significantly, the criminal and administrative investigations were not properly separated and information from the administrative investigation was impermissibly shared with the investigator in the related criminal case.</p>
<p>Pre-Disciplinary Assessment</p>	<ol style="list-style-type: none"> 1. Did the Hiring Authority adequately consult with OLES regarding the incident? <p>No. A consultation was not held with the hiring authority and the OLES.</p> 2. Did the Hiring Authority timely notify the department's legal office of the incident? <p>No. A notification to the department's legal office was not made.</p> 3. Did OPS appropriately protect compelled statements obtained in the administrative case from being improperly used in a criminal case? <p>No. The investigator in the administrative case shared information he received from witnesses with the investigator in the criminal case. Although the information shared was not from the compelled statement, it was information received after the compelled statement was already taken.</p> 4. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? <p>No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.</p> 5. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?

	No. The hiring authority did not consult with the OLES during the pre-disciplinary/investigative phase.
Disposition	The hiring authority sustained the allegation and dismissed the psychiatric technician. The OLES was not consulted.
Department Corrective Action Plan	In this case, the criminal investigation was completed and submitted to the District Attorney before the administrative investigator was assigned. The administrative investigator did share information with the criminal investigator, but the information was not shared until after the District Attorney had determined the neglect was not criminal in nature. Consequently, the information was not used improperly in the criminal case. OPS did make notification to the OLES, but OPS conducted its investigation before the OLES decided to monitor the case. In March 2016, OPS issued a policy which states, "In situations where interviews must be initiated immediately based upon the seriousness of the allegations, the investigator shall contact the assigned monitor prior to conducting the interviews. If the investigator has not been advised that OLES has decided it will assign a monitor, or does not know who will be monitoring the case, the investigator shall call the OLES hotline to give OLES the opportunity to have a monitor respond immediately."

Case Table Section	Section Content
Incident Date	03/17/2016
OLES Case Number	2016-00340MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 17, 2016, a licensed vocational nurse allegedly failed to monitor a patient on close and constant observation status. The patient, who was in walking restraints, was allegedly able to climb on top of a table and jump onto a tile floor.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 85 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.

Case Table Section	Section Content
Incident Date	03/29/2016
OLES Case Number	2016-00369MA
Allegations	<ol style="list-style-type: none"> 1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	<p>Initial: Suspension</p> <p>Final: No Change</p>
Incident Summary	On March 29, 2016, four nurses allegedly failed to complete required nursing assessments on a patient in full bed restraints. Two of those nurses were also allegedly dishonest during investigative interviews.
Overall Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department sufficiently complied with policies and procedures governing the pre-disciplinary process.</p>
Disposition	The hiring authority sustained allegations against two of the nurses and imposed a seven-working-day suspension on each. The OLES concurred. A third nurse resigned before completion of the investigation; therefore, no disciplinary action was taken. A letter indicating the third nurse resigned under adverse circumstances was placed in his official personnel file. No allegations were sustained against the fourth nurse. The OLES concurred.

Case Table Section	Section Content
Incident Date	12/11/2015
OLES Case Number	2016-00392MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	<p>Initial: Other</p> <p>Final: No Change</p>
Incident Summary	On December 11, 2015, a psychiatric technician observed a client lying in her bed unresponsive. The psychiatric technician requested assistance. The psychiatric technician and a registered nurse placed the client on the floor and began life-saving measures. Paramedics arrived and took over life-saving measures. The client was transported to an outside hospital where she was pronounced dead.
Overall Assessment	Procedural Rating: Sufficient

	<p>Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.</p>
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.

Case Table Section	Section Content
Incident Date	01/01/2014
OLES Case Number	2016-00399MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	Between January 1, 2014, and December 31, 2015, a psychologist allegedly touched a patient in a sexually inappropriate manner.
Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department's investigative process sufficiently complied with policies and procedures.</p>
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The department did not open an administrative investigation due to lack of evidence. The OLES concurred.

Case Table Section	Section Content
Incident Date	04/07/2016
OLES Case Number	2016-00405MA
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 Change
Incident Summary	On April 7, 2016, a psychiatric technician allegedly touched a patient's stomach and attempted to strangle the patient by grabbing the front of the patient's jacket.
Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department generally complied with policies and</p>

	procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the psychiatric technician. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	04/07/2016
OLES Case Number	2016-00408MA
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Other failure of good behavior
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Sustained 3. Not Sustained 4. Sustained
Penalty	Initial: Counseling Final: No Change
Incident Summary	On April 7, 2016, a nurse and psychiatric technician allegedly failed to timely identify a doctor's order to observe a patient every 15 minutes and allegedly failed to ensure the patient was observed every 15 minutes as ordered.
Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.</p>
Disposition	The hiring authority sustained both allegations against the nurse and issued a letter of counseling. The hiring authority sustained an allegation against the psychiatric technician for failing to ensure the patient was observed every 15 minutes, but determined there was insufficient evidence to sustain an allegation that the psychiatric technician failed to document the observation order. The hiring authority issued a letter of counseling to the psychiatric technician. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	04/08/2016
OLES Case Number	2016-00416MA
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Inexcusable neglect of duty

Findings	1. Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 8, 2016, a psychiatric technician allegedly left a patient who was on an enhanced observation status in order to respond to an alarm.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority sustained an allegation that the psychiatric technician violated the enhanced patient observation policy and determined there was insufficient evidence to sustain an allegation that the psychiatric technician neglected the patient. The hiring authority did not impose discipline because this incident prompted the facility to modify its enhanced patient observation policy to allow staff to interrupt patient observation, in some instances, if an emergency arises. The OLES concurred with the hiring authority's determinations.

Case Table Section	Section Content
Incident Date	04/08/2016
OLES Case Number	2016-00430MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On April 8, 2016, three health care staff allegedly physically abused and sexually assaulted a patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 175 days from the date of the discovery of the incident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with this determination. An administrative investigation was not opened due to lack of evidence.

Case Table Section	Section Content
Incident Date	04/12/2016
OLES Case Number	2016-00441MA
Allegations	<ol style="list-style-type: none"> 1. Discourteous treatment 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	<p>Initial: Salary Reduction</p> <p>Final: No Change</p>
Incident Summary	<p>On April 12, 2016, a senior psychiatric technician allegedly forcibly grabbed a patient by the arm and led her to a seclusion room. It was further alleged the senior psychiatric technician used inappropriate language towards the patient. In addition, the senior psychiatric technician was allegedly less than truthful during her investigatory interview and she allegedly contacted a witness who was interviewed during the course of the investigation, after she was admonished to not discuss the investigation.</p>
Overall Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident and the initial disposition meeting was not held until approximately 80 days after the final report was completed.</p>
Disposition	<p>The hiring authority determined there was sufficient evidence to sustain the allegations that the senior psychiatric technician was discourteous toward the patient and insubordinate by contacting a witness in the case and imposed a salary reduction of five percent for six months. The other allegations were not sustained. The OLES concurred.</p>

Case Table Section	Section Content
Incident Date	04/18/2016
OLES Case Number	2016-00474MA
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Inexcusable neglect of duty

	3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On April 18, 2016, a psychiatric technician allegedly left a client, who required constant supervision, unattended in the restroom for more than an hour. Also, the psychiatric technician was allegedly dishonest during her administrative interview. Further, a senior psychiatric technician allegedly failed to properly document the medical record of the client who was left unattended in the restroom.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the psychiatric technician. The hiring authority also imposed a 10 percent salary reduction for 12 months on the senior psychiatric technician. The OLES concurred with the hiring authority's determinations.

Case Table Section	Section Content
Incident Date	04/19/2016
OLES Case Number	2016-00479MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 19, 2016, a psychiatric technician allegedly touched a client in a sexual manner.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	The department conducted an investigation into this matter; however, there was insufficient evidence to refer the matter to the hiring authority and the matter was closed. The OLES concurred with the determination.

Case Table Section	Section Content
Incident Date	04/22/2016
OLES Case Number	2016-00497MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On April 22, 2016, a client was discovered to have a broken toe.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Case Table Section	Section Content
Incident Date	05/01/2016
OLES Case Number	2016-00502MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On May 1, 2016, a psychiatric technician assistant allegedly sexually assaulted a patient by laying on top of him and fondling his penis.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Case Table Section	Section Content
Incident Date	04/26/2016
OLES Case Number	2016-00506MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On April 26, 2016, a psychiatric technician allegedly verbally abused a patient and gave the patient more medication than prescribed.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. An administrative investigation was not opened due to lack of evidence.

Case Table Section	Section Content
Incident Date	04/28/2016
OLES Case Number	2016-00518MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 28, 2016, a senior psychiatric technician allegedly pushed and verbally abused a patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	01/01/2013
OLES Case Number	2016-00519MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty

Findings	1. Unfounded 2. Unfounded 3. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 29, 2016, a client alleged a psychiatric technician and other staff members hit, punched and slapped him several years earlier.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 150 days from the date of the incident.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	04/27/2016
OLES Case Number	2016-00523MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On April 27, 2016, a senior psychiatric technician allegedly left a client, who was on one-to-one supervision status unattended, to care for another client. While unsupervised, the client engaged in self-injurious behavior by attempting to ingest his socks.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary/investigative process. The OLES advised the OPS the investigation was going to be monitored, however three months after the incident, the OLES was advised that a criminal investigation was closed and an administrative investigation was to be conducted. The OLES was not consulted during the course of the criminal investigation. Also, the department did not complete the investigation in a timely manner, taking over 120 days to complete an investigative report.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the department's legal office of the incident?

	<p>No. The legal department was not notified.</p> <p>2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan?</p> <p>No. The OPS advised the OLES that due to staff shortages, the assigned investigator had higher priority cases to complete before starting the investigation on this case. Approximately three months after the date of the incident, the OPS advised a new investigator was assigned and would contact the OLES to discuss the investigative plan.</p> <p>3. Did OPS adequately consult with OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation?</p> <p>No. The OLES was not consulted on the criminal investigation. The OLES was advised the criminal case was closed when the OLES was advised a new investigator was assigned.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The investigation was not completed until over 120 days from the date of the incident.</p>
Disposition	The hiring authority sustained the allegation and imposed a salary reduction of 5 percent for six months. The OLES concurred in the determination.
Department Corrective Action Plan	In this case, due to no available officers, an investigator was the first responder on the criminal investigation. He took initial statements from the involved parties and was able to immediately rule out any crime prior to making the initial notification to OLES. In the future, OPS will communicate with OLES regarding all Priority 1 & 2 cases where an investigator is carrying out officer responsibilities, to ensure OLES concurs with the results of the preliminary criminal investigation. The initial responding investigator then was off work for an extended period of time. The administrative case was reassigned to another investigator. Staffing shortages and workloads caused a delay in the administrative investigation. The hiring authority is aggressively recruiting to address staffing shortages.

Case Table Section	Section Content
Incident Date	04/28/2016
OLES Case Number	2016-00529MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On April 28, 2016, a patient alleged his roommate and possibly an unknown staff member had sexually assaulted him while he was sleeping.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing pre-disciplinary process.
Disposition	The investigation found sufficient evidence for a probable cause referral to the district attorney's office on the roommate. The OLES concurred with the probable cause determination. No staff member was identified as a suspect.

Case Table Section	Section Content
Incident Date	04/29/2016
OLES Case Number	2016-00545MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On April 29, 2016, a psychiatric technician allegedly gave his personal food to a patient after the food had fallen on the floor.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 150 days from the date of the incident.
Disposition	The hiring authority sustained all allegations against the psychiatric technician and imposed a 10 percent salary reduction for six months. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	05/02/2016
OLES Case Number	2016-00546MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 2, 2016, a psychiatric technician allegedly kicked a patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 100 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation against the psychiatric technician. The OLES concurred.

Case Table Section	Section Content
Incident Date	05/01/2016
OLES Case Number	2016-00553MA
Allegations	1. Discourteous treatment
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 1, 2016, a client alleged a psychiatric technician told another client to tease him.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's pre-disciplinary process sufficiently comply with policies and procedures.
Disposition	The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	04/18/2016
OLES Case Number	2016-00565MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other

	Final: No Change
Incident Summary	On April 18, 2016, a staff member allegedly abused a patient, causing spinal compression fractures.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Case Table Section	Section Content
Incident Date	04/28/2016
OLES Case Number	2016-00572MA
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 Change
Incident Summary	On April 28, 2016, two psychiatric technicians allegedly caused a patient to strike his head while placing him against a wall, forced his arms up behind his back, and pushed their knees into his back during wall and floor containment procedures. A unit supervisor allegedly failed to ensure two patient containment and seclusion incidents were video-recorded.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	05/08/2016
OLES Case Number	2016-00580MA
Allegations	1. Inexcusable neglect of duty

	2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 8, 2016, a patient alleged that a psychiatric technician grabbed her right hand by the index finger, while twisting her arm behind her back, while taking her down to the ground.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120 days from the date of the incident.
Disposition	The hiring authority determined that there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	05/08/2016
OLES Case Number	2016-00581MA
Allegations	1. Discourteous treatment 2. Inexcusable neglect of duty
Findings	1. Unfounded 2. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 8, 2016, a psychiatric technician allegedly gave a patient morphine without a prescription and another psychiatric technician allegedly verbally challenged the patient to a fight.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	04/26/2016
OLES Case Number	2016-00594MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 26, 2016, a psychiatric technician trainee allegedly orally copulated a patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	01/11/2016
OLES Case Number	2016-00596MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 11, 2016, a psychiatric technician allegedly grabbed and pushed a patient onto the patient's bed. Also, on March 29, 2016, the psychiatric technician allegedly slammed the same patient into a wall. The psychiatric technician also allegedly failed to properly report the patient's allegations of abuse.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.

Case Table Section	Section Content
Incident Date	05/10/2016
OLES Case Number	2016-00600MC
Allegations	1. Criminal Act 2. Criminal Act

Findings	1. Not Referred 2. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On May 10, 2016, two psychiatric technicians allegedly bruised and scratched a client.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 100 days from the date of the incident and the investigative report was not completed until over 60 days later.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Case Table Section	Section Content
Incident Date	01/28/1978
OLES Case Number	2016-00603MA
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 Change
Incident Summary	On May 11, 2016, a patient alleged six staff members had held him down on the floor on January 28, 1978.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The OPS conducted the subject interview without notice to the OLES. In addition, the investigation was not completed until approximately 96 days from the date the incident was discovered.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident.

	<p>2. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The investigator conducted the subject interview without notice to the OLES.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The alleged incident was discovered on May 11, 2016, however the report was not completed until August 15, 2016, 96 days later.</p>
Disposition	The department conducted an investigation into this matter; however, there was insufficient evidence to refer the matter to the hiring authority and the matter was closed.
Department Corrective Action Plan	The department utilizes a multitude of factors to determine how we prioritize investigations. Some of these factors include severity of the crime, assessment of the evidence, likelihood of prosecution, and the possibility of a collateral administrative investigation. The 75-day timeline is only one of the factors considered. Although this investigation was completed 21 days beyond that timeline, it was well within the statute established in the Penal Code. Also, the department has established a process that requires written justification for any case exceeding the timeframe be approved by a supervisor and the chief of police. The time extension process was implemented by the department on November 10, 2016.

Case Table Section	Section Content
Incident Date	05/14/2016
OLES Case Number	2016-00616MC
Allegations	1. Other
Findings	1. Unfounded
Penalty	Initial: Other Final: No Change
Incident Summary	On May 14, 2016, a patient was found in his bed unresponsive with no pulse. After the administration of life-saving measures and transportation to an outside hospital, the patient was pronounced deceased. An autopsy determined the cause of death was cardiac arrest.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies

	and procedures governing the pre-disciplinary process.
Disposition	The department reviewed this matter and determined no staff misconduct or policy violations were identified as part of a death review. The OLES concurred.

Case Table Section	Section Content
Incident Date	05/11/2016
OLES Case Number	2016-00632MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 11, 2016, a patient alleged a psychiatric technician slapped him on his hand after he failed to leave the food line in the dining hall.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the investigative process. The OPS did not provide the OLES with either a draft or final copy of the investigative report. The investigation was not completed in a timely manner.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The OLES was not provided with a draft copy of the investigative report. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The OPS did not provide the OLES with either a copy of the draft or final investigative report. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The incident was discovered on May 17, 2016, however the investigation was not completed until August 23, 2016, 98 days later.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Department Corrective Action Plan	We utilize a multitude of factors to determine how we prioritize investigations. Some of these factors include severity of the crime, assessment of the evidence, likelihood of prosecution, and the possibility of a collateral administrative investigation. The 75-day timeline is only one of the factors considered. Although this investigation was completed 23 days beyond that timeline, it was well within the statute established in the Penal Code. Also, the department has established a process that requires written justification for any case exceeding the timeframe be approved by a supervisor and the chief of police.

Case Table Section	Section Content
Incident Date	05/19/2016
OLES Case Number	2016-00649MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On May 19, 2016, a client alleged two psychiatric technicians kneed her in the stomach.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's pre-disciplinary process sufficiently complied with policies and procedures.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation.

Case Table Section	Section Content
Incident Date	05/20/2016
OLES Case Number	2016-00656MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 20, 2016, a staff member allegedly allowed a patient to ingest rocks from the facility's grounds, resulting in

	the death of the patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	05/24/2016
OLES Case Number	2016-00665MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 24, 2016, a nurse allegedly failed to timely conduct a required nursing assessment.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 110 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the nurse. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	05/25/2016
OLES Case Number	2016-00668MA
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 Change
Incident Summary	On May 25, 2016, a unit supervisor allegedly grabbed a patient's chest.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	The department substantially complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to support the allegations. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	05/20/2016
OLES Case Number	2016-00672MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On May 20, 2016, a client alleged she had been struck and sexually assaulted by a staff member.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation.

Case Table Section	Section Content
Incident Date	05/20/2016
OLES Case Number	2016-00676MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On May 20, 2016, a client alleged that a psychiatric technician pushed her into a flower shrub while she was sitting in her wheelchair.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The

	OLES concurred with the probable cause determination. The OPS did not open an administrative investigation.
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Case Table Section	Section Content
Incident Date	05/28/2016
OLES Case Number	2016-00678MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 28, 2016, two patients were involved in a physical altercation. One of the involved patients alleged a psychiatric technician hit her once on the head.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to sufficiently comply with policies and procedures governing the pre-disciplinary process. The department failed to provide the OLES with a copy of the draft report and the investigation was not completed until approximately 85 days from the date of the incident.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. A draft copy of the investigative report was not forwarded to OLES to allow for feedback before it was forwarded to the hiring authority. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed within the 75-day period recommended by OLES.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Department Corrective Action	OSI Investigators have been instructed to utilize the "Draft" watermark on all reports and email them directly to the OLES

Plan	monitor. The email copy will be kept with report binder. OSI office staff was instructed to upload the “Draft” watermarked report to WatchDox for verification by Chief/SSI with a copy in file for referencing. Chief/SSI will meet with investigative staff to establish due dates for better compliance with time frames. OSI office staff were instructed to develop a 75 day schedule of due dates to keep Chief/SSI informed.
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Case Table Section	Section Content
Incident Date	05/30/2016
OLES Case Number	2016-00693MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On May 30, 2016, a psychiatric technician allegedly choked a client.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.

Case Table Section	Section Content
Incident Date	05/22/2016
OLES Case Number	2016-00695MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 22, 2016, a staff member allegedly left a patient lying in feces, and a senior psychiatric technician refused to allow the patient to shower.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120

	days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	06/02/2016
OLES Case Number	2016-00700MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 2, 2016, it was alleged that an unknown staff member physically abused a non-verbal client, resulting in a fractured bone in the client's right leg.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the District Attorney. The OLES concurred with this determination. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.

Case Table Section	Section Content
Incident Date	05/22/2016
OLES Case Number	2016-00708MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 2, 2016, a patient's mother called the facility and alleged that on May 22, 2016, a staff member threw the patient to the ground.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.

Case Table Section	Section Content
Incident Date	06/04/2016
OLES Case Number	2016-00709MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 4, 2016, two psychiatric technicians allegedly punched a patient twice in the stomach.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The Office of Special Investigations did not open an administrative investigation. The OLES also concurred with this determination.

Case Table Section	Section Content
Incident Date	06/08/2016
OLES Case Number	2016-00725MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On June 8, 2016, two patients alleged that a psychiatric technician had engaged in sexual activities with them over the course of the past month. The patients also alleged that the psychiatric technician provided money and food to patients.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the sexual misconduct did not occur. The OLES concurred with the hiring authority's

	determination. However, the hiring authority determined that there was sufficient evidence to sustain an allegation that the psychiatric technician did inappropriately provide food to patients and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
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Case Table Section	Section Content
Incident Date	06/12/2016
OLES Case Number	2016-00756MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On June 12, 2016, a psychiatric technician allegedly failed to properly monitor an agitated client who was placed in a shower stall.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 85 days from the date of the incident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 10 percent salary reduction for six months. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	06/10/2016
OLES Case Number	2016-00760MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 10, 2016, a psychiatric technician allegedly pushed a patient from the patient's wheelchair.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The detective failed to adequately consult with the OLES at the start and conclusion of the investigation. Also, although the draft investigative report was provided, the detective failed

	to consult with the OLES prior to finalizing the report.
Pre-Disciplinary Assessment	<p>1. Did the Hiring Authority respond timely to the incident?</p> <p>No. The reporting party who witnessed the alleged incident delayed four days before submitting a form to report alleged abuse.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?</p> <p>No. The draft investigative report did not include all relevant penal code sections, listing battery as the only possible crime investigated. Abuse of a dependent adult was also applicable since the psychiatric technician allegedly battered a patient who qualified as a dependent adult.</p> <p>4. Was the final investigative report thorough and appropriately drafted?</p> <p>No. The report did not include all applicable penal code sections that were investigated.</p> <p>5. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The detective conducted several witness interviews before consulting with the OLES. The detective also failed to advise the OLES if any of the OLES recommendations were incorporated in the final investigative report and failed to advise when the criminal investigation was closed before referring the matter to the Office of Special Investigations for possible administrative investigation.</p>
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES was not consulted regarding the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for

	monitoring.
Department Corrective Action Plan	The Detective Unit will provide all draft monitored reports to the OLES Monitor for review.

Case Table Section	Section Content
Incident Date	06/14/2016
OLES Case Number	2016-00763MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 14, 2016, two registered nurses and a psychiatric technician allegedly stabbed a patient in the genitals with a large needle, and the patient alleged this conduct had been occurring for two years.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. An administrative investigation was not opened due to lack of evidence. The OLES concurred with these determinations.

Case Table Section	Section Content
Incident Date	06/16/2016
OLES Case Number	2016-00770MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 16, 2016, a patient alleged a registered nurse approached his cell and asked to see his penis.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 106 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegations. The OLES concurred.
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Case Table Section	Section Content
Incident Date	06/15/2016
OLES Case Number	2016-00773MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 15, 2016, three psychiatric technicians and a psychiatric technician assistant allegedly punched a client in the face.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. An administrative investigation was not opened due to lack of evidence.

Case Table Section	Section Content
Incident Date	06/17/2016
OLES Case Number	2016-00782MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 17, 2016, a client alleged a teacher's assistant struck him behind his ear.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's pre-disciplinary process did sufficiently comply with the policies and procedures.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation.

Case Table Section	Section Content
Incident Date	06/06/2016
OLES Case Number	2016-00788MA

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 6, 2016, a registered nurse allegedly failed to respond to a physical altercation between two patients because she was wearing earphones.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	06/21/2016
OLES Case Number	2016-00791MA
Allegations	1. Other
Findings	1. Unfounded
Penalty	Initial: Other Final: No Change
Incident Summary	On June 21, 2016, a patient died of heart failure while at an outside hospital.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures related to death investigations.
Disposition	The hiring authority reviewed this matter and determined no staff misconduct or policy violations were identified as part of a death review. The OLES concurred.

Case Table Section	Section Content
Incident Date	06/18/2016
OLES Case Number	2016-00792MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 18, 2016, a senior psychiatric technician allegedly "chest bumped" a patient then took the patient to the

	ground, causing a laceration to the patient's eyebrow.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until over 90 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	06/22/2016
OLES Case Number	2016-00798MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 22, 2016, a non-verbal client was found to have a fracture to his right toe of unknown origin.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Case Table Section	Section Content
Incident Date	06/19/2016
OLES Case Number	2016-00803MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 19, 2016, a client alleged that two psychiatric technicians grabbed her arms, resulting in a small bruise and laceration.
Overall Assessment	Procedural Rating: Insufficient

	<p>Substantive Rating: Sufficient</p> <p>The department did not sufficiently comply with policies and procedures governing the investigative process. The OPS did not assess the statute of limitations for either a criminal or an administrative investigation. The OPS did not consult with the OLES concerning whether criminal and administrative investigations should be conducted concurrently, did not properly bifurcate the criminal and administrative investigations and did not indicate in the investigative report whether the subjects were provided with legally required admonitions before obtaining their statements. Further, if the subjects' statements were compelled, they appear to have been improperly included in the criminal report, and the OPS did not provide the OLES with a draft copy of the investigative report or consult with the OLES on whether the criminal investigation should be referred to the district attorney's office. The investigation was not appropriately conducted and the final report was not properly drafted due to the deficiencies noted. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings.</p>
<p>Pre-Disciplinary Assessment</p>	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the department's legal office of the incident? <p>No. The hiring authority did not notify the department's legal office of the incident.</p> 2. Did the department appropriately determine the deadline for taking disciplinary action (statute of limitation date)? <p>No. There is no indication the department assessed the deadline for taking either criminal or administrative action.</p> 3. Did OPS adequately consult with OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? <p>No. The OPS apparently conducted a criminal and administrative investigation together and did not consult with OLES.</p>

	<p>4. Was the administrative and criminal investigation properly and completely bifurcated?</p> <p>No. The investigation contained elements of both a criminal and administrative investigation and it was not bifurcated.</p> <p>5. Were all of the interviews thorough and appropriately conducted?</p> <p>No. There is no indication in the investigative report that the subjects were provided with either criminal or administrative admonitions as required by law.</p> <p>6. Did OPS appropriately protect compelled statements obtained in the administrative case from being improperly used in a criminal case?</p> <p>No. There is no indication in the investigative report whether the statements obtained from the subjects were obtained pursuant to a criminal or administrative investigation.</p> <p>7. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES did not receive a draft copy of the investigative report to allow for feedback.</p> <p>8. Was the final investigative report thorough and appropriately drafted?</p> <p>No. The final investigative report contained elements of a criminal and administrative investigation. There is no indication whether the subjects were provided appropriate legal admonitions prior to providing statements.</p> <p>9. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS did not provide the OLES with a copy of the draft report or consult concerning whether the matter should be referred to the appropriate</p>
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	<p>prosecuting agency to file charges.</p> <p>10. Was the investigation thorough and appropriately conducted?</p> <p>No. The investigation was not appropriately conducted in that it appears that a single investigator conducted both a criminal and administrative investigation at the same time. It does not appear that the subjects were given legally required admonitions prior to providing statements.</p> <p>11. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.</p> <p>12. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?</p> <p>No. The hiring authority did not consult with the OLES about the sufficiency of the investigation and investigative findings.</p>
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation.
Department Corrective Action Plan	In this case, the client immediately recanted her allegation and there was no evidence or reasonable suspicion that the event occurred. However, the investigator has been counseled regarding bifurcation, admonishments, and consultation with OLES.

Case Table Section	Section Content
Incident Date	06/20/2016
OLES Case Number	2016-00810MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred

Penalty	Initial: Other Final: No Change
Incident Summary	On June 20, 2016, two psychiatric technicians allegedly allowed several clients to punch another client. The client also alleged that a third psychiatric technician slapped and kicked him.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation.

Case Table Section	Section Content
Incident Date	06/20/2016
OLES Case Number	2016-00811MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 20, 2016, a psychiatric technician allegedly pushed a patient to the ground, causing a fracture to the patient's left arm.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	06/11/2016
OLES Case Number	2016-00825MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty 4. Insubordination
Findings	1. Sustained 2. Sustained 3. Sustained

	4. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On June 11, 2016, a registered nurse was allegedly sleeping while she was assigned to a one-on-one observation of a patient. Additionally, the registered nurse allegedly had her personal mobile phone plugged into a wall socket within reach of other patients. It was further alleged the registered nurse refused to put her mobile phone away after being instructed to do so. On June 14, 2016, it was alleged the same registered nurse was again sleeping while she was assigned to a one-on-one observation of a patient. The registered nurse allegedly again, had her personal mobile phone plugged into a wall socket within reach of other patients. It was also alleged that the registered nurse was dishonest during the course of the investigation.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department's pre-disciplinary process did not comply with policies and procedures. The investigative report did not clearly identify all relevant allegations for the hiring authority's consideration and the investigation was not completed until approximately 90 days from the date the allegations were made.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report did not properly identify all applicable allegations. 3. Was the final investigative report thorough and appropriately drafted? No. The final investigative report did not properly identify all applicable allegations.
Disposition	The hiring authority sustained all of the allegations and dismissed the registered nurse. The OLES concurred with the hiring authority's determinations.
Department	No corrective plan. All applicable allegations were

Corrective Action Plan	identified, investigated, and charged. The investigation, including possible allegations were discussed with the OLES monitor.
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Case Table Section	Section Content
Incident Date	06/23/2016
OLES Case Number	2016-00827MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 23, 2016, a staff member allegedly entered a patient's room and punched him on his left hand.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	03/10/2016
OLES Case Number	2016-00829MA
Allegations	1. Other failure of good behavior
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 10, 2016, a patient alleged a psychiatrist who performed a body cavity search without his permission sexually assaulted him. Allegedly, the patient was given an intramuscular injection that caused him to fall asleep during which time a body cavity search was performed on him.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
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Incident Date	06/26/2016
OLES Case Number	2016-00830MA
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Other failure of good behavior 3. Other failure of good behavior 4. Other failure of good behavior 5. Other failure of good behavior
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	<p>Initial: Counseling</p> <p>Final: No Change</p>
Incident Summary	<p>On June 26, 2016, a psychiatric technician and a psychiatric technician trainee allegedly failed to notify supervisors that a patient claimed he had swallowed a battery. A unit supervisor and a second psychiatric technician allegedly failed to take appropriate action after discovering the patient swallowed the battery. The second psychiatric technician also allegedly improperly co-signed the interdisciplinary note written by the psychiatric technician trainee.</p>
Overall Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120 days from the date of the incident.</p>
Disposition	<p>The hiring authority sustained an allegation for improperly co-signing the interdisciplinary note against the second psychiatric technician and issued a letter of counseling. The OLES concurred with the hiring authority's determination. The hiring authority determined there was insufficient evidence to sustain the remaining allegations against the second psychiatric technician and the other staff members. The OLES concurred.</p>

Case Table Section	Section Content
Incident Date	06/26/2016
OLES Case Number	2016-00831MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	<p>Initial: No Penalty Imposed</p> <p>Final: No Change</p>

Incident Summary	On June 26, 2016, a psychiatric technician allegedly restrained a patient in a headlock and slammed the patient's head on a table.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Although the department did not notify the OLES of the incident as required, the department generally complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	06/27/2016
OLES Case Number	2016-00833MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 27, 2016, a client alleged a psychiatric technician hit her on the hand with a plastic clipboard.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not sufficiently comply with procedural policies and procedures governing the disciplinary process. The OPS did not make a determination concerning the deadline for taking disciplinary action, did not consult with the OLES concerning whether there was probable cause to refer the matter to the local prosecuting agency, whether the investigation was complete and whether an administrative case should have been opened. Further, the OPS did not provide the OLES with a draft copy of the investigative report. Overall, the investigation was substantively sufficient.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. Did the department appropriately determine the deadline for taking disciplinary action (statute of

	<p>limitation date)?</p> <p>No. There is no indication in the report that the department made a determination concerning the deadline for taking criminal or disciplinary action.</p> <p>3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES did not receive a draft copy of the investigative report.</p> <p>4. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS did not consult with the OLES concerning whether there was probable cause to refer the matter to the local prosecuting agency, whether the investigation was complete and should be closed or whether an administrative case should have been opened. The OPS did not provide the OLES with a draft copy of the investigative report.</p>
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination.
Department Corrective Action Plan	This was a criminal case alleging abuse by a staff member. There was no evidence of abuse and the victim recanted soon after the allegation was made. Consequently, the criminal case was closed as unfounded the next day, and OPS did not open an administrative case, so there was no need to determine the deadline for taking criminal or disciplinary action. OPS acknowledges they did not consult with OLES or send a draft copy of the investigative report to OLES before the case was closed. OPS has provided additional training to supervisors and investigators to ensure compliance in the future.

Case Table Section	Section Content
Incident Date	06/29/2016
OLES Case Number	2016-00847MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change

Incident Summary	On June 29, 2016, a client alleged he had been placed in a chokehold by a psychiatric technician.
Overall Assessment	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not comply with policies and procedures governing the pre-disciplinary process. The OPS did not assess the deadline for taking criminal or administrative action. The OPS did not consult with the OLES concerning whether the matter should have been referred to the appropriate prosecuting attorney, whether the investigation was complete and ready for closure and whether an administrative investigation should have been opened. The OPS did not provide the OLES with a draft of the investigative reports for review and feedback. Overall, the investigation was substantively sufficient.</p>
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The OPS did not confer with the OLES at any time during the investigation. The investigation was concluded without any consultation with the OLES. 3. Did the department appropriately determine the deadline for taking disciplinary action (statute of limitation date)? No. There is no indication in the report that the department determined the deadline for taking disciplinary action. 4. Did OPS adequately consult with OLES, the department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? No. The OPS did not consult with the OLES prior to closing the criminal investigation and opening an administrative investigation.

	<p>5. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES was not provided with a copy of the draft investigative report.</p> <p>6. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The investigator did not provide the OLES with a copy of the draft report or consult with the OLES prior to closing the investigation. The investigator did not consult with the OLES concerning whether there was sufficient probable cause to refer the matter to the local prosecuting agency.</p>
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination.
Department Corrective Action Plan	This was a criminal case alleging abuse by a staff member. There was no evidence of abuse and the victim recanted soon after the allegation was made. Consequently, the criminal case was closed as unfounded the next day, and OPS did not open an administrative case, so there was no need to determine the deadline for taking criminal or disciplinary action. OPS acknowledges they did not consult with OLES or send a draft copy of the investigative report to OLES before the case was closed. OPS has provided additional training to supervisors and investigators to ensure compliance in the future.

Case Table Section	Section Content
Incident Date	06/24/2016
OLES Case Number	2016-00848MA
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Other failure of good behavior
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	<p>Initial: Training</p> <p>Final: No Change</p>

Incident Summary	On June 24, 2016, a psychiatric technician allegedly grabbed a patient's arm and kicked the patient in the knee. A second psychiatric technician and nurse allegedly failed to report the incident. The nurse also allegedly failed to properly document his assessment of the patient's minor knee injury.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 150 days from the date of the incident.
Disposition	The hiring authority sustained an allegation against the nurse for failing to properly document his assessment of the patient's injury. The hiring authority ordered training for the nurse. The OLES concurred with the hiring authority's determination. The hiring authority determined there was insufficient evidence to sustain the remaining allegations against the nurse, and the two psychiatric technicians. The OLES concurred.

Case Table Section	Section Content
Incident Date	07/01/2016
OLES Case Number	2016-00859MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 1, 2016, a patient alleged a senior psychiatric technician slammed her into a wall and twisted her arm.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. A copy of the draft report was not provided in a timely manner. Also, the investigation was not completed until over 90 days from the date of the incident.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 2. Upon completion of the investigation, was a draft

	<p>copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. A draft copy of the investigative report was not forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The investigation was not completed until over 90 days from the date of the incident.</p>
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Department Corrective Action Plan	OSI Investigators have been instructed to utilize the "Draft" watermark on all reports and email them directly to the OLES monitor. The email copy will be kept with report binder. OSI office staff was instructed to upload the "Draft" watermarked report to WatchDox for verification by Chief/SSI with a copy in file for referencing. Chief/SSI will meet with investigative staff to establish due dates for better compliance with time frames. OSI office staff were instructed to develop a 75 day schedule of due dates to keep Chief/SSI informed. The time extension process was implemented by the department on November 10, 2016.

Case Table Section	Section Content
Incident Date	06/21/2016
OLES Case Number	2016-00871MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On June 21, 2016, a staff member allegedly fractured a client's finger.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an

	administrative investigation due to lack of evidence. The OLES concurred.
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Case Table Section	Section Content
Incident Date	07/08/2016
OLES Case Number	2016-00876MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 8, 2016, a registered nurse allegedly held a patient in a headlock.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	07/12/2016
OLES Case Number	2016-00888MC
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On July 12, 2016, a client alleged that four psychiatric technicians kicked and punched him.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an

	administrative investigation due to lack of evidence.
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Case Table Section	Section Content
Incident Date	07/13/2016
OLES Case Number	2016-00908MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On July 13, 2016, a registered nurse allegedly sexually assaulted a patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Although the department failed to notify the OLES of the incident, the department complied with policies and procedures governing the investigative process in all other respects.
Disposition	The department conducted an initial inquiry into the allegation; however, there was insufficient evidence to refer the matter for a full investigation and the case was closed. The OLES concurred with the determination.

Case Table Section	Section Content
Incident Date	06/10/2016
OLES Case Number	2016-00916MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Other failure of good behavior
Findings	1. Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	Initial: Training Final: No Change
Incident Summary	On June 10, 2016, a psychiatric technician allegedly pushed a patient from the patient's wheelchair. A psychiatrist allegedly failed to timely submit a required form to report the incident.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Disposition	The hiring authority determined that the psychiatrist failed to timely submit the required form and ordered re-training. The OLES concurred with the determination because the psychiatrist was still new to the facility and had never completed the form before. Additionally, the psychiatrist did initially report his concerns to other staff. The hiring authority did not sustain any allegations against the psychiatric technician. The OLES concurred.
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Case Table Section	Section Content
Incident Date	07/28/2016
OLES Case Number	2016-00960MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On July 28, 2016, a registered nurse allegedly sexually assaulted a patient.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The incident was not reported to the OLES in a timely manner. 2. Did the Hiring Authority properly characterize the nature and scope of the incident during his/her notification to OLES? No. The incident was not characterized as a sexual assault incident on the daily log of incidents that was submitted to the OLES. 3. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative

	investigation due to lack of evidence.
Department Corrective Action Plan	All HPD personnel have been educated that sexual battery incidents are OLES Reportable incidents whether involuntary; or whether patient is the subject or victim of the incident. All HPD personnel have been educated regarding all sexual battery incidents are Level 1 reportable items whether involuntary; or whether patient is the subject or victim.

Case Table Section	Section Content
Incident Date	07/28/2016
OLES Case Number	2016-00967MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 28, 2016, a patient alleged, that approximately six years earlier, she had sexual contact with a staff member.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The OLES was not timely notified of the incident, was not provided a draft copy of the investigative report, and the investigation was not timely conducted.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The allegation was discovered on July 28, 2016, however was not reported to the OLES until August 2, 2016. 2. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The OLES was not provided with a draft copy of the investigative report.

	<p>4. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS did not provide the OLES with a draft copy of the investigative report.</p> <p>5. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The alleged incident was discovered on July 28, 2016, however the investigative report was not completed until October 13, 2016, 77 days later.</p>
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's decision.
Department Corrective Action Plan	We utilize a multitude of factors to determine how we prioritize investigations. Some of these factors include severity of the crime, assessment of the evidence, likelihood of prosecution, and the possibility of a collateral administrative investigation. The 75-day timeline is only one of the factors considered. Although this investigation was completed two days beyond that timeline, it was well within the statute established in the Penal Code. Also, the department has established a process that requires written justification for any case exceeding the timeframe be approved by a supervisor and the chief of police.

Case Table Section	Section Content
Incident Date	08/06/2016
OLES Case Number	2016-00992MC
Allegations	1. Criminal Act 1. Criminal Act
Findings	1. Referred 2. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 6, 2016, a psychiatric technician allegedly grabbed a client's shirt collar, pulled it over the client's head, and slapped the client. A second psychiatric technician assigned to maintain enhanced observation of the client allegedly failed to observe and report noticeable injuries to the client.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	Overall, the department complied with policies and procedures governing the investigative process.
Disposition	The investigation established sufficient evidence for a probable cause referral to the district attorney's office regarding the second psychiatric technician's failure to observe and report the client's injuries. There was insufficient evidence to support a probable cause determination that the first psychiatric technician physically abused the client. The OLES concurred with the probable cause determinations.

Case Table Section	Section Content
Incident Date	08/04/2016
OLES Case Number	2016-00993MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 4, 2016, a psychiatric technician allegedly pushed a patient.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The department did not timely notify the OLES of the incident. The detective failed to provide the draft investigative report to the OLES for review, and did not consult with the OLES prior to closing the investigation.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not timely notify the OLES, delaying 45 minutes beyond the two-hour notification requirement. 2. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to

	<p>allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES did not receive a copy of the draft investigative report for review prior to closure of the investigation.</p> <p>4. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The detective did not notify the OLES when the investigative report was completed, and only provided a final copy of the report. The detective also did not consult with the OLES prior to closing the criminal investigation.</p>
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Department Corrective Action Plan	The Assessment finding that the hiring authority notification to OLES was 45 minutes late does not take into account that the report was received during an unrelated investigatory interview. Rather than stop the interviews to call OLES, the phone notification was made as soon as the officer could reasonably gather the expected information to make the OLES notification. No corrective action required. The final report was submitted to the AIM immediately after approval by the supervisor, rather than prior to supervisory approval. The detective was reminded that a draft investigative report must be provided to OLES.

Case Table Section	Section Content
Incident Date	08/04/2016
OLES Case Number	2016-00994MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 4, 2016, a patient alleged that she was touched in an inappropriate manner by a registered nurse. The patient later alleged the registered nurse drugged and sexually assaulted her.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Case Table Section	Section Content
Incident Date	08/16/2016
OLES Case Number	2016-01044MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 16, 2016, a psychiatric technician allegedly verbally abused a patient and then punched the patient in the head.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	08/14/2016
OLES Case Number	2016-01052MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 14, 2016, a registered nurse allegedly fell asleep while assigned to constantly observe a patient who was on suicide precaution watch.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred

	with the hiring authority's determination.
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Case Table Section	Section Content
Incident Date	08/25/2016
OLES Case Number	2016-01099MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 25, 2016, a staff member allegedly pushed and choked a patient.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services did not adequately consult with the OLES during the course of the investigation.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The OPS did not consult with the OLES upon case initiation and prior to finalizing the investigative plan. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The OPS failed to notify the OLES regarding the scheduling of the victim interview. 4. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The OPS failed to consult with the OLES during critical junctures of the investigation.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.

Department Corrective Action Plan	Protocols were established to address Criminal Cases of Patient Abuse until completion and/or filing with the District Attorney's Office. Detectives have been instructed to upload all investigative plans/reports to WatchDox and email them directly to OLES Monitor with copies of receipts for verification/referencing. The Detective Unit has been educated on protocols and instructed to coordinate victim interviews with assigned OLES participation.
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Case Table Section	Section Content
Incident Date	08/23/2016
OLES Case Number	2016-01112MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 23, 2016, a psychiatric technician allegedly choked and slapped a client.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Although the department did not timely notify the OLES of the incident, the department complied with policies and procedures governing the investigative process in all other respects.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The Office of Protective Services did not open an administrative investigation. The OLES concurred with the determinations.

Case Table Section	Section Content
Incident Date	08/31/2016
OLES Case Number	2016-01120MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 31, 2016, a psychiatric technician allegedly removed a patient's blanket and pulled the patient by the ankles.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
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Case Table Section	Section Content
Incident Date	06/13/2016
OLES Case Number	2016-01127MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 13, 2016, a registered nurse allegedly was sleeping while assigned to observe patients in an enhanced observation area.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	09/02/2016
OLES Case Number	2016-01144MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	Between September 2, 2016, and September 6, 2016, an unidentified person allegedly sexually assaulted a patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disposition	The department conducted an initial inquiry into the allegation; however, there was insufficient evidence to refer the matter for a full investigation and the case was closed. The OLES concurred with the determination

Case Table Section	Section Content
Incident Date	09/03/2016
OLES Case Number	2016-01149MA
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	<p>Initial: Salary Reduction</p> <p>Final: No Change</p>
Incident Summary	<p>On September 3, 2016, a senior psychiatric technician and three psychiatric technicians allegedly left a client, who was restrained, alone in an unsecured room and failed to properly document the incident. It was further alleged the senior psychiatric technician failed to provide his direct supervisors with complete information about the incident, inappropriately removed himself from client contact and relieved one of the psychiatric technicians from her duties without authorization.</p>
Overall Assessment	<p>Procedural Rating: Insufficient</p> <p>Substantive Rating: Insufficient</p> <p>The OPS failed to comply with policies and procedures governing the pre-disciplinary process. The OPS investigator failed to adequately consult and cooperate with the OLES. The investigator interviewed a subject without notice to the OLES and scheduled the remaining subject interviews on a day the investigator knew the OLES monitor was unavailable. The investigation was not appropriately conducted in that the investigator was not adequately prepared. He interviewed subjects without first gathering all relevant documents including policies or interviewing witnesses who could provide foundational information. Additionally, the interviews were not appropriately conducted. The investigator interrupted the witness and subjects and spoke over them making the record unclear. He asked leading questions and suggested the answer. The investigator provided his opinion as to controlling policy without reference to actual policy and sometimes in error, the investigator provided his view of how he would have conducted himself under the circumstances, and prejudged the investigation by telling a subject that she</p>

	<p>would be "cleared" of the allegations against her. The draft report did not accurately or clearly define the allegations against the three subjects, did not reference all relevant policies, did not refer to all relevant documents, did not document whether the subjects were provided with the appropriate legal admonitions, did not contain all relevant interviews, misquoted what subjects said, and lacked clarity. Finally, the investigation was not conducted with due diligence and took 106 days to complete.</p>
<p>Pre-Disciplinary Assessment</p>	<ol style="list-style-type: none"> <li data-bbox="553 457 1437 651"> <p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <li data-bbox="553 693 1437 1039"> <p>2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan?</p> <p>No. Although the OPS consulted with the OLES upon case initiation, the investigator had already interviewed one of the subjects without notification to the OLES. Further, the investigator rejected several of the OLES recommendations and did not productively engage in fruitful consultation.</p> <li data-bbox="553 1081 1437 1501"> <p>3. Did the investigator adequately prepare for all aspects of the investigation?</p> <p>No. The OPS investigator did not adequately prepare for all aspects of the investigation. The investigator did not obtain and review all relevant policy and documents before interviewing the subjects. The investigator interviewed the subjects prior to interviewing key witnesses. The investigator did not thoroughly interview the subjects necessitating each be re-interviewed two additional times.</p> <li data-bbox="553 1543 1437 1890"> <p>4. Were all of the interviews thorough and appropriately conducted?</p> <p>No. The interviews were not thorough or appropriately conducted. During the subject interviews, the investigator was not fully prepared in that he was not familiar with controlling policy and directives. In the middle of one of the subject interviews, while still on the record and talking to the</p>

subject, the investigator began searching his computer in an attempt to find applicable policy. Likewise, the investigator did not possess the relevant documents needed to conduct a thorough examination of the subjects. During interviews, the investigator interrupted and talked over witnesses making the record unclear. The investigator asked leading questions, suggested answers and provided his opinion as to controlling policy and procedure without reference to a specific policy, he interjected his opinion on how he would have acted under the circumstances, and discussed his personal knowledge and involvement in the case with the subjects. The investigator pre-judged the investigation and told one subject that she was "cleared" of the allegations. The investigator did not ask relevant questions in the first instance requiring each of the subjects to be interviewed a total of three times.

5. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?

No. The draft report did not accurately or clearly define the allegations against the three subjects, did not reference all relevant policies, did not refer to all relevant documents, did not document whether the subjects were provided with the appropriate legal admonitions, did not contain all relevant interviews, misquoted what subjects said, and lacked clarity.

6. Did OPS cooperate with and provide continued real-time consultation with OLES?

No. The OPS investigator conducted a subject interview without notification to the OLES. The investigator scheduled the remainder of the subject interviews on a day he knew the OLES monitor was not available.

7. Was the investigation thorough and appropriately conducted?

No. The investigation was not appropriately conducted. During the subject interviews, the investigator was not fully prepared in that he was not

	<p>familiar with controlling policy and directives. In the middle of one of the subject interviews, while still on the record and talking to the subject, the investigator began searching his computer in an attempt to find applicable policy. Likewise, the investigator did not possess the relevant documents needed to conduct a thorough examination of the subjects. During interviews, the investigator interrupted and talked over witnesses making the record unclear. The investigator asked leading questions, suggested the answers and provided his opinion as to controlling policy and procedure without reference to a specific policy, he interjected his opinion on how he would have acted under the circumstances, and discussed his personal knowledge and involvement in the case with the subjects. The investigator pre-judged the investigation and told one subject that she was "cleared" of the allegations. The investigator did not ask relevant questions in the first instance requiring all of the subjects to be interviewed a total of three times.</p> <p>8. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on September 6, 2016, however the final report was not completed until December 21, 2016, 106 days later.</p>
Disposition	The hiring authority sustained all of the allegations against the senior psychiatric technician and imposed a salary reduction of 5 percent for 12 months. The hiring authority did not sustain the allegations against the three psychiatric technicians, however served each with a letter of expectation concerning appropriate client care. The OLES concurred with the hiring authority's determinations.
Department Corrective Action Plan	The investigator has been issued a Memorandum of Counseling and has been scheduled to attend additional Interview & Interrogation training.

Case Table Section	Section Content
Incident Date	09/12/2016
OLES Case Number	2016-01181MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change

Incident Summary	On September 12, 2016, a patient alleged that a doctor had sexually assaulted her.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation due to lack of evidence.

Case Table Section	Section Content
Incident Date	09/10/2016
OLES Case Number	2016-01183MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On September 10, 2016, a psychiatric technician allegedly grabbed a patient's leg, which caused her to fall on the floor.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The OPS did not adequately consult with the OLES during the investigation.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The OPS failed to notify the OLES regarding the scheduling of the victim interview. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The OPS failed to consult with the OLES during a

	critical juncture of the investigation by failing to notify the OLES of the victim interview.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Department Corrective Action Plan	The Detective Unit has been educated on protocols and instructed to coordinate all victim interviews with assigned OLES for participation.

Case Table Section	Section Content
Incident Date	08/22/2016
OLES Case Number	2016-01196MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 22, 2016, a psychiatric technician assistant allegedly fell asleep while assigned to provide constant observation of a patient, who then injured herself. It was also alleged a senior psychiatric technician intentionally failed to document the incident.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.

Case Table Section	Section Content
Incident Date	09/13/2016
OLES Case Number	2016-01208MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 13, 2016, a psychiatric technician allegedly

	pushed a patient that caused the patient to fall and hit his head on the floor, which resulted in a laceration to the patient's head.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	02/04/2016
OLES Case Number	2016-01217MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 4, 2016, a patient alleged that while he was in restraints, several staff members entered his room, placed a blanket over his head, and punched in him in the face and head.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The OLES was not provided with either a copy of the draft or final investigative reports. The investigation was not conducted in a timely manner.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The department's legal office was not notified of the incident. 2. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The OLES was not provided with a draft copy of the investigative report. 3. Did OPS cooperate with and provide continued real-

	<p>time consultation with OLES?</p> <p>No. The OLES was not provided with either a copy of the draft or final reports.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>The alleged incident was discovered on February 4, 2016, however the final report was not completed until August 25, 2016, 201 days later.</p>
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Department Corrective Action Plan	The department utilizes a multitude of factors to determine how we prioritize investigations. Some of these factors include severity of the crime, assessment of the evidence, likelihood of prosecution, and the possibility of a collateral administrative investigation. The 75-day timeline is only one of the factors considered. Although this investigation was completed 126 days beyond that timeline, it was well within the statute established in the Penal Code. Also, the department has established a process that requires written justification for any case exceeding the timeframe be approved by a supervisor and the chief of police. The time extension process was implemented by the department on November 10, 2016.

Case Table Section	Section Content
Incident Date	09/16/2016
OLES Case Number	2016-01222MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On September 16, 2016, a psychiatric technician allegedly battered a parole agent.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the determination.

Case Table Section	Section Content
Incident Date	09/20/2016
OLES Case Number	2016-01225MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 20, 2016, a physician allegedly rubbed his crotch against a patient's knee.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	09/20/2016
OLES Case Number	2016-01226MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On September 20, 2016, a former client alleged a psychiatric technician was sexually inappropriate with her on several different occasions by masturbating in front of her and touching her breasts.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The OPS did not consult with the OLES concerning whether there was sufficient probable cause to refer the matter to the local district attorney's office, did not provide the OLES with a copy of the draft investigative report and did not inform the OLES that the investigation had concluded.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident.

	<p>2. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES was not provided with a draft copy of the investigative report.</p> <p>3. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS did not provide the OLES with a draft copy of the investigative report, did not consult with the OLES concerning the probable cause nor inform the OLES that the case had concluded.</p>
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Department Corrective Action Plan	The OLES monitor was present at all interviews during the investigation and was aware that there was no evidence to substantiate the allegation. However, the Investigator did not provide OLES with a draft copy of the report before it was finalized. The Investigator has been counseled to prevent a recurrence.

Case Table Section	Section Content
Incident Date	09/21/2016
OLES Case Number	2016-01232MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On September 21, 2016, a patient alleged a psychiatric technician would not allow her to use the restroom.
Overall Assessment	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process, by failing to consult with the OLES at a critical juncture of the investigation.</p>
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the department's legal office of the incident?

	<p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS did not consult with the OLES regarding the victim interview.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The OLES was not consulted or included during a critical juncture of the investigation.</p>
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Department Corrective Action Plan	The Detective Unit has been educated on protocols and instructed to coordinate all victim interviews with assigned OLES for participation.

Case Table Section	Section Content
Incident Date	09/21/2016
OLES Case Number	2016-01233MA
Allegations	<ol style="list-style-type: none"> 1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	<ol style="list-style-type: none"> 1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	<p>Initial: No Penalty Imposed</p> <p>Final: No Change</p>
Incident Summary	On September 21, 2016, a nurse allegedly fell asleep while assigned to maintain enhanced observation of a patient.
Overall Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the pre-disciplinary process.</p>
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	09/23/2016
OLES Case Number	2016-01236MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On September 23, 2016, a psychiatric technician allegedly slapped a patient's head.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
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 district attorney declined to file charges. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.

Case Table Section	Section Content
Incident Date	09/24/2016
OLES Case Number	2016-01238MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On September 24, 2016, a patient alleged a staff member slapped and threw water on him.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services conducted an interview of the patient without notice to the OLES. The investigative report did not include all appropriate interviews or investigative activities. Also, the report contained inappropriate conclusions regarding the patient's state of mind.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the

	<p>department's legal office of the incident.</p> <p>2. Did the investigator adequately prepare for all aspects of the investigation?</p> <p>No. The investigator did not adequately prepare for all aspects of the investigation. The investigator failed to locate and interview a witness.</p> <p>3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?</p> <p>No. The draft investigation report provided to the OLES for review was not thorough and appropriately drafted. The draft report did not include all appropriate interviews or investigative activities. The OPS investigator made inappropriate conclusions regarding the patient's state of mind.</p> <p>4. Was the final investigative report thorough and appropriately drafted?</p> <p>No. The final investigative report was not thorough and appropriately drafted. The final investigative report did not include all appropriate interviews or investigative activities. The OPS investigator made inappropriate conclusions regarding the patient's state of mind.</p> <p>5. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS failed to consult with the OLES during a critical juncture of the investigation.</p> <p>6. Was the investigation thorough and appropriately conducted?</p> <p>No. The investigation was not thorough and appropriately conducted. The investigator failed to locate and interview a witness.</p> <p>7. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The OPS failed to notify and include the OLES of</p>
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	the interview with the victim, which is a critical juncture of the investigation.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The case was referred for a review to determine if an administrative investigation will be conducted.
Department Corrective Action Plan	All OPS personnel have been trained regarding all guidelines and established protocols as provided by the OLES. The OLES monitored cases will now be address by the Detective's Unit Sergeant with administrative supports in place.

Case Table Section	Section Content
Incident Date	09/27/2016
OLES Case Number	2016-01253MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On September 27, 2016, a patient alleged that a psychiatric technician hit her on the shoulder and back several times.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. The department failed to interview all appropriate witnesses, despite recommendations to do so. Also, the OLES was not notified during a critical juncture of the investigation, when the patient was interviewed.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. Were all of the interviews thorough and appropriately conducted? No. The investigator did not interview the subject despite OLES' recommendations. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?

	<p>No. The draft investigative report provided to OLES for review was not thorough and appropriately drafted because it did not include all appropriate interviews and investigative activities.</p> <p>4. Was the final investigative report thorough and appropriately drafted?</p> <p>No. The final investigative report was not thorough and appropriately drafted because it did not include all appropriate interviews and investigative activities.</p> <p>5. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS failed to notify the OLES during a critical juncture of the investigation by not noticing the OLES of the patient interview.</p> <p>6. Was the investigation thorough and appropriately conducted?</p> <p>No. The investigation was not thorough and appropriately conducted because the subject was not interviewed, despite OLES' recommendation.</p>
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred with the determinations.
Department Corrective Action Plan	All OPS personnel have been trained regarding all guidelines and established protocols as provided by OLES. The OLES monitored cases will now be addressed by the Detective's Unit Sergeant.

Case Table Section	Section Content
Incident Date	08/03/2016
OLES Case Number	2016-01262MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 3, 2016, a patient alleged having pain in his ribs. The patient was given treatment for the pain when he was discovered to have a fractured rib.

Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department sufficiently complied with policies and procedures governing the pre-disciplinary process.</p>
Disposition	<p>The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.</p>

Case Table Section	Section Content
Incident Date	08/04/2016
OLES Case Number	2016-01303MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 4, 2016, a psychiatric technician allegedly pushed a patient.
Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department complied with policies and procedures governing the pre-disciplinary process.</p>
Disposition	<p>The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.</p>

Case Table Section	Section Content
Incident Date	10/15/2016
OLES Case Number	2016-01353MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On October 15, 2016, a client alleged he was being trafficked for sex with other clients.
Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the investigative process.</p>

Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The Office of Protective Services did not open an administrative investigation. The OLES concurred with the determinations.
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Case Table Section	Section Content
Incident Date	10/23/2016
OLES Case Number	2016-01385MA
Allegations	1. Other
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 23, 2016, a psychiatric technician discovered a patient unresponsive in his wheelchair and initiated emergency life-saving measures. The patient was transported to the facility's urgent care room, where he died.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigator did not consult with the OLES prior to closing the investigation.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The investigator did not adequately consult with the OLES to advise he had completed the investigative report and closed the investigation. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not consult with OLES before closing the investigation and submitting the report.
Disposition	The hiring authority determined that no policy violations could be identified. The OLES concurred with the hiring authority's determination.
Department	The department will ensure that consultations occur with

Corrective Action Plan	the OLES and draft reports are provided timely.
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Case Table Section	Section Content
Incident Date	10/10/2016
OLES Case Number	2016-01393MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On October 10, 2016, a psychiatric technician allegedly exposed his genitals to a client, told the client to touch the psychiatric technician's genitals, and asked the client to orally copulate him. On October 22, 2016, the same psychiatric technician allegedly hugged and kissed the client on the mouth.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.

Case Table Section	Section Content
Incident Date	10/23/2016
OLES Case Number	2016-01399MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Penalty Imposed
Incident Summary	On October 23, 2016, a patient unexpectedly died while in his wheelchair
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disposition	The investigation failed to establish sufficient evidence for a

	probable cause referral to the district attorney's office. The OLES concurred with this determination. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
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Case Table Section	Section Content
Incident Date	10/30/2016
OLES Case Number	2016-01417MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On October 30, 2016, an unidentified staff member allegedly punched a client in the face and threw the client to the ground.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.

Case Table Section	Section Content
Incident Date	11/03/2016
OLES Case Number	2016-01445MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On November 3, 2016, a patient alleged that a psychiatric technician called her a derogatory name and stepped on her foot.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The case was referred for a management review to determine if an administrative investigation will be conducted. The

	OLES concurred with the determinations.
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Appendix C: Discipline Phase Cases

The OLES assesses every discipline phase case for both procedural and substantive sufficiency:

- Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion.
- Substantive sufficiency assesses 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 Table Section	Section Content
Incident Date	01/28/2016
OLES Case Number	2016-00124MA
Allegations	1. Dishonesty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	On January 28, 2016, a registered nurse allegedly intentionally falsified medical documents. Furthermore, it was alleged that the registered nurse was dishonest during the investigatory interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the registered nurse. The OLES concurred in the determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The employee filed an appeal with the State Personnel Board. Pursuant to a settlement agreement, the registered nurse resigned in lieu of dismissal and agreed to never seek employment with the department in the future. The OLES found the settlement reasonable. Overall, the department sufficiently complied with the policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	01/29/2016
OLES Case Number	2016-00131MA
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior
Findings	1. Sustained

	2. Sustained
Penalty	Initial: Suspension Final: Other
Incident Summary	On January 29, 2016, an off-duty officer was allegedly driving under the influence of an intoxicant.
Disposition	The hiring authority sustained the allegations and imposed a 30 working-day suspension. Following the Skelly hearing, the department entered into a settlement agreement with the officer whereby the penalty was modified to a 15 working-day suspension and a salary reduction of 5 percent for three months. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process, however the disciplinary action was served over six months after the determination was made to take disciplinary action.

Case Table Section	Section Content
Incident Date	02/01/2016
OLES Case Number	2016-00307MA
Allegations	1. Discourteous treatment 2. Inexcusable neglect of duty 3. Insubordination
Findings	1. Not Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: Resigned
Incident Summary	On February 1, 2016, it was alleged that a psychiatric technician engaged in an inappropriate relationship with a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the psychiatric technician and rejected the psychiatric technician while on probation. The OLES concurred with the determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The psychiatric technician filed an appeal with the State Personnel Board. Prior to an evidentiary hearing the psychiatric technician and department entered into a settlement agreement whereby the psychiatric technician resigned in lieu of the rejection on probation and agreed to

	withdraw her appeal. The OLES concurred with the settlement. The department's disciplinary process sufficiently complied with policies and procedures.
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Case Table Section	Section Content
Incident Date	02/23/2016
OLES Case Number	2016-00343MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	It was alleged that on February 23, 2016, a medical technical assistant provided a urine sample that tested positive for a controlled substance.
Disposition	The hiring authority sustained the allegation and imposed a salary reduction of ten percent for 12 months. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	01/09/2016
OLES Case Number	2016-00586MA
Allegations	1. Inefficiency
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 9, 2016, a patient attacked a psychiatric technician allegedly attempting to gouge out his eye. Hospital police officers responded and aided in subduing the patient and conducted an investigation into the incident. It was alleged the hospital police officer submitted an incident report lacking sufficient information for proper follow up investigation and successful prosecution for an incident where a patient physically assaulted hospital staff.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	The department failed to timely conduct a disposition meeting; however, they complied with the disciplinary phase in all other respects.
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Case Table Section	Section Content
Incident Date	01/29/2016
OLES Case Number	2016-00631MA
Allegations	<ol style="list-style-type: none"> 1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	<p>Initial: Dismissal</p> <p>Final: Resigned In Lieu of Dismissal</p>
Incident Summary	On January 29, 2016, a food service worker allegedly encouraged a client to expose his genitals to another employee. The food service worker, a psychiatric technician, and a psychiatric technician assistant allegedly witnessed the client grab at the crotch and buttocks of the other employee and failed to report the incident.
Disposition	The hiring authority sustained the allegations against the food service worker and dismissed him. The hiring authority also sustained the allegations against the psychiatric technician and the psychiatric technician assistant and rejected both on probation. The OLES was not consulted.
Disciplinary Assessment	<p>Procedural Rating: Insufficient</p> <p>Substantive Rating: Sufficient</p> <p>The psychiatric technician and the psychiatric technician assistant filed appeals with the State Personnel Board. The hiring authority agreed to enter into settlement agreement with the psychiatric technician, accepting the psychiatric technician's resignation and withdrew the rejection on probation action in exchange the psychiatric technician withdrew his appeal. The hiring authority agreed to reinstate the psychiatric technician assistant in exchange for the psychiatric technician assistant's withdrawal of his appeal and waiver of back pay. The psychiatric technician assistant also agreed to re-start the probation period. The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority did not consult with the OLES regarding the disciplinary</p>

	<p>determinations and subsequent settlement agreements for the psychiatric technician and psychiatric technician assistant. The OLES did not timely receive draft copies of a rejection on probation action and the pre-hearing settlement conference statement.</p>
<p>Disciplinary Assessment Questions</p>	<ol style="list-style-type: none"> 1. Did the Hiring Authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision? <p>No. The hiring authority did not consult with the OLES prior to making disciplinary determinations.</p> 2. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? <p>No. The rejection on probation action for one of the psychiatric technicians was served on May 27, 2016; however a draft of the action was not provided to the OLES until May 26, 2016, less than one day before service. Therefore, OLES did not have adequate time to provide input on the action.</p> 3. Was OLES provided with a draft of the pre-hearing settlement conference statement prior to it being filed? <p>No. The OLES did not receive a copy of the pre-hearing settlement conference statement until after it had been filed.</p> 4. Did the Hiring Authority consult with OLES and the department attorney (if applicable) before modifying the penalty or agreeing to a settlement? <p>No. The hiring authority did not consult with the OLES prior to agreeing to a settlement.</p> 5. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? <p>No. The disciplinary officer did not provide to the</p>

	<p>OLES a rejection on probation action and a pre-hearing settlement conference statement in a timely manner.</p> <p>6. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. The hiring authority did not consult with the OLES when making disciplinary determinations and deciding to modify the penalty.</p>
Department Corrective Action Plan	<p>The hiring authority will notify OLES staff, five days prior to the date/time of the administrative review of the case, when the disciplinary determination will be made (or, if regularly scheduled, the meeting schedule will be provided). The OLES will be apprised of a phone number to call to participate in the case review, if an in-person appearance is not possible. For future cases, the draft documents will be sent at least five days prior to finalizing the documents with the department attorney and or the labor relations specialist. With respect to required settlement conferences, the hiring authority will send the draft pre-hearing settlement conference statements to OLES at least the days prior to the conference settlement meeting. The hiring authority will notify the OLES staff assigned to the case of the date/time and location of the pre-hearing settlement conference, at least 5 days prior to the date of the conference, or as soon as notice is received by the department, if less than 5 days. The hiring authority will notify the department attorney and or the discipline officer of the assigned OLES staff for the case prior to the discussion of the penalty phase of the case if the department conducts a separate administrative review. If penalty consideration is included as part of standard case review, the regularly scheduled times will be communicated. This requirement will be communicated to the department's labor relation and human resources staff.</p>

Case Table Section	Section Content
Incident Date	11/13/2013
OLES Case Number	2016-00842MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On July 14, 2015, a supervising special investigator alleged that in November 2013, a chief helped another supervising special investigator with the promotional testing and interview process by providing her confidential information based on their close personal relationship. The supervising special investigator also alleged the chief initiated and influenced an internal affairs investigation of him.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred in the determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	12/11/2015
OLES Case Number	2016-00952MA
Allegations	1. Discourteous treatment 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	In December 2015, a patient alleged officers had compromised his safety by reporting false information about him to other patients, and that supervisory staff had failed to take appropriate action when he reported the incident. The patient also alleged officers subjected him to inappropriate force during a clothed body search.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred in the determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's disciplinary process sufficiently complied with policies and procedures.

Case Table Section	Section Content
Incident Date	01/08/2016
OLES Case Number	2016-01126MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 8, 2016, a patient alleged a hospital police officer had been harassing him and making demeaning remarks towards him every time he sees him since 2007.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	02/09/2016
OLES Case Number	2016-01257MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 9, 2016, a patient alleged a medical technical assistant spoke in a sexually inappropriate manner to patients and watched them masturbate.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with the disciplinary process.

Case Table Section	Section Content
Incident Date	01/10/2016
OLES Case Number	2016-01396MA
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 10, 2016, a medical technical assistant allegedly used offensive language towards a patient who was threatening to harm himself by banging his head on the wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.

Disciplinary Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department's disciplinary process sufficiently complied with policies and procedures.</p>
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Case Table Section	Section Content
Incident Date	12/15/2015
OLES Case Number	2016-01564MA
Allegations	1. Discourteous treatment
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 15, 2015, a patient alleged a registered nurse made an inappropriate statement to him regarding his transgender sexual orientation.
Disposition	The hiring authority determined the investigation conclusively proved the misconduct did not occur.
Disciplinary Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.</p>

Case Table Section	Section Content
Incident Date	01/09/2016
OLES Case Number	2016-01565MA
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 9, 2016, a patient alleged an officer made threatening statements towards him by saying, "he will learn the hard way." The patient further alleged, the officer conducted a search of his living area out of retaliation and was discourteous towards him by calling him by his first name and arguing with him.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Disciplinary Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.</p>

Case Table Section	Section Content
Incident Date	12/30/2015
OLES Case Number	2016-01584MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 27, 2015, an officer allegedly did not proceed with due diligence when evaluating the allegations a client made regarding a genital injury.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	02/24/2016
OLES Case Number	2016-01585MA
Allegations	1. Discourteous treatment
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 24, 2016, an investigator alleged an acting supervisor investigator asked her inappropriate questions during a sexual assault investigations training. She further alleged the acting supervisor investigator was discourteous and rude to her because of her gender.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.

Case Table Section	Section Content
Incident Date	02/24/2016
OLES Case Number	2016-01586MA
Allegations	1. Discourteous treatment

	2. Unlawful discrimination
Findings	1. Unfounded 2. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 24, 2016, an investigator alleged a commander failed to take appropriate action when an acting supervisor investigator asked her inappropriate questions during a sexual assault investigations training. She further alleged the commander was discourteous and rude to her because of her gender.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix D: Combined Pre-disciplinary and Discipline Phase Cases

On the following pages are cases that the OLES monitored in both their pre-disciplinary phase (OLEs monitored the department's investigation) as well as the discipline phase. Each phase was rated separately.

Investigations conducted by the departments are rated for procedural and substantive sufficiency:

- Procedural sufficiency is assessing the notifications to the OLES, consultations with the OLES and investigation activities for timeliness, among other things.
- Substantive sufficiency is assessing the quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

Discipline is rated for procedural and substantive sufficiency:

- Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion.
- Substantive sufficiency assesses 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 Table Section	Section Content
Incident Date	12/21/2015
OLEs Case Number	2016-00024MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Counseling Final: No Change
Incident Summary	On December 21, 2015, a patient alleged that a psychiatric technician physically abused her. Allegedly, the patient was agitated and the psychiatric technician suggested she sit or lay on her bed. The patient allegedly charged at the psychiatric technician who grabbed the patient and pushed her down, then restrained her with other responding staff members. The patient suffered multiple rib fractures. It was further alleged that the psychiatric technician failed to familiarize himself with the patient's preference plan and

	failed to debrief after the incident.
Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120 days from the date of the incident. In addition, the disposition meeting was not conducted until over 70 days from the completion of the investigative report.</p>
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation the psychiatric technician abused the patient. However, the hiring authority determined the psychiatric technician failed to familiarize himself with the patient preference plan and failed to debrief after the incident in violation of policy. The psychiatric technician received corrective counseling. The OLES concurred with the determination.
Disciplinary Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.</p>

Case Table Section	Section Content
Incident Date	02/10/2016
OLES Case Number	2016-00181MA
Allegations	<ol style="list-style-type: none"> 1. Inexcusable neglect of duty 2. Dishonesty
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Sustained
Penalty	<p>Initial: Dismissal Final: Resigned In Lieu of Dismissal</p>
Incident Summary	On February 10, 2016, a nurse allegedly poured a bottle of water over a patient's head. It was further alleged that the nurse was dishonest during the investigatory interview.
Overall Assessment	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120 days from the date of the incident.</p>
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and served the employee with a notice of dismissal. The OLES concurred

	with the hiring authority's determination. The employee filed an appeal with the State Personnel Board. Prior to the hearing, the department and employee entered into an agreement whereby the employee resigned in lieu of dismissal. The OLES found the settlement reasonable.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's disciplinary process sufficiently complied with policies and procedures.

Case Table Section	Section Content
Incident Date	03/15/2016
OLES Case Number	2016-00330MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	On March 15, 2016, a psychiatric technician allegedly used an unauthorized air freshener dispenser to intentionally spray a patient.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 80 days from the date of the incident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation that the psychiatric technician had used an unauthorized dispenser, but did not intentionally spray a patient, and served the psychiatric technician with a letter of instruction. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	03/20/2016
OLES Case Number	2016-00336MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained

	2. Sustained
Penalty	Initial: Dismissal Final: Dismissal
Incident Summary	On March 20, 2016, two psychiatric technicians allegedly were overly aggressive with a wheelchair-bound patient. One psychiatric technician pulled the patient out of the wheelchair, dragged him down a hall, and threw the patient into bed. When the patient tried to get out of bed, the other psychiatric technician threw the patient back into bed. Both psychiatric technicians subsequently were dishonest during their investigatory interviews.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process, however, although the investigation was completed within 45 days, the department failed to provide the OLES with a copy of the report until it was finalized and submitted to the hiring authority. The OLES received a final copy of the report approximately 60 days after it was complete.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the department's legal office of the incident? No. The hiring authority did not notify the department's legal office of the incident. 2. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. A draft copy of the investigative report was not forwarded to the OLES to allow for feedback before it was forwarded to the hiring authority.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed both employees. Neither psychiatric technician filed an appeal with the State Personnel Board.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.
Department	The Investigator has been educated on the following

Corrective Action Plan	<p>procedures:</p> <p>1) Distribution of a case to the hiring authority after OLES has reviewed the draft report and sent an approval confirmation e-mail.</p> <p>2) A case is not to be approved in RMS until OLES has approved the draft case. In addition to these steps, an OSI AGPA has been assigned to track case progress from start to finish.</p>
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Case Table Section	Section Content
Incident Date	05/24/2016
OLES Case Number	2016-00675MA
Allegations	<ol style="list-style-type: none"> 1. Incompetency 2. Incompetency 3. Incompetency
Findings	<ol style="list-style-type: none"> 1. Sustained 2. Unsubstantiated 3. Unsubstantiated
Penalty	<p>Initial: Letter of Instruction</p> <p>Final: No Change</p>
Incident Summary	On May 25, 2016, a client alleged that a psychiatric technician pulled her hair and that another psychiatric technician choked her.
Overall Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 90 days from the date of the incident.</p>
Disposition	The hiring authority determined there was insufficient evidence to sustain the original allegations against either employee. However, the hiring authority determined there was sufficient evidence to sustain an allegation that the psychiatric technician, who had been accused of choking the client, had failed to report the allegation of abuse, and served the psychiatric technician with a letter of instruction. The OLES concurred with the hiring authority's determinations.
Disciplinary Assessment	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the disciplinary process.</p>

Case Table Section	Section Content
Incident Date	06/02/2016
OLES Case Number	2016-01369MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	On June 2, 2016, it was alleged a psychiatric technician assistant improperly lifted a non-verbal client, which may have resulted in a fractured bone in the client's right leg.
Overall Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply policies and procedures governing the pre-disciplinary process by failing to consult with the OLES concerning the sufficiency of the investigation.
Pre-Disciplinary Assessment	<ol style="list-style-type: none"> 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 the OLES concerning the sufficiency of the investigation. 2. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued the psychiatric technician assistant and letter of instruction. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply policies and procedures governing the disciplinary process by failing to consult with

	the OLES concerning the disciplinary determinations.
Disciplinary Assessment Questions	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Did the Hiring Authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision?</p> <p>No. The hiring authority did not consult with the OLES regarding disciplinary determinations prior to making a final decision.</p> <p>3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. The hiring authority did not consult with the OLES regarding disciplinary determinations prior to making a final decision.</p> <p>4. Was the disciplinary phase conducted with due diligence by the department?</p> <p>No. The hiring authority did not consult with the OLES regarding disciplinary determinations prior to making a final decision.</p>
Department Corrective Action Plan	The Executive Director created a tracking grid for OLES cases. All OLES cases are included on this grid. Once the investigation is completed, a disposition meeting is scheduled and the OLES Monitor is notified of the date and time. By using the OLES tracking grid, OLES will be notified of the disposition meeting and will be consulted prior to final decisions are made regarding disciplinary determinations.

Case Table Section	Section Content
Incident Date	12/21/2015
OLES Case Number	2016-00024MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained

Penalty	Initial: Counseling Final: No Change
Incident Summary	On December 21, 2015, a patient alleged that a psychiatric technician physically abused her. Allegedly, the patient was agitated and the psychiatric technician suggested she sit or lay on her bed. The patient allegedly charged at the psychiatric technician who grabbed the patient and pushed her down, then restrained her with other responding staff members. The patient suffered multiple rib fractures. It was further alleged that the psychiatric technician failed to familiarize himself with the patient's preference plan and failed to debrief after the incident.
Overall Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department generally complied with policies and procedures governing the pre-disciplinary process, however, the investigation was not completed until approximately 120 days from the date of the incident. In addition, the disposition meeting was not conducted until over 70 days from the completion of the investigative report.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation the psychiatric technician abused the patient. However, the hiring authority determined the psychiatric technician failed to familiarize himself with the patient preference plan and failed to debrief after the incident in violation of policy. The psychiatric technician received corrective counseling. The OLES concurred with the determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix E: Monitored Issues

Case Table Section	Section Content
Incident Date	04/22/2016
OLES Case Number	2016-00498MI
Case Type	Use of Force
Incident Summary	<p>On April 22, 2016, police officers responded to an emergency alarm activated by level of care staff. The first responding officer noted a patient staring at a wall with blood on his left hand and forearm. The patient had his right fist clenched and appeared to be holding something. The level of care staff advised the officer that the patient had been cutting himself with an unknown object. The officer ordered the patient to drop the item in his hand, but the patient refused to comply. The officer then used physical force to attempt to retrieve the item and additional officers began assisting. The patient resisted the officers' attempts to retrieve the item. The first responding officer sprayed pepper spray in his own hand and rubbed his hand across the patient's eyes and face. The pepper spray was effective and the patient was restrained.</p>
Disposition	<p>The OLES reviewed this use-of-force incident and learned that this method of pepper spray application has been used by the same officer on prior occasion. Although the department determined the use-of-force by the officer was within policy, the OLES had concerns regarding this method of pepper spray application. The OLES contacted a number of law enforcement agencies in the state regarding this method of pepper spray application and learned that none of the agencies teaches this method of pepper spray application and they do not consider this method as a best practice. The OLES also contacted a retired chemical agents expert, who stated this method of pepper spray application is not taught in the basic Peace Officers Standards and Training course. Based on the opinion and information received from several state and local law enforcement agencies, the OLES recommended the department refrain from using this method of pepper spray application and the specifically train officers that this method is not the best practice.</p>
Overall Assessment	<p>Rating: Sufficient</p> <p>The department responded to the concerns raised by the OLES. The department noted that this method of application of pepper spray was limited to two instances by the same</p>

	<p>officer, and neither instance was considered an improper use of force. Also, the department stated this method of application is not taught to the incoming officers, however, the use-of-force policy states, "It is also recognized that circumstances may arise in which officers reasonably believe that it would be impractical or ineffective to use any of the tools, weapons or methods provided by OPS. Officers may find it more effective or reasonable to improve their response to rapidly unfolding conditions that they are confronting. In such circumstances, the use of any improvised device or method must nonetheless be reasonable and utilized only to the degree that reasonably appears necessary to accomplish a legitimate law enforcement purpose." The department also stated that the number of state law enforcement agencies contacted by the OLES have a number of other force options available, that the department does not have. The department disagreed with the recommendations of the OLES and believes this matter is an isolated incident. The department intends to discuss alternative methods with the individual officer.</p>
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Case Table Section	Section Content
Incident Date	05/03/2016
OLES Case Number	2016-01095MI
Case Type	Significant Interest - Other
Incident Summary	<p>On May 3, 2016, the lesson plans for the police academy was reviewed. It was discovered that a lesson plan being utilized was titled, "The art of getting away with MURDER!" The lesson plan covered tactical communications, however, contained a number of references that led to the appearance that communications was secondary to use of force.</p>
Disposition	<p>The OLES reviewed the entire lessons plans of the police academy as part of the mandated statutory review of law enforcement training. Upon review of the lesson plans, a serious concern was raised by the tactical communications lesson plan. The OLES requested the department to revise the lesson plan to appropriately express a positive ideology for tactical communications by law enforcement officers, not one that would foster tactical communications as secondary to use of force.</p>
Overall Assessment	<p>Rating: Sufficient</p> <p>The department appropriately responded to the concerns raised by the OLES. The department provided the OLES with</p>

	revised lesson plans with the troublesome language removed. The lesson plans demonstrate an improvement in the tactical communications training.
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Appendix F: 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.

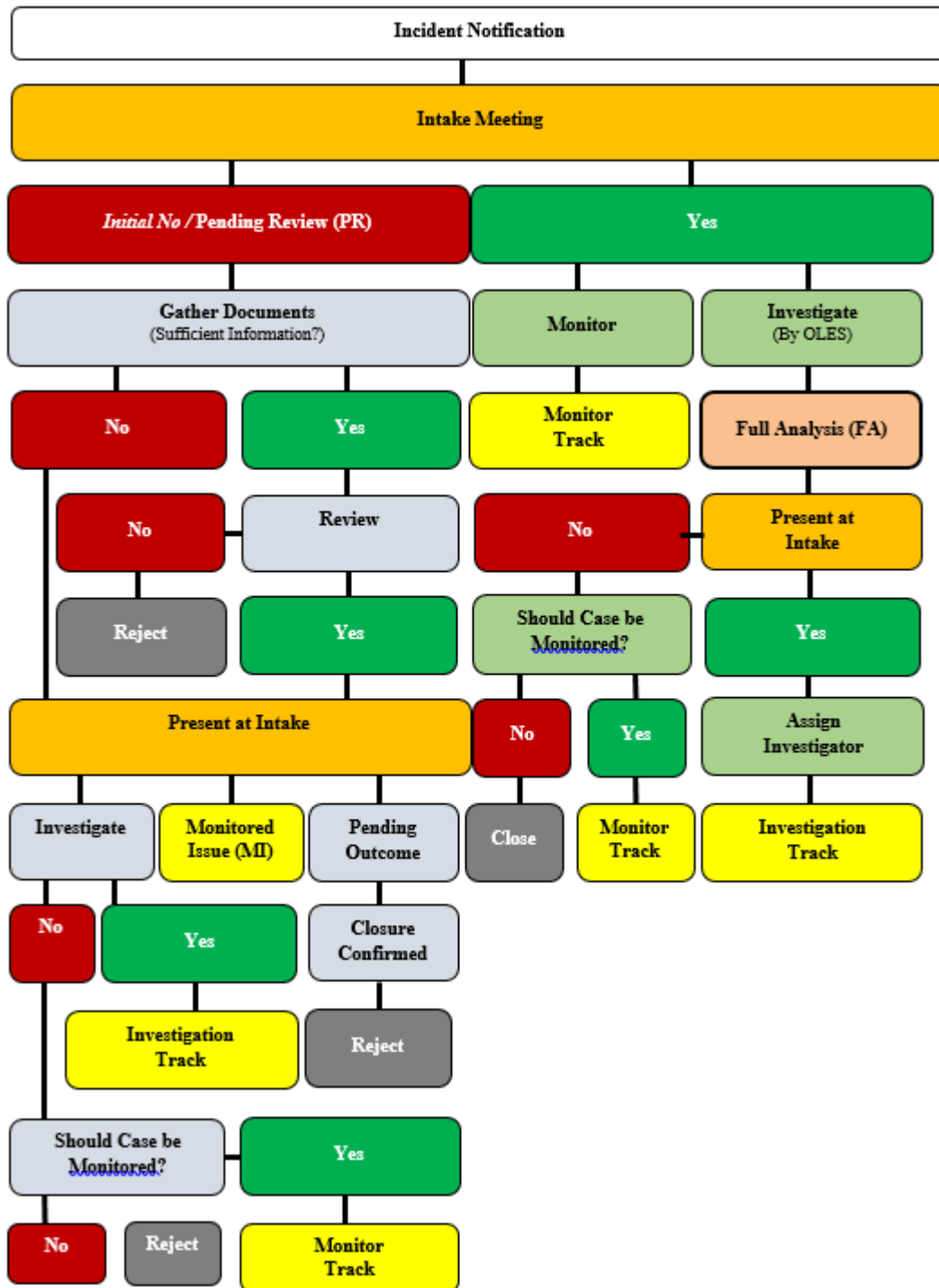
California Welfare and Institutions Code 4427.5

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.

Appendix G: 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. Initial No/Pending Review
 - b. OLES Monitored Case

c. OLES Investigation Case

3. If the disposition is “Initial No/Pending Review”, the case is reviewed for sufficient information and is represented at an intake meeting. From there, the case may be investigated, become a monitored issue, be monitored, be investigated or be rejected.

Appendix H: Guidelines for the OLES Processes

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

If, instead, an incident is investigated by DSH or DDS but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH or DDS investigator and the department attorney, if one is designated¹⁸, throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 75 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 75-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (75 Days)

1. Department notifies OLES of an incident that meets threshold requirements
2. OLES Analysis Unit reviews initial case summary and determines OLES involvement
3. OLES AIM meets with OPS administrative investigator and identifies critical junctures
4. DSH or DDS law enforcement (or OLES) completes investigation and submits final report
5. OLES AIM provides oversight of investigations requiring an immediate response

Critical Junctures

1. Site visit
2. Initial case conference
 - a. Develop investigation plan
 - b. Determine statute of limitations
3. Critical witness interviews
 - a. Primary subject(s) recorded
4. Investigation draft proposal

¹⁸ 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. Neither DSH nor DDS had the resources in the six-month period to dedicate to this best practice.

It is recommended that within 30 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 4023.8, subdivision (a)(2)(C), (D), and (E), the hiring authority shall 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 that should be sustained; and 2) the appropriate discipline for sustained allegations, if any. If either the AIM attorney or the hiring authority believes the other party's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.

30 Days

1. AIM attends disposition conference; discusses case and analyzes with the appropriate department
2. Additional investigation may be requested
3. AIM meets with executive director at the facility to finalize disciplinary determinations
4. 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 30 days.

30 Days

1. Human resources unit at the facility completes NOAA and forwards to AIM
2. Approved NOAA is provided to the executive director for service on the affected 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, i.e. whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee¹⁹. It is recommended that the Skelly due process meeting be completed within 30 days.

30 Days

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

¹⁹ Skelly v. State Personnel Board, 15 Cal. 3d 194 (1975)

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, the OLES continues to monitor the case until final resolution.

Conclusion

1. Department counsel notifies AIM of any SPB hearing dates as soon as known (AIM present at all hearings).
2. Department counsel notifies and consults with AIM prior to any changes to disciplinary action
3. AIM notes quality of prosecution and final disposition