Office of Law Enforcement Support

Semiannual Report

July 1, 2017–December 31, 2017

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.

Contents

Introduction

I am pleased to present this fourth report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency that details the oversight and monitoring conducted at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). This report covers the period from July 1, 2017, through December 31, 2017.

The OLES is authorized to provide real-time oversight of the DSH and DDS employee discipline process and law enforcement programs. The OLES also conducts internal investigations of DSH and DDS police personnel. All OLES activities are focused on helping to ensure safe and secure environments for residents, staff and visitors at DSH and DDS facilities so care and treatment of the mentally ill and developmentally disabled can be optimized.

With this report, the OLES finalizes its second year of oversight and monitoring. Both departments reported fewer incidents in 2017 than in 2016, but the decreases accompanied major declines in the numbers of DSH patients and DDS residents. At DSH, reported incidents declined 14.3 percent in 2017 compared with 2016. But DSH transferred psychiatric programs that it operated at three facilities at Stockton, Vacaville and Salinas Valley/Soledad to the California Department of Corrections and Rehabilitation (CDCR) on July 1, 2017. This transfer reduced the DSH population by just over 14 percent, according to census numbers from the three now-CDCR facilities.

Approved by the Legislature and the Governor, the DSH transfer also ended oversight for the three psychiatric programs by the OLES as of July 1, 2017. The OLES worked with the California Office of Inspector General (OIG) to explain the oversight that the OLES provided at the facilities, because OIG monitors the CDCR facilities.

Meantime, at DDS, the total incident count dropped by 12.5 percent from 2016 to 2017. The DDS also had 28 percent fewer residents at year-end 2017 than it had at year-end 2016. The largest population decline – 44.7 percent -- was at the Sonoma Developmental Center, which is slated to close by year-end 2018. The Fairview Developmental Center in Costa Mesa had 28.2 percent fewer residents at year-end 2017 than it had at year-end 2016. Fairview has a settlement agreement with the Centers for Medicare and Medicaid Services to close in October 2019.

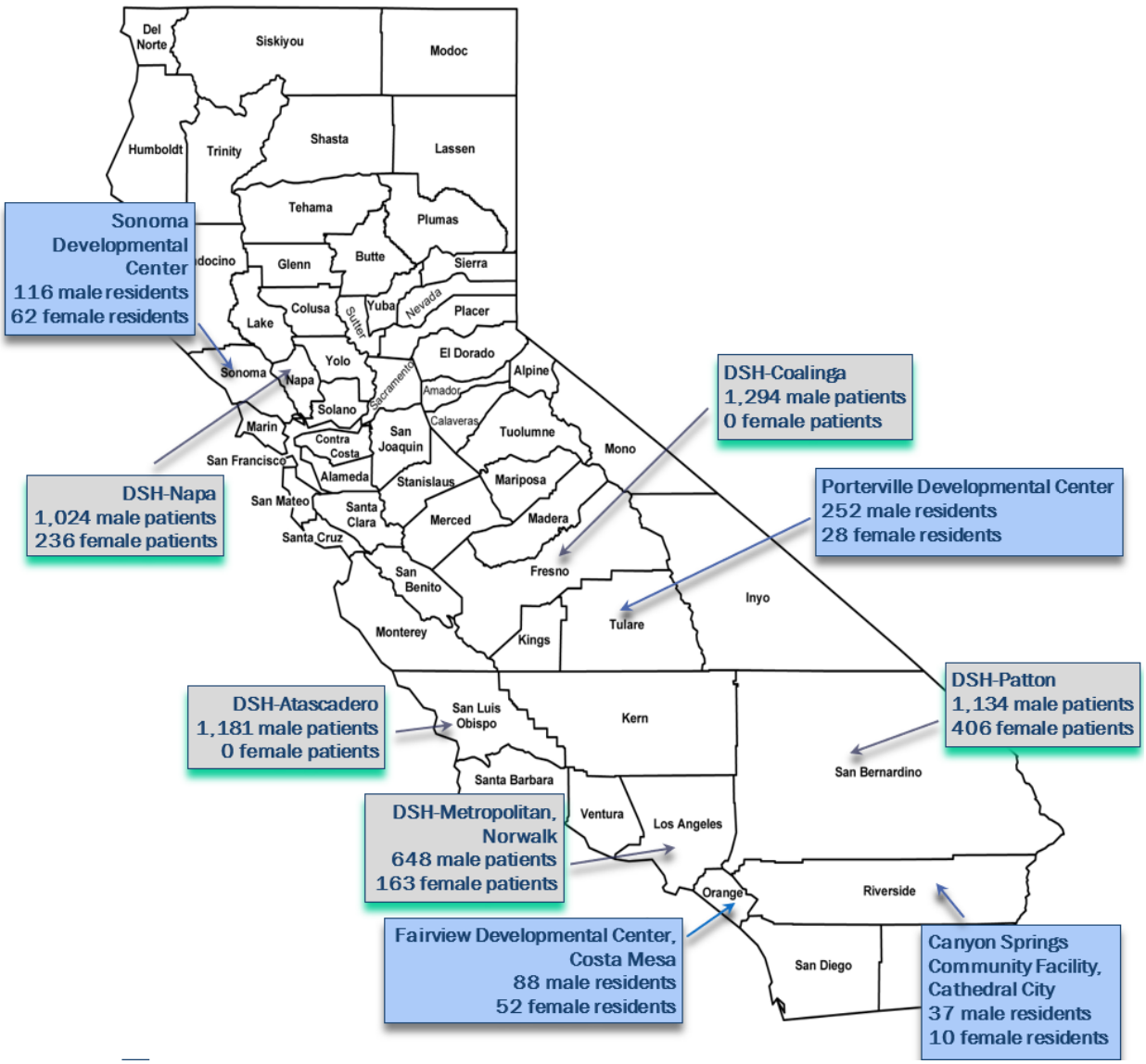
This report also provides the status, as of December 31, 2017, of 22 recommendations made by the OLES in 2015 and 2016 and which the departments continue to address for best practices in law enforcement, employee discipline processes and the tracking and management analysis of employee misconduct cases.

This reporting period ended the consulting services of OIG attorneys at the OLES. I appreciate the assistance and subject matter experts that the OIG provided during the OLES's first two years. The OLES also remains grateful for the ongoing support and assistance of our stakeholders, including Disability Rights California and the Association of Regional Care Agencies. As always, the OLES welcomes comments and questions. Please visit the OLES website at www.oles.ca.gov.

Ken Baird
Chief, Office of Law Enforcement Support

Facilities

The five DSH and four DDS facilities where the OLES conducted investigations and provided contemporaneous oversight (monitoring) during the reporting period are shown below.



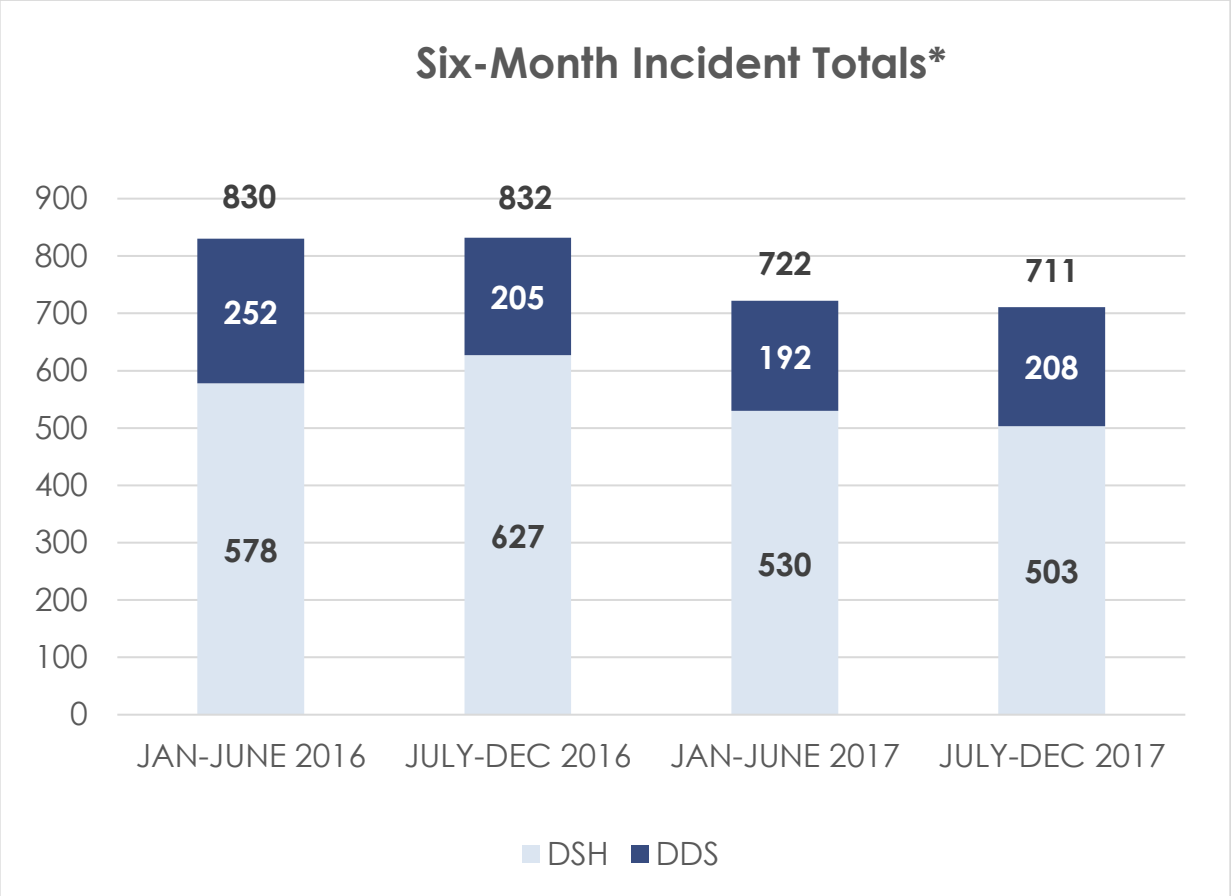
Note: Population numbers as of December 31, 2017, were provided by the departments. The DSH total of 6,086 patients decreased by 1,053 patients compared with the patient numbers of Dec. 31, 2016, primarily because DSH relinquished three psychiatric programs at Stockton, Vacaville and Salinas Valley/Soledad. The DDS total of 645 residents declined by 251 residents compared with the last day of December 2016.

DSH and DDS Facility Population Chart

Facility	Number of Male Residents/Patients	Number of Female Residents/Patients
DSH-Atascadero	1,181	0
DSH-Coalinga	1,294	0
DSH-Metropolitan	648	163
DSH-Napa	1,024	236
DSH-Patton	1,134	406
Fairview	88	52
Porterville	252	28
Sonoma	116	62
Canyon Springs	37	10

Executive Summary

From July 1, 2017, through December 31, 2017, the Office of Law Enforcement Support (OLES) received and processed 711 reports of prescribed incidents[1] 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 patients, resident and patient deaths and other occurrences. As the adjacent chart shows, the 711 reports were the fewest number of incident reports in a six-month period since the OLES began oversight operations on January 1, 2016.



* Historical numbers are unadjusted and are provided as they were previously published.

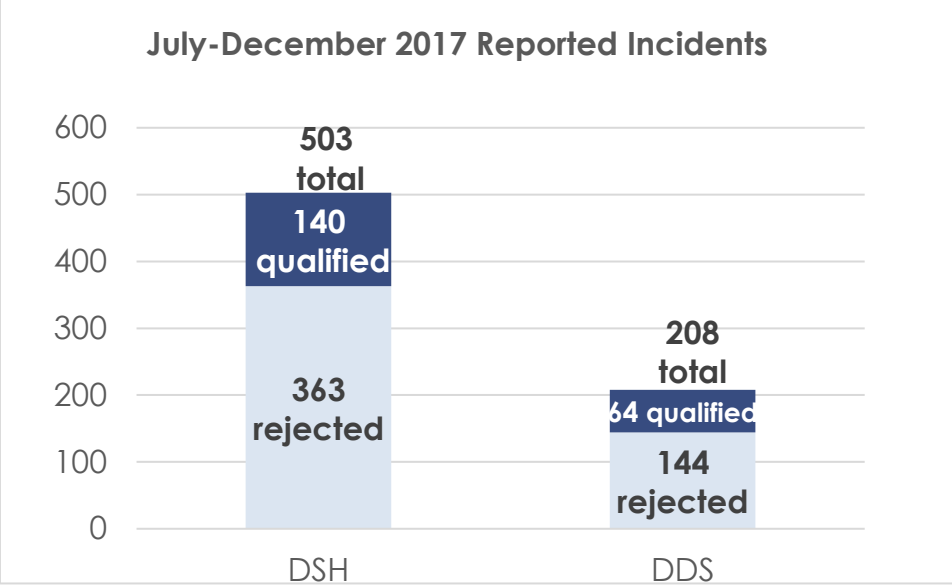
The overall decline was due to DSH and stemmed from the transfer of more than 1,000 patients to the care of the California Department of Corrections and Rehabilitation (CDCR).

In the last six months of 2017, DSH posted its largest reporting period decline ever – down 19.8 percent, from 627 incident reports in the last half of 2016 to 503 in the

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

same period of 2017. The lower incident count in 2017 stemmed from the department's transfer of three psychiatric programs at state prisons in Stockton, Vacaville and Salinas Valley/Soledad to CDCR on July 1, 2017[2]. With the three, now-CDCR psychiatric programs removed from the year-ago data, the DSH incident count actually rose 3.1 percent at the department's remaining five mental health hospitals in the last half of 2017 compared with a year earlier.

As the adjacent chart shows, 27.8 percent, or 140 of the reported incidents at DSH in the July through December 2017 period, met the criteria to qualify for OLES investigation, monitoring and/or led to OLES research into a systemic departmental issue.[3]



As shown in the charts on the previous page, DDS had 208 incidents reported to the OLES in the last half of 2017, which were on par with the 205 incidents reported in the July through December 2016 period. But, DDS had just 645 residents at all its facilities at the end of 2017, which was 28 percent fewer than the facilities had on the last day of 2016[4]. So, the DDS ratio of incidents-to-residents increased. Nearly a third of the DDS incidents reported in the last half of 2017 – 30.8 percent, or 64 reported incidents – met the criteria to qualify for OLES investigation, monitoring and/or led to the OLES researching a systemic departmental issue.

For the 2017 calendar year, the 1,433 total incidents reported at DSH and DDS amounted to a 13.8 percent decrease from the 1,662 incidents reported at the departments in all of calendar 2016. The decline stemmed primarily from DSH having

[2] The transfer was approved by the Legislature and Governor pursuant to the state budget of the 2017-18 fiscal year.
[3] The OLES chief determined whether an issue in DSH or DDS appeared to be systemic and, if so, directed OLES staff to research the matter. The OLES labeled such matters "monitored issues" and reported on their status in a separate section of each Legislative report.
[4] Resident population numbers were provided by DDS.

three fewer facilities in the last six months of 2017 than it had in the last half of 2016.

Types of incidents

The single largest category of incident reported at DSH in the July through December 2017 period involved patient allegations of sexual assault. The 115 reports of alleged sexual assault in the six months accounted for 22.9 percent of all DSH incidents that were reported to the OLES and marked a 22.3 percent decrease from the 148 sexual assault reports received in the July through December period of 2016.

As shown in the adjacent chart, allegations of patient abuse comprised the second largest category of incidents reported at DSH in the last half of 2017 and totaled 108. This was down 34.1 percent from 164 alleged abuse reports received in the last half of 2016.

Most Frequent DSH Incidents July 1, 2017, through December 31, 2017

Incident Categories	2017 Number of Reports	Change Compared With Year-Ago Period*	2017 Number Meeting OLES Criteria
Sexual Assault	115	-22.3%	20
Abuse	108	-34.1%	77
Broken Bone**	66	+725%	6
Head/Neck Injury	52	-43.5%	7
Misconduct***	48	+585.7%	18

* Percentages in this column derive from historic numbers, as previously published, that included the three psychiatric programs where mental health care was provided by DSH until July 1, 2017.
** Starting in the last half of 2016, the OLES required DSH to report all broken bones, regardless of cause. Previously, the OLES had required notification only "when the cause of injury is undetermined".
*** To more clearly present all reports of alleged misconduct, the OLES in 2017 eliminated two categories that were used in the year-earlier period – "law enforcement" and "use of force" – and included these incidents in other categories, including the general "misconduct" category.

For the first time since the OLES began monitoring incidents at DSH, reports of broken bones comprised the third largest incident category, totaling 66 in the last six months of 2017. This was a 725 percent increase from the eight broken bone reports in the year-earlier period. In the second half of 2016, the OLES changed the reporting criteria at DSH so all broken bone injuries required notification to the OLES, not just broken bones that the departments deemed were of "undetermined" cause.

Most Frequent DDS Incidents July 1, 2017, through December 31, 2017

Incident Categories	2017 Number of Reports	Change Compared With Year-Ago Period	2017 Number Meeting OLES Criteria
Abuse	105	+15.4%	47
Head/Neck Injury	21	-36.4%	1
Death	18	+80%	4
Broken Bone	16	-30.4%	3
Sexual Assault	16	-11.1%	2

As shown in the chart on this page, allegations of abuse at DDS that did not involve sexual assault comprised the top incident category in the last six months of 2017. The 105 reports of alleged abuse in the period marked a 15.4 percent increase from the 91 abuse allegations reported in the last half of 2016. Head and/or neck injuries ranked second as the most common incident at DDS to be reported to the OLES. The DDS, whose population includes residents with developmental disabilities, was required to report to the OLES all head and neck injuries if they required treatment beyond first aid because such injuries can cause lasting health impairment or lead to death and may be indicative of assault, battery or neglect. The 21 head/neck injury reports at DDS in the last half of 2017 were down 36.4 percent from the 33 reports the OLES received in the same period in 2016.

Deaths of DDS residents in the last six months of 2017 rose to 18 from the year-earlier period and overall for the 2017 calendar year increased 16.7 percent from the previous year. The majority of the deaths in both the first and last half of 2017 involved residents of the Sonoma Developmental Center. All deaths were reported to the OLES and were investigated by the DDS Office of Protective Services (OPS), with no unusual findings. However, due to the increase in the total number of deaths at the Sonoma Developmental Center, DDS took additional steps to conduct internal and external reviews which were under way as of December 31, 2017.

Results of OLES investigations

Per the statute[5], 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.[6] From July 1, 2017, through December 31, 2017, the OLES completed 23 investigations, which was a 20.7 percent decrease from the 29 completed investigations in the same period a year earlier. Of the 23 completed OLES investigations in late 2017, 15 were criminal cases and eight were administrative. All were at DSH.

Appendix A of this report provides information on the 23 OLES investigations. Three of the investigations involved incidents that occurred in 2016, and 20 investigations

[5] Welfare and Institutions Code Section 4023.6 (2). (See Appendix F).
[6] An OLES investigation also could start when ordered by the California Health and Human Services Secretary, Undersecretary or the OLES chief.

focused on incidents in 2017. Only one investigation resulted in probable cause for referral to a prosecuting agency, and the agency declined to prosecute the case. Fifteen of the closed OLES investigations determined there was insufficient evidence to support the allegations, and summaries of the investigatory findings were provided to the department. Another three completed investigations were submitted to the hiring authorities at the facilities for disposition. Three other completed investigations were referred to the department for review and consideration of further departmental administrative action or administrative investigation. One completed OLES investigation was closed after it was determined the allegation did not rise to the level of serious misconduct meeting the OLES criteria.

Results of OLES monitored cases

In this report's Appendices B, C and D, the OLES provides information on 170 monitored incident cases that, by December 31, 2017, had reached completion. Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct. Seventy-eight percent, or 133 of the 170 cases, were at DSH. The OLES found that 57 monitored cases at the two departments, combined, were insufficient either procedurally, substantively or both. Procedural sufficiency assesses the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency assesses the quality, adequacy and thoroughness of the investigative interviews and reports. During the July through December 2017 period, 26 monitored administrative cases at DSH and DDS had sustained allegations. Another six criminal investigations conducted by DSH and DDS law enforcement in the period resulted in referrals to prosecuting agencies.

Monitored Issues

In the course of its work, the OLES identified systemic issues -- 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, often requesting the response within a specific time. In most instances, the OLES also asked the departments for corrective action plans. Appendix E contains the two monitored issues that were resolved during the July through December 2017 reporting period. One of these monitored issues was at DSH and one was at DDS. The OLES also provides information on pending monitored issues starting on page 41 of this report.

OLES recommendations for best practices

For this report, the OLES followed up with the departments on 22 recommendations that the OLES had made to them in 2015 and 2016 that would bring them in line with best practices in law enforcement and employment discipline. The departments' responses, as of December 31, 2017, are provided verbatim starting on page 52.

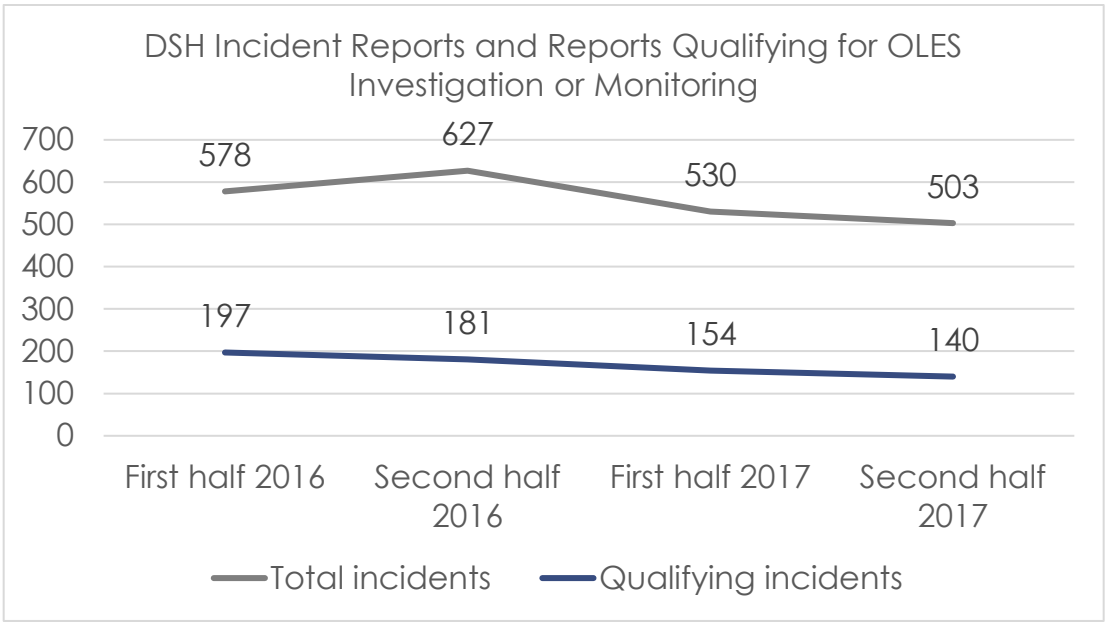
DSH Incidents

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 24/7. In the July through December 2017 reporting period, virtually all incident reports came from the departments.

Fewer DSH facilities, fewer incidents this period

Overall, the number of DSH incidents reported to the OLES from July 1, 2017, through December 31, 2017, decreased 19.8 percent, from 627 in the last six months of 2016 to 503 in the last six months of 2017. This was the largest reporting period decline since the OLES began its oversight on January 1, 2016. Declines were seen in seven of the 17 incident categories, including incidents involving allegations of sexual assault, abuse and neglect.

But the lower incident count in the last half of 2017 coincided with DSH transferring three psychiatric programs that it had operated in the year-ago period. On July 1, 2017, DSH transferred to the California Department of Corrections and Rehabilitation (CDCR) three psychiatric programs that DSH had operated at state prisons at Stockton, Vacaville and Salinas Valley/Soledad.[7] This effectively transferred more than 1,000 patients who had been receiving mental health care from DSH employees to CDCR and left DSH with only five remaining mental hospitals to operate. Thus, the 503 incident reports from these five remaining facilities in the last six months of 2017 were a 3.1 percent increase over the 488 incidents that these facilities recorded in the July through December 2016 period.



[7] The transfer was approved by the Legislature and Governor and was pursuant to the state budget of the 2017-18 fiscal year.

As shown in the chart above, DSH continued its trend of fewer incidents that qualified for OLES action. In the final six months of the year, 140 incidents at DSH qualified for OLES investigation or monitoring or led to OLES research into a systemic departmental issue. These 140 incidents were 22.7 percent fewer than the 181 incidents that qualified at DSH in the comparable period of 2016 and which included the three psychiatric facilities.

Most frequent DSH incidents reported this period

As they did in the first half of 2017, allegations of sexual assault topped all other reported incidents at DSH in the July through December 2017 period. The total 115 sexual assault allegations in the last six months of the year accounted for 22.9 percent of all the incidents reported.

But this number was a 22.3 percent decrease from the 148 reports of alleged sexual assault that the OLES received in the last six months of 2016. The decrease is likely explained by DSH's transfer of the three psychiatric facilities at Stockton, Vacaville and Salinas Valley/Soledad and the more than 1,000 patients in them to CDCR on July 1, 2017. With the incident reports of alleged sexual assault from the three now-CDCR facilities removed from the 148 total in the final half of 2016, the tally for the remaining five DSH hospitals was 117. This translates into a slight reduction -- of two alleged sexual assault incidents -- at DSH in the last half of 2017 vs. the same period in 2016.

Abuse allegations that did not involve sexual assault were the second most frequent reported incident at DSH in the last six months of 2017, totaling 108 and accounting for 21.5 percent of all incident reports. Furthermore, in the last half of 2017, more abuse allegations – 77, or 71.3 percent of the total abuse allegations received-- qualified for OLES investigation and/or monitoring or led to OLES research into systemic departmental issues than any other kind of incident, as the chart on page 14 shows.

But the 108 reports of alleged abuse that the OLES received in the July through December 2017 period were down 34.1 percent from the 164 reports in the comparable year-earlier period. After adjusting year-ago numbers to include just the five remaining hospitals at DSH, the 108 incident reports actually are down 16.9 percent, from 130 incident reports in the last half of 2016.

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/or monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.[8]

[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

As shown in the chart on page 14, incident reports of alleged misconduct at DSH rose to 48 in the last half of 2017, which is the highest that the OLES has recorded and is a 585.7 percent increase over the seven misconduct reported incidents in the same period in 2016. Note that the OLES eliminated two categories that were used in 2016 – "law enforcement" and "use of force" – because they were not accurate descriptors of reportable activity. For example, being a member of law enforcement is not a reportable issue. Likewise, "use of force" is not necessarily a reportable matter because appropriate use of force in certain circumstances and according to policy is acceptable. It is when use of force results in an allegation of excessive force that an incident becomes reportable to the OLES and is captured in the "misconduct" category. Of the 48 misconduct incidents received at DSH in the last 2017 reporting period from July through December, 18, or 37.5 percent, qualified for OLES investigation, monitoring or research into a systemic issue. The OLES also includes information on DSH employee misconduct starting on page 37 in the Mandated Data section of this semi-annual report.

Reported incidents of alleged neglect at DSH totaled only 20 in the July through December 2017 period, down 62.3 percent from the 53 incidents reported in the year-earlier period. With the three psychiatric facilities removed from the year-ago data, the OLES finds the decrease in reports of alleged neglect in the last half of 2017 at the five remaining DSH hospitals is 58.3 percent compared with numbers from the same hospitals in the last six months of 2016.

The OLES clarified the proper reporting of child pornography incidents during the first half of 2017. As a result, reported child pornography incidents rose from zero in the last half of 2016 to seven in the final six months of 2017, and all seven cases were at DSH-Coalinga, where sexual offenders receive treatment. The OLES had focused on child pornography at the Coalinga facility in 2017 and will report on this monitored issue in an upcoming semi-annual report.

DSH recorded a 70 percent decline, going from 10 to three, attempted suicides in

---

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.

the last half of 2017 compared with the final six months of 2016. The adjusted incident numbers, however, reveal that eight of the 10 attempted suicides in the last half of 2016 occurred at the three psychiatric facilities at Stockton, Vacaville and Salinas Valley/Soledad that were transferred to CDCR on July 1, 2017. Thus, the three attempted suicides at the remaining five DSH hospitals in the last half of 2017 are an increase of one attempted suicide compared with the year-ago period at the same five hospitals.

The complete list of reported incidents at DSH during the last half of 2017 is in the chart on the next page.

Reported DSH Incidents This Period

Incident Categories	Number Reported July 1-Dec 31, 2017	Number Reported July 1-Dec 31, 2016*	Change	Number Meeting OLES Criteria July 1-Dec 31, 2017	Number Meeting OLES Criteria July 1-Dec 31, 2016*
Sexual Assault	115	148	-22.3%	20	40
Abuse	108	164	-34.1%	77	98
Broken Bone	66	8	+725%	6	1
Head/Neck Injury	52	92	-43.5%	1	2
Misconduct**	48	7	+585.7%	18	2
Significant Other***	31	27	+14.8%	2	5
Death	28	31	-9.7%	8	8
Neglect	20	53	-62.3%	7	16
AWOL	18	9	+100%	1	1
Child Pornography****	7	0	+700%	0	0
Attack on Staff*****	4	0	+400%	0	0
Attempted Suicide	3	10	-70%	0	0
Burn	2	2	0%	0	0
Genital Injury	1	2	-50%	0	0
Pregnancy	0	0	0%	0	0
Riot	0	0	0%	0	0
Non-Resident Assault	0	1	-100%	0	0
Law Enforcement**	NA	56	See note	NA	5
Use of Force**	NA	16	See note	NA	3
Professional	NA	1	See	NA	0

Incident Categories	Number Reported July 1-Dec 31, 2017	Number Reported July 1-Dec 31, 2016*	Change	Number Meeting OLES Criteria July 1-Dec 31, 2017	Number Meeting OLES Criteria July 1-Dec 31, 2016*
Board Violation******			note		
Totals	503	627	-19.8%	140	181

* Numbers in these columns are unadjusted and are provided as they were previously published. They include the three psychiatric programs where mental health care was provided by DSH until July 1, 2017.
** The OLES eliminated two categories that were used in 2016 – "law enforcement" and "use of force" – because they were not accurate descriptors of reportable activity. For example, being a member of law enforcement is not a reportable issue. Likewise, "use of force" is not necessarily a reportable matter because appropriate use of force in certain circumstances and according to policy is acceptable. It is when use of force results in an allegation of excessive force that an incident becomes reportable to the OLES and is captured in the "misconduct" category.
*** Any incident of significant interest, e.g., serious crimes committed by a patient; unusual facility events that have the potential to involve patients such as several kitchen personnel fainting without perceptible cause; major patient-on-patient fights resulting in no broken bones and no head/neck injuries but which require first aid treatment; inappropriate visitor-patient behavior that results in the discovery of contraband.
**** The OLES clarified to DSH the required proper reporting of child pornography incidents during the first half of 2017.
***** The number of attacks on staff reported to the OLES is a small percentage of all staff attacks. The department only reports to the OLES the attacks that resulted in serious injury to the employee.
****** All reports to licensing boards are now captured in the Additional Mandated Data tables on page 40 of this semi-annual report.

Broken bone reports at DSH in the period

Reports of broken bones at DSH increased eightfold, to 66, in the last half of 2017 compared with eight broken bone reports in the year-earlier period. This occurred as the OLES required notification starting in the last half of 2016 of all patient injuries involving broken bones. Previously, the OLES required notification of broken bones only "when the cause of the break is undetermined". As an example, in summer 2017, a patient at DSH-Metropolitan State Hospital was reported to have a broken finger, and he alleged his finger was shut in a doorjamb. Would hospital personnel consider this an injury whose cause was "determined" or would personnel alert law enforcement at the hospital to investigate whether the patient's finger was jammed with the door on purpose, say, by another patient? To ensure thorough data, the OLES directed DSH to report every broken bone injury so the OLES could review. The OLES further analyzed the causes that DSH attributed to the 66 broken bone

reports involving patients in the last six months of 2017. The results are shown in the adjacent chart.

Patient Broken Bone Reports at DSH This Period

Cause Reported	Number of Incidents
Patient Assault on Another Patient	19
Exercise or Sports Activity	11
Unwitnessed Fall	10
Behavioral Episode	6
Unknown	4
Witnessed Fall	4
Medical Related	3
Occurred Off Premises	3
Accident	2
Law Enforcement Containment Related	1
Law Enforcement Handcuff Related	1
Use of Force by Law Enforcement in Transport	1
Self Inflicted	1
Work Related	1
Total	66

The OLES also noted that 42.4 percent of the broken bone incident reports during the six months came from one hospital – DSH-Coalinga. This facility had approximately the same number of patients as DSH facilities in Napa and Atascadero, which accounted for only 7.6 percent and 3.0 percent, respectively, of the broken bone reports during the July through December 2017 period.

Most frequent DSH incidents reported in 2017

As shown in the chart on the next page, five categories of reported incidents accounted for 75.9 percent of all 2017 reports at DSH. These categories are sexual assault, abuse, broken bones, head and/or neck injuries and misconduct. These same five categories accounted for 83.3 percent of all the DSH incidents during the year that met the criteria for the OLES to investigate and/or monitor.

Reported DSH Incidents in 2017

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 2017 Incident Reports	2017 Totals Meeting OLES Criteria
Sexual Assault	115	20	147	24	262	44
Abuse	108	77	121	79	229	156
Broken Bone	66	6	45	4	111	10
Head/Neck Injury	52	1	49	1	101	2
Misconduct	48	18	33	15	81	33
Significant Other**	31	2	29	4	111	10
Death	28	8	24	11	52	19
Neglect	20	7	34	14	54	21
AWOL	18	1	14	1	32	2
Child Pornography	7	0	19	0	26	0
Attack on Staff	4	0	3	0	7	0
Attempted Suicide	3	0	8	1	11	1
Burn	2	0	2	0	4	0
Genital Injury	1	0	2	0	3	0
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Non-Resident Assault	0	0	0	0	0	0
Totals	503	140	530	154	1,033	294

*Numbers in these columns are unadjusted and are provided as they were previously published. They include the three psychiatric programs where mental health care was provided by DSH until July 1, 2017.

** Any incident of significant interest, e.g., serious crimes committed by a patient; unusual facility events that have the potential to involve patients such as several kitchen personnel fainting without perceptible cause; major patient-on-patient fights resulting in no broken bones and no head/neck injuries but which require first aid treatment; inappropriate visitor-patient behavior that results in the discovery of contraband.

Distribution of DSH incidents

With 503 incidents reported from July through December 2017, DSH accounted for the majority, or 70.7 percent, of the reports the OLES received in the period. This was

not unexpected since DSH's five facilities held 6,086 patients, which is more than nine times as many people as the 645 residents at the four DDS facilities as of December 31, 2017.

The DSH-Coalinga hospital had the highest number of reports – 121 – in the period. This translated into a rate of 9.35 incidents per 100 patients at Coalinga during the period, which is a decrease from the rate of 9.63 incidents per 100 patients that the OLES received for Coalinga for the last half of 2016. But Coalinga's 2017 incident rate still was lower than the 13.07 incidents per 100 patients for DSH-Metropolitan in Norwalk during the final half of 2017.

The charts on the next page show the distribution of reported incidents at the five DSH facilities.

Reported DSH Incidents By Facility This Period

Facility	Number of Patients*	Incidents Reported July 1-Dec. 31, 2017	Incidents Per 100 Patients July 1-Dec. 31, 2017	Incidents Per 100 Patients July 1 Dec. 31, 2016
DSH-Coalinga	1,294	121	9.35	9.63
DSH-Patton	1,540	114	7.40	6.73
DSH-Metropolitan	811	106	13.07	15.16
DSH-Atascadero	1,181	83	7.03	8.89
DSH-Napa	1,260	79	6.27	3.94
Totals	6,086	503	8.26	8.87

* The DSH provided patient population numbers as of December 31, 2017.

Reported DSH Incidents By Facility In 2017

Facility	Number of Patients*	Incidents Reported Jan 1-Dec. 31, 2017	Incidents Per 100 Patients Jan 1-Dec. 31, 2017	Incidents Per 100 Patients Jan 1 Dec. 31, 2016
DSH-Coalinga	1,294	238	18.39	17.05
DSH-Metropolitan	814	217	26.66	30.04
DSH-Patton	1,546	217	14.04	13.68
DSH-Atascadero	1,176	155	13.18	14.48
DSH-Napa	1,265	136	10.75	10.29
Totals	6,095	963	15.80	17.11

* This is the average of the patient population numbers as of June 30, 2017, and December 31, 2017, as provided by DSH.

DSH sexual assault allegations

Reports of alleged sexual assault were the largest single category of incident that the OLES received for the reporting period at DSH. The 115 alleged sexual assault incidents reported from July 1, 2017, through December 31, 2017, accounted for 22.9 percent of all DSH incident reports. But only 17.4 percent of the alleged sexual assaults, or 20 incidents out of the 115, met the OLES criteria for investigation, monitoring and/or research into systemic department issues. As shown in the chart on the next page, the DSH-Atascadero hospital had the most reports – 35 - and accounted for 30.4 percent of all alleged sexual assault incident reports in the period.

The largest segment of alleged sexual assaults -- 57 of the total 115 -- involved allegations of patients assaulting other patients. The chart on the next page shows two DSH facilities – Patton and Napa – together accounted for 61.4 percent of these patient-assaulting-another-patient incident reports.

The second largest segment of alleged sexual assaults – 27.8 percent - was defined by the OLES as "miscellaneous" because allegations made by patients did not implicate DSH employees or contactors. This "miscellaneous" 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.

Reports of non-law enforcement hospital employees allegedly sexually assaulting patients accounted for 20.0 percent of all the reports, while law enforcement personnel were alleged to be involved in fewer than 3 percent of the alleged incidents during the six-month period. All reports of alleged sexual assaults that the OLES received during the reporting period are shown in the chart below. It is important to note that the OLES takes every allegation seriously and closely reviews every case.

Reported DSH Sexual Assault Allegations This Period

Facility	*Patient on Patient Incidents*	*Miscellaneous* on Patient Incidents*	*Non-Law Enforcement Staff on Patient Incidents*	*Law Enforcement on Patient Incidents*	Totals
DSH-Atascadero	8	21	5	1	35
DSH-Napa	18	6	9	0	33
DSH-Patton	17	3	4	0	24
DSH-Metropolitan	8	2	2	0	12
DSH-Coalinga	6	0	3	2	11

Facility	*Patient on Patient Incidents*	*Miscellaneous* on Patient Incidents*	*Non-Law Enforcement Staff on Patient Incidents*	*Law Enforcement on Patient Incidents*	Totals
Totals	57	32	23	3	115

* The OLES defined "miscellaneous" as sexual assaults that patients said occurred before they came to DSH as well as allegations of sexual assault that patients said occurred at DSH but where they said they were unsure if another person was involved.

DSH patient deaths

There were 28 patient deaths – 21 men and seven women – reported to the OLES at four DSH facilities during the last half of 2017. This number is down 9.7 percent from the 31 deaths reported in the same July through December period in 2016. Ages in the 2017 period ranged from 38 to 84, with 67 the average age of the deceased. The reported causes of death are shown in the chart below.

Reported Causes of Death of DSH Patients This Period

Facility	Cardiac/ Respiratory	Cancer	Renal/Liver	Cerebral Issue	Other*	Totals
DSH-Metropolitan	4	3	0	0	1	8
DSH-Coalinga	1	4	0	0	2	7
DSH-Patton	4	0	1	0	2	7
DSH-Napa	3	1	1	1	0	6
Totals	12	8	2	1	5	28

* Other deaths were those that were not accounted for in the top four categories. These included a death attributed to sepsis, a death that followed a patient choking on food, a death that occurred at an outside hospital as a patient awaited surgery, and two other deaths that were awaiting coroner reports.

Just over 70 percent of the DSH deaths were classified by facility medical directors or coroners as "expected"[9] due to underlying health conditions, such as cancer and kidney disease. Six 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 the deaths and monitored the departmental investigations into the unexpected deaths at DSH.

[9] 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."

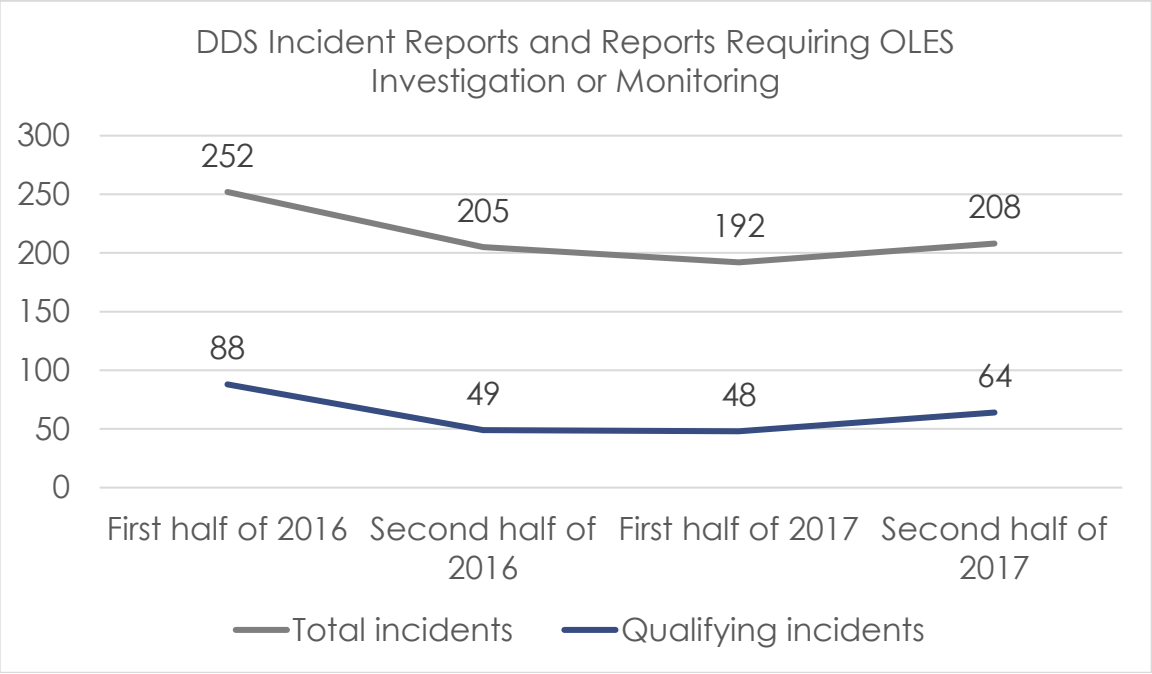
DDS Incidents

In the July through December 2017 reporting period, virtually all DDS incident reports came from law enforcement personnel in the department.

Slight increase in reported DDS incidents this period

Overall, the number of DDS incidents reported in the period increased slightly, by 1.5 percent, or three more reported incidents, from 205 in the last half of 2016 to 208 in the last half of 2017. Reports of head/neck injuries and broken bones as well as sexual assault allegations all decreased.

Of the 208 reported DDS incidents in the final six months of 2017, only 30.8 percent, or 64 incidents, met the criteria for OLES investigation or monitoring or led to OLES research into a systemic departmental issue. As the graph shows, the last half of 2017 marked an upswing in the number of incidents and the number that qualified for OLES action. It should be noted that while the DDS population decreased in the final six months of 2017, the overall percentage of individuals residing in the intermediate care facility residences – which house residents who are most often involved in reportable incidents – rose slightly.



Most frequent DDS incidents this period

Alleged abuse was the most frequent DDS incident reported in the last half of 2017. The 105 abuse allegations from July through December 2017 accounted for half of all DDS incidents received in the period. The 105 reports, however, were a 15.4 percent increase from the 91 abuse incidents reported in the same period in 2016.

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/or monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.[10]

As shown in the chart on the next page, reports of head and/or neck injuries at DDS constituted the second most frequent incident received by the OLES. The OLES required notification of all head/neck injuries from DDS that required treatment beyond first aid because such injuries can cause lasting health impairment or lead to death and may be indicative of assault, battery or neglect. As shown in the chart below, the 21 reported injuries at DDS in the last half of 2017 were a 36.4 percent drop from the 33 head/neck injury reports received in the year-earlier period. Only one 2017 incident met the OLES criteria for further action.

For the first time since the OLES began providing oversight at DDS, deaths were the third most frequently used incident category due to a reduction in broken bone and sexual assault incidents. The department reported 18 deaths in the last six months of 2017, which is an increase from the year-earlier period. Two-thirds of the deaths in the last half of 2017 involved residents of the Sonoma Developmental Center. Overall for the 2017 calendar year, all deaths at DDS increased 16.7 percent from the previous year. Information on all the DDS incident reports in the last half of 2017 is in the chart on page 22.

[10] 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.

Reported DDS Incidents This Period

Incident Categories	Number Reported July 1-Dec. 31, 2017	Number Reported July 1-Dec. 31, 2016	Change	Number Meeting OLES Criteria July 1-Dec. 31, 2017	Number Meeting OLES Criteria July 1-Dec. 31, 2016
Abuse	105	91	+15.4%	47	27
Head/Neck Injury	21	33	-36.4%	1	0
Death	18	10	+80%	4	2
Broken Bone	16	23	-30.4%	3	9
Sexual Assault	16	18	-11.1%	2	4
Neglect	15	9	+66.7%	6	5
AWOL	7	5	+40%	0	0
Significant Interest – Other*	6	7	-14.3%	1	0
Genital Injury	3	7	-57.1%	0	2
Burn	1	1	0%	0	0
Misconduct	0	0	0%	0	0
Attempted Suicide	0	0	0%	0	0
Attack on Staff	0	1	-100%	0	0
Professional Board Violation**	NA	0	See Note	NA	0
Totals	208	205	+1.5%	64	49

* Any incident of significant interest, e.g., serious crimes committed by a resident; unusual facility events that have the potential to involve residents; major resident-on-resident fights resulting in no broken bones and no head/neck injuries but which require first aid treatment; inappropriate visitor-resident behavior that results in the discovery of contraband.

** Starting in 2017, all reports made to licensing boards about employee misconduct were captured in the Additional Mandated Data section on page 40 of this report.

Broken bone reports at DDS in the period

Reports of broken bones at DDS declined 30.4 percent to 16 in the last half of 2017 compared with 23 in the year-earlier period. The OLES required notification of all broken bones at DDS to ensure thorough data and to allow the OLES to review each incident report, aware that the DDS population includes residents with developmental disabilities and fragile health.

The adjacent chart shows the causes that the DDS attributed to the 16 broken bone reports involving residents in the July through December 2017 period.

Resident Broken Bone Reports at DDS This Period

Cause Reported	Number of Incidents
Behavioral Episode	7
Unknown/Medical	3
Assault	2
Witnessed Fall	2
Unwitnessed Fall	1
Unknown/Nonverbal	1
Total	16

Most frequent DDS incidents reported in 2017

The chart below shows three categories of reported incidents -- abuse, head and/or neck injury and broken bones -- accounted for two-thirds of all 2017 reports at DDS. The complete list is below.

Reported DDS Incidents in 2017

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 2017 Incident Reports	2017 Totals Meeting OLES Criteria
Abuse	105	47	76	30	181	77
Head/Neck Injury	21	1	26	1	47	2
Broken Bone	16	3	23	3	39	6
Death	18	4	17	3	35	7
Sexual Assault	16	2	22	7	38	9
Neglect	15	6	6	2	21	8
AWOL	7	0	3	1	10	1
Significant Other*	6	1	5	1	11	2
Genital Injury	3	0	11	0	14	0
Burn	1	0	0	0	1	0
Misconduct	0	0	2	0	2	0
Attempted Suicide	0	0	1	0	1	0
Attack on Staff	0	0	0	0	0	0
Professional Board Violation	NA	0	See note	NA	0	0
Totals	208	64	192	48	400	112

* Any incident of significant interest, e.g., serious crimes committed by a resident;

unusual facility events that have the potential to involve residents; major resident-on-resident fights resulting in no broken bones and no head/neck injuries but which require first aid treatment; inappropriate visitor-resident behavior that results in the discovery of contraband.
** Starting in 2017, all reports made to licensing boards about employee misconduct were captured in the Additional Mandated Data section on page 40 of this report.

Distribution of DDS incidents

The 208 DDS incidents reported from July through December 2017 accounted for 29.3 percent of all reports the OLES received. Overall, the 208 reports were up a slight 1.5 percent from the 205 received in the same period a year earlier. Because there were fewer DDS residents in the period than there were a year earlier, the rate of incidents per 100 residents at DDS increased from 22.26 to 32.25.

As shown in the chart on the next page, the DDS facility in Porterville, which had the most residents, had the most incident reports – 65 -- from July 1, 2017, through December 31, 2017. But this was a decrease of 15.6 percent from the 77 incidents reported during the year-ago period. The DDS Fairview facility in Costa Mesa also reported a decrease in incidents, going from 74 in the year-ago period to 64 in the last six months of 2017.

Reported DDS Incidents By Facility This Period

Facility	Number of Residents*	Incidents Reported July 1-Dec. 31, 2017	*Incidents Per 100 Residents July 1-Dec. 31, 2017*	Incidents Per 100 Residents July 1-Dec. 31, 2016
Porterville	280	65	23.21	22.78
Fairview	140	64	45.71	36.27
Sonoma	178	40	22.47	10.18
Canyon Springs	47	39	82.98	44.44
Totals	645	208	32.25	22.26

* Population numbers from DDS are as of December 31, 2017.

Reported DDS Incidents By Facility in 2017

Facility	Number of Residents*	Incidents Reported Jan. 1-Dec. 31, 2017	*Incidents Per 100 Residents Jan. 1-Dec. 31, 2017*	Incidents Per 100 Residents Jan. 1-Dec. 31, 2016
Porterville	301	131	43.52	45.06
Fairview	150	115	76.67	71.10
Sonoma	219	91	41.55	26.51
Canyon Springs	48	63	131.25	119.57
Totals	718	400	55.71	55.56

* This is the average of population numbers provided as of June 30, 2017, and December 31, 2017.

DDS sexual assault allegations

The OLES received 16 incident reports alleging sexual assault at DDS during the last half of 2017, which amounted to 7.7 percent of all incident reports at the department. Sixty-two percent of the sexual assault reports alleged DDS staff members who are not law enforcement personnel assaulted residents. All 10 of these allegations came from the Canyon Springs Community Facility and all were later recanted by the resident complainants. Eight of the allegations were from the same resident. The complete list of sexual assault allegation incidents is in the chart on page 25.

Reported DDS Sexual Assault Incidents This Period

Facility	*Non-Law Enforcement Staff on Resident Incidents*	*Resident on Resident Incidents*	*Unknown* on Resident Incidents*	*Totals*
Canyon Springs	10	1	0	11
Porterville	0	3	0	3
Fairview	0	1	0	1
Sonoma	0	0	1	1
Totals	10	5	1	16

* The OLES defined the sexual assault as "unknown" because the alleged victim was nonverbal.

DDS resident deaths

There were 18 DDS residents from three facilities who died during the last six months of 2017, according to reports that the OLES received. This compared with 10 deaths in the same period a year earlier. Fourteen of the deceased in the 2017 reporting period were men and four were women. Ages of the deceased ranged from 39 to 85, with 62 being the average age. Two-thirds of the deceased in the last half of 2017 were residents of the Sonoma Developmental Center.

All but three of the deaths at DDS were classified by the department as "expected" due to underlying health conditions such as chronic obstructive pulmonary disease and cancer. The OLES reviewed all deaths that were reported, including those of four Sonoma residents who were evacuated during the October 2017 wildfires in Northern California and who later died of respiratory failure. The chart below shows the reported causes of death of the 18 deceased residents.

Reported Causes of Death of DDS Residents This Period

Facility	*Cardiac/Respiratory*	*Cancer*	*Renal/Bowel*	Sepsis	Totals
Sonoma	9	1	1	1	12
Fairview	2	0	1	2	5
Porterville	1	0	0	0	1

Facility	*Cardiac/Respiratory*	*Cancer*	*Renal/Bowel*	Sepsis	Totals
Totals	12	1	2	3	18

* Other deaths were those that were not accounted for in the top four categories. These included the death of a resident who fell and suffered a stroke, the death of a resident with several underlying health conditions who was in hospice care and a death that was awaiting a coroner report to determine the cause.

Notification 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. Priority 1 and 2 threshold incidents are shown in the tables below.

Priority 1 Threshold Incidents

PRIORITY 1 NOTIFICATIONS- 2-HOUR NOTIFICATION
• Any death of a resident or patient • Any allegation of sexual assault of a resident or patient • An assault with a deadly weapon or an assault with force likely to produce great bodily injury to a resident or patient • Any report of physical abuse of a resident or patient implicating a staff member • Any injury to the genitals of a resident or patient when the cause of injury is undetermined • A broken bone of a resident or patient • Any use of deadly force by staff

Priority 2 Threshold Incidents

PRIORITY 2 NOTIFICATIONS- 1-DAY NOTIFICATION
• A pregnancy involving a resident or patient • Any injury to the head or neck of a resident requiring treatment beyond first aid • Any burns of a resident or patient, regardless of whether the cause is known • Any incident of significant interest to the public including, but not limited to, "AWOL", suicide attempt requiring treatment beyond first aid, commission of serious crimes by a resident or patient, riot and any incident which may potentially draw media attention • Any incident involving a staff member requiring notification to professional licensing or certification boards • Any allegations of peace officer misconduct, whether on-duty or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties • Any staff action or inaction that resulted in, or reasonably could have resulted in, a resident or patient injury requiring treatment beyond first aid or a resident or patient death

Timeliness of notifications this period

In the last half of 2017, both DSH and DDS continued to improve the timeliness[11] of their notifications of incidents to the OLES. The DDS went from a department-wide 90.2 percent rate of timely notifications in the final six months of 2016 to an overall 96.2 percent in the last half of 2017. At three DDS facilities – the Sonoma Developmental Center, Canyon Springs Community Facility and Porterville Developmental Center – every incident but one was reported timely to the OLES in the 2017 period. The DSH timeliness rating also improved, from 80.1 percent in the final six months of 2016 to 94.0 percent in the last half of 2017.

Timely Notifications at DSH – July 1– December 31, 2017

Rank	DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	DSH-Coalinga	1,294	121	117	96.7%
2	DSH-Metropolitan	811	106	101	95.3%
3	DSH-Atascadero	1,181	83	79	95.2%
4	DSH-Napa	1,260	79	73	92.4%
5	DSH-Patton	1,540	114	103	90.3%
	DSH Totals	6,086	503	473	94.0%

* The department provided population numbers as of December 31, 2017.

Timely Notifications at DDS – July 1– December 31, 2017

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Porterville	280	65	64	98.5%
2	Sonoma	178	40	39	97.5%
3	Canyon Springs	47	39	38	97.4%
4	Fairview	140	64	59	92.2%
	DDS Totals	645	208	200	96.2%

** The department provided population numbers as of December 31, 2017.

[11] 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 this and 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.

Intake

All incidents received by the OLES during the six-month period were reviewed at a daily intake meeting by a panel of assigned OLES staff members. 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 and not law enforcement, 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 July through December 2017 reporting period, 507 of the total 711 DSH and DDS incidents that the OLES received were rejected because they did not meet the criteria for the OLES to undertake investigation and/or monitoring. This amounted to 71.3 percent of all the incidents that were reported to the OLES. To ensure the OLES is independently assessing whether an allegation meets its criteria, the OLES requires the departments to broadly report misconduct allegations. It is best practice of an oversight entity to independently determine if an allegation meets its criteria. By analyzing a wide range of allegations, the OLES was able to discover one systemic issue at DSH and one systemic issue at DDS that have been addressed with the departments through monitored issues, and they are displayed in Appendix E.

The DSH accounted for 363 of the 507 rejected incidents, or 71.6 percent of the total rejected incidents. Sexual assault allegations were the single largest DSH category where reported incidents did not meet the OLES criteria; therefore, the vast majority of these sexual assault cases – 95 out of 115 – were rejected. The DDS component of the total 507 rejected incidents during the six-month period totaled 144. This amounted to 28.4 percent of all rejected incidents. Abuse allegations accounted for more than a third of the 144 DDS rejected incidents.

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 criteria[12] 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. 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 resident 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 charts on the next page show the outcomes of all incidents the OLES received in the July 1, 2017, through December

[12] Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix F).

31, 2017, reporting period.

Disposition of DSH Cases

OLES Categories	July 1- Dec. 31, 2017 Number	Percentage of Reported Incidents	July 1- Dec. 31, 2016 Number	Percentage of Reported Incidents
Rejected	334	66.4%	446	71.1%
Monitored, Administrative	18	3.6%	38	6.1%
Monitored, Criminal	102	20.3%	111	17.7%
OLES Investigations, Administrative	7	1.4%	7	1.1%
Monitored Issues*	NA	NA	4	0.6%
OLES Investigations, Criminal	13	2.6%	21	3.3%
Outside Jurisdiction**	29	5.8%	NA	NA
Totals	503	100%	627	100%

Disposition of DDS Cases

OLES Categories	July 1- Dec. 31, 2017 Number	Percentage of Reported Incidents	July 1- Dec. 31, 2016 Number	Percentage of Reported Incidents
Rejected	144	69.2%	156	76.1%
Monitored, Administrative	7	3.4%	6	2.9%
Monitored, Criminal	57	27.4%	43	21.0%
OLES Investigations, Administrative	0	0%	0	0%
Monitored Issues*	NA	NA	0	0%
OLES Investigations, Criminal	0	0%	0	0%
Outside Jurisdiction**	0	0%	NA	NA
Totals	208	100%	205	100%

* Monitored issues are general concerns under review by the OLES and are not reported incidents.

** The OLES did not use Outside Jurisdiction as a category in 2016. Outside Jurisdiction includes incidents that occurred while the resident or patient was not housed with DDS or DSH.

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 2017 period, the OLES completed 23 investigations – 15 were criminal cases and eight were administrative. All were at DSH. Twenty investigations involved incidents that occurred in 2017. Another three investigations involved incidents in 2016.

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. During the last half of 2017, one criminal case from OLES investigators was referred to a prosecuting agency, and the agency declined to prosecute.

All completed OLES investigations into administrative wrongdoing/misconduct are forwarded to facility management for review. In the July through December 2017 period, three administrative cases were referred to management for possible discipline of state employees, and one case was closed after it was determined the allegation did not rise to the level of serious misconduct meeting the OLES criteria. Another four administrative cases were closed for lack of evidence. 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. The chart on the next page shows the results of all the

completed OLES investigations in the reporting period. These investigations are in Appendix A.

Results of Completed OLES Investigations – All at DSH

Type of Investigation	Total completed July 1- Dec. 31, 2017	Referred to prosecuting agency	Referred to facility management	Closed without referral*
Criminal	15	1	2	12
Administrative	8	-	3	5
Totals	23	1	5	17

* The OLES provided the department with findings of all criminal and administrative investigations where it was determined there was insufficient evidence that allegations were true.

OLES-monitored departmental investigations

In this report, the OLES provides information on the 170 monitored cases at the two departments that, by December 31, 2017, had reached resolution. Nearly half of these cases – 47.6 percent or 81 of the 170 total – involved allegations of administrative misconduct by departmental staff, such as failing to maintain one-on-one supervision, as required, for a patient. The results are summarized in the chart below, and synopses of the cases are in Appendices B, C and D.

Results of Completed Monitored Cases at DSH and DDS

Type of Case/Result	DSH	DDS	Totals
Criminal/Not Referred	63	20	83
Criminal/Referred to Prosecuting Agency	2	4	6
Total Criminal	65	24	89
Administrative/Without Sustained Allegations	52	3	55
Administrative/With Sustained Allegations	16	10	26
Total Administrative	68	13	81
Grand Totals	133	37	170

In the July through December 2017 period, 26 of the 81 DSH and DDS monitored administrative investigations, or 32.1 percent, were sustained, meaning sufficient evidence was found to exist for discipline to be considered. This is a higher percentage than the 29.3 percent, or 27 of 92 monitored administrative cases at the departments where allegations were sustained, in the last half of 2016. In addition, six of the 89 criminal investigations that the OLES monitored, or 6.7 percent, were referred to prosecuting agencies in the last half of 2017. This compares with seven out of 57 monitored criminal investigations, or 12.3 percent, in the year-earlier reporting period.

The OLES provides assessments of the completed monitored cases. At DSH, 48 of the departmental investigations, also known as pre-discipline phase cases, were deemed procedurally insufficient by the OLES during the last six months of 2017.

Three also were substantively insufficient. Procedural sufficiency assesses the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency assesses the quality, adequacy and thoroughness of the investigative interviews and reports.

The most prevalent deficiency was delays in completing investigations. Forty-three investigations were not completed timely. The DSH has advised the OLES that it has been working diligently to address the timeliness of investigations. According to DSH, additional staff have been added to the investigative teams at several facilities. The investigative timeframe, in conjunction with the OLES, has been lengthened from 75 days to 120 days. Additional review and monitoring processes have been put in place by the facility police chiefs and the DSH Chief of Law Enforcement to make sure that investigative timelines are being met. Since the previous semi-annual report, the number of report deficiencies has decreased from 50 percent of the monitored investigations having a deficiency to 38 percent of the investigations having a deficiency.

At DDS, six of the departmental investigations, also known as pre-discipline phase cases, were assessed as insufficient by the OLES – five were procedurally insufficient, and one was insufficient both procedurally and substantively.

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 hiring authority decides whether to sustain any allegations against the employee. This decision is based upon the evidence presented. If there is a preponderance of evidence showing the allegations are factual, the hiring authority can sustain the allegations. If one or more allegations are sustained, the hiring authority must impose an appropriate discipline.

Appendix C provides assessments of 20 discipline phase-only cases monitored by the OLES that reached resolution during the reporting period. Sixteen of these 20 cases were at DSH and four were at DDS. The OLES assesses every discipline phase case for both procedural and substantive sufficiency. At DSH, five of the discipline phase cases were deemed insufficient by the OLES, and all five were procedurally insufficient. 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. At DDS, each of the four discipline cases was assessed as insufficient. Three were procedurally insufficient and one was both procedurally and substantively insufficient. 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.

Update on the discipline phase

Since 2015, the OLES has consistently reported that neither DSH nor DDS has standardized or uniform disciplinary processes or procedures. In 2015, the OLES presented to the departments a disciplinary matrix that was in use at two DSH facilities and recommended that the departments adopt the matrix and develop comprehensive disciplinary policies and procedures. The value of department-wide disciplinary policies and a matrix is that it allows for and encourages a consistent and fair application of disciplinary and penalty determinations.

The OLES also recommended in 2015 that the departments implement an executive review process to elevate cases beyond the local hiring authority level in instances when there is significant disagreement among the hiring authority, the OLES monitor and department attorney over whether to impose discipline, and if so, the proper penalty. The DSH incorporated the OLES's recommendations and issued in July 2017 a policy directive called OLES Oversight-Investigation Review Process-Disposition, which includes an executive review process.

The DDS presented the OLES with a similar draft policy that purports to establish expectations for DDS facilities' relationship with the OLES regarding review of OLES-monitored investigations. It also included an executive review process. But, as of December 31, 2017, DDS had not finalized this policy.

Additionally, the OLES recommended that the departments assign attorneys to all OLES cases to assist with investigations and the disciplinary process. Both departments have made improvements in assigning attorneys to the OLES-monitored cases. However, there are resource constraints that prohibit department attorneys from actively participating through all stages of the investigative and disciplinary processes.

Throughout 2016, DSH made progress implementing other OLES recommendations. The DSH established a working group to develop a disciplinary matrix. Additionally, DSH issued a policy on July 29, 2016, that established an investigative review and disposition committee process, which set forth DSH procedures to guide the review of administrative investigation and penalty determinations. In May 2017, DSH presented to the OLES a draft disciplinary policy and matrix that failed to establish penalty levels for specified types of misconduct. The initial draft policy was too broad and did little to ensure consistent penalties for similar acts of misconduct across DSH. The OLES reviewed the draft and made recommendations that would establish penalty ranges for specified categories of misconduct.

In August 2017, DSH presented the OLES with a draft policy directive: Objective Discipline Process, which includes a disciplinary matrix. This draft policy, which incorporates the OLES's recommendations, represents a significant step in establishing a department-wide disciplinary process and provides guidance to hiring authorities and allows for the application of fair and consistent disciplinary and penalty determinations. As of December 31, 2017, the discipline tool was in the

union notification process. Once this review occurs, DSH hoped to finalize and implement the policy.

The OLES recommended that DDS adopt the DSH disciplinary process and matrix or develop a similar policy. As of December 31, 2017, DDS had not instituted a formal disciplinary policy. The OLES was assured that DDS was finalizing a case disposition policy. The OLES will report on DDS' progress in an upcoming semi-annual report.

The OLES has consistently recommended that the departments establish benchmarks and timelines to guide the timeliness of investigative and disciplinary processes. The OLES uses accepted industry timelines to assess and report on the quality of monitored investigations and disciplinary processes. For example, the OLES recommends that the departments complete investigations within 120 days of discovery of the incident and that hiring authorities make disciplinary determinations within 45 days from the conclusion of the investigation.

In the July through December 2017 reporting period, DSH developed an investigation and disciplinary timeframe that incorporates the OLES recommendation to establish timeframes during which threshold or critical junctures in the investigative and disciplinary process must occur. The OLES will continue to monitor and report on the efficacy of the timelines as well as of the other disciplinary tools.

The OLES recommended that DDS adopt the DSH timeframes. As of December 31, 2017, DDS was reviewing the DSH timeframes.

Perspective on departments imposing discipline

The OLES reported in its previous semi-annual report covering January through June 2017 that neither department processed nor served disciplinary actions on employees in a consistent and timely manner. The OLES pointed out that neither department had a policy or procedure that established a standard of when to serve a disciplinary action after the hiring authority had made a decision to impose discipline.

As the previous semi-annual period documented, the average length of time to serve an action at DSH ranged from six to 264 calendar days, with an average length of time to serve disciplinary actions of 118 calendar days. The average length of time to serve an action at DDS ranged from 36 to 286 calendar days, with an average length of time to serve disciplinary actions of 213 calendar days.

The OLES recommended that the departments develop timeliness standards for the service of disciplinary actions. The OLES recommended a standard of 60 days from the date the hiring authority made a determination to impose discipline to the date the hiring authority serves the employee with the disciplinary action. The DSH implemented the 60-day recommendation for the time in which to serve a disciplinary action after the decision is made to impose discipline. The DDS had not

implemented this recommendation and had, as of December 31, 2017, no policy or procedure governing the time period in which hiring authorities must serve disciplinary actions.

In this reporting period ending December 31, 2017, the OLES reviewed 28 disciplinary actions at both departments. The departments served 10 disciplinary actions; five were at DSH and five were at DDS. Another 18 cases were pending service of disciplinary actions, and of these, 11 were at DSH and seven were at DDS.

The DSH served five disciplinary actions on employees between 13 and 322 days after the hiring authority made disciplinary determinations. The average length of time to serve an action increased from last period's average of 118 days to 168 days.

The remaining 11 cases at DSH were pending service of disciplinary actions for up to 468 days. The most egregious delay of 468 days was a case at DSH-Atascadero that involved four nurses who allegedly failed to complete required nursing assessments on a patient in full bed restraints. Two of the nurses also were allegedly dishonest during investigative interviews. The hiring authority made disciplinary determinations on September 19, 2016, and imposed penalties of seven-day suspensions on two nurses. One of the two nurses separated from state service on April 13, 2017. The one remaining disciplinary action was pending service as of December 31, 2017.

The DDS served five disciplinary actions on employees between 75 and 400 days after the hiring authority made disciplinary determinations. The average length of time to serve an action decreased from last period's average of 213 days to 178 days.

The remaining six cases at DDS were pending service of disciplinary actions for up to 593 days. In its previous semi-annual report, the OLES reported on a Fairview Developmental Center case that had been pending service of the disciplinary action on an employee for 409 days. On May 17, 2016, the hiring authority sustained allegations that a psychiatric technician failed to properly monitor a resident who was on a direct observation level of supervision and where the resident swallowed a mobile phone battery. The hiring authority imposed a two-day suspension without pay. On November 7, 2017, the hiring authority revisited the penalty determination and increased it to a 10 percent salary reduction for six months. Yet, 593 days later, the hiring authority had failed to serve the disciplinary action on the employee.

In a Sonoma Developmental Center case, the hiring authority on January 3, 2017, sustained allegations that a psychiatric technician failed to adequately maintain enhanced supervision of a resident, which resulted in the resident escaping the facility. The hiring authority imposed a 5 percent salary reduction for 12 months. At year end 2017, the disciplinary action had been pending service for 362 days.

The three cases mentioned above are serious, and delays of service of the

disciplinary actions of 468, 593, and 362 days are simply unacceptable. One of the principles of effective discipline is that discipline should be imposed in a relatively timely manner; otherwise, its effectiveness is diminished. Additionally, employees often appeal disciplinary cases and evidence and witness memories become stale or unavailable with the passage of time.

The OLES will continue to monitor and report on the departments' efforts to process disciplinary actions in a timely manner.

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 last six months of 2017 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/actions completed*	Adverse action taken (Formal investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/ retired pending adverse action****
DSH-Atascadero	20	3	17	0	0
DSH-Coalinga	70	10	37	23	2
DSH-Metropolitan	60	7	50	3	0
DSH-Napa	29	7	22	0	1
DSH-Patton	58	0	55	3	0
Totals	237	27	181	29	3

* Administrative investigations completed includes all formal investigations and direct actions that resulted in or could have resulted in an adverse action. These numbers do not include background investigations, Equal Employment Opportunity investigations or progressive discipline of minor misconduct that did not result in an adverse action against an employee.

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

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

**** Resigned or retired pending adverse action refers to employees who resigned or retired prior to being served with an adverse action. Note that DSH does not report these instances as completed formal investigations.

DDS Mandated Data – Adverse Actions Against Employees

DDS Facilities	Administrative investigations completed*	Adverse action taken**	No adverse action taken***	Resigned/retired pending adverse action****
Fairview	12	1	10	2
Porterville	10	0	5	5
Sonoma	2	1	0	2
Canyon Springs	10	2	8	0
Totals	34	4	23	9

* Administrative investigations completed includes all formal investigations and direct actions that resulted in or could have resulted in an adverse action. These numbers do not include background investigations, Equal Employment Opportunity investigations or progressive discipline of minor misconduct that did not result in an adverse action against an employee.

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

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

**** Resigned or retired pending adverse action refers to employees who resigned or retired prior to being served with an adverse action. Note that 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	7	1	6	0
DSH-Coalinga	0	0	0	0
DSH-Metropolitan	7	1	6	1
DSH-Napa	0	0	0	0
DSH-Patton	29	14	15	12
Totals	43	16	27	13

* 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 by 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.

DDS Mandated Data – Criminal Cases Against Employees*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Fairview	0	0	0	0
Porterville	3	1	2	0
Sonoma	0	0	0	0
Canyon Springs	22	0	22	0
Totals	25	1	24	0

* 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 by 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 Criminal Cases*

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
DSH-Atascadero	297	181	116	138
DSH-Coalinga	349	157	192	33
DSH-Metropolitan	364	60	304	12

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
DSH-Napa	224	12	212	2
DSH-Patton	219	94	125	73
Totals	1,453	504	949	258

* Patient criminal cases include criminal investigations involving patients. Numbers are for investigations that were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

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

*** 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 by prosecuting agencies.

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

DDS Mandated Data – Resident Criminal Cases*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not Referred***	Rejected by prosecuting agencies****
Fairview	1	0	1	0
Porterville	21	12	8	1
Sonoma	0	0	0	0
Canyon Springs	0	0	0	0
Totals	22	12	9	1

* Resident criminal cases include criminal investigations involving residents. Numbers are for investigations that were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

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

*** 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 by prosecuting agencies.

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

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

DSH Facilities	Registered Nursing	Vocational Nursing	Medical Board	Public Health
DSH-Atascadero	0	2	0	0
DSH-Coalinga	0	0	0	0
DSH-Metropolitan	0	1	0	0
DSH-Napa	1	1	0	0
DSH-Patton	0	0	0	0
Totals	1	4	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	0	0	0	0	16
Porterville	0	2	0	0	2
Sonoma	0	0	0	0	0
Canyon Springs	0	0	0	0	0
Totals	0	2	0	0	18

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

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, 2017, through December 31, 2017, the departments resolved two monitored issues. One was at DSH and one was at DDS. The departments were assessed by the OLES as "sufficient" in how they addressed the matters. Both completed monitored issues are in Appendix E. New monitored issues and updates on long-running monitored issues are provided below. All are at DSH.

New monitored issues

1. Duty to cooperate at DSH

In the course of monitoring investigations, the OLES identified the issue of DSH employees refusing to cooperate with investigators. Public employees have a duty to cooperate with their employer's investigations into misconduct. While employees who are suspects in a criminal investigation have a constitutional right to remain silent, this right does not extend to subjects of administrative investigations or to witnesses in either administrative or criminal investigations. Employees who refuse to cooperate can and should be disciplined for insubordination.

Investigators at DSH should be serving employees with formal notices advising them of their duty to attend and cooperate with investigatory interviews. The OLES has discovered that there is no statewide, written policy concerning the service of notices for interviews. Some investigators simply call or email the employee; others serve a formal notice. The notices, when they are used, are different at every facility. The practice is not even consistent within each facility. For example, at DSH-Napa, the practice of serving notices to employees for interviews varies from investigator to investigator. The OLES recommends DSH develop a statewide, written policy mandating the use of formal interview notices with standardized language. The OLES further recommends that the executive directors at each DSH facility issue a memorandum to all employees reminding them that they have a duty to cooperate with investigations and that failure to do so will be deemed insubordination resulting in disciplinary action.

Another concern regarding employee cooperation with investigations was discovered at DSH-Patton where the OLES learned there is a divide between the Office of Protective Services, which conducts investigations at the facility, and the medical staff. This is especially apparent with doctors, and it negatively affects the investigators' ability to conduct thorough investigations. Investigators have complained that often times, doctors will not return their emails or phone

calls and will not present for an interview. In one case, when asked a question by an investigator about a patient's condition, the doctor told the investigator to "read the chart" and walked away. The OLES recommends that the executive director work on improving relationships by providing training to medical staff on the investigative process and the purpose and importance of investigations. There should be an understanding between the facility law enforcement and the medical staff so they can all carry out their responsibilities without undue interference.

2. Lack of patient separation policy at DSH

In the course of an investigation during the July through December 2017 reporting period, the OLES discovered a lack of specific, written policy at DSH-Metropolitan governing the relocation and separation of patients after they have been in a physical altercation. In the specific case, one patient committed a battery on another patient. Both resided in the same unit as roommates at the facility and continued to do so after the fight, which resulted in a second assault the next day. During the second assault, the aggressor patient choked the victim patient to the point of unconsciousness.

The DSH does not have a written, statewide policy to prevent these repeat incidents. The DSH-Metropolitan staff handles the separation of patients who are housed on the same unit and have been involved in an altercation as a clinical decision and on a case-by-case basis, not as a prescriptive in a written policy. This lack of specific policy directive, however, puts patient safety at risk. The best practice is to have a written policy that provides a clear protocol and procedure to separate patients, especially those housed on the same unit as roommates, after they are involved in a physical altercation.

The existing practice of giving the clinical treatment team the discretion to decide whether to move and/or to separate patients involved in altercations puts patients at risk of harm and unnecessary victimization. The OLES recommends DSH develop statewide, written policy and procedures regarding separation of patients who are involved in altercations.

3. Deficiencies in Use of Force reporting at DSH

An OLES analysis of 12 incidents involving the use of force on DSH patients by department police officers or other DSH staff found that departmental law enforcement investigation reports for all 12 incidents lacked critical information and indicated a lack of thorough supervisory and management review. The 12 incidents occurred between June 2016 and March 2017, and the OLES was notified, as required by statute, because the incidents involved head injuries, broken bones or other significant issues.

Well-prepared police reports on use-of-force incidents are not only required by DSH law enforcement policy but become essential evidence should officers be

accused of excessive force. DSH Policy 300.5 entitled "Reporting the Use of Force" states, in relevant part,

> "Any use of force by an employee of OPS (the DSH Office of Protective Services) shall be documented promptly, completely and accurately in an appropriate report, depending on the nature of the incident. The officer should articulate the factors perceived and why he/she believed the use of force was reasonable under the circumstances. To collect data for purposes of training, resource allocation, analysis and related purposes, OPS may require the completion of additional report forms, as specified in OPS policy, procedure or law."

However, the OLES analysis of the 12 investigatory reports found that all exhibited deficiencies in documentation. These deficiencies included officers failing to interview or identify all relevant witnesses, failing to obtain reports from all participants in the incident and failing to describe the circumstances leading to the officers' use of force. Most reports provided insufficient detail as to officers' actions before, during and after the incidents. There also were incidents involving allegations of excessive force that were not sufficiently investigated and not included in the required executive reviews. The frequency and pervasiveness of these reporting deficiencies indicate there is inadequate supervisory review. Yet, Section 4 of DSH Policy 300.5 requires the review of certain use-of-force incidents by an Executive Committee at the hospitals where the incidents occurred:

> "All of the following types of incidents shall be reported to, and reviewed by, an Executive Committee consisting of a cross-section of disciplines, as well as DSH Legal:
> - All use of force incidents which result in serious bodily injury
> - All interventions involving the use of OC (Oleoresin Capsicum) spray, police baton, carotid hold, excessive force or deadly force."

Additionally, Section 4 of DSH Policy 300.5 provides:

> "The CLE (Chief of Law Enforcement Support at DSH headquarters) will conduct an independent review of all Executive Committee Reviews (ECRs) to examine DSH policy compliance, ensure that a thorough investigation and management review occurred and follow up on issues that may impact DSH. To facilitate this review, all incident reports, including a written summary of the Executive Committee findings, will be forwarded to the CLE within 30 working days of the date of occurrence."

Of the 12 incidents the OLES reviewed, 10 were eligible, but only seven went to an ECR. An analysis of the dates for the seven incidents show six had significant delays in meeting the 30-day deadline for submission to the CLE as required by policy. Delays ranged from 53 days to 328 days for an average delay of 144 days beyond the 30-working-day policy directive. Three other incidents in the analysis appeared to qualify for the ECR process, but there is no evidence this occurred.

While the OLES's analysis of the 12 incidents cannot conclude that employee misconduct occurred, the OLES is aware that reporting deficiencies would make detection and investigation of potential misconduct difficult. The cases that the OLES reviewed revealed systemic issues directly affecting the quality of use-of-force reports and a need for greater attentiveness in reviewing reports at multiple supervisory levels within DSH. Applicable departmental policy places the ultimate responsibility for ensuring the accuracy and completeness of such reports with the hospital police chief at each DSH facility. DSH Policy 300.5.2 states:

> "The Hospital Police Chief is responsible for ensuring that documentation and the resulting investigation are strictly scrutinized for purposes of accuracy and completeness, to include a description of the attendant circumstances, review of witness statements and recordation of evidence."

The hospital police chiefs rely on the chain of command of officers to ensure that each use-of-force incident is "strictly scrutinized." However, the use-of-force reporting and review process at all DSH facilities leaves out lieutenants, meaning hospital police chiefs depend on sergeants, who rank below lieutenants, to get the job done.

The OLES recommends DSH improve its use-of-force review process in these ways:

1. Executive reviews for all use-of-force incidents. Rather than limiting ECRs to use-of-force incidents that result in serious bodily injury, or interventions involving OC spray, police baton, carotid hold, excessive force or deadly force, the OLES recommends the policy be expanded to all use-of-force incidents, regardless of whether a patient sustains serious injury. All parties should be made aware of any allegations of excessive force and the status of the investigation, so all allegations can be addressed during the executive review. DSH law enforcement also should ensure that facility executive directors are aware of any OLES investigations of use-of-force incidents pending executive review.
2. Limit ECR attendance to reviewers. The ECRs allow staff and officers who were directly involved in an incident, or who may have used or witnessed force being used on a patient, to participate in deliberations about staff and officers' compliance with use-of-force policy. OLES recommends the ECRs rely solely upon written documentation of each incident and exclude from participation staff or officers directly involved in the incident, whether they used force or witnessed force being used.
3. Ensure DSH legal staff representation at ECRs. The OLES recommends that DSH legal staff participate in legal reviews of all use-of-force ECRs. The DSH legal representative should be given clear instructions on his/her role and function as a member of the executive committee.
4. Require supervisor supplemental report. DSH policy 300.7 provides that sworn supervisors are to perform specific actions when they are "able to respond to an incident in which there has been a reported application of force," and ". . . in the event that a supervisor is unable to respond to the scene of an

incident involving the reported application of force, the supervisor is still expected to complete as many of the above items as circumstances permit." These specific actions include identifying any witnesses not already included in related reports and, when possible, separately obtaining a recorded interview with the patient upon whom force was applied. The OLES recommends that this policy be amended to require the sworn supervisor to complete a supplemental report detailing the actions he/she performed in compliance with this policy, or the reason such actions were unnecessary.

5. Set review timeline. The OLES recommends that DSH establish a timeframe for supervisors to complete their use-of-force reviews.
6. Provide written guidance on what constitutes thorough reports. The OLES recommends that DSH delineate the minimum information required to complete a thorough incident report, supplemental report and investigation.
7. Strengthen the Documentation of Quality Control and Report Supervision. Sworn supervisors who identify a report requiring correction should ensure they "reject the report through the computerized Records Management System (RMS), with notes stating the reasons for rejection" (DSH policy 322.4). The OLES found that supervisors did not provide specific reasons for rejecting reports. For example, some notes stated simply "incomplete incident report," "reviewed report requires correction," "have officers make corrections and return," or "as per our conversation, please make corrections and return." The OLES recommends this policy be amended to require supervisors to clearly identify the specific reasons for rejecting a report and to document their notes in RMS so the information is accessible to others who may be assigned to conduct a followup investigation.
8. Witnesses and Participants Should Provide Independent Reports. DSH policy 321.1 states, "It is the responsibility of the assigned employee to complete and submit all reports taken during the shift before going off duty unless permission to hold the report has been approved by a supervisor." The OLES recommends the policy be amended to require that supervisors assume responsibility for ensuring that every sworn officer identified as a participant or witness to a use-of-force incident, or who has conducted an interview with a person involved in an incident, has submitted required reports before the end of his/her shift. DSH should require all staff who use or witness force to write their own independent reports. The practice of allowing staff members to interview other staff who witnessed or used force and write reports for them should be prohibited.
9. All Patients Subjected to Use-of-Force Should Receive Medical Assessment. According to DSH policy 300.6, "Medical assistance shall be obtained for any patient who exhibits signs of physical distress, who has sustained a visible injury, expresses a complaint of injury or continuing pain, or who was rendered unconscious." A patient subjected to any use of force should be offered an assessment by a medical provider trained to make medical determinations, rather than allowing sworn staff to make this determination. The OLES recommends the policy be changed to require that patients receive a medical assessment when they are subjected to any use of force, regardless

of whether the force was used by sworn or non-sworn staff.

10. Supervisors Should Be More Alert to Delays in Case Progress. Law enforcement supervisors must ensure that those assigned to a case for initial or followup investigation "investigate crimes thoroughly and with due diligence, and evaluate and prepare criminal cases for appropriate clearance or submission to a prosecutor" according to DSH Policy 600. The OLES recommends the policy be amended to require sworn supervisors to utilize the features and programmed capabilities of RMS to monitor case activity, inquire about prolonged periods of case inactivity and ensure investigations are not delayed without proper cause.
11. Identify All Participants and Potential Witnesses in Use-of-Force Incidents. Officers assigned to complete incident reports are required by DSH Policy 322 to "accurately reflect the identity of the persons involved, all pertinent information seen, heard, or assimilated by any other sense, and any actions taken," but frequently report they are unsuccessful in identifying or locating non-sworn participants and witnesses to incidents. This lack of access may prevent officers from obtaining required information. Non-sworn shift leads and supervisors must assume a greater role in incidents occurring in their area of supervision. The OLES recommends non-sworn shift leads and supervisors be required to assist sworn staff during incidents by providing names of participants and witnesses, including providing duty rosters for the date and time of the incident. Furthermore, we recommend non-sworn shift leads and supervisors be required to ensure their staff complete reports by the end of the shift for incidents in which they witnessed or used force unless doing so would compromise patient/client care.
12. Ensure that Report Revisions Cannot Be Made Without Supervisory Notification. DSH policy 322.5 regarding changes to reports provides that incident or supplemental reports which "have not yet been submitted to Records may be corrected or modified by the authoring employee only with the knowledge and authorization of the reviewing supervisor." However, the present RMS system permits revisions to an incident or supplemental report to be made without supervisory knowledge or authorization, potentially compromising the integrity of investigations. The OLES recommends that programming changes to RMS be made to ensure initial incident or supplemental reports as submitted to a supervisor are treated as originals, and that an accurate and unalterable submission date be recorded. Further, RMS should require an officer to submit a supplemental report when an officer needs to provide additional information or provide clarification to their original report, all with proper date-stamped submission dates.
13. Establish a Manager-Level Review of All Reports. The OLES recommends that DSH formalize a policy requiring a final manager-level review of every use of force incident before it is submitted to the hospital Chief of Police. This ensures every member of the chain of command is involved in use of force reporting and review i.e., officer, sergeant, lieutenant and chief. This reviewing manager should utilize the RMS system to record their concerns, document needed followup procedures and approve the overall incident report within a

prescribed timeframe. This will assist the facility law enforcement chief in his or her requirement to "strictly scrutinize for purposes of accuracy and completeness" all use of force incidents as required by DSH Policy 300.5.2.

Update on monitored issues

1. Physician Review Panel

The OLES discussed with DSH in May 2016 the need for medical and psychological expert witnesses for consultation in investigations of serious allegations against medical and/or psychological standards of care. The OLES recommended the creation of a three-member panel of subject matter experts that would meet monthly to provide an objective medical opinion for these DSH issues. The OLES further proposed the panel 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.

Over the last year, DSH clinicians have participated in several cases brought forward by the OLES chief, chief of DSH OPS and facility hiring authorities. DSH indicated this participation provided valuable experience and information that helped department clinicians fine-tune their consultative process and policy development. The DSH reported a draft policy was in the formal policy approval stage. Upon finalization, the policy will establish a process by which clinical consultation will be provided by DSH to its in-house law enforcement as well as the OLES.

Both the intake, which is a consultation that is available prior to initiation of a local, specific hospital investigation, and an informal consultation, which occurs during an open local investigation, will be routed to the DSH medical director or designee, who will provide assistance to the OLES monitor and assigned department law enforcement investigator. If a formal consultation is requested, it will be assigned by the DSH medical director or designee to subject matter experts. These experts are either a single consultant or a three-member panel of medical directors or their designees. Should an investigation require a specialized field of medicine, panel members will have the authority to select proxy members to fill their position on the panel, provided those members are senior-level clinicians or have specialized knowledge in the area being reviewed as approved by the DSH medical director. Consultation with experts can be requested in three circumstances: 1. Where a local conflict of interest is operative (e.g. when an administrative clinician is the subject of the investigation); 2. To address an appeal of clinically related conclusions made in an investigation. (These requests must come from a hiring authority or designee.), or 3. Any case selected by the DSH medical director, OLES chief, or DSH head of

law enforcement.

The consultant or the panel will review, discuss and offer a written, professional opinion regarding the standards of clinical care identified in the investigation. As with the informal consultations, the consultant and the assigned panel members for a formal consultation shall not be assigned to the facility where the investigation is taking place, and if a designee is appointed, he or she shall be a senior-level clinician or have specialized knowledge in the area being reviewed. The expert consultant(s) may consult with the OLES chief or head of DSH law enforcement and may meet with the investigators and OLES staff monitors as needed.

On December 5, 2017, DSH submitted Policy Directive 3104, entitled "DSH Investigation Support: Clinical Subject Matter Expert Panel and Clinician Consultation" to the OLES. Depending on the nature and complexity of the investigation, the DSH medical directors council will provide intake, formal or informal consultation to DSH facility law enforcement and/or the OLES upon request as outlined above. This policy will support the OLES in the monitoring and investigation of hospital-based incidents pursuant to the OLES' statutorily defined responsibilities outlined in Welfare & Institutions Code section 4023.7.

As of December 31, 2017, DDS did not have a similar policy. However, DDS agreed to evaluate the DSH policy in an effort to adopt a similar policy to meet the specific needs of DDS.

2. Personal Electronic devices at work

In the previous semi-annual report covering January through June 2017, the OLES recommended that DSH draft and implement a statewide policy prohibiting DSH staff from having and using personal electronic devices at their workstations and while screening staff and visitors. These devices can distract staff, thereby compromising the care of residents, and can violate patient privacy or fall into the hands of patients.

In response to the OLES recommendation, DSH formed a workgroup comprised of executive directors of the department facilities. They developed a draft policy on the use of cell phones at the facilities. The draft policy was sent to various leadership committees for review and input. The draft policy was provided to the OLES to evaluate and provide input before DSH finalizes and implements the policy.

The draft policy prohibits the possession of personal cell phones only at DSH-Coalinga and DSH-Atascadero. Staff at DSH-Napa, DSH-Patton and DSH-Metropolitan would still be allowed to possess and use their personal cell phones within the secured patient treatment areas while on work breaks. The department advised that these three hospitals are exceptions because they are considered open campuses where the secured patient treatment areas are a

great distance away from the unsecured areas. This means that the staff would not have time to reach the unsecured areas to use their personal phones during breaks.

The OLES still recommends best practice, which is to prohibit personal cell phones from secure treatment areas. However, the OLES recognizes the department's concerns for its staff being able to communicate with family members and attend to personal business while on breaks. As a compromise, the department agreed to add to its policy a prohibition against cell phone possession while working at certain posts such as while monitoring a patient on a one-to one basis or while monitoring patient visits. The department also agreed to add a provision in the policy requiring staff to turn off WiFi and hot spot capabilities on their phones while on facility grounds. As of December 31, 2017, the policy was still in draft stage, and the department had agreed to provide the proposed final draft to the OLES for review and input before it is implemented.

3. DSH patient pregnancies

In the previous semi-annual report covering January through June 2017, the OLES made several recommendations to DSH with the goal of minimizing patient pregnancies. The OLES also made a recommendation on how best to handle patients who become pregnant while residing in a state hospital or if they are pregnant when they are admitted to a DSH facility.

The DSH maintains that some hospitals have a need for co-ed units in order to best provide patients with real-life experiences needed to improve their skill development in preparation for discharge to community settings. Additionally, DSH maintains that it provides some specialized services on co-ed units as there is not sufficient bed capacity in the system to maintain gender specific units for these services (e.g. Skilled Nursing, Gero-psychiatric, Dialectical Behavioral Therapy). The DSH-Patton and DSH-Napa are the current facilities that provide co-ed living units. However, in an effort to make co-ed units safe, the DSH drafted a policy titled "Patient Sexuality" that spells out what must be considered when determining patient placement in co-ed living quarters at DSH facilities.

For example, the new, draft policy states patients will be excluded from a co-ed unit if they are registered sex offenders, have a history of sexual offenses or have demonstrated behaviors inconsistent with community standards. They also will be excluded if they are females of child-bearing age with a history of becoming pregnant while in psychiatric facilities and are not amenable to taking birth control. Additional factors that may exclude a patient from a co-ed unit include a history of sexual victimization and a known lack of capacity to consent to sexual contact. So long as these factors are consistently applied, the OLES is optimistic that harmful sexual activity can be minimized.

The second draft policy titled "Child Placement" allows the pregnant patient to decide where and with whom her infant will be placed after birth. Before this

occurs, however, the OLES recommends if the patient lacks capacity, the department should take appropriate steps with a clinical social worker to safeguard the child's well-being. The OLES also recommends that the patient be provided with sufficient information on all of the resources and options available to her.

The OLES is optimistic that these issues will be addressed before the draft policy is finalized in 2018.

4. Staff Return to Patient Care Without Facility Law Enforcement Consultation

As reported in the previous OLES semi-annual report for January 1, 2017, through June 30, 2017, the OLES identified a systemic issue involving DSH employees who were accused of physical or sexual abuse of patients or patient neglect being allowed back to patient care before investigations into the allegations were completed. Specifically, at DSH-Metropolitan in Norwalk, the DSH policy allowed clinical staff to decide whether an employee who was accused of abuse by a patient could be reinstated to a patient-care position without consultation with facility law enforcement and before facility law enforcement completed an investigation of the abuse allegation. Best practice in law enforcement is to keep alleged perpetrators and alleged victims separate through the completion of the investigation if there is a reasonable belief that a crime was committed.

The OLES discussed with DSH management that consultation between clinical staff and the Office of Special Investigations (OSI) at each DSH facility is critical for the protection of DSH patients. The OLES further pointed out that DSH policy allowing staff to return to patient care was not consistent among the DSH facilities.

The DSH developed a draft policy to address the OLES concerns. The policy requires each DSH facility to take immediate and appropriate action to protect patients, including removing suspected perpetrators from direct contact with patients pending the outcome of investigations. If the allegations appear to be physically impossible or lack credibility, then the draft policy allows for the DSH program director to refer a case for administrative review by the executive director.

Meantime, clinical staff shall complete a standardized "allegation checklist" whenever allegations of patient abuse and/or neglect are made. The checklist will determine the appropriate placement for staff members who are accused. This placement of accused employees may precede or be concurrent with the start of an OSI investigation, and OSI will receive a copy of the checklist as notification of where the accused staff members are put to work in the facility. As the investigation proceeds, the facility management or designee shall contact OSI to discuss the status of the investigation on an ongoing basis and review the placement of accused staff members until the investigation is completed.

The DSH said this statewide policy, once finalized in 2018, will be incorporated into the administrative directives at all five DSH facilities. The OLES will monitor the implementation and efficacy of the policy.

5. Recording of DSH investigatory interviews

In the previous report covering January through June 2017, the OLES discussed DSH's inconsistent use of portable audio/video recording devices for investigatory interviews. The OLES observed that police officers at DSH facilities were not regularly recording their investigatory interviews. The OLES recommended that the department draft and implement policy requiring mandatory recording of investigatory interviews by officers, as the benefits certainly outweigh any potential burden of recording the interviews.

The recording of interviews protects staff against allegations that a patient was coerced or tricked into recanting serious allegations, especially in sexual assault cases or cases alleging misconduct by department employees. It also provides safeguards against diminishing memories of patients, helps officers write accurate reports, removes reliance upon written notes which may get lost or destroyed and provides a means for preserving evidence. For court purposes, recorded interviews provide availability of transcripts and accuracy and can be a tool for the impeachment of witnesses. Recordings also can give parties in court access to statements of a witness who may have become unavailable at the time of a trial.

The OLES indicated an exception to recorded interviews should be made in cases where the recording would make a patient anxious or uncomfortable or cause him or her to refuse to be interviewed. In these cases, the OLES recommended that policy require officers to document in their reports why they didn't make a recording.

As of year end 2017, DSH had drafted a policy requiring the recording of most interviews statewide. It had also purchased and deployed a recording system for its law enforcement personnel. Training was scheduled for early 2018 with deployment to follow shortly after. The OLES will continue to report on DSH's progress in implementing this policy.

6. DSH extraction policy, training

In the previous semi-annual report, covering January through June 2017, the OLES identified a systemic issue concerning room and area extractions of patients. At times, it is necessary to remove a patient from his/her room when the patient is uncooperative and where there is a potential of self-harm or harm to others. Best practice in law enforcement crisis intervention calls for staff to de-escalate situations involving the mentally ill and seek alternatives to force, if possible. However, when it is necessary to remove a patient from a room/area, facility law enforcement must have guidelines to assist in determining when a

situation calls for an immediate, exigent response or if a more planned, calculated intervention is the better option. The OLES discovered that DSH law enforcement may not be evaluating the circumstances of events to determine if exigency exists or if calculated intervention would be a better and a safer option to remove a patient from an area. While the DSH has a Use of Force policy that defines calculated interventions as "instances where time and circumstances permit a planned response to a pending or current conflict scenario involving a patient," there was no policy or procedure outlining how DSH officers are to conduct a calculated intervention. Therefore, the OLES recommended that DSH develop a draft policy on room and area extractions as well as a mandatory training program.

In December 2017, DSH provided the OLES with a draft policy and proposed training plan. Overall, the policy and training plan are comprehensive and address most OLES concerns. The policy ensures that all extractions are videotaped and documented. However, there were some remaining issues that the OLES discussed with DSH including ensuring the policy applied to all areas of each facility, ensuring staff are trained to remove themselves from the area if they were involved in the precipitating events and providing staff training on report writing. As of December 31, 2017, DSH was making the recommended changes and was to present the draft policy and training program again to the OLES before it is finalized and implemented. The OLES will continue to monitor and report in subsequent semi-annual reports on DSH's progress.

OLES Recommendations

As required by statute,[13] the OLES in March 2015 provided the Legislature with a report that described the challenges faced by DSH and DDS law enforcement and the OLES recommendations. Additionally, in the OLES reports to the Legislature released October 1, 2016, and March 1, 2017, the OLES updated the recommendations for best practices in law enforcement and employee discipline that the OLES made to the departments. Below are the 22 unfinished recommendations –14 at DSH and eight at DDS –and their December 31, 2017, status as provided verbatim by DSH and DDS.

DSH law enforcement organizational structure

OLES Recommendation of best Practice	Status as of June 30, 2017	Status as of December 31, 2017
A Legislation should be drafted and enacted to consolidate all DSH law enforcement under the department's chief of law enforcement. This would upgrade the chief from consultant to supervising manager, speed up standardization and centralize the fragmented law enforcement authority at DSH.	Not yet implemented. Legislation has not been enacted to effect this change. DSH 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.	Not yet implemented. Legislation has not been enacted to effect this change. DSH 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.

DSH law enforcement policies and procedures

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
B By December 1, 2016, DSH should decide on one	In process. DSH approved the use of the Rapid Containment	Implemented. The Rapid Containment Baton is issued to all new officers

[13] Penal Code Section 830.38(c) and Welfare and Institutions Code Section 4023.5(a).

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
police baton statewide, excluding specialized and tactical police teams, and begin to phase out the other baton. Standardized tools reduce on-the-job confusion about which tools to use and when to use them and reduces complexity of training.	Baton. It is fully implemented at Patton, Metropolitan and Coalinga for current officers and at the DSH law enforcement academy for newly hired police officers. Hospitals at Atascadero and Napa will phase out all other batons in conjunction with retraining their officers. Full implementation is expected by June 30, 2019.	and is continuing to be phased out by DSH-Atascadero and DSH-Napa. DSH is on track to complete the phase out of other batons by June 30, 2019.
C DSH should ensure that all equipment needed for law enforcement personnel is available to staff so they can follow policy/ procedure that calls for the use of the equipment.	In process. A workgroup has been formed to select and implement a recording program for DSH. Implementation is anticipated in October 2017.	In progress. OPS purchased audio recording equipment and it has been deployed at the facilities. Training and full implementation is anticipated by January 30, 2018. The project was delayed by technical and contractual challenges.

DSH standardized training

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
D By December 31, 2016, DSH should compile and submit to the OLES standardized lesson plans for continued professional training of law enforcement personnel. Standardized lesson plans help ensure consistency in ongoing training of DSH law	Not yet implemented. Once the Envisage Training software is fully deployed at the DSH law enforcement academy on September 1, 2017, law enforcement will begin working on standardizing the	In progress. DSH fully implemented the academy portion of the software and is finalizing the field training section. The final section is the Continuing Professional Training portion. DSH anticipates full implementation by

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
enforcement personnel at all facilities statewide.	lesson plans for continued professional training.	May 1, 2018.
E 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. The specialized environment at DSH facilities necessitates ongoing professional development training.	In progress. 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 the next academy in 2017. DSH will also provide this training to its existing law enforcement personnel by December 31, 2017.	Implemented. The Critical Incident Training program has been developed and implemented. DSH has provided two separate sessions of this program to existing law enforcement personnel at all facilities. Additional sessions are scheduled in 2018 to continue the training of all law enforcement staff with completion anticipated by July 1, 2018.

Implementation of Mental Health Training

OLES comment: In its previous semi-annual reports, the OLES recommended DSH develop comprehensive training for law enforcement officers who interact with DSH patients who have significant mental illnesses. The OLES recommended the training include mental health topics, with mental health professionals as the trainers. On June 30, 2017, DSH presented the OLES with an outline for mental health training entitled "Crisis Intervention Team (CIT)." This 24-hour course for new and long-term law enforcement personnel includes training topics such as mental illness symptoms, interventions, body language, impulse control, patient's rights and building patient rapport. Mental health professionals will teach the training. The training will help law enforcement personnel understand the dynamics of mental illness and cognitive impairment effects on behavior.

Obtaining Credible Recantations

OLES comment: The CIT training is a strong and positive step forward to provide law enforcement personnel with the necessary tools and specialized skills to work successfully with the patient population. The OLES additionally recommended in previous semi-annual reports that DSH create procedures and add a training section on best practice interviewing techniques for mentally ill patients with special attention to the area of allegation recantations. The OLES recommended DSH law enforcement establish forensic interviewing protocols to ensure that patient recantations are credible and reliable. The DSH has since gathered forensic interview materials which are being developed into an online training course that all

law enforcement personnel will be required to take. The OLES commends DSH for its efforts in creating the training course.

DSH standardized training (cont'd)

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
F 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. Consistent training and evaluation in the field after initial new-hire training, ensures that initial standardized training is retained and reinforced.	In progress. 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.	Implemented. This was completed and implemented on December 1, 2017. The Field Training Officer manual and all appropriate forms were deployed to the facilities and are in use.
G 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. The specialized environment at DSH facilities necessitates regular professional development training on this topic.	In process. See Item E on training on mental health topics.	Implemented. See Item E (above) on training on mental health topics
H DSH should centralize law enforcement training records at the department	Partially implemented. DSH is manually tracking information via spreadsheets pending	In progress. See Item D (above). DSH anticipates full implementation by May 1, 2018.

level. Centralized training data can be tracked and analyzed across the department and allows for department-wide budgeting for training.	implementation of a more robust solution. DSH will be implementing the Envisage software to centralize all DSH law enforcement training data. DSH anticipates full implementation by October 2017.	

DSH standardized assessments of investigations

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
I 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. This provides consistent, fair and reasoned assessment of the quality of investigations and strives to equalize how results of investigations are handled across all state facilities.	In process. In conjunction with the development of the Objective Discipline tool discussed in OLES recommendation N (below), DSH has developed Policy Directive 5315, Objective Discipline Process, which incorporates a procedure for the hiring authority to assess investigation reports. DSH presented the draft policy directive to the OLES on May 15, 2017. On June 15, 2017, the OLES provided feedback to the policy directive. DSH will present a revised version to the OLES with expected completion by December 31, 2017.	In progress. DSH has developed an objective discipline tool and process as noted via Policy Directive 5315. DSH's executive team approved the policy directive in June 2017, noticed the unions on October 30, 2017, and held meet and confers with various unions in November 2017. This policy directive is expected to be implemented by February 28, 2018.

DSH standardized discipline process

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
J 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. This helps provide formalized, consistent and fair imposition of discipline penalties across all state facilities.	In progress. DSH established a workgroup that developed an Objective Discipline tool. DSH presented the draft tool to the OLES on May 14, 2017. The OLES provided feedback to the tool. The DSH workgroup will reconvene to incorporate the requested updates and will present a revised tool to the OLES. Expected completion by December 31, 2017.	In progress. Policy Directive 5315 was approved by the DSH executive team in June 2017. DSH noticed the unions on October 30, 2017, and held meet and confers with various unions in November 2017. This policy directive is expected to be implemented by February 28, 2018
K 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. This helps improve quality of investigations so they can serve as a solid foundation for potential legal proceedings.	Not yet implemented. 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.	Alternate process implemented. Due to limited DSH Legal Services Division resources and competing legal priorities, DSH does not have the resources to fully implement this recommendation. Instead, DSH evaluates each OLES case to identify high-profile and/or complex cases and will assign attorneys to these cases during the investigation phase as needed. Additionally, DSH attorneys are now assigned to all OLES cases when adverse actions are drafted and provides legal counsel in all aspects of the adverse

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
		action for disciplinary determinations. This includes providing legal advice throughout the disciplinary process on critical matters such as supporting documents for the action, evaluating evidence, appropriateness of penalties.

DSH standardized discipline tracking

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
L DSH should implement department-wide policy and procedures for collecting, organizing, centralizing and keeping consistent records of all employee misconduct reports. This ensures consistent and centralized data collection and record-keeping department-wide.	In process. DSH has developed and approved Policy Directive 5316 – Discipline Record Keeping and it will be implemented in concert with the Objective Discipline Tool by December 31, 2017.	In progress. Policy Directive 5316 was approved by the executive team on June 15, 2017. The PD will be finalized and released at the same time as Policy Directive 5315. Therefore, it is expected that this policy directive will be completed by January 31, 2018.
M DSH should develop a centralized discipline tracking computer system similar to CDCR's to provide secure, efficient, real-time access to ongoing discipline cases and tracks delays and outcomes so they can be analyzed.	Not implemented. At this time, DSH is continuing to explore technological options to address this recommendation. In the meantime, DSH has created procedures to address the tracking of disciplinary actions and they have been implemented.	Not implemented. DSH continues to explore technological options. In the meantime, DSH is tracking disciplinary actions via the processes identified via Policy Directive 5316.
N DSH should establish department-wide policy and procedures for	In process. DSH drafted Policy Directive 5316 that was presented to DSH executives on	In progress. See Recommendation L (above) for additional information.

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
documenting and recording its analysis of trends and patterns of all DSH employee misconduct. This ensures that centralized data collection and records are used as a management tool to identify and address patterns and trends of employee misconduct.	June 15, 2017. After review by the OLES, this policy directive is expected to be completed by December 15, 2017.	

DDS standardized investigation reports

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
A DDS should implement standardized investigation report formats in calendar 2016 to help ensure consistency in reports and investigation facts and in how the facts are presented.	DDS law enforcement has developed draft standardized formats that are in final review. Once finalized by August 2017, they will be routed to the OLES for review/input. Once approved, they will be implemented immediately.	The Records Management System (RMS) is now implemented. Draft formats for criminal and administrative investigations have been completed.

DDS standardized assessments of investigations

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
B By December 1, 2016, 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. This provides formalized, consistent, fair and reasoned assessment of the	Policy was drafted and circulated; should be issued by August 2017	DDS consulted with the OLES regarding the policy in December 2017. The expected release date is January 2018.

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
quality of investigations and strives to equalize how results of investigations are handled across all state facilities.		

DDS law enforcement recruitment

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
C DDS should update and upgrade its law enforcement recruitment materials to improve the department's image with applicants and draw more interest, potentially attracting more law enforcement hires.	In June 2017, DDS law enforcement entered into a contract with a graphic designer to design and brand recruitment materials including rack cards, banners, poster boards and table aprons. DDS law enforcement is currently collecting photographs from the various facilities to use in the flyers and other materials.	DDS/OPS has a service order with a graphic artist firm to design recruitment flyers.

DDS standardized training

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
D 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. A standardized curriculum helps ensure standardized training.	DDS developed a crisis intervention behavioral health training course that was submitted to the California Commission on Peace Officers Standards and Training (POST) in 2016 and certified by POST in March 2017. The course will be taught by law enforcement managers and DDS mental health professionals. All law	DDS is reviewing the DSH CIT program to see what, if any, components might be adapted into the DDS POST-approved training.

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
	enforcement employees will complete the training by fall of 2017, and DDS will open the course for attendance by local law enforcement.	

Mental Health Training

OLES comment: Every day, DDS law enforcement officers interact with residents who have significant cognitive impairments. This unique population presents extra challenges for law enforcement personnel as they are called upon to investigate allegations of resident abuse. Residents at DDS facilities may report abuse as an expression of their anxieties or in an effort to get their needs met. And, of course, allegations of abuse can be grounded in fact. Despite cognitive impairment, residents can be accurate reporters of abuse. In its previous semi-annual reports, the OLES made a recommendation to DDS to develop comprehensive training curricula for law enforcement personnel that includes mental health topics, with mental health professionals as the trainers. The training would help law enforcement personnel understand the dynamics of cognitive impairment effects on behavior. The training should include instruction on how to conduct interviews with residents who present unique challenges to law enforcement.

In November 2017, the OLES learned that DDS had developed a four-hour Crisis Intervention Training (CIT) course and had begun training its staff. The DDS CIT course falls short for several reasons. First, the training is only four hours long and is not comprehensive. Secondly, the course is taught solely by DDS law enforcement personnel and does not incorporate subject matter experts as instructors. Thirdly, DDS did not consult with the OLES before implementing the training.

As noted in Item E on page 53, DSH has developed an outline for mental health CIT training. The OLES recommends that DDS adopt and amend the DSH 24-hour course to fit the DDS mission and population it serves. The DSH course is comprehensive and allots four hours covering mental health symptoms such as delusions, cognitive disorders, borderline personality disorder, antisocial personality disorder and depression. The DDS course only briefly touches upon mental illness and intellectual disabilities symptomology. This critical topic is covered in only 1.5 hours. Most concerning is that this topic is taught by law enforcement personnel and not by a mental health professional. Having an in-depth understanding of the nature and reasons for the behaviors of
residents is foundational for DDS law enforcement personnel so they can determine how to best respond to a resident in crisis.

The DDS CIT course includes a two-hour block on tactical communication. In

contrast, the DSH CIT course allots four hours for tactical communication and is taught by subject matter experts. Because communication, both verbal and non-verbal, is a critical skill for law enforcement personnel dealing with a resident in crisis, it should be covered in depth with the aid of experts. The DSH CIT course includes a panel discussion with patient family members to help law enforcement personnel gain insight and understanding of the effects on families. The DSH course also includes a three-hour presentation on patient's legal rights provided by the California Office of Patients' Rights. These important topics are missing from the DDS CIT curriculum. Finally, DDS is required to consult with the OLES before implementing training programs and this did not occur. Once DDS amends the CIT course, the OLES looks forward to reviewing the proposed training and providing feedback.

DDS standardized training (cont'd)

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
E 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. Consistent training and evaluation in the field, after initial, new-hire training, helps ensure that initial standardized training of new hires is retained and reinforced.	DDS has developed a field training manual that is in final review. Upon DDS approval, a draft will be presented to the OLES for review/input in September 2017 and then will be submitted to POST for approval. In the interim and in an effort to establish standardization, DDS law enforcement is using the draft manual to train new hires through the field training process.	DDS/OPS has completed a draft field training manual for all new OPS peace officer 1s. The draft manual was submitted to the OLES for review on December 21, 2017.

OLES comment: The OLES previously recommended that DDS draft a field training program for newly deployed law enforcement personnel. On December 21, 2017, DDS provided the OLES with a draft field training manual. The proposed program will provide new officers with training on abuse prevention and mandated reporting, sexual assault investigations, child abuse prevention, interview and interrogation techniques, homicide and death investigations, autism and crisis intervention. In addition, new officers will review and acknowledge all OPS policies and procedures in Lexipol, complete daily training bulletins and review and be familiar with facility policies. The manual includes objectives, a means for evaluating the trainee's demonstration of the objectives and a procedure for determining whether the trainee successfully demonstrated the training objective, or whether remediation is

required. It is real time recording and offers a process for immediate feedback from the training. The OLES commends DDS for developing the proposed field training program and will continue to report on the implementation of the program.

DDS standardized discipline tracking

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
F 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. This ensures hat centralized data collection and records are used as a management tool to identify and address patterns and trends of employee misconduct.	On March 19, 2017, the Developmental Centers Division (DCD) of DDS modified its "Policy Memorandum 323 "Governing Body" to require DCD to conduct periodic reviews of investigations and outcomes using the investigations data collected by the developmental centers. The Health and Direct Care Services (HDCS) section in DDS will use incident reporting data collected by the facilities to ensure proper tracking and trending of their analysis, with findings and recommendations forwarded to the deputy director. Beginning July 2017, law enforcement at headquarters updates the investigations and allegations report with employee misconduct outcomes. HDCS prepares from the law enforcement data a quarterly report which analyzes employee	Implemented. The Quality Assurance Department at each center/facility tracks and trends allegations and OPS investigation reports with the employee misconduct outcomes. The centers take appropriate action as part of their quality assurance program. This information is reported to the department by each center/facility at their individual governing body meeting held quarterly with the department.

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
	trend data.	

DDS standardized discipline process

OLES Recommendation of Best Practice	Status as of June 30, 2017	Status as of December 31, 2017
G By December 1, 2016, DDS should implement a comprehensive written, statewide policy and procedures involving standardized penalty matrices for all state employees assigned to facilities who are found to be involved in misconduct. This provides formalized, consistent and fair imposition of discipline penalties across all state facilities	A draft policy and procedures involving standardized penalty matrices is in draft review. DDS anticipates it to be issued by December 2017.	See response provided in B (above).
H 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. This provides consistent and formalized review process of discipline penalties across all state facilities.	Policy was drafted and circulated; should be issued by August 2017.	See response provided in B (above).

Appendix A: OLES Investigations

Investigation Detail	Section Content
Incident Date	03/23/2017
OLES Case Number	2017-00354C
Case Type	Broken Bone
Incident Summary	On March 23, 2017, an officer allegedly used unnecessary force on a patient who was refusing orders to return to his unit. The officer and patient both sustained injuries and were transported to an outside medical facility for medical attention.
Disposition	The OLES conducted an investigation into this matter and referred the case to the district attorney's office. The District Attorney's office declined prosecution.

Investigation Detail	Section Content
Incident Date	08/11/2016
OLES Case Number	2017-00406C
Case Type	Misconduct
Incident Summary	Between August 11, 2016, and January 9, 2017, an officer allegedly falsified police reports by stating that the victims did not want to prosecute the offenders.
Disposition	The OLES conducted an investigation 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	02/25/2016
OLES Case Number	2017-00520A
Case Type	Misconduct
Incident Summary	On February 25, 2016, a lieutenant allegedly consumed alcohol while on duty. Between August 4, 2014, and January 23, 2017, the lieutenant allegedly used a department computer to write a book for personal gain and directed subordinate employees to misuse state time to read his book.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	05/23/2017
OLES Case Number	2017-00654C

Case Type	Abuse
Incident Summary	On May 23, 2017, an officer allegedly hit a patient on his forehead with a flashlight.
Disposition	The OLES 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	06/19/2017
OLES Case Number	2017-00720A
Case Type	Misconduct
Incident Summary	On June 19, 2017, officers allegedly placed a patient in a holding area with a known enemy and failed to supervise the patient.
Disposition	The OLES 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	02/03/2017
OLES Case Number	2017-00765C
Case Type	Misconduct
Incident Summary	An officer allegedly stole money from a citizen who had been stopped on hospital grounds for failing to stop at a stop sign.
Disposition	The OLES 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	07/08/2017
OLES Case Number	2017-00799C
Case Type	Misconduct
Incident Summary	On July 8, 2017, an officer was arrested for allegedly battering his live-in girlfriend and vandalizing property.
Disposition	The OLES conducted an inquiry into this matter and referred the incident to the department for review and consideration to conduct an administrative investigation into the officer's actions.

Investigation Detail	Section Content
Incident Date	07/07/2017
OLES Case Number	2017-00806C
Case Type	Abuse
Incident Summary	On July 7, 2017, officers allegedly used excessive force on a patient prior to and while escorting him for placement into five-point restraints.
Disposition	The OLES 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	05/25/2017
OLES Case Number	2017-00816A
Case Type	Misconduct
Incident Summary	On May 25, 2017, May 26, 2017, and May 31, 2017, an officer allegedly used a State gas card for personal use. The officer was allegedly dishonest during the investigation.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	07/22/2017
OLES Case Number	2017-00868C
Case Type	OPS Law Enforcement
Incident Summary	On July 22, 2017, an officer was arrested for allegedly driving under the influence and hit and run. The officer also allegedly had an un-registered firearm in the vehicle at the time of his arrest.
Disposition	The OLES conducted an inquiry into this matter and determined the alleged criminal activity was pending the judicial process and the matter was referred to the department for administrative action. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/06/2017
OLES Case Number	2017-00882A
Case Type	Misconduct
Incident Summary	On June 6, 2017, an officer allegedly was absent without leave and was subsequently discourteous and dishonest to a supervisor.

Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	08/29/2016
OLES Case Number	2017-00938A
Case Type	Misconduct
Incident Summary	On August 29, 2016, an officer allegedly carried a concealed firearm to an off-site training class in violation of department policy.
Disposition	The OLES conducted an inquiry into this matter and determined the allegation did not rise to the level of serious misconduct meeting the OLES criteria and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	08/05/2017
OLES Case Number	2017-00954A
Case Type	Abuse
Incident Summary	On August 5, 2017, officers and medical staff allegedly grabbed a patient by the neck and scratched his neck and leg when he attempted to escape.
Disposition	The OLES 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	05/25/2017
OLES Case Number	2017-00973C
Case Type	Misconduct
Incident Summary	On May 25, 2017, May 26, 2017, and May 31, 2017, an officer allegedly used a State gas card to purchase gasoline for his personal vehicle.
Disposition	The OLES 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	08/20/2017
OLES Case Number	2017-00993C

Case Type	Misconduct
Incident Summary	On August 20, 2017, an officer was arrested for allegedly driving under the influence.
Disposition	The OLES conducted an inquiry and referred the matter back to the department for administrative action.

Investigation Detail	Section Content
Incident Date	08/24/2017
OLES Case Number	2017-01034A
Case Type	Misconduct
Incident Summary	On August 24, 2017, an officer allegedly failed to use appropriate force to control a combative patient allowing the patient to assault several officers and staff members.
Disposition	The OLES 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	09/01/2017
OLES Case Number	2017-01060C
Case Type	Misconduct
Incident Summary	On September 1, 2017, an executive director and a lieutenant allegedly ordered an illegal search of a patient's room and improperly seized electronic devices. It was later determined to be a proper search and seizure of contraband items.
Disposition	The OLES 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	09/24/2017
OLES Case Number	2017-01135C
Case Type	Misconduct
Incident Summary	On September 24, 2017, an officer allegedly kneed a patient in his side while the patient was on the ground.
Disposition	The OLES 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	10/04/2017
OLES Case Number	2017-01175C
Case Type	Abuse
Incident Summary	On October 5, 2017, five to six staff members, including an officer, allegedly entered a patient's room and battered him in the face.
Disposition	The OLES 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	10/26/2017
OLES Case Number	2017-01268C
Case Type	Misconduct
Incident Summary	On October 26, 2017, an officer allegedly stared at a co-worker's buttocks and inappropriately touched a second employee.
Disposition	The OLES conduct an inquiry into whether a criminal battery occurred and determined there was insufficient evidence that a crime was committed and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	11/08/2017
OLES Case Number	2017-01333C
Case Type	Sexual Assault
Incident Summary	On November 14, 2017, several individuals including officers allegedly entered a patient's room and sexually assaulted him.
Disposition	The OLES 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	11/12/2017
OLES Case Number	2017-01374A
Case Type	Misconduct
Incident Summary	On November 22, 2017, an officer allegedly inappropriately interviewed a suspect in a criminal investigation in front of

	witnesses to the criminal investigation.
Disposition	The OLES 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	12/04/2017
OLES Case Number	2017-01407C
Case Type	Sexual Assault
Incident Summary	On December 4, 2017, an officer allegedly raped a patient.
Disposition	The OLES 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 officer. 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.

Appendix B1 – DSH Pre-Disciplinary Cases

Case Table Section	Section Content
Incident Date	02/09/2016
OLES Case Number	2016-00180MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Training Final: No Change
Incident Summary	On February 9, 2016, a unit supervisor allegedly allowed a patient to continuously hit her head on the wall.
Disposition	The hiring authority sustained the allegation and provided training and a counseling memorandum. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/14/2016
OLES Case Number	2016-00184MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 14, 2016, a patient complained of difficulty breathing and was given two inhaler treatments. The patient continued to complain of breathing problems; however, the patient was not provided with further medical interventions. The patient died unexpectedly several hours later.

Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/12/2016
OLES Case Number	2016-00438MA
Allegations	1. Discourteous Treatment
Findings	1. Sustained
Penalty	Initial: Counseling Final: No Change
Incident Summary	On April 12, 2016, two registered nurses and a psychiatric technician allegedly asked a patient about his daughter, knowing the question would emotionally distress the patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation of discourteous treatment against one registered nurse and issued a counseling memorandum with training for the misconduct. The hiring authority determined there was insufficient evidence to sustain the allegations against the other registered nurse and psychiatric technician. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	04/23/2016
OLES Case Number	2016-00486MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 23, 2016, a psychiatric technician allegedly

	referred to a patient in a derogatory manner. In response, the patient hit the psychiatric technician in the face. The psychiatric technician then allegedly hit the patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 460 days from the date of discovery.
Pre-Disciplinary Assessment	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 adequately consult with OLES regarding the incident? No. The consultation with the OLES was not timely. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 23, 2016; however, the investigation was not completed until July 27, 2017, 460 days later.
Department Corrective Action Plan	OPS provided training to all OPS Supervisors on the OLES reporting guidelines the week of December 17, 2017. OPS will conduct periodic refresher training. OPS provided training to all OPS Supervisors on the OLES reporting guidelines the week of December 17,2017. During this training the investigative staff was reminded to consult with the assigned OLES monitor. The Chief/OPS discussed with the entire investigative staff the importance of meeting OLES notification time frame criteria. In addition, it was explained the used of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/11/2016
OLES Case Number	2016-00697MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 11, 2016, a registered nurse allegedly grabbed and twisted a patient's arm behind her back.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority did not properly notify the OLES of the incident. The investigation was not completed until 369 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not telephonically notify the OLES of the incident. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on June 1, 2016; however, the investigation was not completed until June 6, 2017, 369 days later.
Department Corrective Action Plan	Administrative staff has established a tracking log of all cases which includes the OLES 75-day due date for monitored cases. Chief/SSI now meet bi-monthly with investigative staff to review cases and to establish investigative plans that will meet compliance time frame criteria. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	05/12/2016
OLES Case Number	2016-00816MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On May 12, 2016, a licensed vocational nurse was allegedly involved in an inappropriate relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 355 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The facility did not timely meet the incident notification procedures established by OLES. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered June 22, 2016; however, the investigative report was not completed until June 12, 2017, 355 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	07/29/2016
OLES Case Number	2016-00954MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 29, 2016, a senior psychiatric technician and psychiatric technician allegedly kicked a patient in his ribs and pushed his face into the floor and wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.

Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 327 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 30, 2016; however, the investigation was not completed until June 22, 2017, 327 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	08/10/2016
OLES Case Number	2016-01005MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 10, 2016, a patient alleged she had been raped approximately four to five years previously by three staff members.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not properly notify the OLES of the incident. The responding officers did not provide the staff members with the required legal admonishment prior to their interviews. The investigation was not completed until 301 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?

	No. The hiring authority did not telephonically notify the OLES of the incident. 2. Was the Hiring Authority's response to the incident appropriate? No. The Office of Protective Services did not provide appropriate legal admonishments prior to the staff members' interviews. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on August 10, 2016; however, the investigation was not completed until June 7, 2017, 301 days later.
Department Corrective Action Plan	OPS staff have been reminded of the reporting requirements for Priority 1 notifications to OLES.OPS staff did not provide the Beheler admonishment prior to conducting the interview. The Chief/OPS retrained the staff during briefing of the proper legal requirements including advising and admonishing staff members and /or patients prior to interviews. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	01/01/2016
OLES Case Number	2016-01011MA
Allegations	1. Other failure of good behavior 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	Beginning in January 2016, a unit supervisor allegedly engaged in a sexual relationship with a patient.
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.
Investigative 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 timely notify the OLES and outside law enforcement of the alleged incident. The investigation was not completed until approximately 439 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on August 11, 2016, at approximately 1630 hours; however, the OLES was not notified until 2011 hours, almost four hours later. 2. Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames required by law? No. The Office of Protective Services learned of the incident on August 11, 2016, at approximately 1630 hours; however, outside law enforcement was not notified until 1959 hours, over three hours later. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on August 11, 2016; however, the investigation was not completed until October 23, 2017, 439 days later.
Department Corrective Action Plan	OPS provided training to all OPS supervisors on OLES reporting guidelines in January 2017. The command staff provided roll call training to their staff. OPS has provided training to all OPS supervisors on incidents that require reporting to outside law enforcement. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a

	timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	08/30/2016
OLES Case Number	2016-01121MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 30, 2016, a psychiatric technician allegedly struck a patient in the head while he was restraining the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely notify the OLES of the incident. The investigation was not completed until 280 days after the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not notify the OLES for approximately three hours after discovery of the incident. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on August 31, 2016; however, the investigation was not completed until June 7, 2017, 280 days later.
Department Corrective Action Plan	Staff were reminded to comply with the reporting procedures for the different priority guidelines. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	09/08/2016
OLES Case Number	2016-01157MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 8, 2016, a patient alleged he had been involved in a romantic relationship with a registered nurse for approximately 25 years.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 287 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on September 8, 2016; however, the investigation was not completed until June 22, 2017, 287 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	09/15/2016
OLES Case Number	2016-01221MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On September 15, 2017, a senior psychiatric technician

	allegedly failed to monitor and separate two patients who had been in a physical alteration the previous day, resulting in a similar incident, which left one of the patients unconscious.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 398 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not meet the incident notification procedures established by OLES. 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 notify OLES of the incident. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 398 days from the date of discovery.
Department Corrective Action Plan	OPS provided training to all OPS supervisors on the OLES reporting guidelines the week of December 17, 2017. The command staff provided roll call training to their staff. OPS provided training to all OPS supervisors on the OLES reporting guidelines the week of December 17, 2017. OPS will conduct biweekly refresher training. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the

	investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	10/14/2016
OLES Case Number	2016-01349MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 14, 2016, an unidentified male staff member allegedly sexually assaulted a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/15/2016
OLES Case Number	2016-01350MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 15, 2016, a senior psychiatric technician allegedly sexually assaulted a patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 275 days from the date of discovery.
Pre-Disciplinary	1. Was the pre-disciplinary/investigative phase

Assessment	conducted with due diligence? No. The incident was discovered on October 15, 2016; however, the investigation was not completed until July 17, 2017, 275 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	10/15/2016
OLES Case Number	2016-01361MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 15, 2016, a psychiatric technician allegedly spit on and threatened to kill a patient.
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 because of insufficient evidence. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 284 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 15, 2016; however, the investigation was not completed until July 26, 2017, 284 days later.
Department Corrective Action	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame

Plan	criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	10/23/2016
OLES Case Number	2016-01383MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 23, 2016, a 58-year-old patient was discovered non-responsive in his room. Two psychiatric technicians performed life-saving measures but a responding physician declared the patient dead. It was determined that the cause of death was coronary artery disease.
Disposition	The hiring authority determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority failed to comply with the department's policies and procedures governing the pre-disciplinary phase. The hiring authority received the investigative report on November 2, 2016, and delayed consulting with the OLES regarding the sufficiency of the investigation and the investigative findings until July 6, 2017, 246 days later.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The hiring authority did not timely consult with OLES regarding the sufficiency of the investigation and the investigative findings. The hiring authority received the investigative report on November 2, 2016, but did not consult with the OLES until July 6, 2017, 246 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The hiring authority did not timely consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Department Corrective Action Plan	The Hiring Authority will consult timely with OLES regarding the sufficiency of the investigation and the investigation finding prior to final determination. A tracking system has been implemented to ensure timely follow up on disposition for all monitored cases.

Case Table Section	Section Content
Incident Date	10/30/2016
OLES Case Number	2016-01419MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 30, 2016, a senior psychiatric technician allegedly kneed a patient in the back while the patient sat in a wheelchair.
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 insufficient evidence. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 290 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. Although the department made notification to the OLES, the department failed to telephone the OLES on-duty staff to make proper notification. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 30, 2016; however, the investigation was not completed until August 16, 2017, 290 days later.
Department	The Chief/OPS discussed with the entire Investigative staff

Corrective Action Plan	the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	10/27/2016
OLES Case Number	2016-01421MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 27, 2016, a psychiatric technician allegedly hit a patient in the back two times during a physical containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not notify the OLES upon discovery of the incident. The hiring authority failed to consult with the OLES regarding the sufficiency of the investigation and the investigative findings. The investigation was not completed until 320 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not notify the OLES of the incident. 2. Did the Hiring Authority adequately consult with OLES regarding the incident? No. The hiring authority did not consult with the OLES. 3. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?

	No. The hiring authority failed to consult with the OLES regarding the sufficiency of the investigation and the investigative findings. 4. 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 notify the OLES of the incident nor consult with the OLES regarding the sufficiency of the investigation and the investigative findings. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 27, 2016; however, the investigation was not completed until September 12, 2017, 320 days later.
Department Corrective Action Plan	OPS staff have been reminded of the reporting requirements for Priority 1 notifications to OLES. In the future, the Hiring Authority will consult with OLES as required. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	11/04/2016
OLES Case Number	2016-01478MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 4, 2016, two psychiatric technicians and a program assistant allegedly injured a patient during a floor containment procedure.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 228 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 14, 2016; however, the final investigative report was not completed until June 30, 2017, 228 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	11/14/2016
OLES Case Number	2016-01493MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 14, 2016, a licensed vocational nurse allegedly kicked the chair on which a patient was seated.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	11/19/2016
OLES Case Number	2016-01512MC
Allegations	1. Criminal Act
Findings	1. Referred

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 19, 2016, a registered nurse allegedly pushed a patient in the chest.
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 referral. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The Office of Protective Services failed to comply with policies and procedures governing the investigative process. The Office of Protective Services did not provide the OLES with a draft or final copy of the report.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency? No. The OLES was not provided with a draft copy of the investigative report before it was forwarded to the prosecuting agency. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services did not provide the OLES with a copy of the draft or final report.
Department Corrective Action Plan	The Chief/OPS discussed with the investigative staff the importance of providing OLES with a copy of the draft report prior to finalizing the report. The Chief/OPS discussed with the investigative staff the importance of providing OLES with a copy of the draft report and the final report.

Case Table Section	Section Content
Incident Date	11/19/2016
OLES Case Number	2016-01523MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 19, 2016, two psychiatric technicians allegedly ordered several patients to give another patient a shower against the patient's will.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on November 19, 2016; however, the investigation was not completed until October 25, 2017, 330 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 330 days from the date of discovery.
Department Corrective Action Plan	The Chief of Hospital Police discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	11/24/2016
OLES Case Number	2016-01540MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 24, 2016, a senior psychiatric technician and two psychiatric technicians allegedly injured a patient while attempting to stop two patients from fighting.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 260 days after the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 24, 2017; however, the investigation was not completed until August 11, 2017, 260 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	12/02/2016
OLES Case Number	2016-01574MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 2, 2016, a nurse, a psychiatric technician, and a pre-licensed psychiatric technician, allegedly failed to appropriately respond when they discovered a patient lying in bed with a sheet around the patient's neck.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	12/07/2016
OLES Case Number	2016-01589MA
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment
Findings	1. Not Sustained

	2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 7, 2016, a psychiatric technician allegedly grabbed and dragged a patient out of bed after she refused to get up for breakfast. A senior psychiatric technician and a registered nurse allegedly made inappropriate hand gestures towards the patient as she exited her bedroom.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officer failed to provide the psychiatric technician, senior psychiatric technician, and the registered nurse proper legal admonitions prior to their interviews. The investigation was not completed until 258 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The responding officer interviewed the subjects of the allegation without providing the required legal admonitions. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on December 7, 2016; however, the investigation was not completed until August 22, 2017, 258 days later.
Department Corrective Action Plan	OPS staff did not provide the required legal admonishment prior to conducting the interview. The Chief/OPS retrained the staff during briefing of the proper legal requirements including advising and admonishing staff members and /or patients prior to interviews. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	12/08/2016
OLES Case Number	2016-01599MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 8, 2016, a psychiatric technician allegedly kicked a patient and pushed his head against a wall during a physical containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	12/11/2016
OLES Case Number	2016-01608MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 11, 2016, a patient died unexpectedly from acute coronary syndrome.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/01/2017
OLES Case Number	2017-00006MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On January 2, 2016, a registered nurse allegedly grabbed food from a patient and pushed the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 253 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 2, 2017; however, the investigation was not completed until September 12, 2017, 253 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	01/04/2017
OLES Case Number	2017-00017MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 4, 2017, numerous health care staff members allegedly threw a patient to the ground, injuring the patient's back, arms, hips, and neck.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with the department's policies and procedures governing the investigative process.

	The incident was discovered on January 4, 2017; however, the investigation was not completed until October 5, 2017, 274 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 4, 2017; however, the investigation was not completed until October 5, 2017, 274 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	01/04/2017
OLES Case Number	2017-00020MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 3, 2016, a staff member allegedly took a patient to the ground, kicked him in the rib cage, and punched him in his groin.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 190 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 5, 2017; however, the investigation was not completed until July 14, 2017, 190 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the

	extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	01/16/2017
OLES Case Number	2017-00057MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On January 16, 2017, a patient died unexpectedly from acute bronchopneumonia.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The hiring authority determined there was no evidence of staff misconduct, therefore an administrative investigation was not opened. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/16/2017
OLES Case Number	2017-00063MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 16, 2017, a psychiatric technician allegedly ordered a patient to her room, entered the room behind the patient, and pushed the patient in the chest, stating "This is my house."
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The

	investigation was not completed until approximately 234 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 17, 2017; however, the investigation was not completed until September 8, 2017, 234 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/18/2017
OLES Case Number	2017-00067MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 18, 2017, a patient alleged he had been raped by unknown staff members approximately 20 times within the past year.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. An officer interviewed two of the suspect employees without first providing them with proper legal admonitions. The investigation was not completed until 239 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. A hospital police officer interviewed two of the suspect staff members without first providing them with proper legal admonitions. 2. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The incident was discovered on January 18, 2017; however, the investigation was not completed until September 14, 2017, 239 days later.
Department Corrective Action Plan	OPS staff did not provide the required legal admonishment prior to conducting the interview. The Chief/OPS retrained the staff during briefing of the proper legal requirements including advising and admonishing staff members and /or patients prior to interviews. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	08/22/2016
OLES Case Number	2017-00080MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal 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. A senior psychiatric technician allegedly failed to document the incident and was dishonest during an investigative interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty for both employees. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	10/23/2016
OLES Case Number	2017-00095MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 23, 2016, a psychiatric technician allegedly pushed and punched a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	01/26/2017
OLES Case Number	2017-00114MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 26, 2017, a psychiatric technician assigned to enhanced observation of a patient allegedly failed to protect a second patient from being attacked by the first patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 181 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 27, 2017; however, the investigation was not completed until July 26, 2017, 181 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the

	investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	01/29/2017
OLES Case Number	2017-00119MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 29, 2017, a psychiatric technician allegedly struck and broke a patient's arm.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 185 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 29, 2017; however, the investigation was not completed until August 2, 2017, 185 days later.
Department Corrective Action Plan	Administrative staff has established a tracking log of all cases which includes the OLES 120-day due date for monitored cases. Chief/SSI now meet bi-monthly with investigative staff to review cases and to establish investigative plans that will meet compliance time frame criteria. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	01/31/2017
OLES Case Number	2017-00129MC
Allegations	1. Criminal Act 2. Criminal Act

	3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 31, 2017, a psychiatric technician allegedly took a package of candy bars from a patient and slapped a second patient after the second patient took the candy bars from the psychiatric technician.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services did not make timely notification to the OLES. The investigation was not completed until 189 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on February 2, 2017, at 0955 hours, but did not notify the OLES until February 2, 2017, at 1237 hours, more than two hours later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 2, 2017; however, the investigation was not completed until August 10, 2017, 189 days later.
Department Corrective Action Plan	OPS provided training to all OPS supervisors on OLES reporting guidelines in January 2017. The command staff provided roll call training to their staff. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a

	timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	02/01/2017
OLES Case Number	2017-00130MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 1, 2017, three staff members allegedly assaulted a patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 182 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 2, 2017; however, the investigation was not completed until August 4, 2017, 182 days later.
Department Corrective Action Plan	Administrative staff has established a tracking log of all cases which includes the OLES 75-day due date for monitored cases. Chief/SSI now meet bi-monthly with investigative staff to review cases and to establish investigative plans that will meet compliance time frame criteria. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	01/31/2017
OLES Case Number	2017-00135MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On January 31, 2017, a nurse allegedly touched a patient's buttocks and genitals inappropriately while applying a medicated cream on the patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 160 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 3, 2017; however, the investigation was not completed until July 13, 2017, 160 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on ta timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	02/05/2017
OLES Case Number	2017-00141MA
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	Initial: Counseling Final: No Change
Incident Summary	On February 5, 2017, a psychiatrist allegedly interfered with hospital police officers by blocking their access to a room where a patient had barricaded himself.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a non-disciplinary letter of expectation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The department failed to comply with the department's policies and procedures governing the pre-disciplinary process. The psychiatrist's supervisor issued a non-disciplinary letter of expectation prior to the disposition meeting.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The psychiatrist's supervisor provided a non-disciplinary letter of expectation prior to the disposition meeting.
Department Corrective Action Plan	The Hiring Authority will consult with the appropriate supervisory personnel to ensure that the policies and procedures governing the pre-disciplinary process are properly adhered to.

Case Table Section	Section Content
Incident Date	02/02/2017
OLES Case Number	2017-00152MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 2, 2017, a psychiatric technician assistant allegedly struck a patient's foot with a food cart.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 246 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 6, 2017; however, the investigation was not completed until October 10, 2017, 246 days later.
Department Corrective Action	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame

Plan	criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	02/07/2017
OLES Case Number	2017-00159MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 7, 2017, a patient alleged a psychiatric technician rubbed his genitals against her arm and touched her forehead in a sexual manner while she was in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 184 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 7, 2017; however, the investigation was not completed until August 10, 2017, 184 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	02/08/2017
OLES Case Number	2017-00166MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 8, 2017, a building paint supervisor allegedly was engaged in a sexual relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 184 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 8, 2017; however, the investigation was not completed until August 11, 2017, 184 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	02/11/2017
OLES Case Number	2017-00181MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 11, 2017, a psychiatric technician allegedly slapped a patient on the forehead when she asked for her medication.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The

	investigation was not completed until 213 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 13, 2017; however, the investigation was not completed until September 14, 2017, 213 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	02/15/2017
OLES Case Number	2017-00193MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 15, 2017, an unidentified male staff member allegedly forced a patient to the floor. While the patient was on the floor, unidentified staff allegedly hit the back of patient's head numerous times.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 247 days from the date the Office of Protective Services discovered the alleged incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The alleged incident was discovered on February 16, 2017; however, the investigation was not

	completed until October 20, 2017, 247 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	02/11/2017
OLES Case Number	2017-00197MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 11, 2017, a psychiatric technician allegedly elbowed a patient in the ribs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/20/2017
OLES Case Number	2017-00208MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 20, 2017, a staff member allegedly punched and urinated on a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/16/2017
OLES Case Number	2017-00219MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On February 16, 2017, a psychiatric technician allegedly challenged a patient to a fight.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued the psychiatric technician a letter of instruction and provided additional training regarding de-escalation procedures. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process

Case Table Section	
Incident Date	02/13/2017
OLES Case Number	2017-00246MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 13, 2017, a registered nurse allegedly failed to properly treat and evaluate a patient who was complaining of stroke-like symptoms.
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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 244 days from the date of discovery.
Pre-Disciplinary	1. Was the pre-disciplinary/investigative phase

Assessment	conducted with due diligence? No. The incident was discovered on March 1, 2017; however, the investigation was not completed until October 31, 2017, 244 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	02/03/2017
OLES Case Number	2017-00249MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 3, 2017, a psychiatric technician allegedly slammed a patient on the floor and forcefully pulled up the patient's underwear. The psychiatric technician also allegedly made sexually intimidating remarks to the patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 203 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 2, 2017; however, the investigation was not completed until September 21, 2017, 203 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension

	memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/04/2017
OLES Case Number	2017-00278MA
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Not Sustained 4. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On March 4, 2017, two psychiatric technicians allegedly failed to maintain enhanced observation over their assigned patients. On March 5, 2017, a nurse allegedly failed to change a patient's intravenous line and left the patient's room in disarray. On March 6, 2017, a third and fourth psychiatric technician allegedly failed to maintain enhanced patient observation.
Disposition	The hiring authority sustained the allegation against the nurse for failing to change the patient's intravenous line and issued a letter of instruction and ordered additional training. The hiring authority sustained an allegation against the third psychiatric technician for failing to maintain enhanced patient observation and issued a letter of expectation and ordered retraining. The hiring authority determined there was insufficient evidence to sustain the remaining allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	03/09/2017
OLES Case Number	2017-00284MA
Allegations	1. Other failure of good behavior

Findings	1. Not Sustained
Penalty	Initial: Training Final: No Change
Incident Summary	On March 9, 2017, a senior psychiatric technician and a psychiatric technician allegedly failed to ensure a patient was regularly weighed per a physician's orders.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. However, the hiring authority ordered training for the employees. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	03/10/2017
OLES Case Number	2017-00289MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 10, 2017, a psychiatric technician allegedly used excessive force while tapping a patient on the shoulder.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 188 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 10, 2017; however, the investigation was not completed until September 14, 2017, 188 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of

	Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	03/11/2017
OLES Case Number	2017-00300MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 11, 2017, a psychiatric technician allegedly struck a patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 165 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 11, 2017; however, the investigation was not completed until August 23, 2017, 165 days later.
Department Corrective Action Plan	The Chief/OPS trained all the investigative staff on the importance of meeting the OLES notification time frame criteria. On November 2, 2017, OPS issued OPS Policy 607, Office of Law Enforcement Support to all staff. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review to case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	03/14/2017
OLES Case Number	2017-00314MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On March 14, 2017, a patient's mother alleged the patient had been raped.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/17/2017
OLES Case Number	2017-00328MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 17, 2017, a senior psychiatric technician allegedly grabbed a patient's arm during a wall stabilization procedure causing bruising and scratching to the patient's arm. Another senior psychiatric technician, a psychiatric technician, and several staff members also allegedly forced the patient against the wall and choked the patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 231 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 17, 2017; however, the investigation was not completed until November 2, 2016, 231 days later.
Department	The Chief/OPS discussed with the entire Investigative staff

Corrective Action Plan	the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	03/22/2017
OLES Case Number	2017-00349MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On March 22, 2017, a psychiatric technician failed to properly monitor, supervise, and account for all patients, allowing a patient an opportunity to leave hospital grounds. The patient broke his foot while climbing a hospital fence.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 147 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 22, 2017; however, the investigation was not completed until August 16, 2017, 147 days later.
Department Corrective Action Plan	The Chief of Hospital Police discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/15/2017
OLES Case Number	2017-00351MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 15, 2017, after undergoing surgery for an ankle fracture, a patient sustained a second fracture to the same ankle.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/09/2017
OLES Case Number	2017-00374MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 9, 2017, a social worker allegedly withheld a patient's funds and solicited sexual favors from the patient in order to release the funds.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/13/2016
OLES Case Number	2017-00387MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 13, 2016, a patient sustained a laceration to her scalp due to a fall. The patient received four sutures that were to be removed in seven days. Two of the sutures were timely removed; however, the remaining two sutures were not removed until March 31, 2017, eight months later. A doctor and nurse were allegedly negligent when they failed to timely remove all of the sutures.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 165 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 31, 2017; however, the investigation was not completed until September 12, 2017, 165 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	02/07/2017
OLES Case Number	2017-00393MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	In February 2017, an unknown staff member allegedly sexually assaulted a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/05/2017
OLES Case Number	2017-00409MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 5, 2017, a patient alleged she was sexually assaulted on two separate occasions by a psychiatric technician.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/21/2017
OLES Case Number	2017-00414MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 21, 2017, two psychiatric technicians allegedly dragged a patient into a seclusion room and forcefully administered medication to the patient.
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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 211 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 6, 2017; however, the investigation was not completed until November 3, 2017, 211 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigative case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/05/2017
OLES Case Number	2017-00418MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 5, 2017, a psychiatric technician allegedly pushed a patient onto the floor, which caused the patient to injure his arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	03/06/2017
OLES Case Number	2017-00427MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 6, 2017, a psychiatric technician allegedly attempted to sexually assault a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process

Case Table Section	Section Content
Incident Date	08/20/2016
OLES Case Number	2017-00431MA
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 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 August 20, 2016, a nurse and a senior psychiatric technician allegedly grabbed a patient's arms and stepped on the patient's feet while escorting the patient to a seclusion room. A second senior psychiatric technician and two psychiatric technicians allegedly continuously knocked on the door and called out the patient's name to deliberately deprive the patient of sleep.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures

	governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	04/14/2017
OLES Case Number	2017-00451MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 14, 2017, a patient alleged he was pushed by a psychiatric technician.
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 Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/14/2017
OLES Case Number	2017-00454MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 14, 2017, a psychiatric technician allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/27/2016
OLES Case Number	2017-00463MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On July 27, 2016, a psychiatric technician allegedly hit the back of a patient's head while the patient was being restrained.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	04/17/2017
OLES Case Number	2017-00464MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 17, 2017, a registered nurse allegedly pulled a patient's hair.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. An administrative investigation was not opened due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/18/2017
OLES Case Number	2017-00467MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 18, 2017, a registered nurse allegedly punched a patient in the face during a wall containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	04/21/2017
OLES Case Number	2017-00475MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 21, 2017, a patient alleged that he was sexually assaulted by a psychologist and other staff members during the last five to 20 years.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/22/2017
OLES Case Number	2017-00487MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Counseling Final: No Change
Incident Summary	On April 22, 2017, a senior psychiatric technician and a psychiatric technician allegedly left a patient unattended in a locked courtyard.
Disposition	The hiring authority sustained allegations against the senior psychiatric technician and the psychiatric technician for violating policies regarding courtyard coverage and issued letters of counseling. The hiring authority determined there was insufficient evidence to sustain allegations of abuse or neglect. The OLES concurred with the hiring authority's determinations.

Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	04/25/2017
OLES Case Number	2017-00502MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 25, 2017, a psychiatric technician allegedly twisted a patient's arm while stabilizing the patient.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The hiring authority did not timely notify the OLES of the incident and the investigation was not completed until 189 days from the date of discovery.
Pre-Disciplinary Assessment	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. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 25, 2017; however, the investigative report was not completed until October 31, 2017, 189 days later.
Department Corrective Action Plan	OPS provided training to all OPS supervisors on OLES reporting guidelines. The command staff provided roll call training to their staff. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the

	OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting.

Case Table Section	Section Content
Incident Date	04/24/2017
OLES Case Number	2017-00529MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 24, 2017, a registered nurse allegedly kicked a patient in the foot while helping the patient into a wheelchair.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/08/2017
OLES Case Number	2017-00550MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 8, 2017, a patient alleged she had been raped by a male staff member.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/16/2017
OLES Case Number	2017-00586MC

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 16, 2017, a patient alleged that a psychiatric technician forcefully placed her on a chair, choked her, and pulled her hair.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. An administrative investigation was not opened due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	05/17/2017
OLES Case Number	2017-00591MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 17, 2017, a custodian allegedly pulled a napkin from a patient in an aggressive manner.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	05/18/2017
OLES Case Number	2017-00594MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 18, 2017, a patient alleged a staff member bruised

	her bicep.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. An administrative investigation was not opened due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	05/03/2017
OLES Case Number	2017-00617MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 3, 2017, a psychiatric technician allegedly used unnecessary force to place a patient against a wall. Staff members also allegedly unnecessarily placed the patient in full bed restraints, denied him food, and inappropriately touched his genitals while attempting to place a catheter on the patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/06/2017
OLES Case Number	2017-00650MA
Allegations	1. Behavior that results in death
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 6, 2017, a patient died from cardiovascular disease while being treated at an outside hospital.
Disposition	The hiring authority determined the investigation

	conclusively proved that the death was due to natural causes and no staff misconduct occurred. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/25/2017
OLES Case Number	2017-00651MA
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 25, 2017, a psychiatric technician and unidentified staff allegedly used improper techniques while attempting to control a patient during a wall stabilization procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative 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 timely notify the OLES of the alleged incident.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on June 5, 2017, at 1458 hours, but did not notify the OLES until June 6, 2017, at 0713 hours, more than 16 hours later.
Department Corrective Action Plan	Training was provided to the OPS staff concerning the required reporting time frames to ensure OLES is notified timely for Priority 1 Incidents.

Case Table Section	Section Content
Incident Date	06/04/2017
OLES Case Number	2017-00673MA

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 4, 2017, a psychiatric technician allegedly choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	10/18/2016
OLES Case Number	2017-00722MA
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 October 18, 2016, a psychiatric technician allegedly used excessive force while restraining a patient. A second psychiatric technician allegedly used a chokehold on the patient, then slammed the patient's head into a wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	01/30/2017
OLES Case Number	2017-00723MA
Allegations	1. Other failure of good behavior 2. Other failure of good behavior
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On January 30, 2017, a unit supervisor allegedly twisted a patient's arm. On March 1, 2017, the unit supervisor allegedly placed the patient in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/19/2017
OLES Case Number	2017-00726MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 19, 2017, health care staff members allegedly injured a patient while restraining the patient in order to transfer him to a seclusion room.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/22/2017
OLES Case Number	2017-00732MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 22, 2017, a psychiatric technician allegedly shut a door on a patient's fingers.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/03/2017
OLES Case Number	2017-00761MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 3, 2017, a psychiatric technician allegedly slammed a medication port window on a patient's hand.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/02/2017
OLES Case Number	2017-00780MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 2, 2017, a psychiatric technician allegedly punched a patient in the shoulder multiple times.
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. The OLES concurred.

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

Case Table Section	Section Content
Incident Date	07/01/2017
OLES Case Number	2017-00783MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 1, 2017, a nurse allegedly failed to ensure a patient received appropriate care after the patient complained of chest pains.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 141 days from the date the Office of Protective Services discovered the alleged incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 3, 2017; however, the investigation was not completed until November 20, 2016, 141 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review case log and a solution on timely reporting

Case Table Section	Section Content
Incident Date	07/04/2017
OLES Case Number	2017-00784MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 4, 2017, two psychiatric technicians allegedly assaulted a patient while he was being restrained.
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 Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/16/2016
OLES Case Number	2017-00791MA
Allegations	1. Other failure of good behavior 2. Discourteous treatment
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 16, 2016, a psychiatric technician allegedly struck a patient on the side of the head after the patient refused to remove his headphones.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/06/2017
OLES Case Number	2017-00792MC
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 6, 2015, a unit supervisor allegedly grabbed and twisted a patient's arm behind the patient's back, forcing the patient to release paper bags the patient had pulled from a trash can.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/16/2016
OLES Case Number	2017-00802MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 16, 2016, an officer allegedly used unreasonable force when she pepper sprayed a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/10/2017
OLES Case Number	2017-00810MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 10, 2017, a psychiatric technician allegedly spit on a patient.

Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	12/26/2016
OLES Case Number	2017-00811MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On December 26, 2016, a psychiatric technician allegedly intentionally gave the wrong medication to a patient and then intimidated a nurse from reporting the incident.
Disposition	The hiring authority sustained the allegations and dismissed the psychiatric technician. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/13/2017
OLES Case Number	2017-00819MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 13, 2017, a patient was discovered to have a fractured arm.
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. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/13/2017
OLES Case Number	2017-00825MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 13, 2017, a patient alleged that a psychiatric technician punched him in the stomach.
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. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/18/2017
OLES Case Number	2017-00854MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 18, 2017, and July 18, 2017, a psychiatric technician allegedly attempted to grab a patient's genitals.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred

	with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/19/2017
OLES Case Number	2017-00858MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 19, 2017, a psychiatric technician assistant allegedly slapped a patient on the wrist.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/25/2017
OLES Case Number	2017-00887MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 25, 2017, a psychiatric technician allegedly threw a patient to the ground and kneed him in the stomach.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/26/2017
OLES Case Number	2017-00889MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 26, 2017, a psychiatric technician allegedly kicked a patient.
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. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/03/2017
OLES Case Number	2017-00929MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 3, 2017, health care staff members allegedly hit a patient in the chest and pulled down the patient's pants in order to administer an injection.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority failed to comply with the department's policies and procedures governing the investigative process. The detective failed to properly consult with the OLES monitor to allow for the contemporaneous monitoring of critical interviews.
Pre-Disciplinary	1. Did OPS cooperate with and provide continued real-

Assessment	time consultation with OLES? No. The detective failed to properly consult with the OLES monitor to allow for the monitoring of critical Interviews.
Department Corrective Action Plan	The Chief/OPS discussed the importance of notifying the OLES monitor prior to an interview to allow for sufficient time, so the monitor can be present if necessary.

Case Table Section	Section Content
Incident Date	03/09/2017
OLES Case Number	2017-00945MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 9, 2017, a social worker allegedly withheld a patient's funds and solicited sexual favors from the patient in order to release the funds.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/22/2017
OLES Case Number	2017-00948MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 22, 2017, three health care staff members allegedly failed to intervene in a fight between two patients.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/22/2017
OLES Case Number	2017-00957MA
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 March 22, 2017, to March 25, 2017, staff members allegedly failed to ensure a patient received meals. A unit supervisor also allegedly refused the patient's request to submit a complaint.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	08/15/2017
OLES Case Number	2017-00970MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 15, 2017, a registered nurse allegedly slapped a patient.
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. The OLES concurred.
Investigative	Procedural Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	08/17/2017
OLES Case Number	2017-00983MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 17, 2017, a psychiatric technician allegedly pushed a patient by placing his knuckles into the patient's back.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/19/2017
OLES Case Number	2017-00986MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 19, 2017, an anonymous caller alleged a patient was assaulted by staff and suffered a broken jaw.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and

	procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/20/2017
OLES Case Number	2017-00989MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On August 20, 2017, a psychiatric technician allegedly grabbed a patient's wrist and punched the patient's palm.
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 case was referred for review to determine if an administrative investigation will be conducted.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/21/2017
OLES Case Number	2017-00997MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 21, 2017, a psychiatric technician allegedly struck a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/13/2017
OLES Case Number	2017-00998MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 13, 2017, staff members allegedly struck a patient in the chest after the patient had been placed in restraints.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/25/2017
OLES Case Number	2017-01021MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 25, 2017, a staff member allegedly pushed a wheelchair bound patient against a wall.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/01/2017
OLES Case Number	2017-01030MC

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 1, 2017, two psychiatric technicians allegedly sexually assaulted two patients.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/28/2017
OLES Case Number	2017-01031MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 28, 2017, a psychiatric technician assistant allegedly struck a patient twice in the throat and attempted to choke the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/03/2017
OLES Case Number	2017-01080MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Unfounded 2. Unfounded
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On May 25, 2017, a psychiatric technician allegedly grabbed a patient's arm and used a control hold on the patient's wrist to press the patient against a wall. Three nurses allegedly inappropriately touched the patient's genitals when attempting to place a condom catheter on the patient. Unidentified staff members also allegedly denied the patient food.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	09/13/2017
OLES Case Number	2017-01094MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 13, 2017, staff members allegedly left a patient in dirty diapers for an extended period of time.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	09/15/2016
OLES Case Number	2017-01111MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	In approximately September of 2007, a health care staff member allegedly had a sexual relationship with a patient.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	09/20/2017
OLES Case Number	2017-01115MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 20, 2017, a psychiatric technician allegedly repeatedly struck a patient in the back of the head.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	09/29/2017
OLES Case Number	2017-01150MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: Other
Incident Summary	On September 29, 2017, a patient died from cardiac arrest while receiving treatment at an outside hospital.
Disposition	The investigation failed to establish sufficient evidence for a

	probable cause referral to the district attorney's office. The OLES concurred. The hiring authority determined there was no evidence of staff misconduct, therefore an administrative investigation was not opened. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	09/28/2017
OLES Case Number	2017-01154MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 29, 2017, a staff member allegedly struck a patient on the back of the head.
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. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/11/2017
OLES Case Number	2017-01195MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 11, 2017, a registered nurse allegedly ignored a patient's complaint that the patient was in pain and unable to urinate.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/20/2017
OLES Case Number	2017-01231MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: Other
Incident Summary	On October 20, 2017, a patient died from congestive heart failure while receiving treatment at an outside hospital.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The hiring authority determined there was no evidence of staff misconduct, therefore an administrative investigation was not opened. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/31/2017
OLES Case Number	2017-01263MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 31, 2017, a psychiatric technician allegedly took a package of candy bars from a patient and slapped the back of a second patient after the second patient jokingly took the candy bars away from the psychiatric technician.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	Procedural Rating: Sufficient

Assessment	Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	10/26/2017
OLES Case Number	2017-01266MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 26, 2017, a registered nurse allegedly pushed and shouted at a patient, then slapped the patient on the buttocks.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	10/29/2017
OLES Case Number	2017-01300MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 29, 2017, a staff member allegedly forced a towel in a patient's mouth, breaking the patient's tooth.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and

	procedures governing the investigative Process.

Appendix B2 – DDS Pre-Disciplinary Cases

Case Table Section	Section Content
Incident Date	10/14/2016
OLES Case Number	2016-1348MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 14, 2016, a nurse allegedly failed to properly monitor a resident who was at risk to detach medical tubing. The resident subsequently detached his medical tubing which resulted in a medical emergency.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	11/13/2016
OLES Case Number	2016-1486MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 13, 2016, a health care staff member allegedly fractured a resident's leg.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/19/2016
OLES Case Number	2016-1648MC
Allegations	1. Criminal Act
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 19, 2016, a resident died at a facility. The cause of death was unknown at the time of the resident's death.
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.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 252 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on December 19, 2016; however, the investigation was not completed until August 28, 2017, 252 days later.
Department Corrective Action Plan	The investigator assigned this case was reassigned to an Acting Lieutenant position. He was also assigned to assist with the implementation of the new Report Management System (RMS), statewide. In the future, OPS will endeavor to reassign investigations such as this to another investigator.

Case Table Section	Section Content
Incident Date	03/01/2016
OLES Case Number	2017-0112MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 1, 2016, a health services specialist, an

	individualized patient care coordinator, and a senior psychiatric technician allegedly failed to report a resident's allegation that he was sexually assaulted and battered by an unidentified male.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	12/05/2016
OLES Case Number	2017-0309MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Training Final: No Change
Incident Summary	On December 5, 2016, four psychiatric technicians allegedly assaulted a resident. Two of the psychiatric technicians and a health services specialist allegedly failed to complete proper documentation after the resident fell on a table.
Disposition	The hiring authority sustained the allegation that two psychiatric technicians and a health services specialist failed to properly document the resident's fall and ordered training. The hiring authority found insufficient evidence to sustain the allegation that the resident was assaulted. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	03/01/2017
OLES Case Number	2017-0323MC
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 1, 2017, a unit supervisor allegedly denied a wheelchair bound client the use of a wheelchair and ignored the resident's complaints of pain.
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 Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/18/2017
OLES Case Number	2017-0341MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 18, 2017, a psychiatric technician allegedly slapped a resident on the face. On March 20, 2017, a second psychiatric technician allegedly threatened the resident and attempted to kick the resident's groin. Both psychiatric technicians also allegedly choked, and struck a second resident in the chest.
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 insufficient evidence. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/07/2017

OLES Case Number	2017-00381MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: Training Final: No Change
Incident Summary	On March 7, 2017, a psychiatric technician allegedly slapped a resident on her buttocks and made inappropriate remarks about the client's buttocks.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation; however, the hiring authority ordered additional training regarding maintaining resident boundaries for the employee. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	04/07/2017
OLES Case Number	2017-0423MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 7, 2017, a health care staff member allegedly fractured a client's ankle.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/11/2017
OLES Case Number	2017-0430MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On January 11, 2017, a psychiatric technician assistant allegedly put his arm around a resident and gave the resident candy after having an altercation with the resident. The psychiatric technician assistant also allegedly loaned small amounts of money to residents on several occasions.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The psychiatric technician assistant retired before completion of the investigation; therefore, no disciplinary action was taken. A letter indicating the psychiatric technician assistant retired under adverse circumstances was placed in his official personnel file. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	04/17/2017
OLES Case Number	2017-0480MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 17, 2017, and April 19, 2017, a psychiatric technician allegedly locked a wheelchair bound resident into a room.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 130 days from the date of discovery.
Pre-Disciplinary	1. Was the pre-disciplinary/investigative phase

Assessment	conducted with due diligence? No. The incident was discovered on April 24, 2017; however, the final investigation report was not completed until September 1, 2017, 130 days later.
Department Corrective Action Plan	The assigned investigator in this case was a retired annuitant and as such, his work hours were limited and resulted in a delay in the investigation. The Department is attempting to address permanent full-time staffing shortages through its recruitment efforts.

Case Table Section	Section Content
Incident Date	08/06/2016
OLES Case Number	2017-0488MA
Allegations	1. Other failure of good behavior 2. Dishonesty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 6, 2016, a psychiatric technician assigned to maintain enhanced observation of a resident allegedly failed to observe, and report noticeable injuries to the resident. The psychiatric technician was also allegedly dishonest during the administrative and criminal investigations.
Disposition	The hiring authority sustained the allegations against the psychiatric technician; however, the psychiatric technician retired before completion of the investigation; therefore, no disciplinary action was taken. A letter indicating the psychiatric technician retired under adverse circumstances was placed in his official personnel file. Although the OLES was not consulted, the OLES would have concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Pre-Disciplinary Assessment	1. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding

	the sufficiency of the investigation and the investigative findings? No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation, and the investigative findings. 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 consult with the OLES regarding the sufficiency of the investigation, and investigative findings.
Department Corrective Action Plan	In this case, the Executive Director's review of the OPS investigation occurred on June 8, 2017. The employee suspect retired on April 14, 2017 prior to the executive review. As a result, a letter was placed in the employee's Official Personnel File (OPF) reflecting the employee retired while under adverse circumstances. This information was provided to the OLES monitor. Since any action was moot, no consultation was required. In the revised DDS policy, when a case is still being finalized, and the employee status would affect the service of a recommended action, then an Executive Review of Case Disposition Worksheet will be provided.

Case Table Section	Section Content
Incident Date	04/25/2017
OLES Case Number	2017-0503MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 25, 2017, four psychiatric technicians allegedly forced a resident to the ground and battered him because he refused to flush the toilet and clean the floor where he had urinated.
Disposition	The Office of Protective Services conducted an investigation and found insufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which the OLES accepted for monitoring.

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

Case Table Section	Section Content
Incident Date	05/12/2017
OLES Case Number	2017-0579MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 12, 2017, a psychiatric technician allegedly hit a patient several times.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/09/2017
OLES Case Number	2017-0693MA
Allegations	1. Incompetency 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On June 9, 2017, a psychiatric technician assistant allegedly failed to monitor a resident who required constant observation, thereby allowing the resident an opportunity to ingest a zipper, earrings, and a necklace. Furthermore, the psychiatric technician assistant was allegedly dishonest during an investigatory interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a 10

	percent salary reduction for 12 months. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/15/2017
OLES Case Number	2017-0697MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 15, 2017, a psychiatric technician allegedly threw water on a patient.
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 department did not open an administrative investigation due to lack of evidence.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	01/01/2017
OLES Case Number	2017-0718MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	In January 2017, a psychiatric technician allegedly slapped a resident.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	02/18/2016
OLES Case Number	2017-0729MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On February 18, 2016, a psychiatric technician assistant allegedly kicked a resident in the leg. A second psychiatric technician assistant allegedly was uncooperative during the investigation.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the first psychiatric technician assistant and issued a letter of reprimand to the second psychiatric technician assistant. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/25/2017
OLES Case Number	2017-0741MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 25, 2017, a psychiatric technician assistant allegedly used profanity and applied pressure with his finger behind a resident's ear. A psychiatric technician allegedly punched the resident in the stomach.
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.

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

Case Table Section	Section Content
Incident Date	10/14/2016
OLES Case Number	2017-0776MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Other
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: No Penalty Imposed
Incident Summary	On October 14, 2016, a nurse allegedly failed to properly monitor a resident who was at risk to detach medical tubing. The resident subsequently detached his medical tubing which resulted in a medical emergency.
Disposition	The hiring authority sustained the allegations and dismissed the nurse. The OLES concurred. However, the nurse retired before disciplinary action could be imposed.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/22/2017
OLES Case Number	2017-0818MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 22, 2017, and July 10, 2017, a psychiatric technician assistant allegedly slapped a resident. A psychiatric technician allegedly witnessed the abuse and failed to report it.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/12/2017
OLES Case Number	2017-0820MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On July 12, 2017, a psychiatric technician assistant allegedly forcefully shoved a sandwich into a resident's mouth.
Disposition	The investigation established 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 declined to file charges. The Office of Special Investigations opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/09/2017
OLES Case Number	2017-0832MC
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 12, 2017, two staff members allegedly forced a resident to the ground and failed to report and document 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 the probable cause determination. The Office of Protective Services did not open an

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

Case Table Section	Section Content
Incident Date	07/22/2017
OLES Case Number	2017-0865MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: No Change
Incident Summary	On July 22, 2017, a resident fell and was transported to an outside hospital for treatment of head injuries. The resident subsequently died from complications of blunt force injury to the head with ischemic cerebral vascular stroke.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The hiring authority determined there was no evidence of staff misconduct, therefore an administrative investigation was not opened. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The incident was discovered on July 22, 2017; however, the investigation was not completed until December 7, 2017, 138 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 22, 2017; however, the investigation was not completed until December 7, 2017, 138 days later.
Department Corrective Action Plan	A weekly investigation status will be run on cases that are open and will be forwarded to command staff. Command staff will closely monitor the cases. Investigators were reminded to keep in constant contact as to the status of their cases with the OLES monitor. Due to the time lapse, it often takes to receive a corners report, consideration of closing a case will be given in death cases where the deaths are expected and of natural causes. The

	investigator will add a supplemental to the original report as to the findings and conclusions of the corners report. In cases, where outside law enforcement is conducting their own investigation, then the investigative timeline should be tolled pending resolution and release of the case back to DDS.

Case Table Section	Section Content
Incident Date	07/25/2017
OLES Case Number	2017-0877MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 25, 2017, a psychiatric technician allegedly twisted a resident's arm and choked her. A second psychiatric technician allegedly slammed the resident's head against a bed multiple times. A third psychiatric technician allegedly pushed her and pulled her hair.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's investigative process sufficiently complied with policies and procedures.

Case Table Section	Section Content
Incident Date	04/25/2017
OLES Case Number	2017-0911MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 25, 2017, a psychiatric technician allegedly forced a resident to the ground and battered him because he refused to flush the toilet and clean the floor where he had urinated.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	Procedural Rating: Insufficient

Assessment	Substantive Rating: Insufficient The department failed to comply with policies, and procedures governing the pre-disciplinary process. The Office of Protective Services did not consult with the OLES before an administrative investigation was opened, and opened the administrative investigation while the criminal investigation was still pending. The hiring authority did not consult with the OLES regarding the sufficiency of the administrative investigation, and investigative findings.
Pre-Disciplinary Assessment	1. 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 Office of Protective Services did not consult with the OLES prior to opening an administrative investigation and opened the administrative investigation before the criminal investigation was completed. 2. Was the administrative and criminal investigation properly and completely bifurcated? No. An administrative investigation was opened even though investigative work was still pending in the criminal investigation. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services failed to adequately consult with the OLES regarding when the administrative investigation should be opened. 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? No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Department Corrective Action	DDS and OLES met together regarding resources needed for PDC monitoring in order to prevent recurrence of the

Plan	issues.

Case Table Section	Section Content
Incident Date	07/12/2017
OLES Case Number	2017-0955MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On July 12, 2017, a psychiatric technician assistant allegedly forcefully shoved a sandwich into a resident's mouth and was allegedly dishonest during the investigative interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the psychiatric technician assistant. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	08/13/2017
OLES Case Number	2017-0961MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 13, 2017, health care staff allegedly failed to properly care for a resident, which resulted in the resident sustaining a fractured knee.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with the

	policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/12/2017
OLES Case Number	2017-0968MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 12, 2017, a psychiatric technician assistant allegedly punched a resident's face and a second psychiatric technician assistant allegedly witnessed the incident and failed to report it. Two unidentified staff members allegedly slapped the resident on the face.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/24/2017
OLES Case Number	2017-1017MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 24, 2017, a resident was discovered with a fractured knee possibly related to the resident's severe osteoporosis and bone disease.
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.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies

	and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/26/2017
OLES Case Number	2017-1025MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 26, 2017, a psychiatric technician allegedly used a mobile phone while monitoring a resident who was on a one to one level of supervision status.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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 consult with OLES during critical junctures of the investigative process.
Pre-Disciplinary Assessment	1. Did the Hiring Authority adequately consult with OLES regarding the incident? No. The Office of Protective Services did not consult with OLES during the course of the investigation. 2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? The Office of Protective Services did not confer with 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 Office of Protective Services did not consult with OLES during critical junctures of the investigative process.
Department Corrective Action Plan	OPS Command staff, OLES monitor and the office technician are now copied on email sent to the investigator which now includes whether the case is OLES monitored.

Case Table Section	Section Content
Incident Date	09/02/2017
OLES Case Number	2017-1050MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On September 2, 2017, a psychiatric technician assistant allegedly cursed at a resident and forced the resident's head into a chair. After being separated from the resident, the psychiatric technician allegedly pushed the resident in the back, grabbed the resident, and slammed his head onto a table.
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 employee was a limited-term non-permanent employee and was terminated prior to the completion of the criminal case; therefore, an administrative case was not opened. The OLES concurred.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	09/03/2017
OLES Case Number	2017-1053MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 3, 2017, a psychiatric technician allegedly hit a patient on the head.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/17/2017
OLES Case Number	2017-1128MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Training Final: No Change
Incident Summary	On April 17, 2017, and April 19, 2017, a psychiatric technician assistant allegedly locked a wheelchair bound resident into a room. A senior psychiatric technician allegedly failed to report the alleged misconduct.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the senior psychiatric technician and ordered training. The hiring authority determined there was insufficient evidence to sustain the allegation against the psychiatric technician assistant. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	11/14/2017
OLES Case Number	2017-1332MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 14, 2017, a psychiatric technician allegedly cursed at and forcefully placed a resident against a wall.
Disposition	The investigation failed to produce 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.
Investigative	Procedural Rating: Sufficient

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

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.

Appendix C1- DSH Discipline Phase Cases

Case Table Section	Section Content
Incident Date	05/09/2016
OLES Case Number	2016-0587MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty 4. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Not Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On May 9, 2016, a psychiatric technician assistant allegedly pulled on a patient's wheelchair and scratched the patient's back. Additionally, it was alleged the psychiatric technician assistant failed to complete interdisciplinary notes and she was less then truthful during her investigatory interview.
Disposition	The hiring authority sustained allegations against the psychiatric technician assistant for being less than truthful and failing to correctly date interdisciplinary notes; however, the hiring authority did not sustain an allegation for patient abuse. The hiring authority imposed a salary reduction of 5 percent for six months. The OLES concurred in the determination.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the penalty was reduced to a 5 percent salary reduction for three months and the psychiatric technician withdrew her appeal. The OLES concurred because the settlement was not unreasonable. The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was not served until 154 days after the hiring authority made disciplinary determinations.
Disciplinary Assessment Questions	1. Did a department attorney attend the Skelly hearing? No. The department policy does not require an attorney to attend the Skelly hearing. 2. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority made disciplinary determinations on January 12, 2017; however, the disciplinary action was not served until June 15, 2017, 154 days later.
Department Corrective Action Plan	The Employee Relations Office has been reorganized with an Employee Relations Manager who will oversee the completion of actions. To ensure OLES timeframes are met.

Case Table Section	Section Content
Incident Date	06/19/2016
OLES Case Number	2016-0776MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty
Findings	1. Not Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On June 19, 2016, a psychiatric technician allegedly threatened to injure a patient, allegedly shared personal information with the patient, and failed to report the patient's inappropriate interactions. The psychiatric technician was allegedly dishonest during the investigation.

Disposition	The hiring authority determined there was sufficient evidence to sustain allegations that the psychiatric technician shared personal information with the patient, failed to report the patient's inappropriate interactions, and was dishonest during the investigation. The hiring authority did not sustain an allegation for abuse. The hiring authority imposed a salary reduction of 10 percent for 12 months. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary determination was completed on October 28, 2016, but as of June 8, 2017, OLES had not been provided with a draft disciplinary action for review. The psychiatric technician was separated from state service on June 8, 2017, for reasons unrelated to this case; therefore, the disciplinary action was not served.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? No. The employee was non-punitively separated for unrelated reasons before OLES received any draft disciplinary action for review. 2. Was the disciplinary phase conducted with due diligence by the department? No. The disciplinary determination was completed on October 28, 2016, but as of June 8, 2017, OLES had not been provided with a draft disciplinary action for review. The psychiatric technician was separated from state service on June 8, 2017, for reasons unrelated to this case, and so a disciplinary action was never served.
Department Corrective Action Plan	The Department will ensure a draft of the disciplinary action is sent and will consult with an OLES monitor. The hiring authority will provide OLES with a draft copy of the disciplinary action within 60 days of penalty determination for review.

Case Table Section	Section Content
Incident Date	01/04/2017
OLES Case Number	2017-0489MA

Allegations	1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On January 4, 2017, an officer allegedly surreptitiously audio recorded a conversation with a sergeant without authorization. Further, the officer allegedly used a personal recording device and retained the recording for personal use in violation of department policy.
Disposition	The hiring authority sustained the allegations and in addition, determined the officer was dishonest during his investigatory interview and determined dismissal was the appropriate penalty. The OLES concurred. Prior to serving the officer with disciplinary action, the officer resigned. A letter was placed in his official personnel file indicating the officer resigned under adverse circumstances.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department's disciplinary process sufficiently complied with policies and procedures.

Appendix C2 – DDS Discipline Phase Cases

Case Table Section	Section Content
Incident Date	01/23/2016
OLES Case Number	2016-0326MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: Resigned in Lieu of Dismissal
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.
Disposition	The hiring authority sustained the allegation and dismissed the psychiatric technician. The OLES was not consulted.
Disciplinary	Procedural Rating: Insufficient

Assessment	Substantive Rating: Sufficient The psychiatric technician filed an appeal with the State Personnel Board. Prior to an evidentiary hearing, the parties entered into a settlement agreement wherein the psychiatric technician resigned in lieu of dismissal and agreed to never seek re-employment with the department. The OLES concurred because it was a reasonable resolution. The hiring authority failed to comply with the department's policies and procedures governing the disciplinary process. OLES was not provided with a draft of the pre-hearing settlement conference statement prior to it being filed with the State Personnel Board.
Disciplinary Assessment Questions	1. Was OLES provided with a draft of the pre-hearing settlement conference statement prior to it being filed? No. OLES was not provided with a draft of the pre-hearing settlement conference statement prior to it being filed.
Department Corrective Action Plan	DDS has developed new procedures, with the DDS-Office of Legal Affairs now providing OLES a copy of the documents prior to filing with SPB.

Case Table Section	Section Content
Incident Date	04/18/2016
OLES Case Number	2016-0474MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: Resigned in Lieu of Dismissal
Incident Summary	On April 18, 2016, a psychiatric technician allegedly left a resident, 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 resident who was left unattended in the restroom.
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.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The psychiatric technician resigned before disciplinary action could be imposed. The senior psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the senior psychiatric technician was demoted to a psychiatric technician and in exchange, he withdrew his appeal. The OLES concurred because the demotion represented a significant penalty. The hiring authority failed to comply with the department's policies and procedures governing the disciplinary process. The disposition meeting took place on September 8, 2016; however, the disciplinary action was not served on the senior psychiatric technician until May 19, 2017, 253 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The disposition meeting took place on September 8, 2016; however, the disciplinary action was not served on the employee until May 19, 2017, 253 days later.
Department Corrective Action Plan	• The Labor Relations Analyst (LRA) had performance concerns resulting in adverse actions (AA) being delayed. Through the probationary process, the LRA has since left the Department. • All pending adverse actions will be reviewed at a bi-monthly Labor meeting (Executive Director, Clinical Director and Administrative Services Director, Human Resources Director and LRA attends this meeting). • For adverse actions that are being delayed for any reason, the ED will determine what barriers are occurring and identify an action plan to address the barrier. • The ED will continue to track the timeliness of these AAs at the bi-monthly meeting. • If there are barriers identified outside of the facility's control, ED will elevate the barrier to Headquarters for resolution.

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.

Appendix D – DSH Combined Cases

Case Table Section	Section Content
Incident Date	03/25/2016
OLES Case Number	2016-01432MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Discourteous treatment 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: Salary Reduction
Incident Summary	On March 25, 2016, a registered nurse allegedly provided a patient's prescription acne medication to a second patient who did not have a prescription for the medication, failed to

	accurately document her actions in the second patient's medical chart, and coerced the second patient into not reporting what had occurred. The registered nurse was also allegedly psychologically abusive to the first patient when the registered nurse denied the accuracy of the first patient's report of what transpired. The registered nurse was allegedly dishonest to her supervisor and during the investigation of the incident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the registered nurse. The OLES concurred with the hiring authority's determination. However, the hiring authority later reduced the penalty to a salary reduction of 5 percent for three months. The OLES did not concur with the reduction in penalty. The registered nurse did not file an appeal with the State Personnel Board.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The level of care staff did not provide timely notice of the incident to the Office of Protective Services. The investigation was not completed until 222 days from the date of discovery. The hiring authority did not consult with the OLES concerning the investigative findings.
Pre-Disciplinary Assessment	1. Did the Hiring Authority respond timely to the incident? No. The alleged incident occurred on March 25, 2016; however, hospital police were not made aware of the incident until March 31, 2016, six days later. 2. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings. 3. 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

	concerning investigative findings. 4. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 31, 2016; however, the investigation was not completed until November 8, 2016, 222 days later.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The hiring authority did not consult with the OLES concerning disciplinary determinations nor provide the OLES with disciplinary documentation. OLES was originally informed the hiring authority dismissed the registered nurse; however, sometime later OLES discovered the hiring authority reduced the penalty to a salary reduction without consultation with the OLES. The department did not provide the OLES with a draft of the disciplinary action before the employee was served and did not inform the OLES when the registered nurse was finally served. The department took 257 days to complete and serve the action.
Disciplinary Assessment Questions	1. Did the Hiring Authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision? No. The hiring authority did not consult with the OLES regarding disciplinary determinations prior to making a final decision. 2. Did the Hiring Authority who participated in the disciplinary conference select the appropriate penalty? No. The hiring authority imposed a minor salary reduction of 5 percent for three months despite the seriousness of the sustained allegations. 3. Did the department attorney or human resources personnel provide to the Hiring Authority and OLES written confirmation of penalty discussion? No. The human resources personnel did not provide the OLES with written confirmation of the penalty discussions.

	4. Did the Hiring Authority consult with OLES and the department attorney (if applicable) before modifying the penalty or agreeing to a settlement? No. Neither the hiring authority nor the department attorney consulted with the OLES prior to reducing the penalty from a dismissal to a salary reduction. 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? No. The OLES was not consulted about the initial disciplinary findings and penalty or the subsequent reduction in penalty. The OLES was not provided with a draft disciplinary action before it was served and was not notified when the action had been served. 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? No. The hiring authority did not cooperate or provide continual real-time consultation with the OLES. 7. Was the disciplinary phase conducted with due diligence by the department? No. The case disposition was completed on November 8, 2016; however, the subject was not served with the action until July 22, 2017, 256 days later.
Department Corrective Action Plan	The Hiring Authority provided training to all the staff regarding timely notification to the Hiring Authority and OPS. The Hiring Authority will consult with OLES concerning the sufficiency of the investigation and the investigative findings. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 120-day time frame. The Chief of Law Enforcement is working with the Chief of

	Police on a timeline to review case log, and identify a solution for timely reporting. The Hiring Authority is in the final stages of approval of Policy Directives to address each of the deficiencies identified by OLES. Policy Directive 5315 was adopted to promote consistency, uniformity and fairness in employee discipline. The policy provides guidance to the Hiring Authority in determining the appropriate corrective and/or disciplinary action to be imposed on the employee. The corrective and/or disciplinary action will range from an informal action, such as a counseling memo or training, through the highest corrective and/or disciplinary action of dismissal. Policy Directive 6601 establishes a Disposition Committee for the Hiring Authority and sets forth the procedures to be used by the Hiring Authority to review administrative investigations that are monitored or conducted by the OLES and sets forth an executive review process if the Disposition Committee and OLES is unable to reach agreement on the misconduct or level of discipline being recommended by the Hiring Authority.

Case Table Section	Section Content
Incident Date	12/13/2016
OLES Case Number	2016-01629MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: Salary Reduction
Incident Summary	On December 13, 2016, a psychiatric technician allegedly failed to maintain constant visual observation of a patient who was on a suicide precaution watch.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 5 percent salary reduction for six months. The OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the penalty was reduced to a 5 percent salary reduction for three months plus additional training because the employee's previously unavailable personnel file reflected 15 years of prior service with no disciplinary action. The psychiatric technician agreed to withdraw her appeal. The OLES concurred with the settlement.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The department failed to inform OLES that a Skelly hearing was taking place.
Disciplinary Assessment Questions	1. If there was a Skelly hearing, was it conducted properly? No. The department failed to inform the OLES of the Skelly hearing.
Department Corrective Action Plan	The Hiring Authority will consult with OLES upon receiving notice of any post determination action that is initiated by the employee.

Case Table Section	Section Content
Incident Date	03/20/2017
OLES Case Number	2017-00350MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Salary Reduction Final: Letter of Reprimand
Incident Summary	On March 20, 2017, a psychiatric technician allegedly failed to maintain proper supervision of patients during their allocated time for shaving. A patient cut his face with blades that had been removed from a razor. The patient was sent to an outside hospital for X-rays to determine if he had swallowed any of the razor blades.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a 5 percent salary reduction for four months. The OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. However, prior to an investigatory hearing, the parties entered into a settlement agreement wherein the salary reduction was reduced to a letter of reprimand and the psychiatric technician agreed to waive back pay for the three month salary reduction that had already taken effect. The OLES concurred because the settlement represented a reasonable resolution.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient

	Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
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

Appendix E1 – DSH Monitored Issues

Case Table Section	Section Content
Incident Date	05/16/2016
OLES Case Number	2016-00625MI
Case Type	Significant Interest - Other
Incident Summary	On May 16, 2016, a review was completed of two investigations involving medical care received by patients. The first matter involved a patient who repeatedly banged her head against the wall when acting out. The second matter involved a patient who complained of pain and difficulty breathing after being placed in restraints. The complaints were logged, but X-rays were not completed until eight days later, at which time the patient was discovered to have broken ribs.
Disposition	The OLES reviewed the completed investigations in both matters. In the first case, the patient repeatedly hit her head on the wall. When a psychiatric technician attempted to stop her, he was advised by a supervisor to not intervene based on the patient's behavior plan. The investigation relied on medical professionals from the facility to determine the reasonableness of the plan. The investigation of the second case revealed the patient behavioral episode that caused the staff to take the patient down to the floor, which led to staff members falling on top of the patient's abdominal area. The patient was placed in restraints and complained of rib pain, difficulty breathing, and at one point commented that she believed her ribs were broken. Both of these cases led the OLES to recommend to the department they establish an independent medical review panel staffed with experts having no relational ties to the facilities where the case arose. This medical review panel would eliminate a conflict of interest and provide a higher level of legitimacy to investigations that deal with the standard of care.
Overall Assessment	Rating: Sufficient The department appropriately responded to the concerns raised by the OLES. The department prepared a policy by which the DSH Medical Directors Council will provide consultation to the Office of Protective Services and the OLES in the monitoring and investigation of hospital-based incidents that require second level clinical expertise.

Appendix E2 – DDS Monitored Issues

Case Table Section	Section Content
Incident Date	05/17/2017
OLES Case Number	2017-00589MI
Case Type	Significant Interest - Other
Incident Summary	After publication of the semi-annual report which covered July 1, 2016, through December 31, 2016, the Legislature had questions regarding why the Department of Developmental Services had considerably higher per-capita allegations compared to the Department of State Hospitals.
Disposition	The OLES met with Department of Developmental Services staff to obtain information that would explain the discrepancy in per-capita allegations. Department of Developmental Services staff identified specific behavioral and psychiatric conditions that are unique to the residents of their facilities that explain the higher rates of allegations.
Overall Assessment	Rating: Sufficient The department appropriately responded to the concerns raised by the OLES. The department provided insightful information regarding the unique behavioral and psychiatric conditions of the department's residents to explain the discrepancy in per-capita allegations between Department of Developmental Services and Department of State Hospitals.

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.

California Welfare and Institutions Code 4023

4023

(a) The State Department of State Hospitals shall report to the agency described in subdivision (i) of Section 4900 the following incidents involving a resident of a state mental hospital:

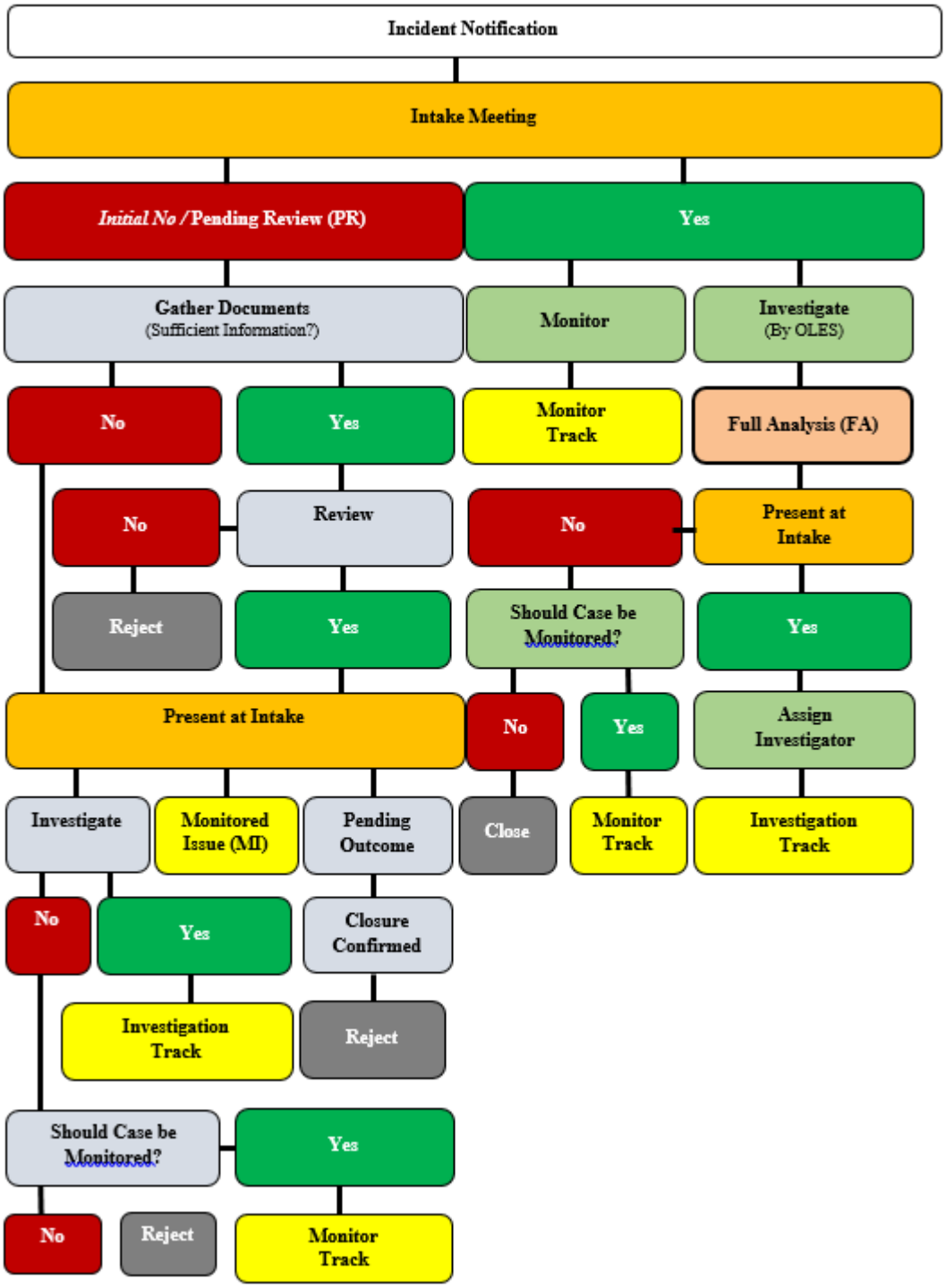
(1) Any unexpected or suspicious death, regardless of whether the cause is immediately known.

(2) Any allegation of sexual assault, as defined in Section 15610.63, in which the alleged perpetrator is an employee or contractor of a state mental hospital or of the Department of Corrections and Rehabilitation.

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

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

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 an OLES investigator. 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 designated,[14] throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

1. Department notifies OLES of an incident that meets 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

[14] 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 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority 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.

45 Days

1. AIM attends disposition conference; discusses case and analyzes with the appropriate department representative
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 60 days.

60 Days

1. Human resources unit at the facility completes NOAA and forwards to AIM for review
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 employee[15]. 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

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

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