Office of Law Enforcement Support

Semiannual Report

July 1, 2018–December 31, 2018

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 the sixth semi-annual report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency. This report 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, 2018, through December 31, 2018.

The OLES fulfills its crucial mission of ensuring the safety and security of the patients and residents within DSH and DDS facilities by providing real-time oversight and monitoring of the DSH and DDS employee discipline process, policies and procedures, and law enforcement programs throughout their nine facilities. The OLES also conducts criminal and administrative investigations of DSH and DDS police personnel. Additionally, the OLES provides technical support and investigative assistance to DSH and DDS upon request. Effective October 9, 2018, the OLES was formally accepted as a participant of the California Commission on Peace Officer Standards and Training (POST) Regular Peace Officer Program. We join more than 600 participating law enforcement agencies in affirming our commitment to adhere to quality, professional selection and training standards that ensure integrity, accountability and cooperation. This is an important recognition for our investigators in the law enforcement community and will allow OLES to recruit and retain the very best law enforcement personnel.

With this report, the OLES finalizes its third year of oversight and monitoring by providing objective, actionable information and recommendations to ensure and improve the safe and secure environments at DSH and DDS facilities for patients, residents, staff, and visitors. This report also provides the status, as of December 31, 2018, of recommendations made by the OLES which the departments continue to address to ensure best practices in law enforcement, employee discipline processes, and the tracking and management analysis of employee misconduct cases.

Combined, both departments reported a net of 26 more incidents as of December 31, 2018, compared to the prior reporting period. At DSH, reported incidents increased from 426 to 485 as of December 31, 2018, compared to the prior reporting period. From July 1, 2018 to December 31, 2018, the population at DSH facilities decreased from 6109 to 6095. At DDS, the total reported incident count dropped from 204 to 171 as of December 31, 2018, compared to the prior reporting period. From July 1, 2018 to December 31, 2018, the population at DDS facilities decreased from 505 to 400.

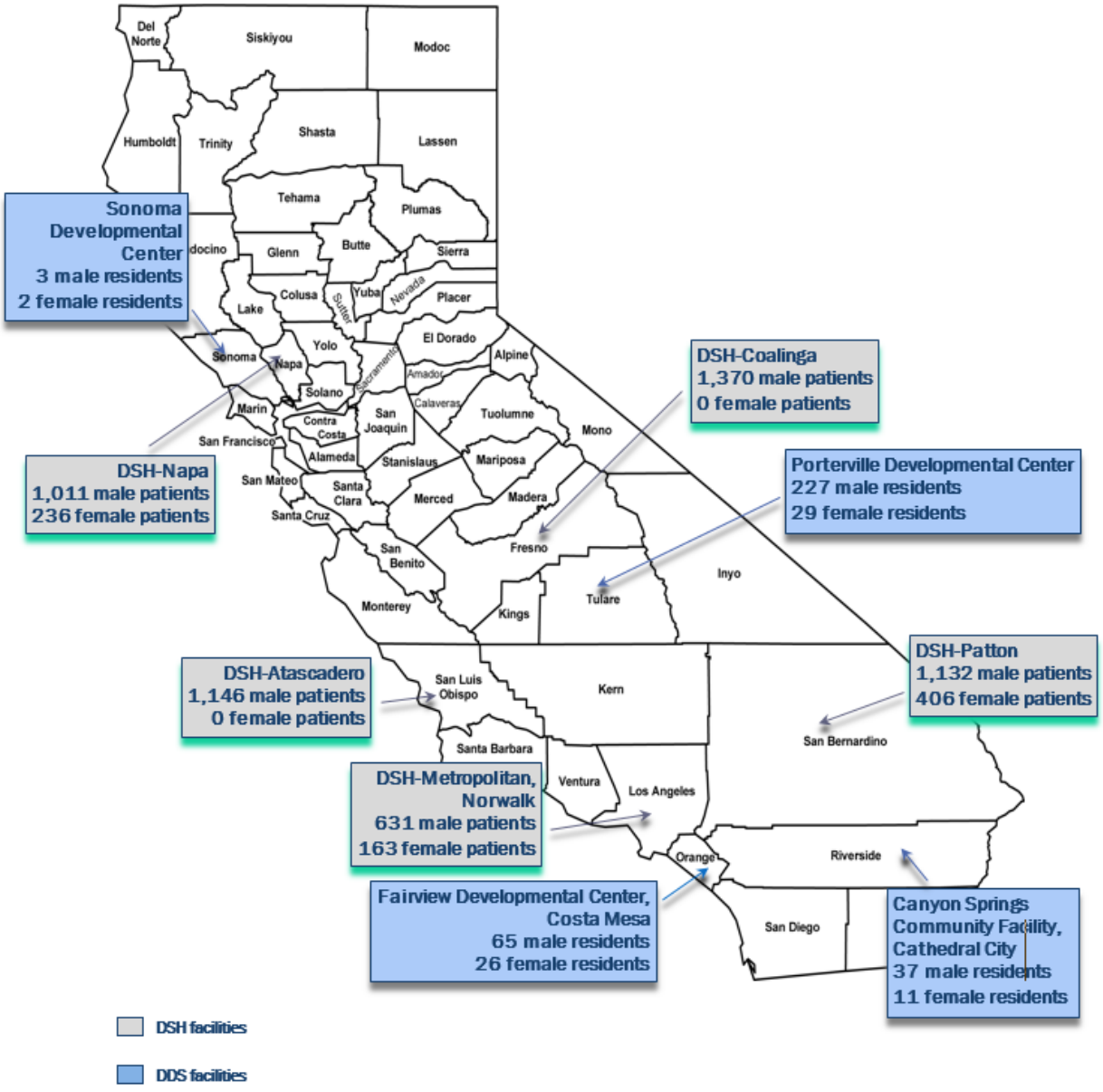
The OLES remains grateful for the ongoing collaboration, dedication, and support of our stakeholders, including Disability Rights California and the Association of Regional Center Agencies, as well as DSH and DDS management and personnel. As

always, the OLES welcomes comments and questions. Please visit the OLES website at www.oles.ca.gov.

Geoff Britton
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, 2018, were provided by the departments.

DSH and DDS Facility Population Chart

Facility	Number of Male Residents/Patients	Number of Female Residents/Patients
DSH-Atascadero	1,146	0
DSH-Coalinga	1,370	0
DSH-Metropolitan	631	163
DSH-Napa	1,011	236
DSH-Patton	1,132	406
Fairview	65	26
Porterville	227	29
Sonoma	3	2
Canyon Springs	37	11

Executive Summary

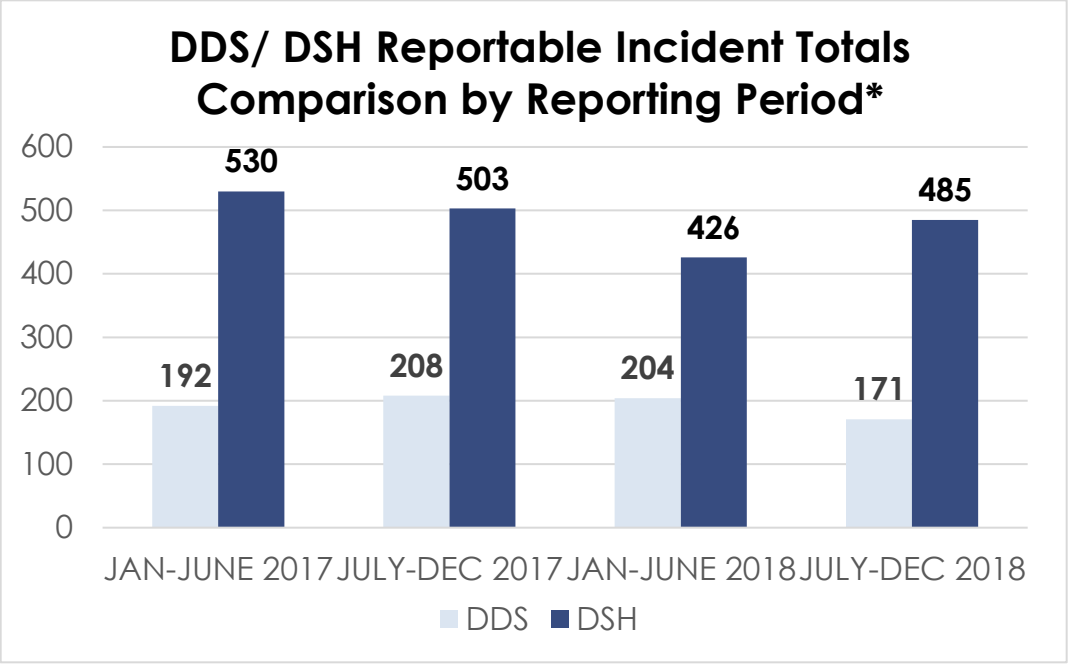
During the reporting period of July 1, 2018 through December 31, 2018, the Office of Law Enforcement Support (OLES) received and processed 656 reportable incidents[1] at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents and patients, resident and patient deaths and other occurrences, per Welfare and Institutions Code, Sections 4023, 4023.6 and 4427.5. This is an increase of 26 incident reports over the prior reporting period which had 630, the lowest number of reportable incidents since the OLES began oversight operations on January 1, 2016. The overall increase in reportable incidents statewide from 630 to 656 is a 4.1 percent increase from the prior reporting period. Of these 656 incidents, the number meeting OLES criteria for investigation, monitoring, and/or research into a systemic issue, decreased from 189 during the prior reporting period to 176 in this reporting period, a decrease of 6.9 percent.

As shown in the adjacent chart, of the total 656 reports, the OLES received 485 incident reports from DSH and 171 from DDS. DSH's 485 reportable incidents reflect an increase of 59 incidents or 13.8 percent from the prior reporting period of January 1 through June 30, 2018. Of these 485 DSH reportable incidents, 30.1 percent, or 146 incidents met the criteria for OLES investigation, monitoring, and/or led to OLES research into a systemic departmental issue.

DDS's 171 reportable incidents reflect a decline of 33 reportable incidents or 16.2 percent from the previous reporting period. Of these 171 reportable incidents, 30 incidents or 17.5 percent met the criteria for OLES investigation, monitoring, and/or led to OLES research into a systemic departmental issue.[2]

[1] Reportable incidents are pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix E).

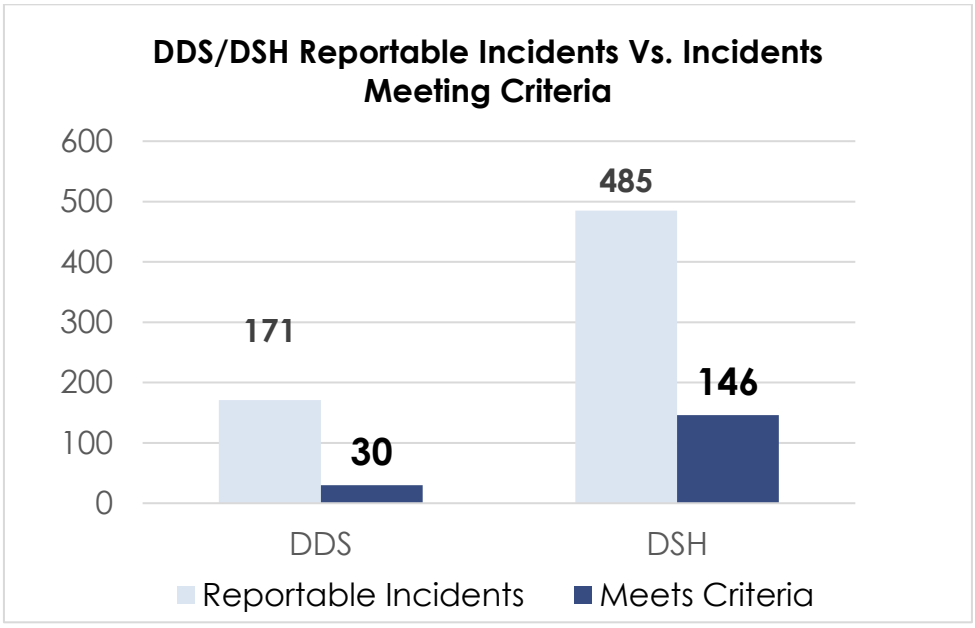
[2] The OLES chief determines whether an issue in DSH or DDS appears to be systemic and, if so, directs OLES staff to research the matter. The OLES labels such matters "monitored issues" and reports on their status in a separate section of each legislative report.



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

Types of Incidents - Reportable Incidents vs. Incidents Meeting Criteria

The OLES defines "reportable incidents" as any incident reportable to the OLES by the DSH and DDS as defined in the Welfare and Institutions Code Sections 4023, 4023.6, and 4427.5. An incident "meeting criteria" is an incident that the OLES Intake Unit determined to meet the OLES criteria for investigation and/or monitoring, or consideration for research as a potential departmental systemic issue.



New Reportable Incident Categories

In the prior reporting period, the OLES added the category of "Sexual Assault-Outside Jurisdiction" to define and separate incidents of sexual assault that are alleged to have occurred before or outside of state care. These incidents were previously included in the total count for the sexual assault category but are now separated. This category is denoted as "Sexual Assault-OJ" throughout the report.

For this reporting period and future reporting periods, the OLES added the categories of "Patient Arrest" or "Resident Arrest" for DSH and DDS respectively, as well as the category of Assault with Great Bodily Injury.

Patient and Resident Arrests

During this reporting period, for the first time, the OLES requested that DSH and DDS report patient and resident arrests. This request was made of the departments to give OLES an opportunity to review the circumstances of patient and resident arrests, specifically when patients and residents are taken into custody and booked in a local jurisdiction holding facility. The purpose of OLES oversight of patient and resident arrests is twofold:

- To ensure continuity of patient/resident treatment and care through an agreement and/or an understanding between the state facility and the local jurisdiction holding facility.
- To determine the circumstances of the arrest, and if there is no arrest warrant filed by a district attorney, that the arrest meets or exceeds the best practices standard for probable cause arrest.

During this reporting period, DSH reported 14 patient arrests. DDS reported five resident arrests. The OLES is working collaboratively with DSH and DDS to ensure patients and residents receive the best possible treatment and care at the local jurisdiction holding facility. The OLES will also review each circumstance to safeguard patient/resident rights and make certain there is strict compliance to the laws of arrest.

DSH – Most Frequent Incidents

Allegations of sexual assault represented the single largest number of alleged incidents reported by DSH during this reporting period. The OLES received 101 reports of alleged sexual assault, which accounted for 20.8 percent of all reported DSH incidents. This marked a 2.0 percent increase from the 99 sexual assault reports received during the prior reporting period.

DSH - Most Frequent Incidents July 1 through December 31, 2018

Incident Categories	Previous Period January 1 through June 30, 2018	Current Period July 1 through December 31, 2018	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Sexual Assault	99	101	2.0	26
Abuse	84	89	6.0	72
Broken Bone	58	76	31.0	7
Head/Neck Injury	36	50	38.9	0
***Sexual Assault-OJ**	33	35	6.1	0
Neglect	16	24	50.0	15
Misconduct	29	23	-20.7	20

*Last reporting period, the OLES added a new category called "Sexual Assault-OJ". All reports of alleged sexual assault outside jurisdiction are calculated separately from the "Sexual Assault" category.

There were a total of 89 reported incidents of patient abuse, making patient abuse the second largest category of incidents reported at DSH during the this reporting period. This is an increase of 6.0 percent from the 84 alleged abuse reports from the prior reporting period.

The OLES revised the reporting policy on broken bone incidents in 2016 to include broken bones of all causes, not just those of unknown origin or cause. This resulted in a significant increase in broken bone reports in the ensuing reporting period. For this reporting period, incidents of broken bones are the third most frequently reported incident. Reports of broken bones increased from 58 reportable incidents during the prior reporting period to 76 during this reporting period, an increase of 31 percent.

Reports of head/neck injuries at DSH were the fourth most frequently reported category in this reporting period. Reportable head/neck injuries increased during this reporting period to 50 reportable incidents from 36 in the prior reporting period, an increase in reportable head/neck injuries of 38.9 percent.

Sexual assault-OJ was the fifth most reported category with 35 reportable incidents in this reporting period compared to 33 in the last. This is an increase of 6.1 percent.

Neglect was the sixth most reported category with 24 incidents in this reporting period compared to 16 in the last period, an increase of 50 percent.

Reportable incidents of misconduct at DSH decreased from 29 in the prior reporting period to 23 during this reporting period, a decrease of 20.7 percent.

In the newly added category of assault with great bodily injury, there were five incidents reported. As this category was not previously tracked, there is no data to

compare from prior reporting periods.

DDS - Most Frequent Incidents

As shown in the chart below, allegations of abuse at DDS comprised the top incident category in this reporting period. The 91 reports of alleged abuse marked a 20.9 percent decrease from the 115 abuse allegations reported in the prior reporting period.

DDS - Most Frequent Incidents July 1 through December 31, 2018

Incident Categories	Prior Period January 1 through June 30, 2018	Current Period July 1 through December 31, 2018	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	115	91	-20.9	24
Head/Neck	20	26	30.0	3
Sexual Assault	25	14	-44.0	0
Broken Bone	10	12	20.0	0
AWOL	7	7	0	0
Resident Arrest	-	5	-	0

The second most reported incident in this reporting period was in the category of head/neck injury. Twenty-six head/neck injury reports were made by DDS in this reporting period, up 30 percent from the 20 reports received by the OLES in the prior reporting period. The DDS, whose population includes residents with developmental disabilities, is required to report to the OLES all head and neck injuries if they required treatment beyond first aid. This is because such injuries can cause lasting health impairment or lead to death and may be indicative of abuse.

Allegations of sexual assault ranked as the third most frequent incident reported by DDS to the OLES with 14 incidents reported. This was a 44 percent decrease from the prior reporting period of 25 incidents.

Reports of broken bones, ranked as the fourth most frequently reported incidents at DDS, increased by 20 percent during this reporting period, from 10 during the prior reporting period to 12 in this reporting period.

DDS had seven reports of residents being AWOL.[3] This was the same number as reported in the prior reporting period.

In the newly added category of assault with great bodily injury, there were four incidents reported. As this category was not tracked previously, there is no data to

[3] AWOL – A patient is "AWOL" when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in staff intervention to recover the patient.

compare from prior reporting periods.

Deaths at DSH and DDS

Deaths of DSH patients totaled 21, a decrease of 38.2 percent from the prior reporting period. Napa State Hospital (NSH) and Patton State Hospital (PSH) had the largest number of deaths reported with six each. At NSH, five deaths were due to cardiac/respiratory issues and one to cancer. At PSH, two deaths were due to cardiac/respiratory issues, one to cancer, and three to sepsis.

Three deaths of DDS residents were reported in this reporting period, a decrease of 79 percent from the prior reporting period. Porterville Developmental Center (PDC) had two deaths due to cardiac/ respiratory issues. Canyon Springs Community Facility (CSCF) had one death due to cardiac/respiratory issues.

Results of OLES investigations

Per statute,[4] an OLES investigation is initiated after the OLES is 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.

Appendix A of this report provides information on 28 OLES investigations. One investigation involved an incident that occurred in 2015, seven in 2017, and 20 investigations focused on incidents in 2018. In two administrative investigations, the OLES determined there was insufficient evidence to support the allegations, and summaries of the investigatory findings were provided to the department. Twelve completed administrative investigations were submitted to the hiring authorities at the facilities for disposition, and the OLES monitored the disposition process. The OLES conducted inquiries into nine criminal allegations and determined there was insufficient evidence that a crime was committed. The cases were closed without referral to a district attorney's office. A summary of the findings was provided to the department. One criminal investigation resulted in a referral to the appropriate district attorney's office.

Results of OLES monitored cases

In Appendices B, C, and D of this report, the OLES provides information on 152 monitored cases that, by December 31, 2018, had reached completion. Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct. Eighty-six percent, or 130 of the 152 cases, were at DSH. The OLES found that 58 monitored cases at the two departments, combined, were insufficient either procedurally, substantively or both. Procedural sufficiency includes the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency includes the quality, adequacy and thoroughness of the investigative interviews and reports.

[4] Welfare and Institutions Code Section 4023, 4023.6, 4427.5. (See Appendix E).

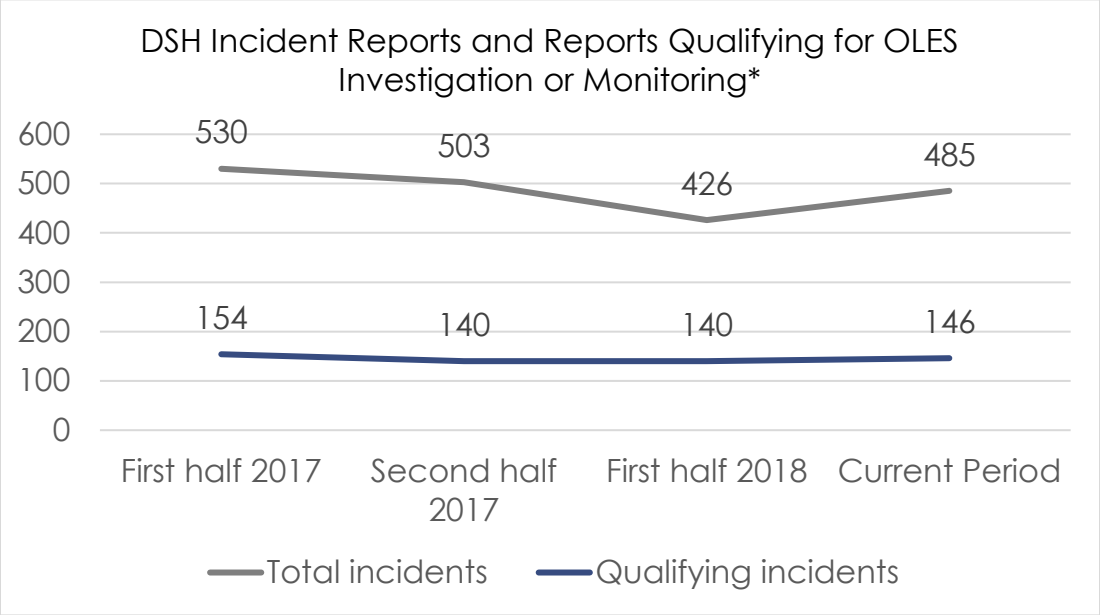
During the July 1 through December 31, 2018 period, 18 monitored administrative cases at DSH and DDS had sustained allegations. Another five criminal investigations conducted by DSH and DDS law enforcement resulted in referrals to prosecuting agencies.

DSH Incidents

Every OLES case is initiated by a report of an incident or allegation. The OLES receives reports 24 hours a day, seven days a week. During this reporting period, the majority of incident reports came from the facilities.

Increased Incidents During This Reporting Period

Overall, the number of DSH incidents reported to the OLES from July 1 through December 31, 2018, increased 13.8% percent, from 426 during the prior reporting period to 485 in this reporting period. Declines were seen in five of the 20 incident categories including death, misconduct, significant interest, attempted suicide, and attack on staff. Increases were seen in nine categories including allegations of sexual assault, abuse, broken bones, head/neck injury, neglect, AWOL, and child pornography.



* Numbers 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.

Most Frequent DSH Incidents Reported This Period

During the reporting period, 146 of 485 reportable incidents at DSH met criteria for OLES investigation and/or monitoring or led to OLES research into a potential systemic issue. This was six more than the prior reporting period. The seven most common categories under which incidents were reported accounted for 82 percent of all reportable incidents from DSH. These categories are sexual assault, abuse, broken bones, head/neck injuries, sexual assault-OJ, neglect, and misconduct. There were 398 reportable incidents in these categories.

These same seven categories accounted for 141 reportable incidents or 97 percent of all DSH reportable incidents that met the criteria for the OLES to investigate and/or monitor.

As previously identified, allegations of sexual assault topped all other reportable incidents at DSH in this reporting period. A total of 101 sexual assault allegations accounted for 20.8 percent of all incidents reported. This was an increase of two incidents from the prior reporting period of 99 allegations of sexual assault. Of the 101 reports in this period, 26 qualified for investigation and/or monitoring, or consideration of a potential systemic issue. This is an increase of 4.0 percent from 25 qualifying reports in the prior reporting period.

Abuse allegations that did not involve sexual assault were the second most frequently reported incident at DSH in this reporting period, totaling 89 and accounting for 18.4 percent of all incidents reported. This was an increase of four reported incidents, or a 4.7 percent increase from the prior reporting period. The number of allegations of abuse that met criteria for investigation and/or monitoring, or consideration of a potential systemic issue in this period also increased by 14.3 percent, from 63 during the prior reporting period, to 72 in this reporting period.

Note that while "abuse" was how certain incidents were described when reported to 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.[5]

On the next page is a chart of all reported incidents at DSH during this reporting period and the two prior reporting periods.

[5] Welfare and Institutions Code Section 15610.63, Physical Abuse (See Appendix E).

DSH Reportable Incidents by Reporting Period

Department of State Hospitals Comparison of Reportable Incidents by Reporting Period*

Incident Categories	Prior Period July 1, 2017 – Dec 31, 2017 (Reported)	Prior Period July 1, 2017 – Dec 31, 2017 (Meets Criteria)	Prior Period January 1, 2018 – June 30, 2018 (Reported)	Prior Period January 1, 2018 – June 30, 2018 (Meets Criteria)	Current Period July 1, 2018 - Dec 31, 2018 (Reported)	Current Period July 1, 2018 - Dec 31, 2018 (Meets Criteria)
Sexual Assault	115	20	132 (99)	25	101	26
Abuse	108	77	85	63	89	72
Broken Bone	66	6	58	7	76	7
Head/Neck Injury	52	1	36	2	50	0
Sexual Assault-O/J**	-	-	33	0	35	0
Neglect	20	7	16	5	24	15
Misconduct	48	18	29	25	23	20
Death	28	8	34	11	21	5
AWOL	18	1	10	0	14	0
Patient Arrest	-	-	-	-	14	0
Child Pornography	7	0	6	0	13	0
Significant Interest***	31	2	10	0	9	0
Assault/GBI	-	-	-	-	5	0
Attempted Suicide	3	0	5	0	4	0
Burn	2	0	1	0	3	0
Attack on Staff	4	0	3	0	2	0
Genital Injury	1	0	1	1	1	0
Non-Resident Assault	0	0	1	1	1	1
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0

Incident Categories	Prior Period July 1, 2017 – Dec 31, 2017 (Reported)	Prior Period July 1, 2017 – Dec 31, 2017 (Meets Criteria)	Prior Period January 1, 2018 – June 30, 2018 (Reported)	Prior Period January 1, 2018 – June 30, 2018 (Meets Criteria)	Current Period July 1, 2018 - Dec 31, 2018 (Reported)	Current Period July 1, 2018 - Dec 31, 2018 (Meets Criteria)
Totals	503	140	426	140	485	146

* Numbers in these columns are unadjusted and are provided as they were previously published.
**Beginning with the prior reporting period covering January 1, 2018 through June 30, 2018, the OLES added a category called "Sexual Assault- OJ". These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DSH.
***Any incident of significant interest, e.g., civilian arrest for providing contraband to a patient; and the smuggling of drugs into a State hospital.

Change From Prior Period Jan 1 – Jun 30, 2018

Incident Categories	Reportable Incidents	Incidents Meeting Criteria
Sexual Assault	2.0	4.0
Abuse	4.7	14.3
Broken Bone	31.0	0
Head/Neck Injury	38.9	-100
Sexual Assault-O/J**	6.1	0
Neglect	50.0	200
Misconduct	-20.7	-20.0
Death	-38.2	-54.5
AWOL	40.0	0
Patient Arrest	-	-
Child Pornography	116.7	0
Significant Interest***	-10.0	0
Assault/GBI	-	-
Attempted Suicide	-20.0	0
Burn	200	0
Attack on Staff	-33.3	0
Genital Injury	0	-100
Non-Resident Assault	0	0
Pregnancy	0	0
Riot	0	0

* Numbers in these columns are unadjusted and are provided as they were previously published.
**Beginning with the prior reporting period covering January 1, 2018 through June 30, 2018, the OLES added a category called "Sexual Assault- OJ". These incidents were previously included in the total count for these categories but are now

identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DSH.
***Any incident of significant interest, e.g., civilian arrest for providing contraband to a patient; and the smuggling of drugs into a State hospital.

DSH Reportable Incidents by Facility This Reporting Period

Department of State Hospitals Summary of Reportable Incidents by Facility July 1 – December 31, 2018

Incident Categories	Atascadero	Coalinga	Metropolitan	Napa	Patton	Totals
Sexual Assault	11	19	30	22	19	101
Sexual Assault- OJ*	18	0	6	3	8	35
Abuse	9	13	23	13	31	89
Broken Bone	19	19	24	4	10	76
Head/Neck Injury	10	5	19	8	8	50
Misconduct	3	10	6	0	4	23
Significant Interest**	1	1	4	3	0	9
Death	2	2	5	6	6	21
Neglect	8	1	10	2	3	24
AWOL	0	1	10	1	2	14
Child Pornography	0	13	0	0	0	13
Attack on Staff	0	0	1	0	1	2
Attempted Suicide	0	0	0	1	3	4
Burn	2	1	0	0	0	3
Genital Injury	0	0	1	0	0	1
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Non-Resident Assault	0	0	0	1	0	1
Patient Arrests	1	8	3	0	2	14
Assault/GBI	1	0	1	1	2	5
Totals	85	93	143	65	99	485

* Beginning with the prior reporting period covering January 1, 2018 through June 30, 2018, the OLES added a category called "Sexual Assault- OJ". These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DSH.
** Any incident of significant interest, e.g., civilian arrest for providing contraband to a patient; and the smuggling of drugs into a State hospital.

Distribution of DSH incidents

With 485 incidents reported from July 1 through December 31, 2018, DSH accounted for 74.0 percent of the reportable incidents to the OLES in this period. With 6,095 patients department-wide, this equates to .080 incidents per patient.

The Metropolitan State Hospital (MSH) had the highest number of reportable incidents in this period with 143 reports, an increase of 11.7 percent from the previous reporting period where MSH had 128 reportable incidents. With a population of 794, the 143 incidents translated to a rate of .18 incidents per patient at MSH during this period. This is an increase from the rate of .16 incidents per patient in the previous reporting period, despite a decrease in patient population of 17 patients.

Coalinga State Hospital (CSH) had an increase of 14.8 percent in reportable incidents, from 81 during the prior reporting period to 93 in this reporting period. The population increased from 1321 to 1370, an increase of 49 patients since the prior reporting period. The number of incidents per patient increased from .06 per patient during the prior reporting period to .068 per patient during this reporting period.

NSH had an increase of 18.2 percent in reportable incidents from 55 during the prior reporting period to 65 during this reporting period. The patient population decreased from 1278 during the prior reporting period to 1247 during this reporting period. The number of incidents per patient increased from .04 per patient to .05 during this reporting period.

PSH had a 20.7 percent increase in reportable incidents from the previous reporting period, from 82 reportable incidents to 99. The patient population increased from 1526 patients during the prior reporting period to 1538 during this reporting period, an increase of 12 patients. The number of incidents per patient increased from .05 to .06 during this reporting period.

Atascadero State Hospital (ASH) had an increase of 6.3 percent in reportable incidents, from 80 during the prior reporting period to 85 during this reporting period. The population decreased by 27 patients, from 1173 to 1146 during this reporting period. The number of incidents per patients increased from .068 to .074 during this reporting period.

DSH Sexual Assault Allegations

Reports of alleged sexual assault were the largest single incident category received by the OLES for the reporting period at DSH. The 101 alleged sexual assault incidents reported from July 1 through December 31, 2018, accounted for 20.8 percent of all DSH incident reports. Of these, only 26 of 101 reported incidents of alleged sexual assault, or 25.7 percent, met the OLES criteria for investigation, monitoring and/or research into systemic department issues.

MSH had the highest number of sexual assault reports with 30 or 29.7 percent of all alleged sexual assault incidents during this reporting period.

When excluding the new category of Sexual Assault-OJ, MSH had the highest number of alleged sexual assault reports at 26, plus four alleged sexual assaults outside jurisdiction, a total of 30 incidents.

The largest segment of alleged sexual assaults, 51.8 percent or 52 of 101 reported incidents involved allegations of patients sexually assaulting other patients.

The second largest segment of alleged sexual assaults, 36 reported incidents or 18.4 percent, was defined by the OLES as "non-law enforcement staff on patient."

The third largest segment of alleged sexual assaults, 12 reported incidents or 11.9 percent was defined by the OLES as "Outside Jurisdiction/Unknown" because allegations made by patients did not implicate DSH employees or contractors. This category included allegations that implicated family, friends, or others in incidents that occurred when patients were not in a DSH facility.

There was one alleged "patient on staff" sexual assault.

There were no alleged sexual assaults on patients by law enforcement personnel during this reporting period. This is down 100 percent from the last reporting period where there was one allegation of sexual assault by law enforcement staff on patients.

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.

DSH - Sexual Assault Allegations Reported July 1 through December 31, 2018

Facility	Patient on Patient Incidents	Non-Law Enforcement Staff on Patient Incidents	Patient on Staff Incidents	Law Enforcement on Patient Incidents	OJ/Unknown Person on Patient Incidents*	Totals
Atascadero	6	4	0	0	1	11
Coalinga	12	6	0	0	1	19
Metropolitan	20	5	1	0	4	30
Napa	4	14	0	0	4	22
Patton	10	7	0	0	2	19
Totals	52	36	1	0	12	101

*Sexual Assault-OJ is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH or outside the jurisdiction of the state hospital. Sexual Assault-Unknown is a patient allegation of sexual assault at DSH when the patient is unsure if another person is involved.

DSH patient deaths

There were 21 patient deaths reported to the OLES at DSH facilities during this reporting period. This number is down 38.2 percent from the 34 deaths reported in the prior reporting period, January 1 through June 30, 2018. Patient age at the time of death ranged from 25 years to 84 years old. Of the 21 deaths, 20 were male patients and one was female.

NSH and PSH had the highest number of deaths at six deaths each. Five deaths at NSH were attributed to cardiac/respiratory and one death was attributed to cancer. At PSH, there were two deaths categorized as cardiac/respiratory; one as cancer; and three as sepsis. Two deaths at MSH were categorized as cardiac arrest, one death as renal/liver, and two categorized as "other." There were two deaths at ASH; one categorized as cardiac/respiratory and one as renal/liver failure. CSH had two deaths, one in the category of cancer and one "other."

DSH - Patient Deaths Reported July 1 through December 31, 2018

Facility	Cardiac/ Respiratory	Cancer	*Renal/Liver*	Cerebral Issue	Sepsis	Other	Totals
Atascadero	1	0	1	0	0	0	2
Coalinga	0	1	0	0	0	1	2
Metropolitan	2	0	1	0	0	2	5
Napa	5	1	0	0	0	0	6
Patton	2	1	0	0	3	0	6
Totals	10	3	2	0	3	3	21

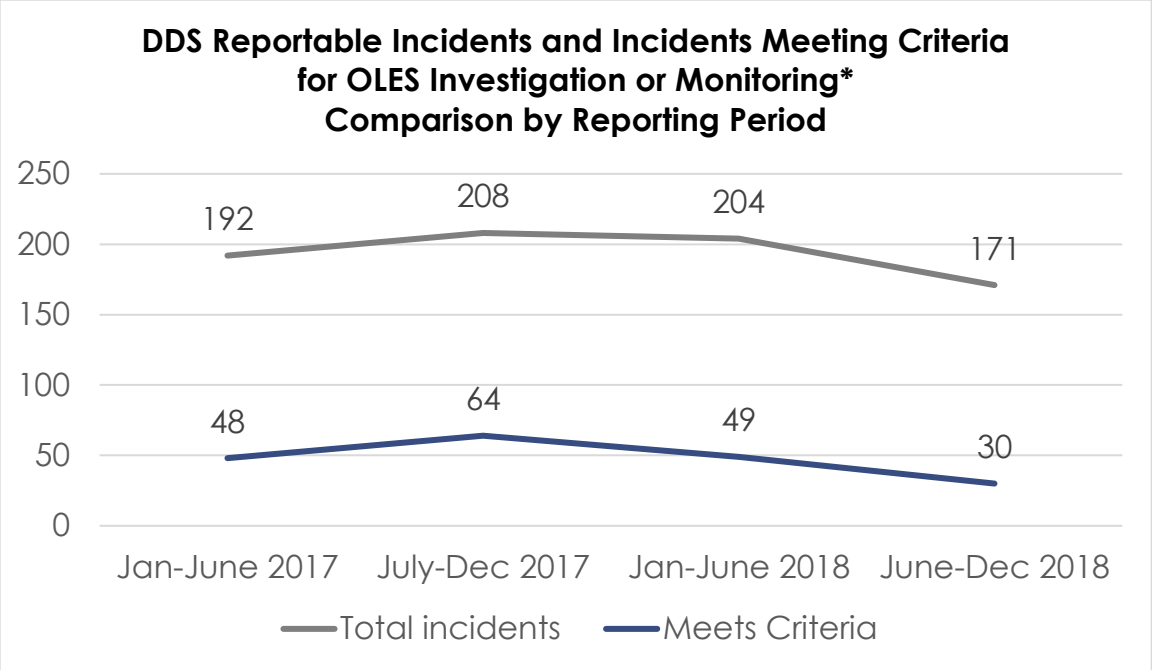
*Other deaths are those pending determination

Twelve or 57 percent of the DSH deaths were classified as "expected" due to underlying health conditions, such as cancer and kidney disease. Nine deaths were classified as "unexpected," and each of these deaths received two levels of review within DSH, per department policy. The OLES also reviewed the deaths and monitored the departmental investigations on the unexpected deaths at DSH.

DDS Incidents

Decreased Incidents During This Reporting Period

Overall, the number of DDS incidents reported during this reporting period decreased by 1.9 percent, from 204 during the prior reporting period to 171 during this reporting period. During this reporting period, the majority of incident reports came from the developmental centers.



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

Of the 171 reportable DDS incidents in this reporting period, 17.5 percent or 30 incidents, met the criteria for OLES investigation or monitoring or led to OLES research into a systemic departmental issue. As the graph shows, the number of reportable incidents dropped slightly, and the number of reportable incidents meeting criteria decreased significantly from 45 in the prior reporting period to 30 in this reporting period. This is a decrease of 38.8 percent or 19 incidents meeting criteria in this reporting period.

DDS Population Decrease

Since June 2016, the DDS population has dropped 60 percent, from 988 to 400 as of December 2018. The pending closure of Sonoma Developmental Center (SDC) accounts for the most significant drop with a population of 360 in June 2016 to five residents in December 2018.

The chart below shows the change in population at the DDS facilities over the past two and a half years.

DDS Population Decrease

Reporting Period End Date	Canyon Springs	Fairview	Porterville	Sonoma	Totals
June 30, 2016	47	232	349	360	988
December 31, 2016	45	204	338	334	921
June 30, 2017	48	166	321	260	795
December 31, 2017	47	140	280	178	645
June 30, 2018	49	108	269	79	505
Current Period	48	91	256	5	400
Percentages	2%	-61%	-27%	-99%	-60%

The DDS facility population decreased for the following reasons:

SDC: The last remaining DDS residents were placed in the community in December 2018, with the exception of five Stabilization, Training, Assistance, and Reintegration (STAR) home individuals. On June 30, 2019 the Department of General Services will take over responsibility of the facility.

Fairview Developmental Center (FDC): It is projected that the remaining residents will be placed in the community by December 2019. On June 30, 2020 the Department of General Services will take over responsibility of the facility.

PDC General Treatment Area: It is projected that the remaining residents in the General Treatment Area (46) will be placed in the community by September 2019. The Secure Treatment Area will remain open.

Most frequent DDS Incidents Reported This period

Of the 171 reported incidents from DDS, 159 incidents or 93 percent of all incidents fell into the following seven categories: abuse, sexual assault, head/neck injuries, broken bone, AWOL, resident arrest, and assault with great bodily injury. These same seven categories accounted for 27 incidents or 15.8 percent of all DDS reportable incidents that met the criteria for the OLES to investigate and/or monitor or research for potential systemic departmental issues.

Alleged abuse was the most frequent DDS incident reported in this reporting period. The 91 abuse allegations accounted for 53.2 percent of all DDS incidents reported. Reports of alleged abuse decreased by 24 incidents or 20.9 percent compared to the prior reporting period. While "abuse" was how certain incidents were described when reported to 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.[6]

[6] Welfare and Institutions Code Section 15610.63, Physical Abuse (See Appendix E).

Reports of head/neck injuries at DDS constituted the second most frequently reported incident by DDS. The OLES requires notification of all head/neck injuries that require 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. There were 26 reports of head/neck injuries at DDS in this reporting period, which is an increase of six incidents or 30 percent from the prior reporting period. None of the 26 reportable incidents for head/neck injury met the OLES criteria for further action.

Alleged sexual assault represented the third highest category for the number of incidents reported, with 14 reported. This is a decrease of 44 percent from the prior reporting period where there were 25 reported. Of the 14 reportable incidents, three incidents or 4.7 percent met criteria for investigation or monitoring. This is a change from the prior reporting period where reports of sexual assault were second in number to abuse.

Broken bone was the fourth most frequently reported incident category, with 12 reports of broken bones in this reporting period, an increase of two incidents or 20 percent from last period. None of the reported incidents met criteria for further action.

The fifth most frequently reported incident category is AWOL. There were seven reports of AWOL in this reporting period. This is an increase of two incidents or 40 percent compared to the prior reporting period.

In the new category of Resident Arrest there were five reported incidents of arrests. This is the sixth most frequently reported incident category. This category was not previously tracked, so there is no information to compare.

The chart on the next page shows DDS Reportable Incidents by Reporting Period over three reporting periods beginning January 1, 2017, through this reporting period.

DDS Reportable Incidents by Reporting Period

Department of Developmental Services Comparison of Reportable Incidents by Reporting Period

Incident Categories	Prior Period July 1, 2017 – Dec 31, 2017 (Reported)	Prior Period July 1, 2017 – Dec 31, 2017 (Meets Criteria)	Prior Period January 1, 2018 – June 30, 2018 (Reported)	Prior Period January 1, 2018 – June 30, 2018 (Meets Criteria)	Current Period July 1, 2018 - Dec 31, 2018 (Reported)	Current Period July 1, 2018 - Dec 31, 2018 (Meets Criteria)
Abuse	105	47	115	40	91	24
Head/Neck Injury	21	1	20	0	26	0
Sexual Assault	16	2	25	1	14	3
Broken Bone	16	3	10	2	12	0
AWOL	7	0	5	0	7	0
Resident Arrest	-	-	-	-	5	0
Assault/GBI	-	-	-	-	4	0
Death	18	4	14	2	3	1
Neglect	15	6	6	1	2	1
Significant Interest*	6	1	4	1	2	0
Genital Injury	3	0	2	0	2	0
Misconduct**	0	0	2	2	1	1
Attempted Suicide	0	0	0	0	1	0
Burn	1	0	1	0	1	0
Attack on Staff	0	0	0	0	0	0
Child Pornography	0	0	0	0	0	0
Non-Resident Assault	0	0	0	0	0	0
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Sexual Assault-OJ***	-	-	0	0	0	0
Totals	208	64	204	49	171	30

* 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 39 of this report.
*** Beginning with the prior reporting period covering January 1, 2018 through June 30, 2018, the OLES added a category called "Sexual Assault-OJ". These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DDS.

Change From Prior Period Jan 1 – Jun 30, 2018

Incident Categories	Reportable Incidents	Incidents Meeting Criteria
Abuse	-20.9	-40.0
Head/Neck Injury	30.0	0
Sexual Assault	-44.0	200
Broken Bone	20.0	100
AWOL	40.0	0
Resident Arrest	-	-
Assault/GBI	-	-
Death	-78.6	-50.0
Neglect	-66.7	0
Significant Interest*	-50.0	-100
Genital Injury	0	0
Misconduct**	-50.0	-50.0
Attempted Suicide	100	0
Burn	0	0
Attack on Staff	0	0
Child Pornography	0	0
Non-Resident Assault	0	0
Pregnancy	0	0
Riot	0	0
Sexual Assault-OJ***	0	0

* 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 39 of this report.
*** Beginning with the prior reporting period covering January 1, 2018 through June 30, 2018, the OLES added a category called "Sexual Assault-OJ". These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DDS.

DDS Reportable Incidents by Facility This Reporting Period

Department of Developmental Services Summary of Reportable Incidents by Facility July 1 through December 31, 2018

Incident Categories	Canyon Springs	Fairview	Porterville	Sonoma	Totals
Sexual Assault	5	2	7	0	14
Sexual Assault-OJ*	0	0	0	0	0
Abuse	22	38	27	4	91
Broken Bone	1	4	6	1	12
Head/Neck Injury	1	5	13	7	26
Misconduct	0	0	1	0	1
Significant Interest**	0	0	2	0	2
Death	1	0	2	0	3
Neglect	0	1	1	0	2
AWOL	3	2	2	0	7
Child Pornography	0	0	0	0	0
Attack on Staff	0	0	0	0	0
Attempted Suicide	0	0	1	0	1
Burn	1	0	0	0	1
Genital Injury	0	1	1	0	2
Pregnancy	0	0	0	0	0
Riot	0	0	0	0	0
Non-Resident Assault	0	0	0	0	0
Assault/GBI	0	0	4	0	4
Resident Arrest	0	0	5	0	5
Total	34	53	72	12	171

* Beginning with the prior reporting period covering January 1, 2018 through June 30, 2018, the OLES added a category called "Sexual Assault- OJ". These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DDS.

** 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.

Distribution of DDS Incidents

The 171 DDS incidents reported July 1 through December 31, 2018, accounted for 26.1 percent of all 656 reports to the OLES in this reporting period. With 400 residents department-wide, this equates to .43 incidents per resident.

PDC, which has 256 residents, had 72 reportable incidents from July 1 through December 31, 2018. This is an increase of 7.5 percent from the 67 incidents reported

in the prior reporting period. PDC had a population reduction from 269 residents in the prior reporting period to 256 during this reporting period.

SDC had a decrease in reportable incidents from 21 to 12 in this reporting period, a decrease of 42.9 percent. SDC had a population reduction from 79 residents in the prior reporting period to five during this reporting period.

CSCF had a decrease in reportable incidents of 40.4 percent, from 57 to 34 during this reporting period with a population reduction of only one resident.

FDC reported 53 incidents during this reporting period, compared to 59 during the prior reporting period, a decrease of 10.2 percent. FDC also experienced a population reduction of 17 residents, from 108 in the prior reporting period to 91 in this reporting period.

DDS Sexual Assault Allegations

The OLES received 14 incident reports alleging sexual assault at DDS in this reporting period, a decrease from 25 reports or 44 percent in the prior reporting period. Of these 14 reportable incidents, five were from CSCF, seven from PDC, and two from FDC. Reportable incidents of alleged sexual assault accounted for 8.2 percent of all reportable incidents from DDS. Five of the reported sexual assault incidents, or 35.7 percent were alleged to be by non-law enforcement staff. Nine of the 14 allegations of sexual assault reported to OLES, or 64.3 percent, were reports of resident on resident assault.

DDS - Sexual Assault Incidents Reported July 1 through December 31, 2018

Facility	*Resident on Resident Incidents*	*Non-Law Enforcement Staff on Resident Incidents*	*Law Enforcement on Resident Incidents*	*OJ/Unknown * on Resident Incidents*	*Total*
Canyon Springs	4	1	0	0	5
Porterville	0	2	0	0	2
Fairview	5	2	0	0	7
Sonoma	0	0	0	0	0
Totals	9	5	0	0	14

*Sexual assault -OJ is a resident report of an alleged sexual assault that occurred before the resident was in the care of the DDS or outside the jurisdiction of the state facility. Sexual assault "Unknown" is a resident allegation of sexual assault at DDS when the resident is unsure if another person is involved.

DDS resident deaths

The DDS reported three deaths during this reporting period. Two deaths were reported by PDC, and one by CSCF. The three deaths reported were due to

cardiac or respiratory issues. The ages of the deceased residents ranged from 33 to 60 years old and were all male. Of the three deaths, two were classified as "expected" and one was "unexpected."

DDS - Resident Deaths Reported July 1 through December 31, 2018

Facility	*Cardiac/Respiratory*	*Cancer*	*Renal/Liver*	Sepsis	Other	Totals
Canyon Springs	1	0	0	0	0	0
Fairview	0	0	0	0	0	0
Porterville	2	0	0	0	0	0
Sonoma	0	0	0	0	0	0
Totals	3	0	0	0	0	0

*Other deaths are those pending determination.

Notification of Incidents

Different types of incidents require different kinds of notification to the OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq. (in Appendix E), and agreements between the OLES and the departments, certain serious incidents are 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 no later than the close of the first business day following the discovery of the reportable incident. "Priority 2" threshold incidents require 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 or patient 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, patient or resident arrest, allegations of possession of child pornography, riot and any incident which may potentially draw media attention • 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

In this reporting period, DSH and DDS timely reporting of incidents to the OLES statewide was 94.4 percent. This is an increase in timely reporting of incidents statewide from the prior reporting period where the timely reporting was 92.9 percent. Of 656 reportable incidents statewide, 619 were reported timely, 37 reportable incidents or 5.6 percent were not.

The DSH had 485 reportable incidents department-wide. Of these, 456 or 94.0 percent were reported timely, compared to 90.6 percent in the prior reporting period. Twenty-nine incidents, or six percent were not reported timely. ASH had the highest percentage of timely notifications at 99 percent during this reporting period. NSH had the lowest percentage of timely notifications with 88 percent of all reportable incidents.

The DDS had 171 reportable incidents department-wide. Of these, 163 or 95.3 percent were reported timely compared to 97.5 percent in the prior reporting period. Eight incidents or 4.7 percent were not reported timely. CSCF reported 100% of their 34 reportable incidents timely. SDC had the lowest percentage of timely notifications with 83 percent of all reportable incidents.

DSH - Timely Notifications July 1 through December 31, 2018

Rank	DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Atascadero	1148	85	84	99%
2	Coalinga	1370	93	87	94%
3	Metropolitan	794	143	135	94%
4	Napa	1247	65	57	88%
5	Patton	1538	99	93	92%
	Totals	6095	485	456	94%

* The department provided population numbers as of December 31, 2018.

DDS - Timely Notifications July 1 through December 31, 2018

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Canyon Springs	48	34	34	100%
2	Fairview	91	53	49	92%
3	Porterville	256	72	70	97%
4	Sonoma**	5	12	10	83%
	Totals	400	181	163	94%

* The department provided population numbers as of December 31, 2018.
** At the beginning of the reporting period, SDC had a population of 79 residents. The facility was closed in December 2018. Please refer to page 22 for an explanation of the population decrease.

Intake

All incidents received by the OLES during the six-month reporting period are reviewed at a daily Intake meeting by a panel of assigned OLES staff members. Based on statutory requirements, the panel determines whether allegations against law enforcement officers warrants an internal affairs investigation by the OLES. If the allegations are against other DSH or DDS staff members and not law enforcement personnel, the panel determines whether the allegations warrant OLES monitoring of any departmental investigation. A flowchart of all the possible OLES outcomes from Intake is shown in Appendix F. To ensure the OLES is independently assessing whether an allegation meets its criteria, the OLES requires the departments to broadly report misconduct allegations.

For this reporting period, 480 of the total 656 DSH and DDS incidents the OLES received were reviewed, but no cases were opened. These Reviewed, Case Closed (RCC) incidents did not meet the criteria for the OLES to undertake an investigation and/or monitoring. This amounted to 73.2 percent of all the incidents that were reviewed by the OLES.

The DSH accounted for 304 of the 480 incidents that were RCC, or 63.3 percent of the total RCC incidents in this reporting period. Sexual assault allegations were the single largest DSH category where reported incidents did not meet the OLES criteria; therefore, the majority of these cases, 121 out of 150, were RCC.

The DDS component of the total 405 incidents that were RCC during the six-month period totaled 141. This amounted to 29.4 percent of all incidents that were RCC. Abuse allegations accounted for 67 of the 139 DDS incidents that were RCC.

Every incident that is deemed RCC by the OLES receives a pending review (PR) – an extra step to ensure that incidents that initially appear to not fit the criteria[7] for OLES involvement are being properly categorized. When allegations are unclear and additional information is needed to finalize an initial intake decision, it can cause a significant delay. 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. This requires more time for the OLES to acquire the recordings from the facility for review. Once the additional material/information is obtained and evaluated by the OLES, the decision to initially deem an incident as not meeting the OLES criteria is reviewed again and may be reversed.

[7] Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix E).

DSH Disposition of Cases

OLES Disposition Categories	January 1 – June 30, 2018 Number	Percentage of Reported Incidents	July 1 – Dec 31, 2018 Number	Percentage of Reported Incidents
Reviewed, Case Closed (RCC)	250	58%	304	63%
Monitored, Criminal	101	24%	90	19%
Outside Jurisdiction*	36	8%	35	7%
OLES Investigations, Administrative	17	4%	8	1%
OLES Investigations, Criminal	12	3%	11	2%
Monitored, Administrative	10	2%	37	8%
Totals	426	100%	485	100

*The OLES did not use Outside Jurisdiction as a category in 2017. Outside Jurisdiction includes incidents that may have occurred while the resident or patient was not housed within DSH or DDS.

DDS Disposition of Cases

OLES Disposition Categories	January 1 – June 30, 2018 Number	Percentage of Reported Incidents	July 1 – Dec 31, 2018 Number	Percentage of Reported Incidents
Reviewed, Case Closed (RCC)	155	76%	141	82%
Monitored, Criminal	42	21%	27	16%
Monitored, Administrative	4	2%	2	1%
OLES Investigations, Administrative	2	.05%	0	0%
OLES Investigations, Criminal	1	.05%	1	1%
Outside Jurisdiction*	0	0%	0	0%
Totals	204	100%	171	100%

*The OLES did not use Outside Jurisdiction as a category in 2017. Outside Jurisdiction includes incidents that may have occurred while the resident or patient was not housed within DSH or DDS.

Investigations and Monitoring

The OLES has several statutory responsibilities under the California Welfare and Institutions Code Section 4023 et seq. (see Appendix E). 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 Investigations

During this reporting period, the OLES completed 28 investigations. Twelve investigations were criminal cases and 16 were administrative.

If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, the OLES submits the investigation to the appropriate prosecuting agency. During the second half of 2018, the OLES referred one criminal investigation to a prosecuting agency. All completed OLES investigations into administrative wrongdoing/misconduct are forwarded to facility management for review. In this reporting period, 12 administrative cases were referred to management for possible discipline of state employees and two 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 warranted.

The following chart shows the results of all the completed OLES investigations in this reporting period. These investigations are in Appendix A.

DSH Only - Results of Completed OLES Investigations

Type of Investigation	Total completed July 1- Dec. 31, 2018	Referred to prosecuting agency	Referred to facility management	Closed without referral*
Administrative	16	N/A	12	4
Criminal	12	1	N/A	11
Totals	28	1	12	15

* 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 152 monitored cases at the two departments that, by December 31, 2018, had reached resolution. Of these cases, 84 or 55.3 percent of the 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	49	14	63
Criminal/Referred to Prosecuting Agency	3	2	5
Total Criminal	52	16	68
Administrative/Without Sustained Allegations	61	5	66
Administrative/With Sustained Allegations	17	1	18
Total Administrative	78	6	84
Grand Totals	130	22	152

The OLES provides assessments of the completed monitored cases. At DSH, 42 of the departmental investigations, also known as pre-discipline phase cases, were deemed procedurally insufficient by the OLES during the last six months of 2018. Three were substantively insufficient. Procedural sufficiency includes the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency includes the quality, adequacy, and thoroughness of the investigative interviews and reports.

The most prevalent deficiency at DSH continues to be the failure to complete investigations within the 120-day required timeframe. During the prior reporting period, 24 percent of the DSH reports were not completed within the required timeframe. During this reporting period, the percentage remained the same at 24 percent or 27 of 111 monitored investigations and reports.

At DDS, seven of the departmental investigations, also known as pre-discipline phase cases, were assessed as procedurally insufficient by the OLES. There were no

substantive insufficiencies.

Monitoring the Discipline Phase

When an administrative investigation, either by the department or by the OLES, is completed, an investigation report with facts about the allegations is sent to the hiring authority. 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 appropriate discipline.

Appendices C and D provide assessments of 13 cases in the disciplinary phase monitored by the OLES that reached resolution during the reporting period. Eleven of these 13 cases were at DSH and two were at DDS. The OLES assesses every discipline phase case for both procedural and substantive sufficiency. Procedural sufficiency includes, 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 includes 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.

At DSH, six cases in the disciplinary phase were deemed procedurally insufficient by the OLES, and one was deemed substantively insufficient. At DDS, two discipline cases were assessed as procedurally insufficient. All were substantively sufficient.

Perspective on Departments Imposing Discipline

As of the last semi-annual report, both departments have implemented policies that incorporate the OLES' recommendation to serve a disciplinary action within 60 days after a decision is made to impose discipline.

In the previous semi-annual period, the average length of time to serve an action at DSH ranged from 17 to 520 calendar days with an average length of time to serve disciplinary actions of 119 calendar days. The length of time to serve an action at DDS ranged from 187 to 752 calendar days with an average length of time to serve disciplinary actions of 409 calendar days.

In this reporting period, the OLES reviewed 24 disciplinary actions. The departments served 20 disciplinary actions: 18 at DSH and two at DDS. Four cases are pending service of disciplinary actions at DSH.

DSH served 18 disciplinary actions on employees between 34 and 268 days after the hiring authority made disciplinary determinations. The average length of time to

serve an action increased from last period's average of 119 days to 129 days. DSH failed to meet its own policy requiring service of the disciplinary action within 60 days from the decision to impose in 14 of the 18 disciplinary actions served this reporting period. The remaining four cases at DSH have been pending service of disciplinary actions between ten and 80 days.

The most egregious lengths of time of 268, 245, and 233 days involve two MSH cases and one PSH case respectively. The first MSH case involved a senior psychiatric technician who allegedly failed to monitor and separate two patients who had been in a physical altercation. As a result, an altercation between the same patients occurred the following day, leaving one of the patients unconscious. The hiring authority made findings and penalty determinations on December 19, 2017; however, the disciplinary action was not served to the employee until September 13, 2018, 268 days later.

The second MSH case involved a psychiatric technician assistant who 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 allegedly dishonest during an investigative interview. The hiring authority made disciplinary determinations on December 27, 2017. The disciplinary actions were not served until August 29, 2018, 245 days later.

The PSH case involved a psychiatric technician who allegedly struck a patient in the back of the head and called the patient a derogatory term because the patient would not leave the dining hall during a fire alarm drill. Additionally, the psychiatric technician was allegedly dishonest during his investigatory interview. The hiring authority made disciplinary determinations on January 10, 2018. The disciplinary actions were not served until August 31, 2018, 233 days later.

DDS served two disciplinary actions on employees between 32 and 169 days after the hiring authority made disciplinary determinations. The average length of time to serve an action decreased from last period's average of 409 days to 100 days. DDS failed to meet its own policy that requires DDS to serve a disciplinary action within 60 days of the disciplinary determination in one of the two disciplinary actions served.

One of the principles of effective discipline is that discipline should be imposed in a 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 and in compliance with their policies.

Additional Mandated Data

The OLES is required by statute to publish data into its semi-annual report about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where patients or residents are the perpetrators. All the mandated data for this reporting period 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****
Atascadero	28	12	15	0	1
Coalinga	62	15	30	15	2
Metropolitan	57	8	41	6	2
Napa	30	9	16	5	0
Patton	62	6	50	4	2
Totals	239	50	152	30	7

* 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 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****
Canyon Springs	5	2	3	0
Fairview	5	0	5	0
Porterville	5	5	0	0
Sonoma	4	2	2	0
Totals	19	9	10	0

* 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 (Direct Action) 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 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****
Atascadero	4	4	0	2
Coalinga	0	0	0	0
Metropolitan	34	1	33	1
Napa	18	0	18	0
Patton	10	9	1	9
Totals	66	14	52	12

* 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****
Canyon Springs	43	0	43	0
Fairview	1	0	1	0
Porterville	7	2	5	0
Sonoma	2	0	2	0
Totals	53	2	51	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****
Atascadero	179	103	76	76
Coalinga	308	99	209	20
Metropolitan	791	37	754	12
Napa	444	22	422	5
Patton	276	139	137	126
Totals	1998	400	1598	239

* 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****
Canyon Springs	2	0	2	0
Fairview	1	0	1	0
Porterville	79	72	7	9
Sonoma	0	0	0	0
Totals	82	72	10	9

* 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	CA Board of Behavioral Science
Atascadero	1	9	0	0	1
Coalinga	2	2	0	0	0
Metropolitan	0	1	0	0	0
Napa	0	2	0	0	0
Patton	0	4	0	0	0
Totals	3	18	0	0	1

*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
Canyon Springs	0	0	0	3	0
Fairview	0	0	0	29	0
Porterville	0	0	0	12	0
Sonoma	0	0	0	4	0
Totals	0	0	0	48	0

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

Special Review – Napa State Hospital

Special Review of NSH Policy and Procedures

In November 2018, the OLES conducted a review of policy and procedures relating to use of force, patient arrests, training, and emergency responses as a result of an incident at NSH. Specifically, the OLES had questions regarding the supervisory response to emergency incidents, supervisory review of reports, and the level of authority required to arrest a patient.

The incident occurred in March 2017 and involved use of force by four hospital police officers and a patient. The patient suffered significant facial and head injuries as a result of the incident, and one of the officers suffered a concussion during the confrontation. The patient was subsequently arrested for assaulting the injured officer. The patient was provided medical treatment and booked into the Napa County Jail.

The OLES determined during the review of the incident that the NSH Office of Protective Services (OPS) has sound policies and procedures in place to address the uses of force, patient arrests, and emergency responses. Additionally, the OPS Report Management System is the appropriate tool for officers to properly document incidents and ensure the events are reviewed by a supervisor.

In reviewing the interviews of the on-scene supervisory personnel in the criminal and administrative investigations related to the incident, it is clear there needs to be a higher level of awareness and involvement by supervision and management in incidents that potentially expose the department to liability. For example, there should be a prioritized effort by supervisors to thoroughly review all reports and gather information related to the case being mindful of the potential for civil liability. In this case, there were steps taken by the investigator to gather evidence for the criminal investigation of the patient; however, there was no documented action by supervision and management to gather information to protect the department. This information is critical as it allows DSH Legal to proactively prepare for potential litigation and ensure departmental management has all the necessary information to improve or create policies that support patient and staff safety.

The OLES recommends OPS managers and supervisors at NSH receive additional training on civil liability prevention and mitigation to assist them in approaching critical incidents that may expose the department to liability.

Monitored Issues

In the course of its oversight duties, the OLES may observe issues that reveal potential patterns, shortcomings, or systemic issues at the facilities. In these situations, the Chief of the OLES instructs OLES staff to research and document the issues. These issues are then brought to the attention of the departments. In most instances, the OLES requests corrective plans. Updates on long-running monitored issues are provided below. There are no new monitored issues for this reporting period.

Child Pornography at CSH

As mentioned in the semi-annual report covering July 1 through December 31, 2017, the OLES focused on what appeared to be a spike in reports of patients in possession of child pornography at CSH. From January 1 through June 30, 2017, there were 19 reports of patients found in possession of child pornography within the state hospital. In the semi-annual report covering July 1 through December 31, 2017, there were seven incidents of child pornography reported by CSH. In the prior reporting period, there were six reports of child pornography as part of the mandated reporting set up by the OLES, and OLES included an extensive article in the previous semi-annual report about the child pornography problem at CSH. During this reporting period, CSH reported 13 incidents of Child Pornography. DSH also reported a total of eight arrests for child pornography related offenses at CSH.

The OLES analyzed the 13 reports of child pornography and discovered that eight of the 13 incidents were a result of the CSH's implementation of the three phase plan to eradicate the illegal material from the facility, which began in early 2018

Phase One was an amnesty program implemented in cooperation with the Fresno County District Attorney's Office. Patients were allowed to turn in their contraband devices voluntarily and anonymously if they chose. Patients would not be subject to prosecution during this phase.

Phase Two was a voluntary program that allowed patients to turn in their contraband devices to facility personnel. These devices would be searched with consent of the patient and mailed out of the facility if deemed legal to possess. It was during this phase two process that eight separate incidents of suspected child pornography were discovered, during this reporting period.

Phase Three included a facility wide sweep for contraband, after patients were given the opportunities in phase one and two to comply with the new contraband regulations. Phase Three is still in effect and ongoing and has resulted in five additional reports of suspected child pornography being discovered by hospital staff during this reporting period. The eight patient arrests were from recent criminal investigations conducted by law enforcement at CSH, for offenses that occurred at the facility, which resulted in filings with the Fresno County District Attorney's office.

The OLES staff recently toured CSH and met with officials and can report that DSH attempts to eradicate, investigate and prevent patient possession of child pornography are working. The OLES continues to monitor and work collaboratively with DSH to increase compliance with the DSH regulations on contraband to improve the safety and security for all patients.

Duty to Cooperate at DSH

In the course of monitoring investigations in the prior reporting period, the OLES identified an issue of DSH employees refusing to cooperate with investigators. The OLES discovered that there is no department-wide, written policy concerning the service of notices for interviews. Some investigators simply call or email the employee; others serve a formal notice. The OLES recommended DSH develop a department-wide, written policy mandating the use of formal interview notices with standardized language. As of December 31, 2018, the department drafted a policy requiring the use of standardized interview notices in administrative investigations. The policy describes the service process of the interview notices to interviewees. DSH is currently drafting a set of standardized interview notices for use by OPS investigators during their investigations. The policy and notices are being reviewed by the department's executive management team and Legal Division. Once the reviews are complete, the policy and interview notices will be provided to OLES for review and comment.

Lack of Patient Separation Policy at DSH

In the course of an investigation during the July 1 through December 2017 reporting period, the OLES discovered a lack of specific, written policy at MSH 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 incident, which resulted in a second battery the next day. During the second battery, the aggressor patient choked the victim patient to the point of unconsciousness.

The DSH does not have a written department-wide policy to prevent these repeat incidents. The existing practice of giving the clinical treatment team the discretion to decide whether to move or separate patients involved in altercations puts patients at risk of harm and victimization. The OLES previously recommended DSH develop department-wide written policy and procedures regarding separation of patients who are involved in altercations. In response to the OLES recommendation, DSH drafted a policy directive which requires the review of a patient's housing to determine the most appropriate housing placement following an assaultive incident. The draft policy directive is still being reviewed by department management to ensure the policy directive addresses all relevant patient and facility needs. Once DSH completes that review, the draft policy directive will be provided to OLES for review and comment.

Deficiencies in Use of Force Reporting at DSH

In the course of monitoring use-of-force incidents, during prior reporting periods, the OLES identified several issues related to policy and reporting of use-of-force incidents and made comprehensive recommendations to DSH in the semi-annual report covering July 1 through December 31, 2017. These observations 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 the officers' actions before, during, and after the incidents. There were also incidents involving allegations of excessive force that were not sufficiently investigated and not included in the required executive committee reviews. The frequency and pervasiveness of these reporting deficiencies indicate there is inadequate supervisory review.

As reported in the previous semi-annual report, the DSH advised the OLES of a pending use-of-force review process, to be introduced in the near future, that will include comprehensive forms designed to capture significant supervisor and managerial review. The OLES continues to collaborate with DSH on policy language that will ensure the on-scene supervisor's actions and observations are incorporated into each use-of-force report. This new process will also include a third level manager review, which will then be forwarded to the Chief of Police for a fourth level review. This third and fourth level of review development for every use of force incident will be a significant improvement for DSH once implemented.

The DSH has committed to engage their supervisory staff more thoroughly with this improvement in use-of-force review and reporting. The OLES will continue to work with the DSH to monitor the implementation of the new process and evaluate the remaining OLES use-of-force recommendations.

Personal Electronic Devices at Work

In the semi-annual report covering January 1 through June 2017, the OLES recommended that DSH draft and implement a department-wide policy prohibiting DSH staff from having and using personal electronic devices at their workstations and while screening staff and visitors. In response to the OLES recommendation, DSH developed a draft policy on the use of personal electronic devices at the facilities. As of December 31, 2018, the draft policy was being reviewed by the various employee bargaining organizations which represent DSH employees.

DSH Patient Pregnancies

In the semi-annual report covering January 1 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 to best manage patients who become pregnant while residing in a state hospital or if they are pregnant when they are admitted to a DSH facility. In response to the OLES recommendations, the

DSH drafted two policies titled "Child Placement" and "Patient Sexuality."

The first policy titled "Child Placement" allows the pregnant patient to decide where and with whom her infant will be placed after birth. This policy was fully implemented. The second policy titled "Patient Sexuality" identifies what must be considered when determining patient placement in co-ed living quarters. DSH completed a draft policy and presented it to OLES for review and comment. Once that process is complete, the policy will be submitted to the DSH Executive Team for review.

DSH Extraction Policy and Training

In the semi-annual report covering January 1 through June 2017, the OLES identified a systemic issue concerning room and area extractions of patients. The OLES discovered that DSH law enforcement might not be evaluating the circumstances of events to determine if exigency exists or if calculated intervention would be a better and safer option to remove a patient from an area. The DSH did not have a 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 response to the recommendation, DSH drafted a policy and proposed training plan. As of December 31, 2018, DSH completed the purchase of extraction equipment and developed a training program for facility trainers scheduled to take place in January 2019. At the end of the training, the facility trainers will return to their home facilities and begin the process of training all law enforcement staff in both the OPS Extraction Policy and Extraction Techniques. Once the facility-based training is completed, the Extraction Policy will be implemented department-wide.

OLES Recommendations-DSH

As required by statute[8], in March 2015 OLES 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 previously, the OLES updated the recommendations for best practices in law enforcement and employee discipline that the OLES made to the departments. Below are the two remaining recommendations provided by OLES to DSH and the status provided verbatim by DSH as of December 31, 2018.

DSH law enforcement organizational structure

OLES Recommendation of best Practice	Status as of June 30, 2018	Status as of December 31, 2018
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.	Partially Implemented. 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. SB1495 was introduced by the Senate Committee on Health on February 28, 2018, and if passed will further clarify DSH's Law Enforcement Reporting Structure.	Fully implemented. Pursuant to SB 1495 (Statutes of 2018) - DSH restructured the Law Enforcement Reporting Structure on January 1, 2019. The hospital Police Chiefs now report to the Hospital Executive Directors, rather than the Hospital Administrators, and are members of each hospital's executive management team. DSH also elevated the DSH Chief of Law Enforcement to the role of Deputy Director. As a Deputy Director, the Chief of Law Enforcement is a member of the DSH Governing Body. The Law Enforcement Reporting Structure is now accomplished through

[8] 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, 2018	Status as of December 31, 2018
		the executive governance structures of DSH with oversight by the DSH Chief of Law Enforcement.

DSH standardized training

OLES Recommendation of Best Practice	Status as of June 30, 2018	Status as of December 31, 2018
B 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 enforcement personnel at all facilities statewide.	The Field training program was fully developed within Envisage training software (OPS TRAIN) on March 14, 2018. Due to unexpected delays the implementation of Continuing Professional Training (CPT) within OPS TRAIN is still ongoing. DSH anticipates full implementation of CPT December 31, 2018	Partially implemented. DSH created and/or updated and entered all lesson plans for the Continuing Professional Training (CPT) into the OPS TRAIN Software. DSH also developed the User's Guide and Training Course for OPS law enforcement training staff, necessary to administer the CPT Program. DSH has scheduled training and expects full implementation of the CPT program and training of all law enforcement staff to begin by February 1, 2019. This training will be ongoing for all DSH law enforcement staff from that point in time forward.

Appendix A: OLES Investigations

Appendix A1 OLES Investigations - DSH

Investigation Detail	Section Content
Incident Date	01/01/2015
OLES Case Number	2017-00932C
Case Type	Misconduct
Incident Summary	In January 2015, an officer allegedly used State training funds for his personal use. In June 2015, the officer was allegedly dishonest when he completed a travel claim form stating the funds had been used for training. In June and July 2017, the officer was allegedly dishonest to his supervisors regarding the misuse of the funds.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the appropriate District Attorney's office.

Investigation Detail	Section Content
Incident Date	08/25/2017
OLES Case Number	2017-01142A
Case Type	Misconduct
Incident Summary	Between August 25, 2017, and August 30, 2017, a law enforcement supervisor allegedly placed adverse documents into an officer's official personnel file without the officer's knowledge and the opportunity to respond resulting in a denial of job opportunities.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	01/17/2018
OLES Case Number	2018-00117A
Case Type	Misconduct
Incident Summary	On January 17, 2018, six officers allegedly grabbed a patient and slammed his head into a metal window frame.
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	12/01/2017
OLES Case Number	2018-00159A
Case Type	Misconduct

Incident Summary	In December 2017, a law enforcement supervisor allegedly purposely dispersed pepper spray in an office hallway.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	03/13/2018
OLES Case Number	2018-00303A
Case Type	Misconduct
Incident Summary	On March 13, 2018, an officer allegedly sexually assaulted a hospital employee. The officer was also allegedly dishonest during the investigative interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	03/20/2018
OLES Case Number	2018-00534A
Case Type	Misconduct
Incident Summary	On March 20, 2018, a law enforcement supervisor allegedly grabbed and yelled at a subordinate employee.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The investigative case was submitted to the hiring authority for review.

Investigation Detail	Section Content
Incident Date	12/01/2017
OLES Case Number	2018-00581A
Case Type	Misconduct
Incident Summary	In December 2017, a law enforcement supervisor allegedly failed to take appropriate action on or report a subordinate's intentional disbursement of pepper spray in an office hallway.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	12/01/2017
OLES Case Number	2018-00582A
Case Type	Misconduct
Incident Summary	In December 2017, a sergeant allegedly provided his supervisor with a canister of pepper spray which the

	supervisor then intentionally disbursed in an office hallway. The sergeant allegedly failed to report the misconduct.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	12/01/2017
OLES Case Number	2018-00583A
Case Type	Misconduct
Incident Summary	In December 2017, a sergeant allegedly failed to report the misconduct of a supervisor who intentionally sprayed pepper spray in an office hallway.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	12/01/2017
OLES Case Number	2018-00584A
Case Type	Misconduct
Incident Summary	In December 2017, a sergeant allegedly made inappropriate sexual comments to a supervisor. In addition, the sergeant was allegedly dishonest during an investigative interview.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	06/14/2018
OLES Case Number	2018-00621C
Case Type	Misconduct
Incident Summary	On June 14, 2018, an officer allegedly grabbed a patient by the arm, threw him into a wall, and pushed his face against the wall.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/13/2018

OLES Case Number	2018-00644C
Case Type	Misconduct
Incident Summary	On June 13, 2018, a sergeant allegedly yelled at a hospital employee and detained him for an excessive period of time during a traffic stop.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed or misconduct occurred. The case was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/22/2018
OLES Case Number	2018-00659A
Case Type	Misconduct
Incident Summary	On June 22, 2018, a law enforcement supervisor allegedly texted a sexually inappropriate image and message to a subordinate employee while on duty.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
Incident Date	06/22/2018
OLES Case Number	2018-00665A
Case Type	Misconduct
Incident Summary	On June 22, 2018, an officer allegedly used a sergeant's login information to gain access to a computer program she was not authorized to access.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that serious misconduct occurred. A summary of the findings and recommendations was provided to the department.

Investigation Detail	Section Content
Incident Date	07/01/2018
OLES Case Number	2018-00697C
Case Type	Abuse
Incident Summary	In July 2018, five to seven officers allegedly assaulted a patient.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's

	office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/23/2018
OLES Case Number	2018-00698C
Case Type	Misconduct
Incident Summary	On June 23, 2018, five officers, a sergeant, and a lieutenant allegedly conducted an unlawful search and arrest of an employee.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	06/23/2018
OLES Case Number	2018-00745C
Case Type	Misconduct
Incident Summary	On June 23, 2018, officers allegedly conducted an unlawful search of an employee and unlawfully seized her personal property.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	01/01/2018
OLES Case Number	2018-00751C
Case Type	Misconduct
Incident Summary	During 2018, a hospital employee allegedly abused multiple patients and retaliated against another employee who reported the abuse. The hospital management allegedly failed to take appropriate action against the employee.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the

	department.

Investigation Detail	Section Content
Incident Date	07/04/2018
OLES Case Number	2018-00832A
Case Type	Misconduct
Incident Summary	On July 4, 2018, an officer allegedly claimed he worked when he in fact took the day off.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The completed investigation was forwarded to the DSH Hiring Authority for review.

Investigation Detail	Section Content
Incident Date	12/08/2017
OLES Case Number	2018-00854A
Case Type	Misconduct
Incident Summary	On December 8, 2017, an officer allegedly sent intimidating text and phone messages to another officer. On December 23, 2017, the first officer allegedly sent nude photographs of the second officer to a third officer. On January 3, 2018, and October 18, 2018, the first officer allegedly was dishonest in his investigative interviews.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES will monitor the disposition process.

Investigation Detail	Section Content
Incident Date	08/06/2018
OLES Case Number	2018-00953C
Case Type	Misconduct
Incident Summary	On August 6, 2018, several officers allegedly pushed a patient to the ground and injured his right hand.
Disposition	The Office of Law Enforcement support conducted an inquiry into this matter and determined the allegations did not meet the statutory criteria of serious law enforcement misconduct for further investigation by the OLES. The OLES provided a summary of the findings to the department and recommended an investigation into misconduct of another staff member. The OLES monitored this criminal investigation.

Investigation Detail	Section Content
Incident Date	09/30/2018
OLES Case Number	2018-01056C
Case Type	Misconduct

Incident Summary	On September 30, 2018, an officer allegedly slammed a patient against a wall, pushed his face into the wall, and kicked his legs apart.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined the allegation did not meet the statutory criteria for an investigation by the OLES. The OLES provided a summary of the findings to the department.

Investigation Detail	Section Content
Incident Date	10/06/2018
OLES Case Number	2018-01076C
Case Type	Misconduct
Incident Summary	On October 6, 2018, an officer allegedly injured a patient's elbow when he took the patient to the ground.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined the allegations did not meet the statutory criteria for investigation by the OLES. The OLES provided a summary of the findings to the department.

Investigation Detail	Section Content
Incident Date	10/17/2018
OLES Case Number	2018-01140C
Case Type	Misconduct
Incident Summary	On October 17, 2018, an officer allegedly used unnecessary force by pushing a patient up against the wall and bending his wrist.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	11/08/2018
OLES Case Number	2018-01216A
Case Type	Misconduct
Incident Summary	On November 8, 2018, an officer allegedly left his assigned post without permission.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined it did not rise to the level of an OLES investigation. The matter was referred back to the department.

Appendix A2 OLES Investigations – DDS

Investigation Detail	Section Content
Incident Date	02/11/2018
OLES Case Number	2018-00262A
Case Type	Significant Interest - Other
Incident Summary	On February 11, 2018, an employee allegedly failed to retain possession of his assigned building keycard and failed to report his keycard missing resulting in the building being burglarized and vandalized. On August 23, 2018, the employee allegedly was dishonest to an outside law enforcement investigator who was investigating the burglary and vandalism. On October 30, 2018, the employee allegedly refused to cooperate with OLES' administrative investigation.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The employee resigned before the case disposition was completed.

Investigation Detail	Section Content
Incident Date	06/22/2018
OLES Case Number	2018-00650A
Case Type	Significant Interest - Other
Incident Summary	On June 22, 2018, it was alleged that a facility manager ordered officers to falsify reports in order to hide cases of resident abuse.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
Incident Date	11/01/2018
OLES Case Number	2018-01178C
Case Type	Misconduct
Incident Summary	On November 1, 2018, an officer allegedly stole $20 from a resident during a room search.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

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

Appendix B1 Pre-Disciplinary Cases - DSH

Case Table Section	Section Content
Incident Date	01/18/2017
OLES Case Number	2017-00072MA
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 was observed to have an unaccounted for bruise on his arm. The patient alleged a psychiatric technician had pushed him, causing the bruise.
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 137 days from the date the administrative investigation was initiated.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 19, 2018. A criminal investigation was completed. This administrative investigation was initiated on March 11, 2018; however, the investigation was not completed until July 25, 2018, 137 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	05/22/2017
OLES Case Number	2017-00605MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 22, 2017, a registered nurse, two senior psychiatric technicians, and three psychiatric technicians allegedly attempted to choke a patient and threatened to break 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: 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. The initial report was not completed for 29 days. The hiring authority failed to make timely disciplinary determinations and likewise failed to consult with the OLES regarding the disciplinary determinations.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The hiring authority failed to consult with 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 failed to contemporaneously consult with the OLES concerning disciplinary determinations. Disciplinary determinations were

	made in March 2018; however, the OLES was not informed of the disciplinary determinations until August 2018, despite having requested the information several times. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on May 22, 2017; however, the investigation was not completed until January 30, 2018, 253 days later. The Office of Protective Services did not complete the initial report for 29 days. The hiring authority did not conduct the disciplinary conference for more than two months after the completion of the investigation.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties. 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	06/13/2017
OLES Case Number	2017-00684MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 13, 2017, a psychiatric technician allegedly struck a patient, which caused the patient's head to strike 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: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring

	authority failed to consult with the OLES concerning disciplinary determinations and did not provide the disposition information to the OLES in a timely manner despite repeated requests. The investigation was not completed until 252 days from the date of discovery.
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 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 concerning disciplinary determinations. Additionally, the hiring authority did not respond to multiple requests for information about the disposition of the case over a course of eight months. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on June 13, 2017; however, the investigation was not completed until February 20, 2018, 252 days later.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties. 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	06/20/2017
OLES Case Number	2017-00725MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 20, 2017, staff members allegedly fractured a patient's arm during a containment procedure after the patient became agitated and attempted to strike staff members.
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 hiring authority did not consult with the OLES regarding the sufficiency of the investigation and investigative findings. The hiring authority failed to consult with the OLES concerning disciplinary determinations and did not provide the disposition information to the OLES in a timely manner despite repeated requests. The investigation was not completed until 212 days from the date of discovery.
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 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 concerning investigative findings. Further, the hiring authority did not provide the OLES with the disposition results for five months despite repeated requests for information. 3. Was the pre-disciplinary/investigative phase

	conducted with due diligence? No. The incident was discovered on July 5, 2017; however, the investigation was not completed until February 2, 2018, 212 days later.
Department Corrective Action Plan	In the future, the hiring authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties. 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	06/22/2017
OLES Case Number	2017-00731MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 22, 2017, a psychiatric technician allegedly struck a patient repeatedly about the head and 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 hiring authority did not consult with the OLES regarding investigative findings. Additionally, the hiring authority did not provide the OLES with the disposition findings for five months despite several requests. The investigation was not completed until 236 days from the date of discovery.
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 investigative findings. Additionally, the hiring authority did not provide the disposition of the investigation to the OLES for five months, despite several requests. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on June 22, 2017; however, the investigation was not completed until February 13, 2018, 236 days later.
Department Corrective Action Plan	In the future, the hiring authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties. 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	07/08/2017
OLES Case Number	2017-00910MA
Allegations	1. Criminal Act
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 8, 2017, an officer was arrested for allegedly committing domestic violence and vandalism.
Disposition	The officer completed counseling and the charges were dismissed. The department did not take disciplinary action

	against the officer.
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	08/16/2017
OLES Case Number	2017-01028MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 16, 2017, a psychiatric technician allegedly broke a patient's wrist.
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 investigation was not completed until 358 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 August 29, 2018; however, the investigation was not completed until August 22, 2018, 358 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	10/07/2017
OLES Case Number	2017-01178MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 7, 2017, a senior psychiatric technician allegedly shined a flashlight in a patient's face and struck him on the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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 conduct the review of the sufficiency of the investigation and make investigative findings until four months after the completion of the investigation. The investigation was not completed until 178 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The investigation was completed on April 3, 2018; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation and investigative findings until August 2018. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 7, 2017; however, the investigation was not completed until April 3, 2018, 178 days later. The initial Office of Protective Services report was not completed until November 14, 2017, 38 days after the incident. The hiring authority did not conduct the review of the investigation and make investigative findings until approximately four months after the completion of the investigation.
Department	In the future, the hiring authority will consult with OLES as

Corrective Action Plan	required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties. In the future, the hiring authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties.

Case Table Section	Section Content
Incident Date	10/07/2017
OLES Case Number	2017-01184MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 7, 2017, a registered nurse and a psychiatric technician allegedly assaulted a patient while the patient was in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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 investigative findings. Additionally, the hiring authority did not provide the OLES with the disposition results for five months despite several requests.
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 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 disposition of the investigation. Additionally, the hiring authority did not provide the OLES with the disposition results for approximately five months despite numerous requests for information.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties.

Case Table Section	Section Content
Incident Date	01/10/2017
OLES Case Number	2017-01223MA
Allegations	1. Discourteous treatment
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On January 10, 2017, an investigator allegedly sent sexually harassing text messages to another employee.
Disposition	The hiring authority sustained the allegations and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
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	09/15/2017
OLES Case Number	2017-01233MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between September 15, 2017, and October 18, 2017, a staff member allegedly inappropriately touched a patient during a wall 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 properly report the incident to the OLES. The hiring authority failed to consult with the OLES regarding the sufficiency of the investigation and investigative findings. Additionally, the hiring authority did not provide the OLES with the investigative disposition for approximately six months despite repeated requests.
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 properly report this incident to the OLES. The OLES was not telephonically notified within two hours of discovery of the allegation. 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 regarding 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 regarding the investigation. Additionally, the hiring authority did not provide the OLES with the investigative disposition for approximately six months despite repeated requests.
Department Corrective Action Plan	In the future, the hiring authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where the OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties.

Case Table Section	Section Content
Incident Date	10/23/2017
OLES Case Number	2017-01246MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On October 23, 2017, a doctor allegedly inappropriately touched a patient over her clothes and, with another staff member, threatened the patient if she reported the incident.
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 consult with the OLES regarding the sufficiency of the investigation and investigative findings. The hiring authority did not provide the OLES with the outcome of the investigative review until five months 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 consult with the OLES regarding the sufficiency of the investigation and 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 concerning disciplinary determinations and did not inform the OLES of the outcome of the disciplinary review for approximately five months. The disciplinary review took place during March 2018; however, the OLES was not provided the results until August 2018.
Department Corrective Action Plan	In the future, the hiring authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties.

Case Table Section	Section Content
Incident Date	10/25/2017
OLES Case Number	2017-01257MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 25, 2017, a psychiatric technician allegedly struck a patient after the patient struck 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 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 225 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 25, 2017; however, the investigation was not completed until June 7, 2018, 225 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	11/06/2017
OLES Case Number	2017-01304MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 6, 2017, two psychiatric technicians allegedly assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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 169 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 6, 2017; however, the investigation was not completed until April 24, 2018, 169 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	11/11/2017
OLES Case Number	2017-01321MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 11, 2017, five staff members allegedly restrained and assaulted 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: 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 investigative findings. The hiring authority did not notify the OLES of the outcome of the case for five months.
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 investigative findings. The hiring authority did not provide the OLES with the outcome of the investigative review for five months. The investigative review took place during March 2018; however, the OLES was not provided the results until August 14, 2018.
Department Corrective Action Plan	In the future, the Hiring Authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties.

Case Table Section	Section Content
Incident Date	03/01/2016
OLES Case Number	2017-01447MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Sustained
Penalty	Initial: Salary Reduction Final:
Incident Summary	From March 2016 to February 2018, a psychiatric technician allegedly engaged in non-therapeutic behavior when she played basketball with patients on multiple occasions. From April 2017 to February 2018, the same psychiatric technician allegedly engaged in an overly-familiar relationship with a patient.
Disposition	The hiring authority sustained allegations against the psychiatric technician for overfamiliarity, but did not sustain any abuse allegations. The hiring authority imposed a 10 percent salary reduction for 13 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 244 days from the date the administrative investigation was opened. The hiring authority did not consult with the OLES regarding investigative findings until 57 days after receiving the completed investigation.
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 completed investigation was forwarded to the hiring authority on August 16, 2018; however, the hiring authority did not consult with the OLES until October 12, 2018, 57 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The Office of Special Investigations opened an administrative investigation on December 13, 2017; however, the investigation was not completed until August 14, 2018, 244 days later.
Department Corrective Action Plan	The Hiring Authority will consult with OLES in the future. 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.

Case Table Section	Section Content
Incident Date	12/13/2017
OLES Case Number	2017-01449MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 13, 2017, a unit supervisor allegedly twisted a patient's arm behind the patient's back and forced the patient's head against the wall while restraining the patient. The unit supervisor and a psychiatric technician also allegedly kneeled on the patient's calves as the patient knelt down.
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	12/30/2017
OLES Case Number	2018-00005MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 30, 2017, a staff member allegedly choked 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: 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 December 30, 2018; however, the investigation was not completed until July 6, 2018, 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	12/30/2017
OLES Case Number	2018-00010MA

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 30, 2017, a registered nurse allegedly did not properly monitor a patient who engaged in self-injurious behavior while in a restroom.
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 approximately 229 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 30, 2017; however, the investigation was not completed until August 15, 2018, 229 days later. The Office of Protective Services did not complete the initial investigative report until March 4, 2018, 65 days after the date of discovery.
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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/16/2018
OLES Case Number	2018-00076MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 16, 2018, a registered nurse allegedly grabbed and pushed 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 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 January 16, 2018; however, the investigation was not completed until June 25, 2018, 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/17/2018
OLES Case Number	2018-00087MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 17, 2018, a patient alleged a staff member put his hand on the patient's shoulder, which caused the patient to fall and hit his head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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 properly notify the OLES of the incident. The hiring authority did not notify outside law enforcement of the incident. The Hospital Police Department did not complete

	the initial report for 57 days from the date of discovery. As a result, the investigation was not completed until 147 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. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on January 17, 2018; however, the Hospital Police Department did not complete its investigation in a timely manner and the case was not received by the Office of Special Investigations until March 15, 2018, 57 days later. As a result, the Office of Special Investigations investigation was not completed until June 13, 2018, 147 days from the date of discovery.
Department Corrective Action Plan	The Chief/OPS reminded the investigative staff of the priority 1 and 2 reporting guidelines and the importance of making the timely and property notifications. On December 19, 2018, the Lieutenant discussed with the Sergeants, to discuss with their investigative staff, the importance of completing the incident reports in a timely manner to ensure the timeliness for reporting is met. The Chief, HPD and OSI will be meeting to discuss a process to streamline the reporting process to ensure it is within the reporting guidelines. In the interim on a weekly basis, a LT will audit to ensure the reports are completed and submitted in a timely manner to OSI. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame was discussed. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/01/2017
OLES Case Number	2018-00099MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: Other

	Final: Other
Incident Summary	During 2017, two officers assigned to the same hospital were involved in a relationship. After the relationship ended, the first officer allegedly sent the second officer harassing text messages, made annoying phone calls, and stalked the second officer. It is further alleged the first officer sent inappropriate photographs of the second officer to a third officer in an effort to humiliate, harass, and embarrass the second officer.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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	01/22/2018
OLES Case Number	2018-00103MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 22, 2018, a psychiatric technician allegedly forced a patient against a wall. Then another staff member allegedly put a sheet over the patient's head and struck 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 Hospital Police Department did not complete its initial investigation for 52 days. As a result, the final investigation was not completed until 141 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The incident occurred on January 22, 2018; however, the Hospital Police Department did not complete its investigation in a timely manner and the case was not received by the Office of Protective Services until March 15, 2018, 52 days later. As a result, the Office of Special Investigations' report was not completed until June 12, 2018, 141 days from the date of discovery.
Department Corrective Action Plan	On December 19, 2018, the Lieutenant discussed with the Sergeants, to discuss with their investigative staff, the importance of completing the incident reports in a timely manner to ensure the timeliness for reporting is met. The Chief, HPD and OSI will be meeting to discuss a process to streamline the reporting process to ensure it is within the reporting guidelines. In the interim on a weekly basis, a LT will audit to ensure the reports are completed and submitted in a timely manner to OSI. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame was discussed. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/29/2018
OLES Case Number	2018-00118MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 29, 2018, a psychiatric technician allegedly sexually assaulted a patient in the patient's room.
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 failed to timely notify the OLES and

	outside law enforcement 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 January 29, 2018, at 1705 hours, but did not notify the OLES until January 29, 2018, at 2034 hours: more than three hours later. 2. Did the hiring authority notify outside law enforcement of the incident within the specified time frames required by law? No. The responding Office of Protective Services officer received information about the alleged sexual assault at 1705 hours; however, the Office of Protective Services did not notify outside law enforcement until 2019 hours, more than two hours later.
Department Corrective Action Plan	Sergeants have been instructed to be more diligent in explaining the reporting criteria for priority 1 notifications to Officers, conduct daily watch briefings regarding this topic, and not to wait for information regarding the incident. Sergeants were instructed to make the call to the OLES and if additional information is needed by the AOD, another call can be made at a later time. Sergeants have been instructed to be more diligent in reporting to local law enforcement with regard to these required incidents. Sergeants were instructed to make the call to local law enforcement prior to contacting OLES, which would ensure they are within the two-hour time period.

Case Table Section	Section Content
Incident Date	02/01/2018
OLES Case Number	2018-00129MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 1, 2018, a patient alleged that a staff member used unnecessary force while placing him on the floor.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/04/2018
OLES Case Number	2018-00146MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 4, 2018, a staff member allegedly pushed a patient, causing the patient to fall and sustain a head laceration.
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 adequately complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/04/2018
OLES Case Number	2018-00147MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 4, 2018, a senior psychiatric technician allegedly grabbed a patient and pushed him against a wall several times.
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 171 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 5, 2018; however, the investigation was not completed until July 25, 2018, 171 days later. The Office of Protective Services did not complete the initial incident report until April 28, 2018, 83 days after the date of discovery.
Department Corrective Action Plan	On December 19, 2018, the Lieutenant discussed with the Sergeants, to discuss with their investigative staff, the importance of completing the incident reports in a timely manner to ensure the timeliness for reporting is met. The Chief, HPD and OSI will be meeting to discuss a process to streamline the reporting process to ensure it is within the reporting guidelines. In the interim on a weekly basis, a LT will audit to ensure the reports are completed and submitted in a timely manner to OSI. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame was discussed. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	02/06/2018
OLES Case Number	2018-00150MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 6, 2018, a psychiatric technician allegedly used excessive force on a patient during a wall 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 investigation was not completed until 220 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, 2018; however, the investigation was not completed until September 14, 2018, 220 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	05/15/2018
OLES Case Number	2018-00152MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 15, 2018, a psychiatric technician allegedly pressed on a patient's neck and upper back, and dragged the patient by the ankle.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also 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 investigator failed to notify the OLES monitor of the psychiatric technician's interview; therefore, the monitor could not attend the interview, and provide input. The investigator also closed the investigation and forwarded the matter to the Office of Special Investigations without first consulting with the OLES monitor.
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 investigator closed the investigation, made a probable cause determination, and forwarded the matter to the Office of Special Investigations before notifying the OLES monitor the investigative report was ready for review. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? The investigator failed to adequately consult with the OLES monitor. The investigator did not notify the monitor about the psychiatric technician's interview, which prevented the monitor from attending the interview and providing real-time feedback.
Department Corrective Action Plan	All of the investigative staff have all been trained and instructed to review the case monitor criteria as it relates to closing criminal Investigations and opening Administrative Investigations. The Investigator was trained and instructed to review the case monitor criteria to ensure this does not happen again.

Case Table Section	Section Content
Incident Date	02/08/2018
OLES Case Number	2018-00164MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 8, 2018, a patient alleged he felt he was being sexually molested by a staff psychiatrist because he was not receiving a particular medication.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/10/2018
OLES Case Number	2018-00173MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 10, 2018, a psychiatric technician allegedly struck a combative patient, causing a cut above the patient's eye.
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 221 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 10, 2018; however, the investigation was not completed until September 19, 2018, 221 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	01/01/2015
OLES Case Number	2018-00180MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between 2015 and 2017, a nurse allegedly watched a patient masturbate, and rubbed the patient's genitals with her feet. A psychiatric technician also allegedly watched the same patient masturbate, allowed the patient to fondle her genitals, and kissed 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: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the investigative process. The department did not timely notify the OLES or outside law enforcement of the incident. The investigation was not completed until 145 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 received notification of the alleged abuse on February 7, 2018; however, they did not notify the OLES until February 12, 2018, five days 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 received notification of the alleged abuse on February 7, 2018; however, they did not notify outside law enforcement until February 12, 2018, five days later. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 7, 2018; however, the investigation was not completed until July 2, 2018, 146 days later.
Department Corrective Action Plan	Sergeants have been instructed to be more diligent in explaining the reporting criteria for priority 1 notifications to Officers, conduct daily watch briefings regarding this topic, and not to wait for information regarding the incident. Sergeants were instructed to make the call to the OLES and if additional information is needed by the AOD, another call can be made at a later time. Sergeants have been instructed to be more diligent in reporting to local law enforcement with regard to these required incidents. Sergeants were instructed to make the call to local law enforcement prior to contacting OLES, which would ensure they are within the two-hour time period.

Case Table Section	Section Content
Incident Date	02/25/2018
OLES Case Number	2018-00236MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 25, 2018, a patient fell and sustained multiple facial injuries. Staff members allegedly failed to complete a post-fall assessment of the patient.
Disposition	The hiring authority determined that the investigation conclusively proved there was no staff misconduct. The OLES concurred with the hiring authority's determination.
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	02/28/2018
OLES Case Number	2018-00246MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 28, 2018, a senior psychiatric technician allegedly pushed a patient and threatened to restrict the patient's hospital access level.
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 criminal investigations unit forwarded the case to the Office of Special Investigations without notifying the OLES. Consequently, the Office of Special Investigations opened an administrative investigation on June 19, 2018, which the OLES was not notified about. The criminal investigator did not notify the OLES that the draft criminal investigative

	report was ready for review until June 25, 2018, and did not confirm that OLES recommendations had been included in the final report until August 3, 2018, 46 days after the administrative investigation had already been opened.
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. On June 25, 2018, the investigator notified the OLES that the draft criminal investigative report was ready for review. The OLES reviewed the report, and provided recommendations. On August 3, 2018, the investigator confirmed the revised report was complete with the OLES' recommendations incorporated therein. However, the case had already been closed and referred to the Office of Special Investigations, unbeknownst to the OLES. The Office of Special Investigations opened an administrative investigation on June 19, 2018, 46 days before the OLES received confirmation that the revised criminal investigative report was complete. 2. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The report was forwarded to the Office of Special Investigations before the OLES had an opportunity to review the draft criminal investigative report. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The criminal investigation had been closed and already forwarded to the Office of Special Investigation before the OLES was notified the draft criminal investigative report was ready for review.
Department Corrective Action Plan	A process has been implemented with the investigative staff to review the case monitor criteria as it relates to the closing of criminal investigations and the opening of administrative investigations.

Case Table Section	Section Content
Incident Date	03/02/2018
OLES Case Number	2018-00264MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 2, 2018, a psychiatric technician allegedly bent a patient's legs while placing her 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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	02/28/2018
OLES Case Number	2018-00265MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 28, 2018, a senior psychiatric technician allegedly grabbed a patient's genitals while searching 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: Sufficient Substantive Rating: Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	03/03/2018
OLES Case Number	2018-00266MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On March 3, 2018, a registered nurse allegedly pushed a patient while separating two patients who were engaged in a verbal altercation.
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 144 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 3, 2018; however, the investigation was not completed until July 25, 2018, 144 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/05/2018
OLES Case Number	2018-00274MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 5, 2018, a psychiatric technician allegedly used excessive force while placing a patient 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 case was referred for review to determine if an administrative investigation will be conducted.
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 129 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 5, 2018; however, the investigation was not completed until July 12, 2018, 129 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/08/2018
OLES Case Number	2018-00297MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 8, 2018, a senior psychiatric technician and a psychiatric technician allegedly struck a patient multiple times in the stomach and ribs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	03/17/2018
OLES Case Number	2018-00313MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 17, 2018, a psychiatric technician allegedly

	forced a patient's arm behind his back, resulting in a fracture to the patient's 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: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 138 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, 2018; however, the investigation was not completed until August 2, 2018, 138 days later. The Office of Protective Services did not complete the initial incident report until May 8, 2018, 52 days after the date of discovery.
Department Corrective Action Plan	On December 19, 2018, the Lieutenant discussed with the Sergeants, to discuss with their investigative staff, the importance of completing the incident reports in a timely manner to ensure the timeliness for reporting is met. The Chief, HPD and OSI will be meeting to discuss a process to streamline the reporting process to ensure it is within the reporting guidelines. In the interim on a weekly basis, a LT will audit to ensure the reports are completed and submitted in a timely manner to OSI. The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame was discussed. The Chief of Law Enforcement is working with the Chief of Police on a timeline to review the investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	03/23/2018
OLES Case Number	2018-00369MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 23, 2018, staff members allegedly pushed and

	struck 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: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 144 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 30, 2018; however, the investigation was not completed until August 21, 2018; 144 days later. The Office of Protective Services did not complete the preliminary report until 29 days after the date of discovery.
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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	07/22/2017
OLES Case Number	2018-00370MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 22, 2017, an unidentified staff member allegedly raped 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 170 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, 2018; however, the investigation was not completed until September 17, 2018, 170 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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	04/02/2018
OLES Case Number	2018-00376MC
Allegations	1. Other
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 2, 2018, a patient was found unresponsive in his bed. Unit staff responded and initiated life-saving measures. The patient was transported to the urgent care room, where he was later pronounced dead. An autopsy determined the patient died as a result of injuries sustained when he ingested a toxic amount of methamphetamine.
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: Insufficient The department failed to comply with policies and procedures governing the investigative process. A psychiatric technician assistant improperly handled possible evidence related to the incident. A responding officer did not properly process the evidence the psychiatric technician had handled. An officer was not continuously posted immediately outside the deceased

	patient's room which was the scene of a possible crime.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. A psychiatric technician assistant noticed a syringe near the patient's bed and placed the syringe in a plastic bag, then moved the plastic bag to the exam room where the patient had initially been moved. 2. Did the OPS adequately respond to the incident? No. Upon learning that a psychiatric technician assistant handled, and moved possible evidence, an officer proceeded to locate that evidence without having the psychiatric technician assistant present to confirm that the item the officer recovered was indeed the same item the psychiatric technician assistant found, and that it was in the same location, and condition the psychiatric technician had left it. Additionally, the officer did not photograph the evidence where he found it before disturbing its location. Finally, the officer then opened the bag the item was in, and transferred the item into a smaller Ziploc bag. Although the deceased patient's room remained locked, and secured, an officer was not continuously posted immediately outside that crime scene.
Department Corrective Action Plan	OPS is providing training during Annual Review Training to all staff on crime scene investigation. OPS will be providing training to the officer on proper procedures for evidence collection and death investigation.

Case Table Section	Section Content
Incident Date	03/30/2018
OLES Case Number	2018-00378MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 30, 2018, a psychiatric technician allegedly fractured a restrained patient's rib.
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 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 April 4, 2018; however, the investigation was not completed until October 5, 2018, 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 with the Chief of Police on a timeline to review the investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	02/01/2018
OLES Case Number	2018-00383MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	During February of 2018, a registered nurse allegedly attempted to expose himself to 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 the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	04/05/2018
OLES Case Number	2018-00386MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 5, 2018, a nursing coordinator allegedly grabbed a patient's forearm, causing pain 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 209 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 5, 2018; however, the investigation was not completed until October 30, 2018, 209 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.

Case Table Section	Section Content
Incident Date	01/21/2017
OLES Case Number	2018-00403MA
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 January 21, 2017, a senior psychiatric technician allegedly twisted a patient's arm while attempting to

	restrain the patient, causing injury to the patient. Two psychiatric technicians allegedly failed to intervene during the incident.
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	03/01/2018
OLES Case Number	2018-00419MC
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	During March 2018, a psychiatric technician allegedly was involved in an inappropriate sexual relationship with a patient and provided mobile phones and narcotics to the patient.
Disposition	The investigation established sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the determination. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
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	04/17/2018
OLES Case Number	2018-00429MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 17, 2018, a program supervisor and licensed vocational nurse allegedly twisted a patient's arms behind

	his back. The program supervisor also allegedly held a closed fist against the patient's head while the patient was 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	
Incident Date	05/05/2018
OLES Case Number	2018-00473MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 5, 2018, a psychiatric technician assistant allegedly bruised a patient's knee during a floor 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: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/05/2018
OLES Case Number	2018-00475MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 5, 2018, a psychiatric technician allegedly gave a patient the incorrect medication.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with this determination. The Office of

	Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
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	04/27/2018
OLES Case Number	2018-00476MA
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 27, 2018, a psychiatrist allegedly instructed unit staff to keep a patient in bed restraints for over 48 hours, without following proper procedures.
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	04/25/2018
OLES Case Number	2018-00492MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On April 25, 2018, a psychiatric technician allegedly pushed a patient out of a treatment room and into a hallway, where the patient fell and injured his thumb.
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 investigation was not completed until 131 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 May 10, 2018; however, the investigation was not completed until September 18, 2018, 131 days later. The Office of Protective Services did not complete the preliminary report until June 26, 2018, 47 days after discovery of the incident.
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 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 investigation case log and develop a solution to ensure timely reporting.

Case Table Section	Section Content
Incident Date	05/11/2018
OLES Case Number	2018-00509MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 11, 2018, numerous 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: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	05/12/2018
OLES Case Number	2018-00536MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On May 12, 2018, a psychiatric technician allegedly inserted an insulin needle repeatedly into 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 the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	05/22/2018
OLES Case Number	2018-00539MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 22, 2018, a psychiatric technician allegedly grabbed and pushed a patient while escorting her to a seclusion room.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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	05/27/2018
OLES Case Number	2018-00555MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 27, 2018, 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	05/30/2018
OLES Case Number	8 2018-00562MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 30, 2018, a registered nurse allegedly dragged a patient and pulled the patient's arms behind her back, causing shoulder pain.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/01/2018
OLES Case Number	2018-00590MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	On June 1, 2018, a psychiatric technician allegedly removed a patient's catheter, which exceeded their scope of licensure. The psychiatric technician subsequently was allegedly dishonest during an investigative interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain 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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/18/2018
OLES Case Number	2018-00633MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 18, 2018, a patient alleged a staff member caused an injury above his eye, after the patient fell while attempting to enter an unauthorized medication area.
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	06/18/2018
OLES Case Number	2018-00638MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 18, 2018, a psychiatric technician allegedly spat on and put semen in a patient's food, then forced the patient's head into a wall during a wall 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	Procedural Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	06/19/2018
OLES Case Number	2018-00639MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 19, 2018, a senior psychiatric technician allegedly twisted a patient's ear. The patient also alleged that on another occasion, the same senior psychiatric technician pulled her hair, poked her in the side, and touched her ear. It is also alleged that a psychiatric technician failed to report the alleged misconduct after she was told about it by the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation against the senior psychiatric technician. The hiring authority sustained the allegation against the psychiatric technician and imposed corrective action. The OLES concurred with the hiring authority's determinations.
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	12/13/2017
OLES Case Number	2018-00651MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On December 13, 2017, a psychiatric technician allegedly repeatedly struck a patient during a floor 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 consultation regarding the sufficiency of the investigation and the investigative findings was delayed 101 days after the completion of the investigation.
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 investigative report was completed on July 2, 2018; however, the disposition hearing was not held until October 11, 2018; 101 days later.
Department Corrective Action Plan	In the future, the hiring authority will consult with OLES as required. An updated procedure has been implemented as of April 2018, where OLES is present during the IRC meeting, either in person or via teleconference. This will allow for real time consultation between all parties.

Case Table Section	Section Content
Incident Date	05/22/2018
OLES Case Number	2018-00653MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 22, 2018, a psychiatric technician allegedly grabbed and pushed a patient while escorting her to a seclusion room.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	06/27/2018
OLES Case Number	2018-00662MC

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 27, 2018, a patient alleged he was assaulted and scratched by a staff member.
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	06/29/2018
OLES Case Number	2018-00669MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 29, 2018, a psychiatric technician allegedly struck and kicked a patient multiple times.
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	07/01/2018
OLES Case Number	2018-00671MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 1, 2018, a psychiatric technician allegedly bruised

	a patient's arm while escorting 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: Insufficient Substantive Rating: Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely notify the OLES of the incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The incident was discovered on July 1, 2018, at 1356 hours; however, the hiring authority did not notify the OLES until 2100 hours.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES priority 1 and 2 notification time frame criteria.

Case Table Section	Section Content
Incident Date	02/21/2018
OLES Case Number	2018-00710MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On February 21, 2018, a psychiatric technician allegedly grabbed a patient and forcefully put the patient back into a wheelchair.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	05/17/2018
OLES Case Number	2018-00711MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 17, 2018, a psychiatric technician allegedly struck a patient, placed the patient on the ground, and put his knee on the patient's back.
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 substantially complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/10/2018
OLES Case Number	2018-00716MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 10, 2018, two 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: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	07/06/2018
OLES Case Number	2018-00719MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 6, 2018, several hospital police officers assisted level of care staff with a combative patient. After the incident, the patient alleged he had been abused by the officers.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	07/16/2018
OLES Case Number	2018-00737MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 16, 2018, a patient was diagnosed with a fractured finger.
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	07/01/2018
OLES Case Number	2018-00739MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	During July 2018, a patient was allegedly sedated and raped multiple times by staff members while she was sleeping.
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	07/21/2018
OLES Case Number	2018-00757MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 21, 2018, a psychiatric technician allegedly sexually assaulted 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 investigative process.

Case Table Section	Section Content
Incident Date	07/23/2018
OLES Case Number	2018-00762MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 23, 2018, staff members allegedly forced a patient to the ground, kicked her, twisted her arm, then forced her 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	03/30/2018
OLES Case Number	2018-00791MA
Allegations	1. Discourteous Treatment
Findings	1. Sustained
Penalty	Initial: Counseling Final: No Change
Incident Summary	On March 30, 2018, a lieutenant allegedly yelled at a subordinate employee and grabbed the employee by the arms.
Disposition	The hiring authority sustained the allegation that the lieutenant yelled at the employee but found insufficient evidence to sustain the allegation that she grabbed her by the arms. The hiring authority imposed counseling. 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	08/02/2018
OLES Case Number	2018-00795MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 2, 2018, a registered nurse allegedly used her thumbnail to cut 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	08/20/2017
OLES Case Number	2018-00797MA
Allegations	1. Inexcusable neglect of duty

Findings	1. Sustained
Penalty	Initial: Dismissal 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 hiring authority determined there was sufficient evidence to sustain the allegation and dismissed the employee. The OLES concurred.
Investigative Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to notify the OLES that the administrative case had been opened and failed to notify the OLES when the victim or subject interviews were scheduled. The draft investigative report failed to incorporate three peace officer witnesses' accounts of the incident. The investigator dismissed the percipient witnesses' accounts as not credible without any basis or reasonable explanation. The Chief of the OLES and the Chief of Office of Protective Services intervened to ensure that all witnesses' accounts were properly summarized and considered.
Pre-Disciplinary Assessment	1. Did the hiring authority adequately consult with OLES regarding the incident? No. The Office of Protective Services failed to notify the OLES that the administrative case had been opened and failed to notify the OLES when the victim or subject interviews were scheduled. 2. 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 OLES to determine if an administrative investigation should be conducted concurrently with the criminal investigation. 3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?

	No. The draft investigative report failed to incorporate three police officer witnesses' accounts of the incident. The investigator dismissed the percipient witnesses' accounts as not credible without any basis or reasonable explanation. 4. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services failed to notify the OLES of the victim and subject interviews.
Department Corrective Action Plan	In the future the hiring authority will consult with OLES as required. In the future OPS will consult with OLES and the prosecuting agency in regards to the criminal and administrative investigation, if they should be conducted concurrently. The investigative staff have been reminded to include all pertinent information from witnesses in the draft and final report. In the future OPS will provide real-time consultation with OLES regarding victim and subject interviews.

Case Table Section	Section Content
Incident Date	12/01/2017
OLES Case Number	2018-00809MA
Allegations	1. Discourteous treatment 2. Misuse of state property 3. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	In December 2017, a lieutenant allegedly dispersed pepper spray in an office hallway without cause contaminating other employees and the area with the material.
Disposition	The hiring authority sustained the allegation. However, the lieutenant retired before the investigation was completed. Therefore, no disciplinary action could be taken. A letter indicating the lieutenant retired under adverse circumstances was placed in his official personnel file.
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	12/01/2017
OLES Case Number	2018-00810MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	In December 2017, a supervising peace officer allegedly failed to properly investigate a report that a lieutenant had negligently dispersed pepper spray in an office hallway.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
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	12/01/2017
OLES Case Number	2018-00811MA
Allegations	1. Misuse of state property
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	In December 2017, a sergeant allegedly provided his pepper spray canister to a lieutenant who then dispersed the pepper spray in an office hallway.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
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	12/01/2017
OLES Case Number	2018-00812MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: No Change

Incident Summary	In December 2017, a sergeant allegedly witnessed a lieutenant negligently disperse pepper spray in an office hallway and failed to report the incident.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction.
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	12/01/2017
OLES Case Number	2018-00813MA
Allegations	1. Dishonesty 2. Discourteous treatment 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Sustained
Penalty	Initial: Letter of Instruction Final: Letter of Instruction
Incident Summary	In December 2017, a sergeant allegedly made inappropriate sexual comments to a supervisor prompting the supervisor to intentionally spray pepper spray in an office hallway. The sergeant allegedly failed to report the misconduct of the supervisor and was allegedly dishonest during an investigative interview.
Disposition	The hiring authority sustained the allegation that the sergeant failed to report misconduct but not the other allegations and issued a letter of instruction. The OLES concurred with the hiring authority's determinations.
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	01/16/2018
OLES Case Number	2018-00821MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On January 16, 2018, a registered nurse allegedly grabbed and pushed a patient.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	07/08/2018
OLES Case Number	2018-00824MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 8, 2018, a psychiatric technician allegedly choked and pushed a patient.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	06/27/2018
OLES Case Number	2018-00825MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 27, 2018, a staff member allegedly assaulted and scratched a patient.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	06/22/2018
OLES Case Number	2018-00826MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Unfounded
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 22, 2018, staff members allegedly assaulted a patient
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	07/26/2018
OLES Case Number	2018-00829MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 26, 2018, a registered nurse allegedly gave a patient a sedative and sexually assaulted 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: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/10/2018
OLES Case Number	2018-00845MC
Allegations	1. Criminal Act
Findings	1. Not Referred

Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 10, 2018, a patient was determined to have a fractured shoulder. The patient indicated it was the result of a fall.
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	08/16/2018
OLES Case Number	2018-00863MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 16, 2018, a psychiatric technician allegedly asked a patient to show him her breasts. During June of 2018, the same psychiatric technician allegedly asked to see the same patient's breasts and genitalia and the patient allegedly lifted her shirt and pulled down her pants.
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	08/21/2018
OLES Case Number	2018-00877MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed

	Final: No Change
Incident Summary	On August 21, 2018, while at an outside hospital, a psychiatric technician allegedly refused to help a patient out of her wheelchair, yelled at the patient, and did not change the patient who had soiled herself.
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 failed to notify OLES of the scheduling of a suspect interview.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services failed to notify OLES of the scheduling of a suspect interview.
Department Corrective Action Plan	OPS provided training to all OPS Supervisors on the OLES reporting guidelines the week of December 17, 2018. During this training the investigative staff was reminded to consult with the assigned OLES monitor and the OLES priority one notification requirements.

Case Table Section	Section Content
Incident Date	08/21/2018
OLES Case Number	2018-00886MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 21, 2018, a senior psychiatric technician allegedly struck a patient in the face multiple times while the patient was 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 policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	08/23/2018
OLES Case Number	2018-00891MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 23, 2018, a staff member allegedly improperly searched 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	08/29/2018
OLES Case Number	2018-00908MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On August 29, 2018, a staff member allegedly grabbed and squeezed a patient's finger.
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	09/04/2018

OLES Case Number	2018-00919MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 4, 2018, it was alleged that a psychiatric technician was involved in a personal relationship with a former patient within less than a year from the date the patient was discharged from the hospital.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. The OLES concurred. However, the psychiatric technician resigned before disciplinary action could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in his official personnel file.
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	09/04/2018
OLES Case Number	2018-00936MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 4, 2018, a psychiatric technician allegedly touched a patient in an inappropriate manner while changing the patient's diaper.
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	07/15/2018
OLES Case Number	2018-00938MA
Allegations	1. Incompetency
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 15, 2018, a psychiatric technician allegedly administered the wrong medication to a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. However, this case highlighted that internal processes at the hospital were flawed and sometimes resulted in patients receiving the wrong medication. The Executive Director stated he will implement training and corrective action regarding this issue.
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	05/22/2018
OLES Case Number	2018-00939MA
Allegations	1. Incompetency
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 22, 2018, a psychiatric technician allegedly administered the wrong medication to a patient, resulting in the patient being sent to an outside hospital for treatment.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination. However, this case highlighted that internal processes at the hospital were flawed and sometimes resulted in patients receiving the wrong medication. The Executive Director stated he will implement training and corrective action regarding this issue.
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	11/01/2017
OLES Case Number	2018-00944MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	During November 2017, a registered nurse allegedly sexually assaulted a patient while the patient was restrained.
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	09/09/2018
OLES Case Number	2018-00949MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 9, 2018, a patient who was receiving treatment at an outside hospital, died from cardiac arrest and complications of a small intestinal obstruction.
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	05/05/2018
OLES Case Number	2018-00954MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Training Final: No Change
Incident Summary	On May 5, 2018, a psychiatric technician allegedly gave a patient the incorrect medication.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and ordered training and issued the psychiatric technician a letter of expectation. 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 process. The Nursing Coordinator prematurely imposed training and issued a letter of expectation to the employee, thereby precluding potential disciplinary action.
Pre-Disciplinary Assessment	1. Did the hiring authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. Prior to the completion of the investigation and without consultation with the OLES, the Nursing Coordinator prematurely imposed training and issued a letter of expectation to the employee, thereby precluding potential disciplinary action.
Department Corrective Action Plan	A meeting was held to determine a corrective action plan. OPS at the respected facility will let the hiring authority ahead of time a case is being monitored so that they can provide the appropriate training but not issue a letter of expectation which would preclude to disciplinary action to the employee.

Case Table Section	Section Content
Incident Date	08/28/2018
OLES Case Number	2018-00958MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On August 28, 2018, a health care staff member allegedly fondled a patient's genitals.
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	01/17/2018
OLES Case Number	2018-00960MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final: No Change
Incident Summary	On January 17, 2018, a sergeant allegedly used unnecessary force to remove a patient from his room during a unit search.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
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	09/11/2018
OLES Case Number	2018-00965MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	On September 11, 2018, a custodian allegedly pushed a patient, causing the patient to fall. The custodian then allegedly slapped the patient's hands and threw a metallic object which struck the patient in the side of the face.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	09/09/2018
OLES Case Number	2018-00974MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 9, 2018, a 25 year old patient was unexpectedly discovered nonresponsive in his communal room. He was declared brain dead on September 12, 2018. The cause of death determination is pending an autopsy.
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. An autopsy is pending and will be included in the administrative investigation.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the investigative process. The hospital police failed to properly secure the room as a potential crime scene, which compromised the integrity of the investigation. Potential evidence was not properly identified nor preserved. Percipient witnesses were not adequately interviewed or separated. The circumstances surrounding a young patient who was found nonresponsive and ultimately died, should have been investigated from the onset more thoroughly.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The hospital police failed to properly secure the room as a potential crime scene, which compromised the integrity of the investigation. Potential evidence was not properly identified nor preserved. Percipient witnesses were not adequately

	interviewed or separated.
Department Corrective Action Plan	Training and counseling will be provided to all OPS staff to ensure all scenes are treated as crime scenes until further information is gathered. OPS staff will be reminded of the need to interview and separate all (potential) witnesses.

Case Table Section	Section Content
Incident Date	09/14/2018
OLES Case Number	2018-00981MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 14, 2018, a psychiatric technician allegedly slapped and pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	09/14/2018
OLES Case Number	2018-00982MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 14, 2018, health care staff allegedly failed to properly treat a patient who had fallen and suffered a hip injury.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	09/19/2018
OLES Case Number	2018-00994MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 19, 2018, staff members allegedly forcefully administered medication to 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	09/23/2018
OLES Case Number	2018-01008MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 23, 2018, a patient who had significant medical issues died of end stage renal disease.
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.
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	09/24/2018
OLES Case Number	2018-01017MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change

Incident Summary	On September 24, 2018, a psychiatric technician allegedly pushed a patient and demanded the patient pay him 80,000 dollars. The patient also alleged that a staff member struck her in the face with a plastic bottle, causing injuries to the patient's 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: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	09/24/2018
OLES Case Number	2018-01020MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On September 24, 2018, a staff member allegedly kicked a resident's wrist.
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	07/01/2018
OLES Case Number	2018-01045MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 1, 2018, a registered nurse allegedly exposed himself and masturbated in front of 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 the policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/22/2018
OLES Case Number	2018-01047MA 1
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	Initial: Demotion Final:
Incident Summary	On June 22, 2018, a lieutenant sent a sexually harassing text message to a subordinate employee.
Disposition	The hiring authority sustained the allegation and demoted the lieutenant to an officer. The OLES concurred with the hiring authority's determination.
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	10/08/2018
OLES Case Number	2018-01069MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 8, 2018, a staff member allegedly slammed a door 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 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	07/04/2018
OLES Case Number	2018-01101MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	Initial: Letter of Instruction Final:
Incident Summary	On July 4, 2018, an officer allegedly claimed he worked when he in fact took the day off.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
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	10/24/2018
OLES Case Number	2018-01142MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 24, 2018, a registered nurse allegedly sexually assaulted a patient while the patient was sleeping.
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	10/30/2018
OLES Case Number	2018-01168MC

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 30, 2018, a patient was observed limping and an x-ray revealed the patient had a fractured ankle. The patient had difficulty communicating and could not provide any information about the cause of the injury.
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	11/21/2018
OLES Case Number	2018-01279MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On November 21, 2018, a senior psychiatric technician allegedly attempted to strike a patient with a clipboard and struck the patient on the 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: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Appendix B2 Pre-Disciplinary Cases - DDS

Case Table Section	Section Content
Incident Date	10/16/2017
OLES Case Number	2017-01274MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On October 16, 2017, a psychiatric technician allegedly kicked and struck a resident. A senior psychiatric technician allegedly observed the abuse and failed to report it. On October 29, 2017, a second psychiatric technician allegedly used profanity directed at the resident and knelt on the resident's 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. 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 250 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 30, 2017; however, the investigative report was not completed until July 6, 2018, 250 days later
Department Corrective Action Plan	In the future, the investigators will expedite reports to be completed in a timely manner.

Case Table Section	Section Content
Incident Date	01/05/2018
OLES Case Number	2018-00033MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 5, 2018, four psychiatric technicians and a

	psychiatric technician assistant allegedly verbally abused and battered a resident while attempting to restrain the resident 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. 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 158 days from the date the alleged incident was discovered.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 6, 2018. However, the final investigative report was not completed until June 12, 2018, 158 days later.
Department Corrective Action Plan	In the future, the investigators will expedite reports to be completed in a timely manner.

Case Table Section	Section Content
Incident Date	03/14/2018
OLES Case Number	2018-00308MC
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 14, 2018, a psychiatric technician allegedly took a resident to the resident's room, and struck the resident's face, causing visible injury.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services will open an administrative investigation which the OLES will monitor.
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	01/13/2018
OLES Case Number	2018-00316MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On January 13, 2018, a psychiatric technician, a psychiatric technician assistant, and other unknown staff members were allegedly drinking alcohol and taking drugs while on duty.
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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
Incident Date	03/01/2018
OLES Case Number	2018-00510MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On March 1, 2018, a psychiatric technician allegedly forced a resident against a wall, while a second psychiatric technician witnessed the incident and did not intervene. On March 23, 2018, a senior psychiatric technician then allegedly used a pressure point technique on the resident's jaw, and the first psychiatric technician allegedly struck the resident's lower back, while a third psychiatric technician held the resident's arm. The senior psychiatric technician

	and the first psychiatric technician also allegedly choked the resident. These employees also allegedly failed to comply with sign-in and sign-out procedures for alternate work assignments.
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	05/16/2018
OLES Case Number	2018-00530MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 16 and 18, 2018, a psychiatric technician assistant allegedly forcefully grabbed a resident's arm, struck a second resident in the head, and threw a shoe at a third resident.
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	04/16/2018
OLES Case Number	2018-00542MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between April 16, 2018, and May 11, 2018, a psychiatric technician allegedly attempted to wake a resident by kicking the resident's 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 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	05/11/2018
OLES Case Number	2018-00553MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Penalty Imposed
Incident Summary	On May 11, 2018, a senior psychiatric technician allegedly choked 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 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	05/29/2018
OLES Case Number	2018-00554MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On May 29, 2018, a resident alleged that while walking in the hallway, a psychiatric technician pushed the resident down and choked him, causing the resident to gasp for air.
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 sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
Incident Date	06/08/2018
OLES Case Number	2018-00608MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: Other
Incident Summary	On June 8, 2018, a resident alleged that a psychiatric technician had previously choked and yelled at her.
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 incident was discovered on June 8, 2018; however, an investigation into the matter was not commenced until three days later. Furthermore, the hiring authority did not notify the OLES of the incident until three days after its discovery. The Office of Protective Services did not provide the OLES with draft or final investigative reports.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. The hiring authority discovered the incident on June 8, 2018; however, did not take a report until June 11, 2018. 2. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority discovered the incident on June 8, 2018; however, did not notify the OLES of the incident until June 11, 2018.

	3. Was the hiring authority's response to the incident appropriate? No. The Office of Protective Services failed to investigate the allegation of abuse on June 8, 2018. 4. Did the OPS adequately respond to the incident? No. The Office of Protective Services failed to investigate the allegation of abuse for three days. 5. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The Office of Protective Services did not provide the OLES with a draft investigative report. 6. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective failed to provide the OLES with the draft or final investigative report.
Department Corrective Action Plan	On December 4, 2018 a meeting was held between OLES and OPS. The issue of providing draft reports and "real time consultation" was discussed. Going forward the investigator will send the OLES monitor a form 226 on a regular basis during the time from the reported incident to the completion of the draft report. The form 226 is required every 10 business days during the investigation.

Case Table Section	Section Content
Incident Date	06/10/2018
OLES Case Number	2018-00609MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: Other
Incident Summary	On June 10, 2018, a psychiatric technician and a psychiatric technician assistant allegedly held a resident's arms behind her back and allowed another resident to slap her face. A second psychiatric technician assistant allegedly slapped the resident's face. A senior psychiatric technician allegedly told the resident that she deserved to

	be slapped.
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 Office of Protective Services did not provide the OLES with the draft or final investigative 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 Office of Protective Services did not provide the OLES with a copy of the draft investigative report before it was finalized. 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 the draft or final investigative report.
Department Corrective Action Plan	On December 4, 2018 a meeting was held between OLES and OPS. The issue of providing draft reports and "real time consultation" was discussed. Going forward the investigator will send the OLES monitor a form 226 on a regular basis during the time from the reported incident to the completion of the draft report. The form 226 is required every 10 business days during the investigation.

Case Table Section	Section Content
Incident Date	06/11/2018
OLES Case Number	2018-00617MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 11, 2018, a psychiatric technician allegedly improperly restrained a resident on a bed by holding the resident's shoulder and leg.
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 policies and procedures governing the investigative process. The draft investigative report was incomplete and contained erroneous information. For example, the draft report contained an incomplete synopsis, reference to an interview that had not taken place, and lacked relevant background information that had precipitated the incident.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report was incomplete and contained erroneous information. For example, the draft report contained an incomplete synopsis, reference to an interview that had not taken place, and lack of relevant background information that had precipitated the incident.
Department Corrective Action Plan	At the time of the monitor's request, the report was not complete and was not reviewed by OPS management. The investigator attempted to satisfy the monitor's request and sent a "draft" report although the report was not yet complete. The monitor responded by noting several errors in the report thus leading to the deficiency.

Case Table Section	Section Content
Incident Date	06/25/2018
OLES Case Number	2018-00652MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: Other Final: Other
Incident Summary	On June 25, 2018, a senior psychiatric technician allegedly struck a 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 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 Office of Protective Services failed to provide the OLES with a copy of the draft or final investigative 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 Office of Protective Services did not forward a copy of the draft report to the OLES before it was finalized. 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 either the draft or final investigative report.
Department Corrective Action Plan	On December 4, 2018 a meeting was held between OLES and OPS. The issue of providing draft reports and "real time consultation" was discussed. Going forward the investigator will send the OLES monitor a form 226 on a regular basis during the time from the reported incident to the completion of the draft report. The form 226 is required every 10 business days during the investigation.

Case Table Section	Section Content
Incident Date	06/26/2018
OLES Case Number	2018-00654MC
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 26, 2018, a psychiatric technician allegedly kicked, kneed, and struck a resistive resident.
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	Procedural Rating: Sufficient

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

Case Table Section	Section Content
Incident Date	06/01/2018
OLES Case Number	2018-00676MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	Between June 1, 2018, and June 14, 2018, five staff members allegedly sexually and physically assaulted 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	06/17/2018
OLES Case Number	2018-00691MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 17, 2018, a senior psychiatric technician allegedly kicked a resident's leg. The senior psychiatric technician, and a psychiatric technician then allegedly forcibly held down the resident. On a later date, a second psychiatric technician allegedly spit on the resident, and a third psychiatric technician allegedly pushed the resident's head into a locker, and kneed the resident's leg.
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	07/09/2018
OLES Case Number	2018-00701MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 9, 2018, a senior 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 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 Office of Protective Services failed to provide the OLES with either a draft or final copy of the investigative 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 investigator did not forward a draft or final copy of the report to the OLES. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not forward a draft or final copy of the report to the OLES.
Department Corrective Action Plan	On December 4, 2018 a meeting was held between OLES and OPS. The issue of providing draft reports and "real time consultation" was discussed. Going forward the investigator will send the OLES monitor a form 226 on a regular basis during the time from the reported incident to the completion of the draft report. The form 226 is required

	every 10 business days during the investigation.

Case Table Section	Section Content
Incident Date	06/14/2018
OLES Case Number	2018-00709MA
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On June 14, 2018, a psychiatric technician assistant allegedly kicked a resident while the resident was on the ground.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	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	07/19/2018
OLES Case Number	2018-00748MC
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	Initial: No Penalty Imposed Final: No Change
Incident Summary	On July 19, 2018, a senior psychiatric technician and a psychiatric technician allegedly struck a 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 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	09/25/2018
OLES Case Number	2018-01021MA

Allegations	1. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal
Incident Summary	On September 25, 2018, a psychiatric technician allegedly placed a resident in a chokehold and pushed the resident against a wall. It is further alleged the psychiatric technician was dishonest during her investigatory interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the psychiatric technician. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Appendix C: Discipline Phase Cases

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

- Procedural sufficiency includes, 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 includes 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 Discipline Phase Cases - DSH

Case Table Section	Section Content
Incident Date	06/11/2016
OLES Case Number	2016-00825MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty 4. Insubordination
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	Initial: Dismissal Final: Suspension
Incident Summary	On June 11, 2016, a registered nurse was allegedly sleeping while she was assigned to a one-on-one observation of a patient. Additionally, the registered nurse allegedly had her personal mobile phone plugged into a wall socket within reach of other patients. It was further alleged the registered nurse refused to put her mobile phone away after being instructed to do so. On June 14, 2016, it was alleged the same registered nurse was again sleeping while she was assigned to a one-on-one observation of a patient. The registered nurse allegedly again, had her personal mobile phone plugged into a wall socket within reach of other patients. It was also alleged that the registered nurse was dishonest during the course of the investigation.
Disposition	The hiring authority sustained all of the allegations and dismissed the registered nurse. The OLES concurred with the hiring authority's determinations.

Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The registered nurse filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board sustained all allegations except for the inefficiency allegation. The Board reduced the penalty from a dismissal to a one year suspension. The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority did not notify the OLES of the date of the Skelly hearing, thereby preventing OLES from attending. Disciplinary determinations were made on November 30, 2016; however, the action was not served until May 4, 2017, 155 days later.
Disciplinary Assessment Questions	1. If there was a Skelly hearing, was it conducted properly? No. The Skelly hearing was held without notice to the OLES. 2. If the penalty modification was the result of an SPB decision, did OLES concur with the modification? No. The OLES did not concur with the SPB decision to modify the penalty. The SPB reduced the penalty from dismissal to a one year suspension even though there was sufficient proof the registered nurse was dishonest and took no responsibility for her actions thereby demonstrating that there is a high likelihood that the misconduct could be repeated in the future. 3. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? No. The discipline officer did not notify the OLES of the date the action was served on the employee and likewise did not notify the OLES of the Skelly hearing, thereby preventing the OLES from attending. 4. Was the disciplinary phase conducted with due diligence by the department?

	No. The disposition hearing was held on November 30, 2016; however, the action was not served until May 4, 2018, 155 days later.
Department Corrective Action Plan	Policy 6001, OLES Oversight -Investigation Review Process – Disposition Committee and AIM notification will be reviewed by all Human Resources staff responsible for processing OLES identified adverse actions. Additionally, the Personnel Officer has been identified as a secondary contact for the AIM, in the event the Employee Relations Officer is not available. Pursuant to Government Code Section 19574, the statute of limitations to take adverse action against an employee is three years. However, the department has many high priority cases and we will continue to make every effort to issue adverse actions in an expeditious manner.

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 Penalty Imposed
Incident Summary	On September 15, 2016, 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.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority initially determined there was sufficient evidence to sustain the allegation and imposed a 10 percent salary reduction for six months against the psychiatric technician. During the Skelly hearing, the psychiatric technician offered evidence that the information which would have required separating the two patients was not communicated to him by staff and administrators. Due to this mitigating information, the hiring authority withdrew the disciplinary action against the

	psychiatric technician and implemented a broad corrective action plan. The OLES concurred with the hiring authority's determination based on the factors learned at the Skelly hearing. The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary determinations were made on December 19, 2017; however, the action was not served until September 13, 2018; 268 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The findings and penalty determinations were made on December 19, 2017; however the disciplinary action was not served until September 13, 2018, 268 days later.
Department Corrective Action Plan	The hiring authority will provide continual consultation with OLES as needed during the disciplinary phase and serving of the adverse action. Also, a tracking system has been implemented to ensure adverse actions are served within a timely manner.

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: Resigned in Lieu of Dismissal
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.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority sustained the allegations and served both employees with a notice of dismissal. However, both employees resigned before the disciplinary actions took

	effect. The investigation was completed on June 6, 2017, and the disciplinary determinations were made on December 27, 2017, 155 days later. The disciplinary actions were not served until August 29, 2018, 245 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The investigation was completed on June 6, 2017, and the penalty conference was conducted on December 27, 2017, 155 days later. The disciplinary actions were served August 29, 2018, 245 days later.
Department Corrective Action Plan	The hiring authority will provide continual consultation with OLES as needed during the disciplinary phase and serving of the adverse action. Also, a tracking system has been implemented to ensure adverse actions are served within a timely manner.

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: Counseling
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.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Insufficient The department failed to comply with policies and procedures governing the disciplinary process. On January 2, 2018, the hiring authority sustained the allegations and imposed a 10 percent salary reduction for six months. However, the human resource department failed to consult with the hiring authority and OLES regarding a counseling memo issued to the employee one month after the incident which precluded any disciplinary action. The OLES was not informed of this action until July 11, 2018, 192 days

	later.
Disciplinary Assessment Questions	1. Did the hiring authority consult with OLES and the department attorney (if applicable) before modifying the penalty or agreeing to a settlement? No. The human resources personnel did not consult with the hiring authority or OLES before determining disciplinary action could not be taken. 2. If the penalty was modified by department action or a settlement agreement, did OLES concur with the modification? No. OLES was not consulted when the decision was made that disciplinary action could not be taken. 3. 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 human resources department did not provide continual real-time consultation with OLES throughout the disciplinary phase. OLES was not informed of the decision to not move forward with the penalty until 192 days after the penalty was determined by the hiring authority. 4. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority determined the final penalty on January 2, 2018; however, the personnel department did not inform the hiring authority until July 11, 2018, that disciplinary action was precluded by a previously issued counselling memo.
Department Corrective Action Plan	The hiring authority will provide continual consultation with OLES as needed during the disciplinary phase and serving of the adverse action. Also, a tracking system has been implemented to ensure adverse actions are served within a timely manner.

Case Table Section	Section Content
Incident Date	10/13/2017
OLES Case Number	2017-01227MA

Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained 7. Sustained 8. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On October 13, 2017, a nurse and a psychiatric technician allegedly failed to conduct a required medical assessment of a patient. A second psychiatric technician also failed to document the alleged failure to assess the patient.
Disposition	The hiring authority sustained the allegations. The hiring authority imposed a 10 percent salary reduction for 15 months on the nurse and first psychiatric technician and issued a counseling memorandum to the second psychiatric technician. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The nurse and the first psychiatric technician filed appeals with the State Personnel Board. Prior to an evidentiary hearing, the department entered into settlement agreements with the employees. The first psychiatric technician's penalty was reduced to a 10 percent salary reduction for ten months and the nurse's penalty was reduced to a 10 percent salary reduction for eight months. The nurse and the first psychiatric technician both agreed to withdraw their appeals. The OLES concurred because the nurse and first psychiatric technician presented new mitigating information that was not previously offered and the penalty reductions were not significant. The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority did not consult with the OLES regarding modification of the second psychiatric technician's penalty, which reduced

	the second psychiatric technician's penalty from a letter of reprimand to a counseling memorandum.
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 initially consulted with the OLES regarding the disciplinary determinations for the nurse, and the two psychiatric technicians. However, the hiring authority later modified the second psychiatric technician's penalty from a letter of reprimand to a letter of counseling without consulting with the OLES. 2. 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? The hiring authority did not consult with the OLES regarding modification of the second psychiatric technician's penalty.
Department Corrective Action Plan	A procedure has been implemented to include the Labor Department in the email notice of Skelly Hearings. With this procedure it will allow an additional reminder to consult with the OLES monitor when any modifications are made from the original agreement. Prior to action, a case conference forum has also been initiated with Labor to evaluate the penalty outcome, with the goal of consistent utilization of the discipline tool.

Case Table Section	Section Content
Incident Date	01/01/2015
OLES Case Number	2018-00044MA
Allegations	1. Misuse of state property 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: No Penalty Imposed
Incident Summary	In January 2015, an officer allegedly used State training funds for his personal use. In June 2015, the officer was allegedly dishonest when he completed a travel claim form stating the funds had been used for training. In June and July 2017, the officer was allegedly dishonest to his

	supervisors regarding the misuse of the funds.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. Before the disciplinary action was served, a key witness became unavailable making the case difficult to prove. Therefore, the hiring authority decided not to issue the disciplinary action. The OLES concurred due to the change in circumstances.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
Incident Date	01/19/2018
OLES Case Number	2018-00346MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	Initial: Salary Reduction Final: No Change
Incident Summary	On January 19, 2018, a registered nurse allegedly failed to make the required notifications regarding a patient's allegation of sexual assault.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the registered nurse and imposed a 5 percent salary reduction for one month. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The employee did not file an appeal with the State Personnel Board. The department did not comply with policies and procedures governing the disciplinary process. The penalty conference was held on May 24, 2018; however, the disciplinary action was not served until August 24, 2018, 92 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The final penalty conference was held on May 24, 2018; however, the disciplinary action was not served until August 24, 2018, 92 days later.

Department Corrective Action Plan	The hiring authority will provide continual consultation with OLES as needed during the disciplinary phase and serving of the adverse action. Also, a tracking system has been implemented to ensure adverse actions are served within a timely manner.

Case Table Section	Section Content
Incident Date	04/20/2018
OLES Case Number	2018-00428MA
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: Resigned in Lieu of Dismissal
Incident Summary	On April 20, 2018, a psychiatric technician allegedly struck a patient in the mouth, fracturing the patient's jaw and dislodging three of the patient's teeth. It was also alleged the psychiatric technician failed to wear his personal alarm as required by policy.
Disposition	The hiring authority sustained the allegations and dismissed the psychiatric technician. The OLES concurred with the hiring authority's determination.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The psychiatric technician filed an appeal with the State Personnel Board. Prior to an evidentiary hearing, the department entered into a settlement agreement wherein the psychiatric technician agreed to resign in lieu of termination and agreed that he would not seek employment with the department in the future. The OLES concurred with the settlement.

Case Table Section	Section Content
Incident Date	02/01/2018
OLES Case Number	2018-00524MA
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained

	5. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	Between February 2018 and April 2018, a psychiatric technician allegedly engaged in an overly familiar relationship with a patient. The psychiatric technician allegedly provided a mobile telephone to the patient, through which the psychiatric technician communicated with the patient and exchanged inappropriate self-photographs. The psychiatric technician also allegedly sent a money order and provided prohibited items to the patient.
Disposition	The hiring authority sustained the allegations against the psychiatric technician and determined dismissal was the appropriate penalty. The OLES concurred.
Disciplinary Assessment	Procedural Rating: Sufficient 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 with the psychiatric technician wherein the psychiatric technician agreed to resign, waive back-pay, and agreed to never apply for a job with the department in the future. In return, the department agreed to remove the disciplinary action from the psychiatric technician's official personnel file; however, the settlement agreement, and the State Personnel Board's approval of the settlement would remain. The department complied with policies and procedures governing the disciplinary process.

Appendix C2 – DDS Discipline Phase Cases

Case Table Section	Section Content
Incident Date	06/09/2017
OLES Case Number	2017-00693MA
Allegations	1. Incompetency 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Salary Reduction Final: No Penalty Imposed
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.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient On September 5, 2017, the hiring authority sustained the allegations and imposed a 10 percent salary reduction for 12 months. The hiring authority reserved a final determination pending review of prior past allegations by the resident and a review of interdisciplinary notes. As of June 5, 2018, the disciplinary action had not been drafted. On June 5, 2018 the hiring authority revisited the original findings and penalty determinations and expressed reservations about the resident's credibility and whether the employee had documented the incident in the interdisciplinary notes. Ultimately, the Office of Protective Services completed a supplemental report 295 days after the original disposition meeting, which contained exonerating evidence that had been overlooked in the original investigation. Based upon the additional information the hiring authority determined the allegations were unfounded. The best practice recommended by the OLES is that findings and penalty determinations should not be made until the investigation is complete, which includes

	completion of all supplemental reports. In this case the Office of Protective Services could have completed the supplemental report more expeditiously.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. It took the Office of Protective Services 295 days to complete a supplemental report. The report contained exonerating evidence, that had been overlooked, but which was available during the initial investigation.
Department Corrective Action Plan	During the case review process in September 2017, it was brought to the attention of OPS by Clinical staff that new evidence was available exonerating the involved employee. This information was verbally addressed by the Commander but due to a miscommunication, the case was never assigned to an investigator. During a subsequent case review in April 2018, the case was again reviewed and it was discovered to still be incomplete. At this time, an investigator was immediately assigned to conduct a follow-up and the employee was exonerated of any misconduct. Due to the miscommunication and to avoid delays in the future, all requests and assignments between management and supervisors will be in writing through Department email.

Case Table Section	Section Content
Incident Date	07/12/2017
OLES Case Number	2017-00955MA
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	Initial: Dismissal Final: Resigned in Lieu of Dismissal
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.
Disciplinary Assessment	Procedural Rating: Insufficient Substantive Rating: Sufficient The hiring authority determined there was sufficient

	evidence to sustain the allegations and dismissed the psychiatric technician assistant. The psychiatric technician assistant filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the psychiatric technician assistant agreed to resign in lieu of dismissal. The psychiatric technician assistant agreed to withdraw his appeal. The OLES concurred because the settlement was reasonable. The hiring authority failed to comply with policies and procedures governing the disciplinary process. The date of the disposition meeting was December 16, 2017; however, the disciplinary action was not served until June 11, 2018, 177 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The date of the disposition meeting was December 16, 2017; however, the disciplinary action was not served until June 11, 2018, 177 days later.
Department Corrective Action Plan	For future disciplinary actions, the hiring authority will monitor the days from the date of the disposition meeting to the service of action to ensure the expected timeframes are met. If the action is not ready for service within 30 days of the requirement, he/she will notify the Developmental Centers Division (DCD) Deputy Director for follow up with DDS Labor Department (who is responsible for writing the disciplinary action).

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

Discipline is rated for procedural and substantive sufficiency:

- Procedural sufficiency includes, 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 includes 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 Combined Cases - DSH

Case Table Section	Section Content
Incident Date	09/24/2017
OLES Case Number	2018-00153MA
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	Initial: Dismissal Final: Resigned In Lieu of Dismissal
Incident Summary	On September 24, 2017, a psychiatric technician allegedly initiated an unwarranted wall stabilization of a patient and forced the patient's head against a window. The psychiatric technician then allegedly falsely documented the incident. The psychiatric technician was also allegedly dishonest during the investigation.

Disposition	The hiring authority sustained the allegations and dismissed the psychiatric technician. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. At the prehearing settlement conference, the department entered into a settlement agreement with the psychiatric technician wherein the psychiatric technician resigned in lieu of termination, and agreed to withdraw her appeal. The OLES concurred because the penalty modification achieved the same result of removing the psychiatric technician from working as a psychiatric technician at the facility.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department complied with policies and procedures governing the disciplinary process

Case Table Section	Section Content
Incident Date	05/07/2017
OLES Case Number	2018-00611MA
Allegations	1. Dishonesty
Findings	1. Sustained
Penalty	Initial: Dismissal Final: No Change
Incident Summary	Between May 7, 2017, and January 6, 2018, an officer allegedly altered three medical notes to give himself additional days off of work.
Disposition	The hiring authority sustained the allegations and dismissed the officer. However, the officer retired before the effective date of the disciplinary action. The OLES concurred with the hiring authority's determination.
Investigative Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	Procedural Rating: Sufficient Substantive Rating: Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix E: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

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

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

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

(4) The reports required by paragraph (1) shall be posted on the Office of

Law Enforcement Support's Internet Web site and otherwise made available to the public upon their release to the Governor and the Legislature.

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

California Welfare and Institutions Code 4427.5

4427.5.

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

(A) A death.

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

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

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

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

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

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

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

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

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

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

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

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

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

California Welfare and Institutions Code 4023

4023

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

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

California Welfare and Institutions Code 15610.63 (Physical Abuse)

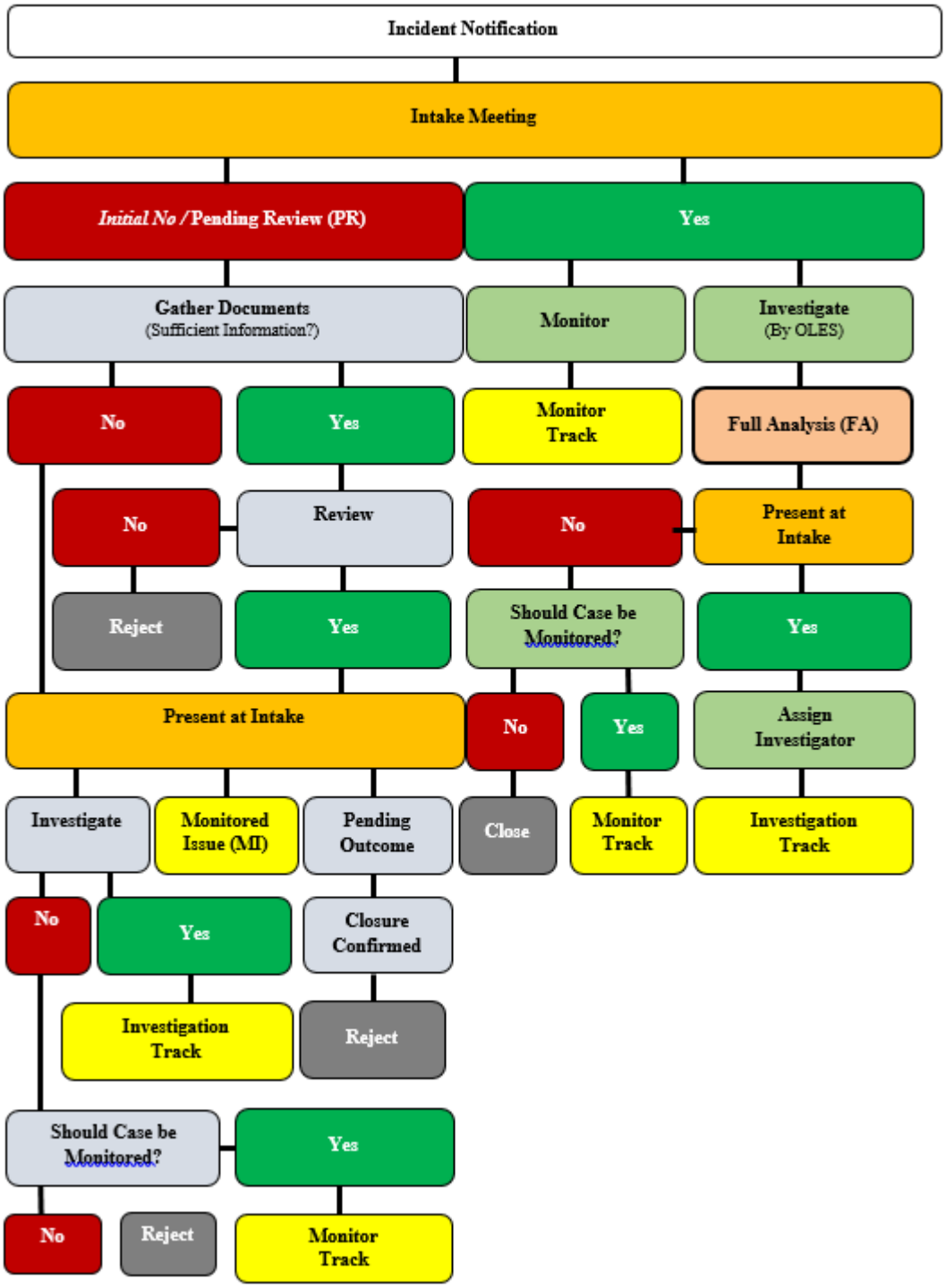
Section 15610.63, states, in pertinent part: "Physical abuse" means any of the following:

(a) Assault, as defined in Section 240 of the Penal Code.
(b) Battery, as defined in Section 242 of the Penal Code.
(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.
(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
(e) Sexual assault, that means any of the following:
(1) Sexual battery, as defined in Section 243.4 of the Penal Code.
(2) Rape, as defined in Section 261 of the Penal Code.
(3) Rape in concert, as described in Section 264.1 of the Penal Code.
(4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code.
(6) Sodomy, as defined in Section 286 of the Penal Code.
(7) Oral copulation, as defined in Section 288a of the Penal Code.
(8) Sexual penetration, as defined in Section 289 of the Penal Code.
(9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.
(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
(1) For punishment.
(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California,

who is providing medical care to the elder or dependent adult at the time the instructions are given.

(3) For any purpose not authorized by the physician and surgeon.

Appendix F: 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 G: 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,[9] 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

[9] 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[10]. 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

[10] 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