Office of Law Enforcement Support

Semiannual Report

January 1, 2019–June 30, 2019

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 seventh semiannual report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency. This report details OLES' oversight and monitoring of the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS) from January 1 through June 30, 2019.

In this report, OLES finalizes its tracking and reporting of OLES' 2015 and 2016 recommendations for the departments and their implementation. These recommendations addressed challenges faced by DSH and DDS law enforcement and provided best practices for law enforcement and employee discipline. The OLES continues to identify systemic issues that hamper efforts to standardize best practices, conduct research and make recommendations for deficiencies identified as "monitored issues".

The number of reported incidents from both departments continue to decline. Combined, both departments reported a net decrease of 68 incidents as of June 30, 2019, compared to the prior reporting period. At DSH, despite having a population increase from 6,095 to 6,115 patients, the total reported incidents decreased from 485 to 448. At DDS, the total reported incident count dropped from 171 to 140 as of June 30, 2019, compared to the prior reporting period. From January 1 to June 30, 2019 the population at DDS facilities decreased from 400 to 333, with eight of the 333 residents receiving Stabilization, Training, Assistance and Reintegration (STAR) services.

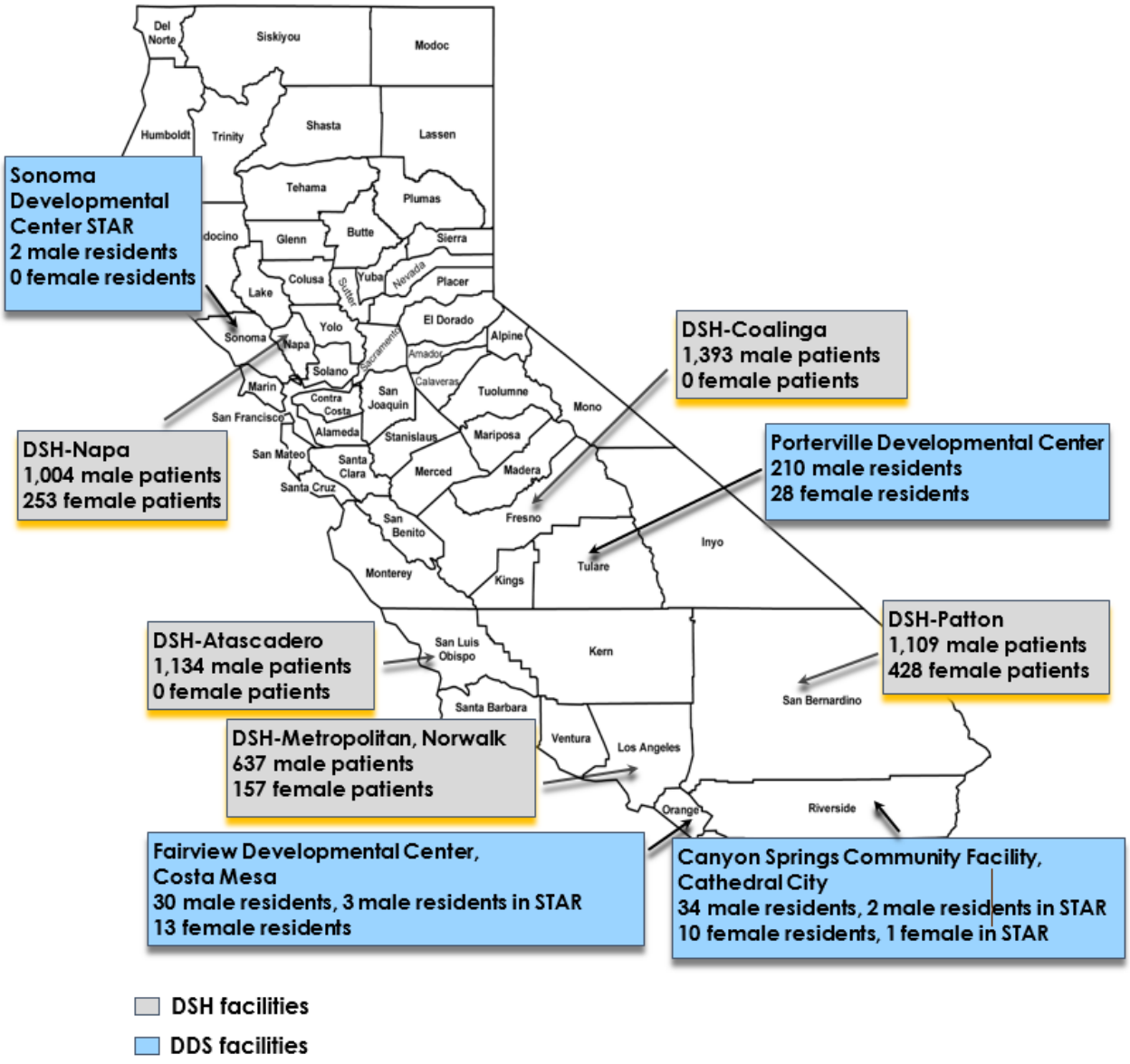
As we continue our fourth year of oversight and monitoring, we look forward to seeing continued progress and improvements within the departments and remain grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DSH and DDS management and personnel. The OLES strives to be the premier investigative and legal monitoring resource driving improvement and instilling accountability at DSH and DDS. Our mission is to ensure the safety and security of patients and residents within California's state hospitals and developmental centers through contemporaneous oversight, investigations and collaborative partnerships to achieve systemic improvements in policies, procedures and partnerships.

We welcome 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 OLES conducted investigations and provided contemporaneous oversight (monitoring) during the reporting period are shown below.



Note: Population numbers as of June 30, 2019, were provided by the departments. Residents in DDS acute crisis centers are listed separately as in a "STAR" (Stabilization, Training, Assistance, and Reintegration) home.

DSH and DDS Facility Population Chart

Facility	Number of Male Residents/Patients	Number of Female Residents/Patients
DSH-Atascadero	1,134	0
DSH-Coalinga	1,393	0
DSH-Metropolitan	637	157
DSH-Napa	1,004	253
DSH-Patton	1,109	428
Canyon Springs	34	10
Canyon Springs STAR	2	1
Fairview	30	13
Fairview STAR	3	0
Porterville	210	28
Sonoma STAR	2	0

Executive Summary

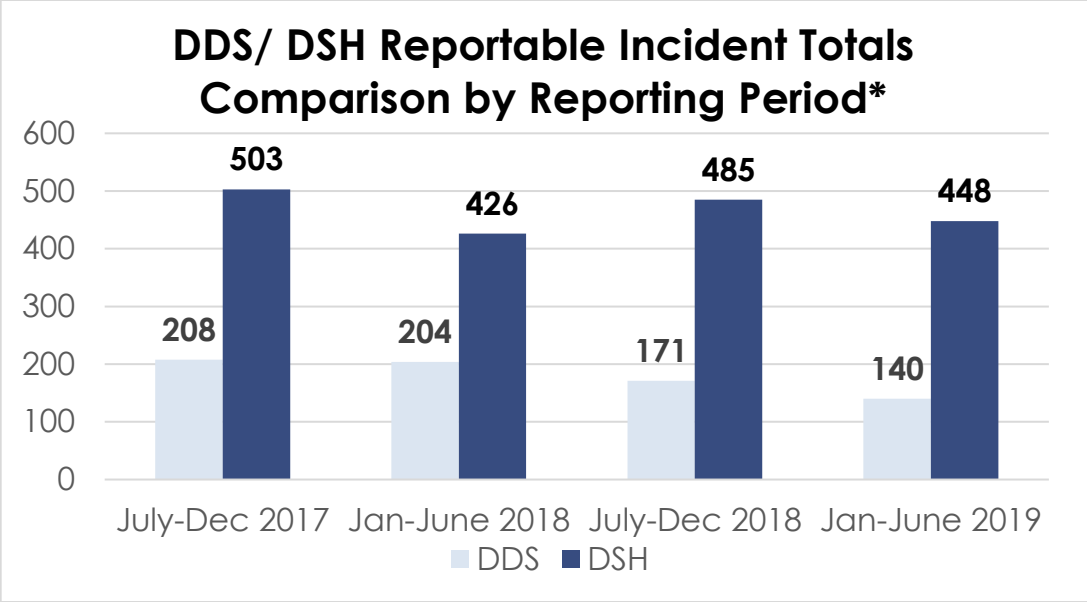
During the reporting period of January 1, 2019 through June 30, 2019, the Office of Law Enforcement Support (OLES) received and processed 588 reportable incidents[1] at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Reportable incidents include 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 a decrease of 68 incident reports over the prior reporting period which had 656 and is the lowest number of reportable incidents since OLES began oversight operations on January 1, 2016. The overall decrease in reportable incidents statewide from 656 to 588 is a 10.4 percent decrease from the prior reporting period. Of these 588 incidents, the number meeting OLES criteria for investigation, monitoring, and/or research into a systemic issue, decreased from 176 during the prior reporting period to 174 in this reporting period, a decrease of 1.1 percent.

As shown in the adjacent chart, of the total 588 reports, OLES received 448 incident reports from DSH and 140 from DDS. DSH's 448 reportable incidents reflect a decrease of 37 incidents or 7.6 percent from the prior reporting period of July 1 through December 31, 2018. Of these 448 DSH reportable incidents, 29.9 percent, or 134 incidents met the criteria for OLES investigation, monitoring, and/or led to OLES research into a systemic departmental issue.

DDS's 140 reportable incidents reflect a decline of 31 reportable incidents or 18.1 percent from the previous reporting period. Of these 140 reportable incidents, 40 incidents or 28.6 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).

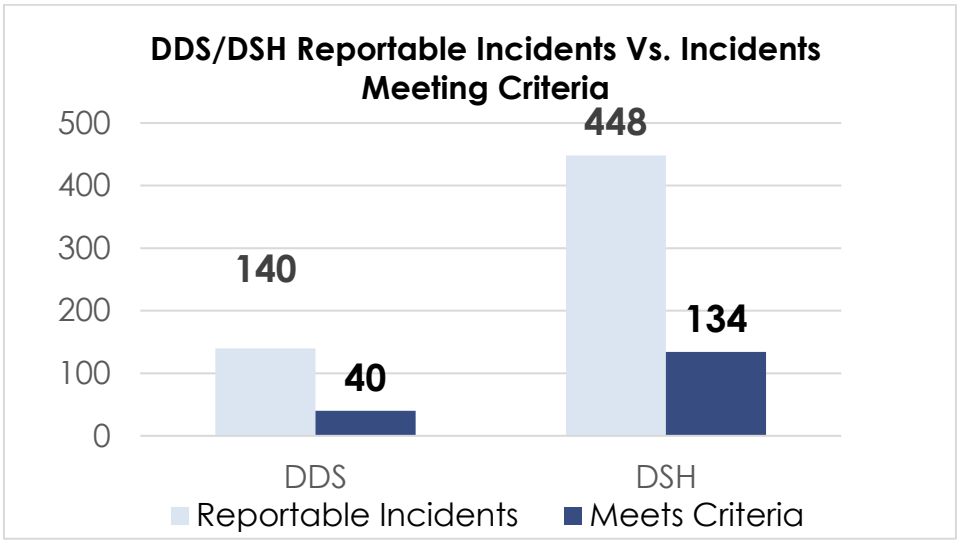
[2] The OLES chief determines whether an issue in DSH or DDS appears to be systemic and, if so, directs OLES staff to research the matter. The OLES labels such matters "monitored issues" and reports on their status in a separate section of each legislative report.



* 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 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 OLES criteria for investigation and/or monitoring, or consideration for research as a potential departmental systemic issue.



Patient and Resident Arrests

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 24 patient arrests, 10 more arrests than reported in the prior reporting period. DDS reported one resident arrest, a decrease of four arrests compared to the prior reporting period. The OLES works 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 also reviews 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 96 reports of alleged sexual assault, which accounted for 21.4 percent of all reported DSH incidents. This marked a 5.0 percent decrease from the 101 sexual assault reports received during the prior reporting period.

DSH - Most Frequent Incidents January 1 through June 30, 2019

Incident Categories	Previous Period July 1 through December 31, 2018	Current Period January 1 through June 30, 2019	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Sexual Assault	101	96	-5.0	27
Abuse	89	80	-10.1	66
Broken Bone	76	71	-6.6	6
Head/Neck Injury	50	40	-20	0
Sexual Assault-OJ*	35	32	-8.6	0
Neglect	24	21	-12.5	14
Misconduct	23	21	-8.7	12

*All reports of alleged sexual assault outside jurisdiction (OJ) are calculated separately from the "Sexual Assault" category.

There were a total of 80 reported incidents of patient abuse, making patient abuse the second largest category of incidents reported at DSH during this reporting period. This is a 10.1 percent decrease from the 89 alleged abuse reports from the prior reporting period.

In this reporting period, incidents of broken bones are the third most frequently reported incident. Reports of broken bones decreased from 76 reportable incidents during the prior reporting period to 71 during this reporting period, a decrease of 6.6 percent.

Reports of head/neck injuries at DSH were the fourth most frequently reported category in this reporting period. Reportable head/neck injuries decreased during this reporting period to 40 reportable incidents from 50 in the prior reporting period, a decrease in reportable head/neck injuries of 20 percent.

Sexual assault-OJ was the fifth most reported category with 32 reportable incidents in this reporting period compared to 35 in the last. This is a decrease of 8.6 percent.

Neglect was the sixth most reported category with 21 incidents in this reporting period compared to 24 in the last period, a decrease of 12.5 percent.

Reportable incidents of misconduct at DSH decreased from 23 in the prior reporting period to 21 during this reporting period, a decrease of 8.7 percent.

DDS - Most Frequent Incidents

As shown in the chart on the following page, allegations of abuse at DDS comprised the top incident category in this reporting period. The 94 reports of alleged abuse marked a 3.2 percent increase from the 91 abuse allegations reported in the prior reporting period. The second most reported incident in this reporting period was in the category of sexual assault. 11 allegations of sexual assault were reported by DDS in this reporting period, down 21.4 percent from the 14 reports received by OLES in the prior reporting period. Reports of broken bones, ranked as the third most frequently reported incidents at DDS, decreased by 33.3 percent during this reporting period, from 12 incidents during the prior reporting period to 8 incidents in this reporting period. Allegations of neglect ranked as the fourth most frequent incident reported by DDS to OLES with six incidents reported. This was a 200 percent increase from the prior reporting period, which had two reported incidents. DDS had five reports of head or neck injuries. This was an 80.8 percent decrease from the prior reporting period, which had 26 reported incidents. In the category of assault with great bodily injury, there were five incidents reported. This was a 25 percent increase from the prior reporting period, which had four reports. There were four reports of alleged

peace officer misconduct, reflecting a 300 percent increase from the prior reporting period, which had one reported incident of misconduct.

DDS - Most Frequent Incidents January 1 through June 30, 2019

Incident Categories	Prior Period July 1 through December 31, 2018	Current Period January 1 through June 30, 2019	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	91	94	3.2	33
Sexual Assault	14	11	-21.4	0
Broken Bone	12	8	-33.3	0
Neglect	2	6	200	4
Head/Neck	26	5	-80.8	0
Assault/GBI	4	5	20	0
Misconduct	1	4	300	3

Deaths at DSH and DDS

Deaths of DSH patients totaled to 27, an increase of 28.6 percent from the prior reporting period. Napa State Hospital (NSH) and Coalinga State Hospital (CSH) had the largest number of deaths reported with 11 deaths reported at NSH and six deaths at CSH. At NSH, five deaths were due to cardiac/respiratory issues, three to sepsis, two to renal/liver issues and one death is still pending determination. At CSH, four deaths were due to cancer and two deaths were due to cardiac or respiratory issues.

Two deaths of DDS residents were reported in this reporting period, a decrease of 33.3 percent from the prior reporting period. Fairview Developmental Center (FDC) had two deaths; one due to cardiac or respiratory issues and another due to a cerebral issue.

Results of OLES Investigations

Per statute[3], an OLES investigation is initiated after 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 the 22 OLES investigations that were completed during this reporting period. One investigation involved an

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

incident that occurred in 2000, two in 2016, one in 2017, 10 in 2018 and eight in 2019. In one administrative investigation, OLES determined there was insufficient evidence to support the allegation, and a summary of the review and decision was provided to the department. Nine completed administrative investigations were submitted to the hiring authorities at the facilities for disposition, and OLES monitored the disposition process. The OLES conducted inquiries into 10 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 review and decision was provided to the departments. In the remaining three administrative investigations, OLES either determined that the misconduct did not rise to the level for further investigation by OLES or determined that the matter should be referred back to the department for appropriate review and determination. In all these cases, OLES provided a summary of the review and decision to the department.

Results of OLES Monitored Cases

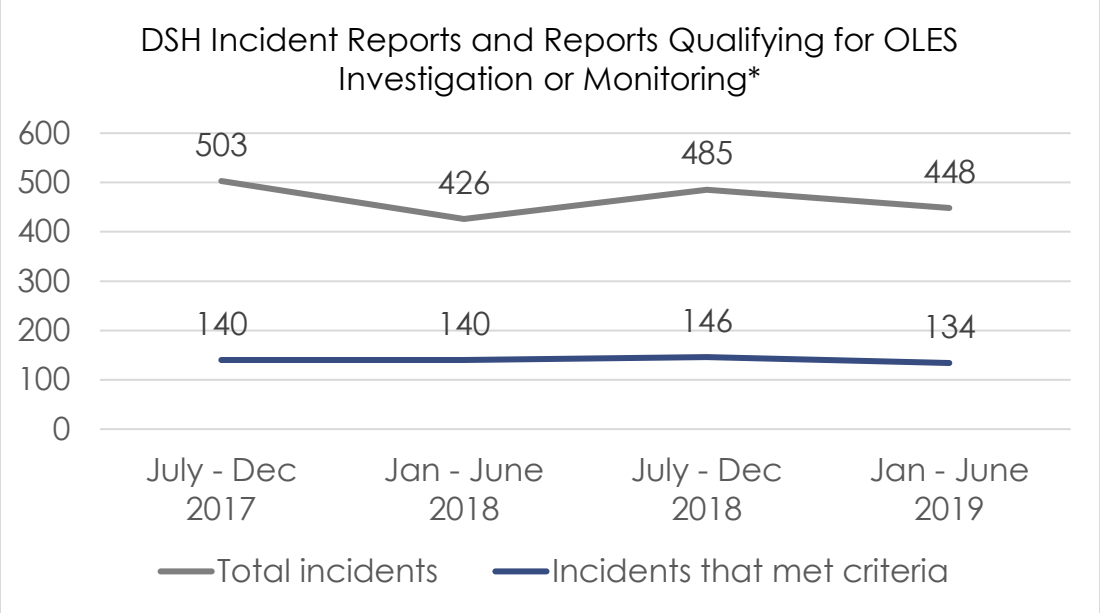
In Appendices B, C, and D of this report, OLES provides information on 164 monitored cases that, by June 30, 2019, had reached completion. Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct. Eighty-three percent, or 137 of the 164 cases, were at DSH. The OLES found that 56 monitored cases at the two departments, combined, were insufficient either procedurally, substantively or both. Procedural sufficiency includes the notifications to OLES, consultations with OLES and investigation activities for timeliness. Substantive sufficiency includes the quality, adequacy and thoroughness of the investigative interviews and reports. During the January 1 through June 30, 2019 period, 25 monitored administrative cases at DSH and DDS had sustained allegations. Another six 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.

Decreased Incidents during this Reporting Period

Overall, the number of DSH incidents reported to OLES from January 1 through June 30, 2019 decreased 7.6 percent, from 485 during the prior reporting period to 448 in this reporting period. Declines were seen in 11 of the 20 incident categories including allegations of sexual assault, sexual assault-OJ, abuse, broken bone, head/neck injury, misconduct, significant interest-other, neglect, absent without official leave (AWOL), child pornography and non-resident assault. Increases were seen in four categories including death, pregnancy, patient arrests and assault/GBI.



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

Most Frequent DSH Incidents Reported this Period

During the reporting period, 134 of 448 reportable incidents at DSH met criteria for OLES investigation and/or monitoring or led to OLES research into a potential systemic issue. This was 12 less than the prior reporting period. The five most common categories under which incidents were reported accounted for 71.2 percent of all reportable incidents from DSH. These categories are sexual assault,

abuse, broken bone, head/neck injury and sexual assault-OJ. There were 319 reportable incidents in these categories.

These same five categories accounted for 99 reportable incidents or 73.9 percent of all DSH reportable incidents that met the criteria for OLES to investigate and/or monitor.

Similar to the previous reporting period, allegations of sexual assault was the most frequently reported incident. A total of 96 sexual assault allegations accounted for 21.4 percent of all incidents reported. This was a decrease of four incidents from the prior reporting period of 101 allegations of sexual assault and sexual assault-OJ. Of the 96 reports in this period, 27 qualified for investigation and/or monitoring, or consideration of a potential systemic issue. This is an increase of 3.8 percent from 26 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 80 and accounting for 17.9 percent of all incidents reported. This was a decrease of nine reported incidents, or a 10.1 percent decrease 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 decreased by 8.3 percent, from 72 during the prior reporting period, to 66 in this reporting period.

Note that while "abuse" was how certain incidents were described when reported to OLES, the determination of whether each incident met the threshold for 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[4].

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

[4] 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 January 1 – June 30, 2018 (Reported)*	Prior Period January 1– June 30, 2018 (Meets Criteria)*	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Current Period January 1- June 30, 2019 (Reported)	Current Period January 1 - June 30, 2019 (Meets Criteria)
Abuse	85	63	89	72	80	66
Assault/GBI	-	-	5	0	9	0
Broken Bone	58	7	76	7	71	6
Burn	1	0	3	0	3	0
Death	34	11	21	5	27	5
Genital Injury	1	1	1	0	1	0
Head/Neck Injury	36	2	50	0	40	0
Misconduct	29	25	23	20	21	12
Neglect	16	5	24	15	21	14
Non-patient assault	1	1	1	1	0	0
Patient Arrest	-	-	14	0	24	0
Pregnancy	0	0	0	0	1	0
Sexual Assault	132 (99)	25	101	26	96	27
Sexual Assault-OJ**	33	0	35	0	32	0
Significant Interest- Attack on Staff	3	0	2	0	2	0
Significant Interest- Attempted Suicide	5	0	4	0	4	0

Incident Categories	Prior Period January 1 – June 30, 2018 (Reported)*	Prior Period January 1– June 30, 2018 (Meets Criteria)*	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Current Period January 1- June 30, 2019 (Reported)	Current Period January 1 - June 30, 2019 (Meets Criteria)
Significant Interest-AWOL	10	0	14	0	8	1
Significant Interest-Child Pornography	6	0	13	0	2	0
Significant Interest-Other* **	10	0	9	0	6	3
Significant Interest-Riot	0	0	0	0	0	0
Totals	426	140	485	146	448	134

*Numbers in this column are unadjusted and provided as they were previously published. A dash (-) is used to indicate that OLES did not collect data for that particular category during the corresponding reporting period.
**These incidents occurred outside the jurisdiction of DSH.
***Any other 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 January 1 – June 30, 2019

Incident Categories	Atascadero	Coalinga	Metropolitan	Napa	Patton	Totals
Abuse	5	13	33	11	18	80
Assault/GBI	1	1	3	1	3	9
Broken Bone	8	23	19	5	16	71
Burn	0	0	2	1	0	3
Death	2	6	3	11	5	27
Genital Injury	0	0	1	0	0	1
Head/Neck Injury	3	9	19	2	7	40
Misconduct	5	6	3	3	4	21

Incident Categories	Atascadero	Coalinga	Metropolitan	Napa	Patton	Totals
Neglect	5	4	7	3	2	21
Non-Patient Assault	0	0	0	0	0	0
Resident Arrests	1	4	7	3	9	24
Pregnancy	0	0	0	1	0	1
Sexual Assault	11	15	18	22	30	96
Sexual Assault-OJ*	16	0	8	2	6	32
Significant Interest- Attack on Staff	1	1	0	0	0	2
Significant Interest-Attempted Suicide	1	0	1	2	0	4
Significant Interest-AWOL	0	1	5	2	0	8
Significant Interest-Child Pornography	0	2	0	0	0	2
Significant Interest-Other**	3	0	2	0	1	6
Significant Interest-Riot	0	0	0	0	0	0
Totals	62	85	131	69	101	448

*These incidents occurred outside the jurisdiction of DSH.
** Any other 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

DSH accounted for 448 or 76.2 percent of the total 588 reported incidents to OLES during this reporting period. With 6,115 patients department-wide, this equates to 0.073 incidents per patient.

The Metropolitan State Hospital (MSH) had the highest number of reportable incidents in this period with 131 reports, a decrease of 8.4 percent from the previous reporting period in which MSH had 143 reportable incidents. With a

population of 794, the 131 incidents translated to a rate of 0.16 incidents per patient at MSH during this period. This is a decrease from the rate of 0.18 incidents per patient in the previous reporting period.

Coalinga State Hospital (CSH) had a decrease of 8.6 percent in reportable incidents, from 93 during the prior reporting period to 85 in this reporting period. The population increased from 1370 to 1393, an increase of 23 patients since the prior reporting period. The number of incidents per patient decreased from 0.068 per patient during the prior reporting period to 0.061 per patient during this reporting period.

NSH had an increase of 6.1 percent in reportable incidents from 65 during the prior reporting period to 69 during this reporting period. The patient population increased from 1,247 during the prior reporting period to 1,257 during this reporting period. The number of incidents per patient is approximately the same as the prior period, 0.05.

Patton State Hospital (PSH) had a 2.02 percent increase in reportable incidents from the previous reporting period, from 99 reportable incidents to 101. The patient population decreased from 1,538 patients during the prior reporting period to 1,537 during this reporting period, a decrease of one patient. The number of incidents per patient increased from 0.06 to 0.07 during this reporting period.

Atascadero State Hospital (ASH) had a decrease of 27.1 percent in reportable incidents, from 85 during the prior reporting period to 62 during this reporting period. The population decreased by 12 patients, from 1,146 to 1,134 during this reporting period. The number of incidents per patients increased from .074 to 0.05 during this reporting period.

DSH Sexual Assault Allegations

Allegations of sexual assault continues to be the most frequently reported incident from DSH. The 96 alleged sexual assault incidents reported from January 1 through June 30, 2019, accounted for 21.4 percent of all incident reports from DSH. Twenty-seven of 96 reported incidents of alleged sexual assault, or 28.1 percent, met OLES criteria for investigation, monitoring and/or research into systemic department issues. There were 32 reported incidents under the sexual assault-OJ category.

PSH had the highest number of sexual assault reports with 30 or 30.9 percent of all alleged sexual assault incidents during this reporting period. ASH had 16 out of the 32 reported incidents of alleged sexual assault-OJ, which was the highest amongst the DSH facilities. This category included allegations that implicated

family, friends, or others in incidents that occurred when patients were not in a DSH facility.

When excluding sexual assault-OJ incidents, allegations of sexual assaults involving a patient assaulting other patient(s) were the most frequently reported, with a total of 45 incidents, or 46.9 percent of the alleged sexual assault incidents. The second most frequent type of alleged sexual assault incident involved non-law enforcement staff on a patient(s), with 26 incidents or 27.1 percent. The third most frequent allegation involved an unknown assailant on a patient, with 24 incidents or 25.0 percent. Incidents involving an unknown assailant include allegations made by patients that did not implicate DSH employees or contractors. There was one alleged "patient on staff" sexual assault. There was no alleged sexual assault on a patient(s) by law enforcement personnel during this reporting period. All reports of alleged sexual assaults received by OLES during the reporting period are shown in the chart on the following page.

DSH - Sexual Assault Allegations Reported January 1 through June 30, 2019

Facility	Patient on Patient	Non-Law Enforcement Staff on Patient	Patient on Staff	Law Enforcement on Patient	Unknown Person on Patient*	OJ **	Totals
Atascadero	3	7	0	0	1	16	27
Coalinga	12	2	0	0	1	0	15
Metropolitan	7	3	0	0	8	8	26
Napa	8	7	1	0	6	2	24
Patton	15	7	0	0	8	6	36
Totals	45	26	1	0	24	32	128

*Sexual Assault by an unknown person on a patient is a patient allegation of sexual assault at DSH when the patient is unsure if another person is involved.
**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.

DSH Patient Deaths

There were 27 patient deaths reported to OLES at DSH facilities during this reporting period. This number increased 22.2 percent from the 21 deaths reported in the prior reporting period, July 1 through December 31, 2018. Patient age at the time of death ranged from 30 years to 85 years old. Of the 27 deaths, 26 were male patients and one was female. As shown in the following chart, NSH and PSH had the highest number of deaths with 11 deaths and five deaths respectively.

DSH - Patient Deaths Reported January 1 through June 30, 2019

Facility	Cancer	Cardiac/ Respiratory	Renal/Liver	Sepsis	Other	Totals
Atascadero	2	0	0	0	0	2
Coalinga	4	2	0	0	0	6
Metropolitan	0	3	0	0	0	3
Napa	0	5	2	3	1	11
Patton	1	3	1	0	0	5
Totals	7	13	3	3	1	27

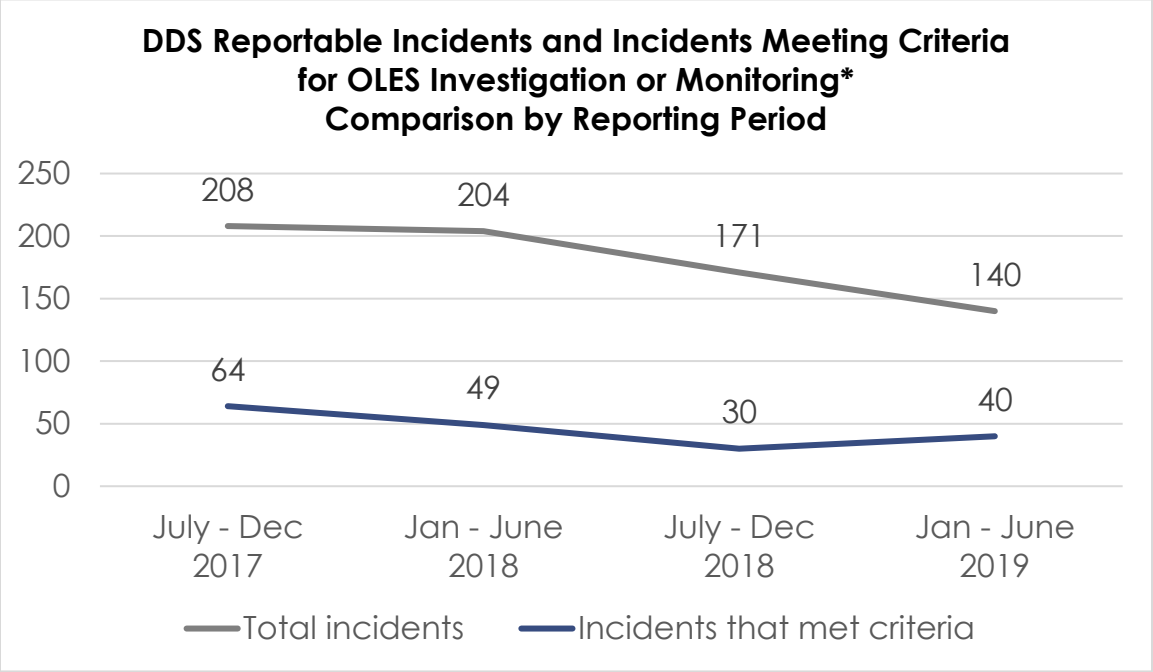
*Other deaths are those pending determination

Approximately 66.7 percent or 18 deaths of the DSH patient 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 into the unexpected deaths at DSH. The final determination for the cause of death of these nine "unexpected deaths" are included in the numbers for chart above.

DDS Incidents

Decreased Incidents during this Reporting Period

Overall, the number of DDS incidents reported during this reporting period decreased by 18.1 percent, from 171 during the prior reporting period to 140 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 140 reportable DDS incidents in this reporting period, 28.6 percent or 40 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 decreased by 31 incidents, and the number of reportable incidents meeting criteria increased by 10 incidents or 33.3%.

DDS Population Decrease

From June 30, 2016 to June 30, 2019, the DDS population has dropped 66.3 percent, from 988 to 333 as of June 30, 2019. The chart on the following page shows the change in population at the DDS facilities.

DDS Population Decrease by Facility

Reporting Period End Date	Canyon Springs	Fairview	Porterville	Sonoma	Total
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
December 31, 2018*	48	91	256	5	400
June 30, 2019*	47	46	238	2	333

*The population numbers include Stabilization, Training, Assistance, and Reintegration (STAR) home individuals.

At Sonoma Developmental Center (SDC), five residents are served in the Northern STAR, a small unit contracted to provide short-term stabilization, training, assistance, and reintegration (STAR) services.

At Fairview Developmental Center (FDC), three residents are served in the Southern STAR. DDS anticipates 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.

DDS anticipates that the remaining 34 residents in the Porterville Developmental Center (PDC) General Treatment Area will be placed in the community by December 2019. The Secure Treatment Area will remain open.

Most Frequent DDS Incidents Reported this Period

Of the 140 reported incidents from DDS, 129 incidents or 92.1 percent of all reported incidents fell into the following six categories: abuse, sexual assault, broken bone, neglect, head or neck injuries and assault with great bodily injury. These same six categories accounted for 37 incidents or 92.5 percent of all DDS reportable incidents that met the criteria for 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 94 abuse allegations accounted for 67.1 percent of all DDS incidents reported. Reports of alleged abuse increased by three incidents or 3.3 percent compared to the prior reporting period, which had 91 reported incidents of alleged abuse. Alleged sexual assault represented the second highest category for the number of incidents reported, with 11 reported. This is a decrease of 21.4 percent from the prior reporting period where there were 14 reported. None of the alleged sexual assault incidents met criteria for investigation or monitoring. The determination of whether alleged abuse or alleged sexual assault incidents

met the threshold for OLES's purposes of investigation 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].

Broken bone was the third most frequently reported incident category, with eight reports of broken bones in this reporting period, a decrease of four incidents or 33.3 percent from last period. None of the reported broken bone incidents met criteria for further action.

Neglect was the fourth most frequently reported incident category, with six reports in this period. Four of these reported incidents met OLES criteria for investigation or monitoring. Compared to the prior reporting period of July 1 through December 31, 2018, the reported incidents of neglect increased by four incidents or 200 percent.

Reports of head or neck injuries and assault with great bodily injury constituted the fifth most frequently reported incident by DDS, with five incidents under each category. Compared to the prior reporting period, reported head or neck injuries decreased by 80.8 percent, or 21 incidents. Reports of assault with great bodily injury increased by 20 percent, or one incident. None of the 10 reportable incidents for head or neck injury or assault with great bodily injury met OLES criteria for investigation or monitoring.

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

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

DDS Reportable Incidents by Reporting Period

Department of Developmental Services Comparison of Reportable Incidents by Reporting Period

Incident Categories	Prior Period January 1 – June 30, 2018 (Reported)*	Prior Period January 1– June 30, 2018 (Meets Criteria)*	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Current Period January 1- June 30, 2019 (Reported)	Current Period January 1 - June 30, 2019 (Meets Criteria)
Abuse	115	40	91	24	94	33
Assault/GBI	-	-	4	0	5	0
Broken Bone	10	2	12	0	8	0
Burn	1	0	1	0	1	0
Death	14	2	3	1	2	0
Genital Injury	2	0	2	0	1	0
Head/Neck Injury	20	0	26	0	5	0
Misconduct	2	2	1	1	4	3
Neglect	6	1	2	1	6	4
Non-resident assault	0	0	0	0	0	0
Pregnancy	0	0	0	0	0	0
Resident Arrest	-	-	5	0	1	0
Sexual Assault	25	1	14	3	11	0
Sexual Assault-OJ**	0	0	0	0	0	0
Significant Interest- Attack on Staff	0	0	0	0	0	0
Significant Interest- Attempted Suicide	0	0	1	0	0	0
Significant Interest- AWOL	5	0	7	0	1	0

Incident Categories	Prior Period January 1 – June 30, 2018 (Reported)*	Prior Period January 1– June 30, 2018 (Meets Criteria)*	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Current Period January 1- June 30, 2019 (Reported)	Current Period January 1 - June 30, 2019 (Meets Criteria)
Significant Interest- Child Pornography	0	0	0	0	0	0
Significant Interest- Other* **	4	1	2	0	1	0
Significant Interest-Riot	0	0	0	0	0	0
Totals	204	49	171	30	140	40

*Numbers in this column are unadjusted and provided as they were previously published. A dash (-) is used to indicate that OLES did not collect data for that particular category during the corresponding reporting period.
**These incidents occurred outside the jurisdiction of DDS.
***Any other incident of significant interest, e.g., civilian arrest for providing contraband to a resident; and the smuggling of drugs into a developmental center.

DDS Reportable Incidents by Facility this Reporting Period

Department of Developmental Services Summary of Reportable Incidents by Facility January 1 through June 30, 2019

Incident Categories	Canyon Springs	Fairview	Porterville	Sonoma	Totals
Sexual Assault	4	1	6	0	11
Sexual Assault-OJ*	0	0	0	0	0
Abuse	20	37	36	1	94
Broken Bone	1	1	6	0	8
Head/Neck Injury	0	2	3	0	5
Misconduct	2	0	2	0	4
Significant Interest**	0	0	1	0	1
Death	0	2	0	0	2
Neglect	2	2	2	0	6
AWOL	0	1	0	0	1
Child Pornography	0	0	0	0	0
Attack on Staff	0	0	0	0	0
Attempted Suicide	0	0	0	0	0

Incident Categories	Canyon Springs	Fairview	Porterville	Sonoma	Totals
Burn	0	1	0	0	1
Genital Injury	0	0	1	0	1
Pregnancy	0	0	0	0	0
Riot	0	0	0	0	0
Non-Resident Assault	0	0	0	0	0
Assault/GBI	0	0	5	0	5
Resident Arrest	0	0	1	0	1
Total	29	47	63	1	140

* Beginning with the prior reporting period covering January 1through June 30, 2018, 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 140 DDS incidents reported January 1 through June 30, 2019, accounted for 23.8 percent of all 588 reports to OLES in this reporting period. With 333 residents department-wide, this equates to 0.42 incidents per resident.

Canyon Springs Community Facility (CSCF) had a decrease in reportable incidents of 14.7 percent, from 34 to 29 during this reporting period with a population reduction of only one resident. FDC reported 47 incidents during this reporting period, compared to 53 during the prior reporting period, a decrease of 11.3 percent. FDC also experienced a population reduction of 45 residents, from 91 in the prior reporting period to 46 in this reporting period. PDC, which has 238 residents, had 63 reportable incidents from January 1 through June 30, 2019. This is a decrease of 12.5 percent from the 72 incidents reported in the prior reporting period. PDC had a population reduction from 256 residents in the prior reporting period to 238 during this reporting period. The Northern STAR at SDC had a decrease in reportable incidents from 12 to one in this reporting period, a decrease of 91.7 percent. SDC's STAR facility had a population reduction from five residents in the prior reporting period to two residents during this reporting period.

DDS Sexual Assault Allegations

The OLES received 11 incident reports alleging sexual assault at DDS in this

reporting period, a decrease from 14 reports or 21.4 percent in the prior reporting period. Of these 11 reportable incidents, six were from PDC, four were from CSCF, and one was from FDC. Reportable incidents of alleged sexual assault accounted for 7.9 percent of all reportable incidents from DDS. Seven of the reported sexual assault incidents, or 63.6 percent were alleged to be by non-law enforcement staff. Three of the 11 allegations of sexual assault reported to OLES, or 27.3 percent, were reports of resident on resident sexual assault. There was one allegation of sexual assault in which a resident was unsure if another person was involved.

DDS - Sexual Assault Incidents Reported January 1 through June 30, 2019

Facility	Resident on Resident	Non-Law Enforcement Staff on Resident	Resident on Staff	Law Enforcement on Resident	Unknown Person on Resident*	OJ **	Totals
Canyon Springs	0	4	0	0	0	0	4
Fairview	0	1	0	0	0	0	1
Porterville	3	2	0	0	1	0	6
Sonoma	0	0	0	0	0	0	0
Totals	3	7	0	0	1	0	11

*Sexual Assault by an unknown person on a resident is a resident allegation of sexual assault at DDS when the resident is unsure if another person is involved.
**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 developmental center.

DDS Resident Deaths

The DDS reported two deaths during this reporting period. Both resident deaths were reported by FDC. Of the two deaths reported, one was due to cardiac or respiratory issues, and one was due to cerebral issues. The ages of the deceased residents were 51 and 53 years old and were both male. Both deaths were classified as "expected".

DDS - Resident Deaths Reported January 1 through June 30, 2019

Facility	Cancer	Cardiac/ Respiratory	Cerebral Issue	Totals
Canyon Springs	0	0	0	0
Fairview	0	1	1	2
Porterville	0	0	0	0
Sonoma	0	0	0	0
Totals	0	1	1	2

Notification of Incidents

Different types of incidents require different kinds of notification to OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq. (in Appendix E), and agreements between OLES and the departments, certain serious incidents are required to be reported to 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 One Notifications- Two Hour Notification

Incident	Description
ADW	An assault with a deadly weapon (ADW) against a patient or resident by a non-patient or non-resident.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a patient.
Broken Bone	A broken bone of a patient or resident.
Deadly force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a patient or resident.
Genital Injury	An injury to the genitals of a patient or resident when the cause of injury is undetermined.
Physical Abuse	Any report of physical abuse of a patient or resident implicating staff.
Sexual Assault	Any allegation of sexual assault of a patient or resident.

Priority Two Notifications – One Day Notification

Incident	Description
Burns	Any burns of a patient or resident.
Head/Neck Injury	Any injury to the head or neck (including teeth) of a patient requiring treatment beyond first-aid.
Neglect	Any staff action or inaction that resulted in, or reasonably could have resulted in a patient death, or injury requiring treatment beyond first-aid.
Patient or Resident Arrest	Any arrest of a patient or resident.
Peace Officer	Any allegations of peace officer misconduct, whether on

Incident	Description
Misconduct	or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties.
Pregnancy	A patient or resident pregnancy.
Significant Interest	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 patient(s) or staff, child pornography, riot (as defined for OLES reporting purposes), and any incident which may potentially draw media attention.

Timeliness of Notifications

In this reporting period, DSH and DDS timely reporting of incidents to OLES statewide was 96.4 percent. This is an increase in timely reporting of incidents statewide from the prior reporting period where the timely reporting was 94.4 percent. Of 588 reportable incidents statewide, 567 were reported timely, 21 reportable incidents or 3.6 percent were not.

The DSH had 448 reportable incidents department-wide. Of these, 428 or 95.5 percent were reported timely, compared to 94.0 percent in the prior reporting period. Twenty incidents, or 4.5 percent were not reported timely. ASH had the highest percentage of timely notifications at 98.4 percent during this reporting period. CSH had the lowest percentage of timely notifications with 94.1 percent of all reportable incidents.

DSH - Timely Notifications January 1 through June 30, 2019

Rank	DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Atascadero	1134	62	61	98.4%
2	Coalinga	1393	85	80	94.1%
3	Metropolitan	794	131	125	95.4%
4	Napa	1257	69	65	94.2%
5	Patton	1537	101	97	96.0%
	Totals	6115	448	428	95.5%

* The department provided population numbers as of June 30, 2019.

The DDS had 140 reportable incidents department-wide. Of these, 139 incidents or 99.3 percent were reported timely compared to 95.3 percent in the prior reporting period. One incident or 0.7 percent was not reported timely. CSCF, PDC and SDC reported 100% of their 93 total reportable incidents timely. FDC had the lowest percentage of timely notifications with 97.9 percent of all reportable incidents.

DDS - Timely Notifications January 1 through June 30, 2019

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Canyon Springs	47	29	29	100%
2	Fairview	46	47	46	97.9%
3	Porterville	238	63	63	100%
4	Sonoma	2	1	1	100%
	Totals	333	140	139	99.3%

* The department provided population numbers as of June 30, 2019. These population numbers include residents in STAR homes.

Intake

All incidents received by OLES during the six-month reporting period are reviewed at a daily Intake meeting by a panel of assigned OLES staff members. Based on statutory requirements, the panel determines whether allegations against law enforcement officers warrant an internal affairs investigation by OLES. If the allegations are against other DSH 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 OLES is independently assessing whether an allegation meets its criteria, OLES requires the departments to broadly report misconduct allegations.

An incident was considered "Reviewed, Case Closed (RCC)" if the incident did not meet the criteria for OLES to conduct an investigation or monitoring and did not result in a case being opened. Prior to placing an incident under the RCC category, OLES categorizes the incident under a "Pending Review" category and conducts an extra step to ensure incidents that initially appear to not fit the criteria[6] for OLES involvement are being properly categorized. When allegations are unclear and additional information is needed to finalize an initial intake decision, OLES may review video files or digital recordings of a particular hallway, day room, or staff area where a patient or resident was located. Once OLES obtains and evaluates the additional materials or information, the decision to initially deem an incident as not meeting OLES criteria is reviewed again and may be reversed.

For the January 1 through June 30, 2019 reporting period, 414 of the total 588 or 70.4 percent of DSH and DDS incidents that OLES received were RCC. DSH reported 314 of the 414 RCC incidents, or 75.8 percent. More specifically, 101 out of 128 alleged sexual assault and sexual assault-OJ incidents, represented the largest categories in which DSH reported incidents did not meet OLES criteria and were RCC. DDS had 100 RCC incidents, or 24.2 percent of all RCC incidents. Abuse allegations accounted for 61 of the 100 DDS RCC incidents.

The charts on the following page provide the outcome of all incidents received by OLES during the prior and current reporting period. Please note that the charts on the following page separate out the Outside Jurisdiction cases from the RCC cases.

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

DSH Cases Opened in the Current and Prior Reporting Period

OLES Disposition Categories	July 1 – December 31, 2018	Percentage of Reported Incidents	January 1 – June 30, 2019	Percentage of Reported Incidents
Reviewed, Case Closed (RCC)	304	63%	282	63%
Monitored, Criminal	90	18%	94	21%
Outside Jurisdiction*	35	7%	32	7%
OLES Investigations, Administrative	8	2%	11	2%
OLES Investigations, Criminal	11	2%	7	2%
Monitored, Administrative	37	8%	22	5%
Totals	485	100%	448	100%

*Outside Jurisdiction includes incidents that may have occurred while the patient was not housed within a DSH facility.

DDS Cases Opened in the Current and Prior Reporting Period

OLES Disposition Categories	July 1 – December 31, 2018	Percentage of Reported Incidents	January 1 – June 30, 2019	Percentage of Reported Incidents
Reviewed, Case Closed (RCC)	141	82%	100	71%
Monitored, Criminal	27	16%	32	23%
Monitored, Administrative	2	1%	6	4%
OLES Investigations, Administrative	0	0%	1	1%
OLES Investigations, Criminal	1	1%	1	1%
Outside Jurisdiction*	0	0%	0	0%
Totals	171	100%	140	100%

*Outside Jurisdiction includes incidents that may have occurred while the resident was not housed within a DDS facility.

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 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, OLES completed 22 investigations. Ten investigations were criminal cases and 12 were administrative.

If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, OLES submits the investigation to the appropriate prosecuting agency. During the first half of 2019, OLES did not refer any criminal investigations to a prosecuting agency. All completed OLES investigations into administrative wrongdoing/misconduct are forwarded to facility management for review. In this reporting period, nine administrative cases were referred to management for possible discipline of state employees and one administrative case was closed for lack of evidence. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted. The following charts show the results of all the completed OLES investigations in this reporting period. These investigations are in Appendix A.

DSH - Results of Completed OLES Investigations

Type of Investigation	Total completed January 1- June 30, 2019	Referred to prosecuting agency	Referred to facility management	Closed without referral*
Administrative	10	N/A	7	3
Criminal	9	0	N/A	9
Total	19	0	7	12

DDS - Results of Completed OLES Investigations

Type of Investigation	Total completed January 1- June 30, 2019	Referred to prosecuting agency	Referred to facility management	Closed without referral*
Administrative	2	N/A	2	0
Criminal	1	0	N/A	1
Total	3	0	2	1

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

OLES Monitored Cases

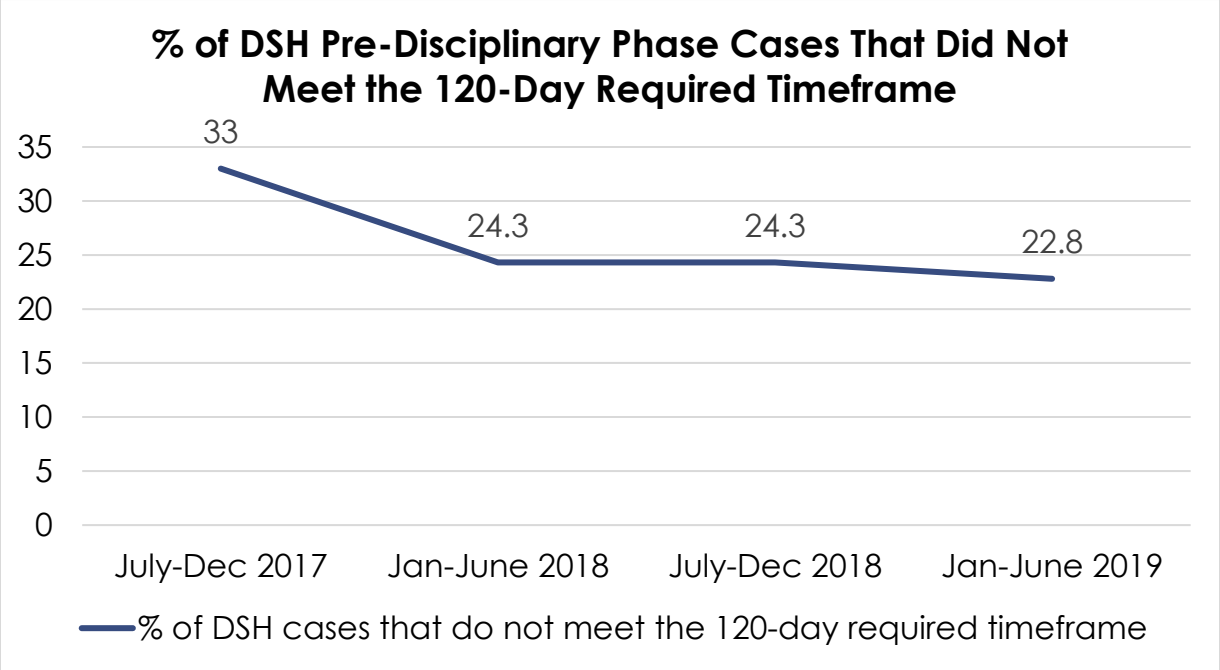
In this report, OLES provides information on the 164 monitored cases at the two departments that, by June 30, 2019, had reached resolution. Of these cases, 82 or 50.0 percent of the total, involved allegations of administrative misconduct by departmental staff, such as failing to maintain one-on-one supervision, as required, for a patient or resident. The results are summarized in the charts below, and synopses of the cases are in Appendices B, C, and D.

Results of Monitored Cases at DSH and DDS

Type of Case/Result	DSH	DDS	Totals
Criminal/Not Referred	61	15	76
Criminal/Referred to Prosecuting Agency	3	3	6
Total Criminal	64	18	82
Administrative/Without Sustained Allegations	52	5	57
Administrative/With Sustained Allegations	21	4	25
Total Administrative	73	9	82
Grand Totals	137	27	164

DSH Pre-Disciplinary Phase Cases

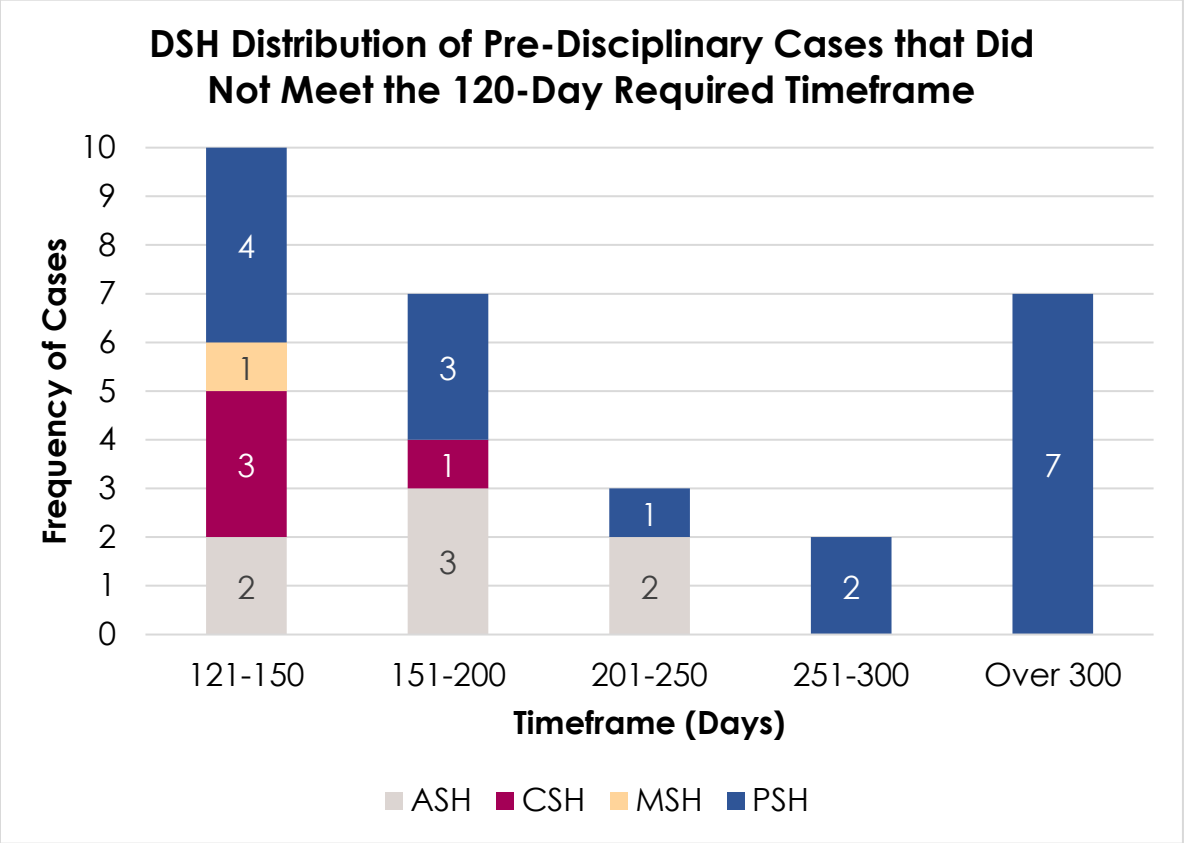
Pre-disciplinary phase cases include cases from Appendix B: Pre-Disciplinary Cases and Appendix D: Combined Pre-Disciplinary and Disciplinary Phase Cases. The OLES rated 42 pre-disciplinary phase cases procedurally insufficient. Procedural sufficiency is determined by factors such as the timeliness for investigation activities, compliance with policies and procedures governing the pre-disciplinary process, notifications to OLES and consultations with OLES. The most prevalent procedural deficiency for DSH pre-disciplinary phase cases continues to be the failure to complete investigations within the 120-day required timeframe. The chart below displays the percentage of DSH pre-disciplinary phase cases that did not meet the 120-day required timeframe in the current and prior three reporting periods.



**Beginning with the July 1 through December 2018 reporting period, OLES no longer includes the number of pre-disciplinary phase cases in which OLES conducted the investigations when calculating the percentage of cases not meeting the 120-day required timeframe.*

Twenty-nine out of the 127 DSH pre-disciplinary phase cases in which DSH conducted the investigation, or 22.8 percent were not completed within the required timeframe. Of these 29 cases, 17 cases were from PSH. Seven PSH investigations took over 300 days to complete, with the longest duration being 674 days and the shortest duration being 132 days. The median duration for cases that did not meet the 120-day timeframe was 292 days. The following chart provides the distribution of DSH pre-disciplinary cases that did not meet the 120-day required timeframe across the state hospitals for this reporting

period. NSH did not have any pre-disciplinary cases that did not meet the required timeframe, and therefore is not included in the chart below.



In addition, eight DSH pre-disciplinary phase cases were rated as substantively insufficient due to the quality, adequacy and thoroughness of investigative interviews and reports.

DDS Pre-Disciplinary Phase Cases

The OLES rated seven of the DDS pre-disciplinary phase cases procedurally insufficient by OLES. Four out of the 26 pre-disciplinary phase cases, or 15.4% were not completed within the 120-day required timeframe. There were no substantive insufficiencies among the DDS pre-disciplinary phase cases.

DSH and DDS Disciplinary Phase Cases

When an administrative investigation, either by the department or by 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.

The OLES assesses every discipline phase case for both procedural and substantive sufficiency. Procedural sufficiency includes, among other things, whether 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. Both departments have implemented policies that incorporate OLES' recommendation to serve a disciplinary action within 60 days after a decision is made to impose discipline. 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.

Appendices C and D provide assessments of nine DSH and one DDS disciplinary phase cases that reached resolution during the current reporting period. Four out of nine of the DSH disciplinary actions were rated as procedurally insufficient due to being served over 60 days after the hiring authority made a disciplinary determination. These four disciplinary actions were served between 81 and 233 days. When compared to last year's average, the average length of time to serve an action in procedurally insufficient cases increased from 129 days to 157 days. DDS served one disciplinary action during this reporting period, which was procedurally insufficient due to being served 169 days after decision to impose discipline was made. All disciplinary phase cases provided in this reporting period were rated as substantively sufficient.

The OLES continues 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 semiannual 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	43	12	26	5	0
Coalinga	50	8	24	16	2
Metropolitan	40	3	31	6	0
Napa	43	4	23	15	1
Patton	73	6	52	13	2
Totals	249	33	156	55	5

* 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	3	1	2	0
Fairview	2	0	2	0
Porterville	7	1	6	0
Sonoma	1	1	0	0
Totals	13	3	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	3	3	0	3
Coalinga	0	0	0	0
Metropolitan	11	0	11	0
Napa	19	0	19	0
Patton	9	6	3	5
Totals	42	9	33	8

* 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	15	0	15	0
Fairview	1	0	1	0
Porterville	6	1	5	3
Sonoma	1	0	1	0
Totals	23	1	22	3

* 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	254	200	54	177
Coalinga	361	123	238	44
Metropolitan	944	38	906	9
Napa	586	28	558	5
Patton	329	168	161	157
Totals	2474	557	1917	392

* 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	0	0	0	0
Porterville	75	71	4	10
Totals	77	71	6	10

* 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	2	14	0	0	0
Coalinga	0	0	0	0	0
Metropolitan	0	0	0	0	0
Napa	0	3	0	0	0
Patton	0	4	0	0	0
Totals	2	21	0	0	0

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

DDS Mandated Data – Reports of Employee Misconduct to Licensing Boards

DDS Facilities	Registered Nursing	Vocational Nursing	Medical Board	Pharmacy	Public Health
Canyon Springs	0	0	0	0	7
Fairview	0	0	0	0	12
Porterville	0	0	0	0	17
Totals	0	0	0	0	36

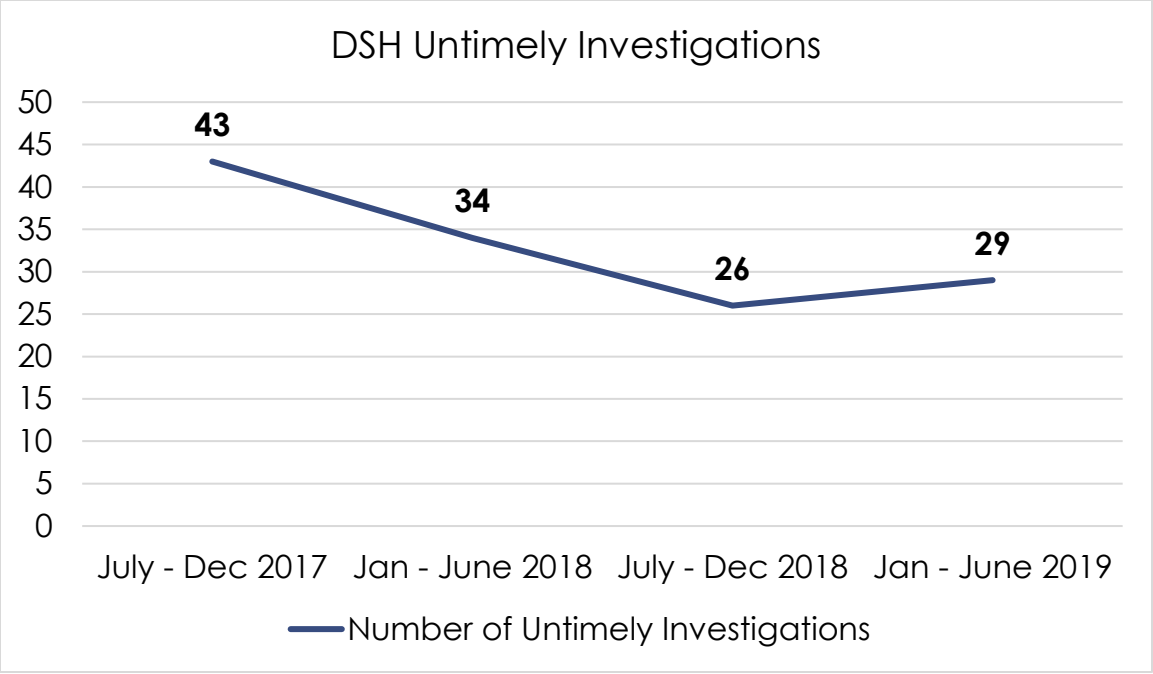
*Reports of employee misconduct to California licensing boards include any reports of misconduct made against a state employee.

Monitored Issues

In the course of its oversight duties, OLES may observe issues that reveal potential patterns, shortcomings, or systemic issues at the facilities. In these situations, the Chief of OLES instructs OLES staff to research and document the issues. These issues are then brought to the attention of the departments. In most instances, OLES requests corrective plans. In this reporting period, there is one new monitored issue regarding untimely investigations at PSH. Updates on long-running monitored issues are provided below.

Untimely Investigations at PSH

In OLES' March 2018 semiannual report, OLES reported that delays in completing investigations were the most prevalent procedural deficiency for pre-disciplinary phase cases at DSH facilities. To address this deficiency, DSH added additional staff to the investigative teams at several facilities and extended the required investigative timeframe from 75 days to 120 days. In addition, DSH implemented additional review and monitoring processes. The chart below shows the overall declining trend for untimely investigations.



Although there is a general decline in the number of untimely investigations, the disproportionately high number of PSH untimely investigations remains a concern. In November 2018, OLES conducted a comparative analysis of DSH's timeliness of investigations. The OLES discovered that during the January 1 through June 2018 reporting period, PSH was responsible for 19 of the 34

untimely investigations. The OLES sent a formal letter to DSH identifying this issue and recommended for DSH to ensure that the Office of Special Investigations at PSH has sufficient resources to ensure investigations are completed in a timely manner.

In the two reporting periods following January 1 through June 2018, PSH continued to have the highest number of investigations among the DSH facilities. The following chart compares the number of PSH investigations from the period of January 1, 2018 to June 30, 2019.

PSH Untimely Investigations

Reporting Period	# of PSH Investigations	Total DSH Untimely Investigations	PSH Range for Untimely Investigations (days)
January-June 2018	19	34	134-588
July-December 2018	20	26	131-358
January-June 2019	18	29	132-674

The OLES continues to monitor this issue and is working with DSH to identify the cause(s) for the untimely investigations.

Duty to Cooperate at DSH

In the course of monitoring investigations during the July 1, 2017 through December 31, 2017 reporting period, OLES identified an issue of DSH employees refusing to cooperate with investigators. The OLES discovered that there was no department-wide, written policy concerning the service of notices for interviews. Some investigators simply called or emailed the employee; others served a formal notice. The OLES recommended DSH develop a department-wide, written policy mandating the use of formal interview notices with standardized language.

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 also drafted a set of standardized interview notices for use by OPS investigators during their investigations. DSH Legal and Labor Units reviewed the investigative interview notices and policy draft. DSH Labor will send out the interview notices and policy out for Bargaining Unit Notice.

Lack of Patient Separation Policy at DSH

In the course of an investigation during the July 1, 2017 through December 31, 2017 reporting period, 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 is being routed through DSH's Internal Executive Review Processes for finalization and approval as a DSH Policy Directive.

Personal Electronic Devices at Work

In the semiannual report covering January 1 through June 30, 2017, 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 June 30, 2019, *PD 1102 – Use of Personally Owned Devices at DSH Hospitals* required additional edits based on feedback from the DSH Technical Services Division (TSD). The revised policy was submitted to OLES for further review. Once the review is complete, the policy directive will go to the DSH Exec Team for approval and then Union Notification prior to implementation.

DSH Patient Pregnancies

In the semiannual report covering January 1 through June 30, 2017, 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 renamed "Patient Sexuality" to *PD 3106 – Patient Sexual Behavior and Health.* This Policy Directive is pending presentation to the DSH Medical Directors. Once that is complete, it will be scheduled for DSH Executive Team review and approval and Union Notification prior to implementation.

OLES Recommendation-DSH

As required by statute[7], 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, OLES updated the recommendations for best practices in law enforcement and employee discipline that OLES made to the departments. Below is the last remaining recommendation provided by OLES to DSH and the status provided verbatim by DSH as of June 30, 2019.

DSH Standardized Training

OLES Recommendation of Best Practice	Status as of December 31, 2018	Status as of June 30, 2019
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.	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.	DSH completed the implementation of a standardized Continuing Professional Training Program (CPT) on March 14, 2019 utilizing the OPS Train Software Program. A comprehensive User's Guide was created for OPS Trainers and all OPS staff have been trained in the use of the OPS Training Software System and its use is now mandatory.

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

Appendix A: OLES Investigations

Appendix A1 OLES Investigations – DSH

Case Details	Description
Incident Date	08/10/2018
OLES Case Number	2018-00848A
Case Type	Misconduct
Incident Summary	On August 10, 2018, an officer allegedly divulged confidential information to another officer after being admonished by a supervisor not to discuss the matter.
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.

Case Details	Description
Incident Date	01/01/2000
OLES Case Number	2018-00952A
Case Type	Misconduct
Incident Summary	Between 2000 and 2001, an officer allegedly committed lewd acts on a child.
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.

Case Details	Description
Incident Date	10/11/2018
OLES Case Number	2018-01099A
Case Type	Misconduct
Incident Summary	Between July 1, 2018, and October 11, 2018, a communications operator and an officer allegedly engaged in excessive public displays of affection while on duty. On October 11, 2018, they allegedly engaged in sexual relations while on duty. Between January 8, 2019, and January 10, 2019, they allegedly discussed the investigation with each other after being admonished not

	to. On January 10, 2019, they were allegedly dishonest during their interviews with the OLES.
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.

Case Details	Description
Incident Date	10/13/2018
OLES Case Number	2018-01100A
Case Type	Misconduct
Incident Summary	On October 13, 2018, an officer allegedly carried a personal firearm off-duty without approval from the department. In addition, the officer allegedly pointed the firearm in an unsafe direction and stored the firearm in an unlocked and unsafe location.
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.

Case Details	Description
Incident Date	10/19/2018
OLES Case Number	2018-01128A
Case Type	Misconduct
Incident Summary	On October 19, 2018, an officer allegedly abandoned his post and left a patient unmonitored at a hospital.
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.

Case Details	Description
Incident Date	01/01/2016
OLES Case Number	2018-01323C
Case Type	Misconduct
Incident Summary	In 2016, an officer allegedly told a patient to rape a

	second patient. On December 3, 2018, officers allegedly reported that the first patient was a "rat" to other patients on his unit. In addition, numerous officers on multiple unknown dates routinely used excessive force on patients.
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 review and decision was provided to the department.

Case Details	Description
Incident Date	12/09/2018
OLES Case Number	2018-01331C
Case Type	Misconduct
Incident Summary	On December 9, 2018, an officer was arrested for allegedly driving under the influence of alcohol and committing child endangerment.
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 review and decision was provided to the department.

Case Details	Description
Incident Date	12/25/2018
OLES Case Number	2018-01380C
Case Type	Misconduct
Incident Summary	On December 25, 2018, an officer allegedly twisted a patient's wrist.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter. It was determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Details	Description
Incident Date	08/10/2018
OLES Case Number	2019-00076A
Case Type	Misconduct
Incident Summary	On August 10, 2018, a sergeant allegedly violated a confidentiality admonishment related to an ongoing criminal investigation.
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.

Case Details	Description
Incident Date	02/14/2019
OLES Case Number	2019-00164C
Case Type	Misconduct
Incident Summary	On February 14, 2019, an officer allegedly hit a patient in the neck.
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 review and decision was provided to the department.

Case Details	Description
Incident Date	10/28/2018
OLES Case Number	2019-00180C
Case Type	Abuse
Incident Summary	On October 28, 2018, several officers allegedly used unreasonable force on 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 review and decision was provided to the department.

Case Details	Description
Incident Date	02/23/2019
OLES Case Number	2019-00198A
Case Type	Misconduct
Incident Summary	On February 23, 2019, an officer was arrested for allegedly committing domestic violence.
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.

Case Details	Description
Incident Date	04/08/2016
OLES Case Number	2019-00210C
Case Type	Misconduct
Incident Summary	On April 8, 2016, a patient was allegedly wrongly arrested and remained incarcerated at the county jail for over two years.
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 review and decision was provided to the department.

Case Details	Description
Incident Date	05/01/2018
OLES Case Number	2019-00337A
Case Type	Misconduct
Incident Summary	On May 1, 2018, and September 18, 2018, an officer allegedly disclosed confidential information regarding an ongoing investigation.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined the matter should be referred back to the department for appropriate review and determination. A summary of the review and decision was provided to the department.

Case Details	Description
Incident Date	04/09/2019
OLES Case Number	2019-00380C
Case Type	Misconduct
Incident Summary	On April 9, 2019, a law enforcement supervisor allegedly committed perjury during a State Personnel Board hearing.
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 review and decision was provided to the department.

Case Details	Description
Incident Date	04/23/2019
OLES Case Number	2019-00411C
Case Type	Misconduct
Incident Summary	On April 23, 2019, officers allegedly twisted a patient's arm while the patient was being placed in restraints.
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 review and decision was provided to the department.

Case Details	Description
Incident Date	05/06/2019
OLES Case Number	2019-00457A
Case Type	Misconduct
Incident Summary	On May 6, 2019, an off-duty officer allegedly was publicly intoxicated and in possession of a personal firearm.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined the misconduct did not rise to the level for further investigation by OLES and a summary of the review and decision was provided

	to the department.

Case Details	Description
Incident Date	06/19/2019
OLES Case Number	2019-00609C
Case Type	Misconduct
Incident Summary	On June 19, 2019, an officer allegedly placed his hands on a patient's arms and forcefully moved the patient approximately five to six feet.
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 review and decision was provided to the department.

Case Details	Description
Incident Date	03/03/2019
OLES Case Number	2019-00690A
Case Type	Misconduct
Incident Summary	On March 3, 2019, an officer allegedly consumed alcohol and then directed his child to blow into a court ordered breathalyzer installed on his personal vehicle.
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 review and decision was provided to the department.

Appendix A2 OLES Investigations – DDS

Case Details	Description
Incident Date	01/01/2017
OLES Case Number	2018-00548A
Case Type	Misconduct
Incident Summary	On numerous occasions in 2017 and 2018, a sergeant allegedly falsified timesheets to claim overtime he had not worked and scheduled himself to work overtime positions he was not eligible for. In addition the sergeant allegedly downloaded numerous personal images and videos on a state computer. In February 2018 and May 2018, the sergeant allegedly made inappropriate sexual comments and threats to colleagues.
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.

Case Details	Description
Incident Date	07/29/2017
OLES Case Number	2018-00620A
Case Type	Misconduct
Incident Summary	Between July 29, 2017, and June 30, 2018, an officer allegedly engaged in unwanted sexual harassment and inappropriate conduct towards a colleague.
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.

Case Details	Description
Incident Date	04/24/2019
OLES Case Number	2019-00419C
Case Type	Misconduct
Incident Summary	On April 24, 2019, two officers allegedly used excessive force on a resident.
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 review and decision was provided to the department.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

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

- Procedural sufficiency includes the notifications to OLES, consultations with 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 Phase Cases – DSH

Case Details	Description
Incident Date	01/11/2017
OLES Case Number	2017-00039MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 11, 2017, two psychiatric technicians allegedly used excessive force on a patient while placing him against a wall and on the ground.
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 administrative investigation was not opened until 197 days after the associated criminal case was rejected by the district attorney's office. The administrative investigation was not completed until 433 days after the administrative case was opened.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The incident was initially investigated as a criminal case and submitted to the district attorney's office for filing. The district attorney's office rejected the case on April 18, 2017; however, the administrative case was not opened until November 1, 2017, 197 days later. The investigation was completed on January 8, 2019, 433 days after the administrative case was opened.
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 Details	Description
Incident Date	04/27/2016
OLES Case Number	2017-00202MC
Case Type	Neglect
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On April 27, 2016, a psychiatrist allegedly intentionally falsified a patient's medical records, thereby indicating she was mentally ill, and forced the patient to take anti-psychotic medication.
Disposition	The Office of Special Investigations conducted an investigation and referred the investigation to the district attorney's office for review. The Office of Special Investigations did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and

	procedures governing the disciplinary process. The deadline to file charges expired before the investigation was completed. The investigation was not completed until 674 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the investigation or subject-only interview completed at least 90 days before the deadline to take disciplinary action or the deadline for a prosecuting agency to file charges? No. The incident is alleged to have occurred on April 27, 2016. Therefore, the deadline to file criminal charges was April 27, 2017. The investigation was completed on December 21, 2018, 603 days after the deadline expired. It is noted the incident was discovered on February 15, 2017, 284 days after the incident, leaving only 81 days to timely complete the investigation and submit the report to the prosecuting agency. 2. Did the deadline for taking disciplinary action or filing charges expire before the investigation was complete? Yes. The deadline for filing criminal charges expired on April 27, 2017; however the investigation was not forwarded to the district attorney until December 21, 2018, 603 days after the deadline expired. It is noted the incident wasn't discovered until February 5, 2017, 284 days after the incident, leaving only 81 days to timely complete the investigation and submit the report to the prosecuting agency. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 5, 2017; however, the investigation was not completed until December 21, 2018, 674 days later.
Department Corrective Action Plan	A tracking system has been implemented to ensure all the necessary timeframes are met regarding disciplinary action and to ensure the timeframe to file charges will not expire. 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 Details	Description
Incident Date	11/01/2015
OLES Case Number	2017-00471MA
Case Type	Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	Between November 2015 and April 19, 2017, a psychiatric technician allegedly was involved in an ongoing overly familiar relationship with a patient. Specifically, it is alleged the psychiatric technician placed money in the patient's trust account, exchanged correspondence and gifts with the patient, provided the patient with a mobile phone, and was in contact with the patient's family.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the finding and penalty 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 632 days from the date of discovery. The psychiatric technician was on medical leave for 195 days during which time the department was unable to conduct the investigative interview.
Pre-Disciplinary	1. Was the pre-disciplinary/investigative phase

Assessment	conducted with due diligence? No. The incident was discovered on April 19, 2017; however, the investigation was not completed until January 11, 2019, 632 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 Details	Description
Incident Date	11/10/2017
OLES Case Number	2017-01323MC
Case Type	Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 10, 2017, a patient allegedly was attacked and cut with a sharp object while he was in the restroom. The patient was unable to identify the assailant.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Special Investigations did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officers failed to conduct a thorough search of the crime scene. The investigation was not completed until 454 days from the date of discovery.

Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. Responding officers searched the crime scene and found no relevant evidence. Three days later, the crime scene was searched again and a patient manufactured knife was located. Based on a review of photographs taken on the date of the incident, the knife was present during the initial search of the crime scene but was not located nor collected. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 11, 2017; however, the investigation was not completed until February 7, 2019, 454 days later.
Department Corrective Action Plan	Training has been provided on the proper crime scene investigation, preservation, containment and documentation. Also discussed was the required proper documentation in the report after a search has been conducted. 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 Details	Description
Incident Date	12/06/2017
OLES Case Number	2017-01414MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 6, 2017, a senior psychiatric technician allegedly twisted a patient's arm, placed his knee on the

	patient's back, and twisted the patient's neck during a containment procedure. A psychiatric technician also allegedly twisted the patient's neck during the same incident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/10/2017
OLES Case Number	2018-00110MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** No Change
Incident Summary	On December 10, 2017, a registered nurse assigned to provide constant observation of a patient allegedly left the patient unattended.
Disposition	The hiring authority sustained the allegation and issued the registered nurse a letter of instruction. 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. Health care staff failed to report the incident to the Office of Protective Services in a timely manner. The investigation was not completed until 343 days from the date of

	discovery. While the investigation was pending, two critical witnesses retired and were not available for interviews.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. The incident was discovered on December 10, 2017; however, health care staff did not notify the Office of Protective Services until January 24, 2018. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on January 24, 2018; however, the investigation was not completed until January 2, 2019, 343 days later.
Department Corrective Action Plan	Health Care Staff was reminded by their administrative staff to respond timely to incidents and prepare reports for notification purposes in a timely manner. 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 log and develop a solution to ensure timely reporting.

Case Details	Description
Incident Date	01/28/2018
OLES Case Number	2018-00148MA
Case Type	Broken Bone
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 28, 2018, a patient was transported to an outside hospital for treatment. She was diagnosed with a fractured hip while receiving treatment for an unrelated illness.

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 draft report did not contain statements from percipient witnesses. The investigation was not completed until 338 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The initial draft investigative report did not contain statements from percipient witnesses. 2. 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 January 9, 2019, 338 days later.
Department Corrective Action Plan	Training has been provided to the investigator to ensure all witnesses are listed that are pertained to the investigation. This information will be listed on the investigative worksheet, verses just listing "all staff members. Also, the investigator will review any and all initial interviews conducted by the responding officer(s). If the initial report does not contain all the necessary information, the assigned investigator will conduct follow up interview(s) with the subject and ask all pertinent questions. Finally, the investigator will follow up with additional witness and or involved partied, in the event additional information is discovered during the investigation. 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 log and develop a solution to ensure timely reporting.

Case Details	Description
Incident Date	02/05/2018
OLES Case Number	2018-00259MA
Case Type	Broken Bone
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 February 5, 2018, a patient was admitted to the hospital from a local jail. During the admissions process, the patient reported that he had fallen while at the jail and had a broken wrist. Hospital staff members allegedly failed to provide the patient with appropriate medical care until February 26, 2018, when his wrist was put in a cast. It is also alleged staff members failed to properly document and report the patient's injury.
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. Staff members failed to timely document and notify the Office of Protective Services of the incident. The initial report was not completed for 33 days. The investigation was not completed until 292 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. Hospital staff did not timely notify the Office of Protective Services of the incident. 2. Was the hiring authority's response to the incident appropriate?

	No. Hospital staff did not appropriately document the incident. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 1, 2018; however, the investigation was not completed until December 18, 2018, 292 days later. Hospital staff did not report the incident for 22 days and the hospital police department did not complete their initial report for 33 days.
Department Corrective Action Plan	The Nursing Coordinator discussed with the staff the various reporting procedures required when staff discovers a patient has been injured or they are made aware of an injury and the process of how to properly report the injury. The Nursing Coordinator discussed the importance of the various reporting and documenting procedures with the staff. Also discussed was the importance of immediately reporting the incident to OPS. This will ensure timely reporting. 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 Details	Description
Incident Date	04/02/2018
OLES Case Number	2018-00380MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On April 2, 2018, a senior psychiatric technician allegedly

	inappropriately touched a patient when placing the patient in restraints. The senior psychiatric technician and a psychiatric technician allegedly threatened 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:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 226 from the date of discovery. The investigator did not consult with the OLES before deciding not to interview the senior psychiatric technician and psychiatric technician.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to adequately consult with the OLES, and unilaterally decided not to interview the senior psychiatric technician and psychiatric technician who allegedly abused and threatened the patient. 2. 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 November 15, 2018, 226 days later.
Department Corrective Action Plan	In the future the investigative staff will provide real-time consultation with OLES, regarding any changes. 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.

Case Details	Description
Incident Date	04/15/2018
OLES Case Number	2018-00412MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On April 15, 2018, a psychiatric technician allegedly physically removed a patient from a day hall and pushed the patient into a side 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:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services did not complete the initial report until 63 days after the incident was discovered. The Office of Special Investigations did not complete the investigation until 297 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 15, 2018; however, the initial report was not provided to the Office of Special Investigations until June 18, 2018, 63 days later. The Office of Special Investigations' report was not completed until February 7, 2019, 297 days from the date of discovery.
Department Corrective Action Plan	OPS will coordinate with the Patrol Operations Lieutenant and the reviewing Watch Commander to ensure timely review and approval of all criminal and patient abuse reports being forwarded to OPS. 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 Details	Description
Incident Date	04/20/2018
OLES Case Number	2018-00425MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 20, 2018, two psychiatric technicians allegedly forced a patient's head into a wall and a hospital police officer forcefully held the patient's head on a bed during the application of physical restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 214 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 20, 2018; however, the investigation was not completed until November 20, 2018, 214 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 Details	Description
Incident Date	05/01/2018
OLES Case Number	2018-00460MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On May 1, 2018, a senior psychiatric technician allegedly struck a patient during an attempt to restrain 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 did not monitor.
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 205 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 1, 2018; however, the investigation was not completed until November 21, 2018, 205 days later.
Department Corrective Action Plan	The Investigator was retrained on how to prioritize their cases to ensure deadlines are met. A tracking system has been implemented to ensure timeliness of the investigations and to prevent further delays. OPS is in the process of hiring two additional investigators to assist with the increased caseload.

Case Details	Description
Incident Date	07/02/2018
OLES Case Number	2018-00680MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On July 2, 2018, health care staff allegedly ignored a patient's complaints of pain and his request to be seen by a physician.
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 investigative process. The OLES was not notified of the completed investigation until 127 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 OLES regarding the sufficiency of the investigation and the investigative findings for more than four months after the investigation was completed. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 2, 2018; however, the OLES was not notified of the completed investigation until November 6, 2018, 127 days later.
Department Corrective Action Plan	The hiring authority will provide continual real-time consultation with OLES to ensure sufficiency of the investigation. Training has been provided to the

	investigators on OLES monitored case procedures to include case plan review. Also, discussed during this training was the importance of providing continual consultation with OLES during and after the completion of the investigative report.

Case Details	Description
Incident Date	07/07/2018
OLES Case Number	2018-00689MA
Case Type	Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On July 7, 2018, two psychiatric technicians allegedly raped and inserted foreign objects into a patient's genitals.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 166 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 7, 2018; however, the investigation was not completed until December 20, 2018, 166 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 log and develop a solution to ensure timely reporting

Case Details	Description
Incident Date	06/11/2018
OLES Case Number	2018-00700MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On June 11, 2018, two psychiatric technicians allegedly injured a patient during an attempt to restrain 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 investigation was not completed until 158 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 9, 2018; however, the investigation was not completed until December 13, 2018, 158 days later.
Department Corrective Action Plan	Department will ensure all investigative phases are conducted in a timely manner. Chief/OPS will meet on a weekly basis to discuss active cases.

Case Details	Description
Incident Date	03/13/2018
OLES Case Number	2018-00712MA
Case Type	Misconduct
Allegations	1. Dishonesty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** To be determined in disciplinary phase
Incident Summary	On March 13, 2018, an officer allegedly struck a hospital employee in the buttocks with a round object. The officer was allegedly dishonest during the investigative interview.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. 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 Details	Description
Incident Date	06/28/2018
OLES Case Number	2018-00725MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On June 28, 2018, a psychiatric technician allegedly pushed a patient while assisting the patient in the shower. On July 11, 2018, the psychiatric technician allegedly grabbed and fell on the patient.
Disposition	The investigation failed to establish sufficient evidence for probable cause; however, the matter was referred to the

	district attorney for review. The OLES concurred with the determination. The Office of Protective Services opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 182 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 12, 2018; however, the investigation was not completed until January 9, 2019, 182 days later.
Department Corrective Action Plan	The Investigator was retrained on how to prioritize their cases to ensure deadlines are met. A tracking system has been implemented to ensure timeliness of the investigations and to prevent further delays. OPS is in the process of hiring two additional investigators to assist with the increased caseload.

Case Details	Description
Incident Date	07/18/2018
OLES Case Number	2018-00743MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On July 18, 2018, a psychiatric technician allegedly struck a patient in the back of the head while the patient was being placed 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	**Procedural Rating:** Insufficient

Assessment	**Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 139 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 18, 2018; however, the investigation was not completed until December 4, 2018, 139 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 Details	Description
Incident Date	07/22/2018
OLES Case Number	2018-00761MC
Case Type	Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On July 22, 2018, a patient died from natural causes while at an outside hospital. The patient had been on compassionate leave and his death was expected.
Disposition	The autopsy report confirmed the patient died due to natural causes. There was no evidence of staff misconduct; therefore, the case was not referred to the district attorney's office. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Details	Description
Incident Date	07/23/2018
OLES Case Number	2018-00763MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** No Change
Incident Summary	On July 23, 2018, a dentist allegedly failed to properly medicate a patient prior to a surgical procedure. The dentist was allegedly uncooperative during his administrative interview
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a 5 percent salary reduction for six months. 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 Details	Description
Incident Date	07/30/2018
OLES Case Number	2018-00782MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty 2. Insubordination 3. Discourteous treatment
Findings	1. Not Sustained

	2. Sustained 3. Sustained
Penalty	**Initial:** Salary Reduction **Final:** No Change
Incident Summary	On July 30, 2018, a licensed vocational nurse allegedly kicked a patient in the groin after he assaulted staff. The nurse allegedly failed to cooperate with the investigation.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation of patient abuse. However, the hiring authority did sustain the allegation of discourteous treatment and insubordination and imposed a salary reduction of 5 percent for six months. 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. Staff members did not report the incident to the Office of Protective Services in a timely manner. The investigation was not completed until 198 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. Staff members did not report the incident to the Office of Protective Services in a timely manner. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 31, 2018; however, the investigation was not completed until February 14, 2019, 198 days later.
Department Corrective Action Plan	The Health Care staff has been reminded by the administrative staff of the importance of reporting and report preparation for notification on all reportable incidence in a timely manner. The involved staff member was injured during the incident. As a result, the staff member was on Industrial Disability Leave (IDL) and several attempts to contact the staff member via phone and certified letter, went unanswered. The investigator

	completed an extension (see attached) as well as advised the Office of Law Enforcement Support of the issue and completed the report without the staff members' statement.

Case Details	Description
Incident Date	08/22/2018
OLES Case Number	2018-00881MA
Case Type	Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On August 22, 2018, a psychiatric technician allegedly sexually assaulted a patient during a search of the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/25/2018
OLES Case Number	2018-00899MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On August 25, 2018, hospital staff allegedly did not properly secure a wheelchair bound patient in a state vehicle while transporting the patient from an outside hospital. The patient's wheelchair flipped over, causing

	injury to the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/30/2018
OLES Case Number	2018-00914MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** No Change
Incident Summary	On August 30, 2018, a psychiatric technician assistant allegedly grabbed, struck, and pushed a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. 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 Details	Description
Incident Date	08/29/2018
OLES Case Number	2018-00918MA
Case Type	Abuse

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On August 29, 2018, a psychiatric technician allegedly twisted a patient's wrist as the patient was being placed into 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 Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/31/2018
OLES Case Number	2018-00923MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On August 31, 2018, staff members allegedly placed a patient in a seclusion room for 24 hours and deprived him of water and access to restroom facilities.
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 172 days from the date of discovery. The Office of Protective Services did

	not complete the initial report for 60 days.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on August 31, 2018; however, the investigation was not completed until February 19, 2019, 172 days later. The Office of Protective Services did not complete the initial report for 60 days, thereby causing a delay in the investigation.
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 Details	Description
Incident Date	09/02/2018
OLES Case Number	2018-00927MC
Case Type	Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 2, 2018, a registered nurse allegedly failed to provide medical attention to a patient who claimed to have fallen.
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 Details	Description
Incident Date	09/04/2018
OLES Case Number	2018-00941MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 4, 2018, health care staff members allegedly pulled a patient from the toilet and forcefully placed him on the floor and against the wall.
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 Details	Description
Incident Date	07/30/2018
OLES Case Number	2018-00946MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On July 30, 2018, a radiology technician allegedly inappropriately touched a patient's genitals during an x-

	ray procedure.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 147 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on September 7, 2018; however, the investigation was not completed until February 1, 2019, 147 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.

Case Details	Description
Incident Date	09/19/2018
OLES Case Number	2018-01005MC
Case Type	Abuse
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 closed 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 Details	Description
Incident Date	09/22/2018
OLES Case Number	2018-01024MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 22, 2018, a psychiatric technician and registered nurse allegedly grabbed a book out of a patient's hand and threw it across his bedroom, forced his head against a wall, squeezed and twisted his fingers, and kicked him.
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 Details	Description
Incident Date	09/26/2018
OLES Case Number	2018-01030MC
Case Type	Abuse
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 26, 2018, a psychiatric technician allegedly struck a wheelchair-bound 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 Details	Description
Incident Date	09/27/2018
OLES Case Number	2018-01036MA
Case Type	Neglect
Allegations	1. Incompetency
Findings	1. Not Sustained
Penalty	**Initial:** Training **Final:** No Change
Incident Summary	On September 27, 2018, a psychiatric technician allegedly gave a patient the incorrect 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 Details	Description
Incident Date	09/23/2018
OLES Case Number	2018-01057MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 23, 2018, a psychiatric technician and a staff member allegedly injured a patient's finger.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	04/06/2018
OLES Case Number	2018-01070MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	Between April 6, 2018, and April 12, 2018, a psychiatric technician allegedly physically and sexually assaulted a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative	**Procedural Rating:** Insufficient

Assessment	**Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The investigator did not adequately consult with the OLES at the initiation of the criminal investigation. The investigator also did not notify the OLES monitor about the psychiatric technician's interview; therefore, the monitor was unable to attend the interview and provide real-time feedback.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The investigator did not provide an investigative plan, nor consult with the OLES before initiating the investigation. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not notify the OLES monitor about the psychiatric technician's interview; therefore, the monitor was not afforded the opportunity to attend the interview, and provide input.
Department Corrective Action Plan	The Supervising Special Investigator discussed with the investigative staff the need to ensure an investigative plan is completed and reviewed with the OLES monitor prior to beginning the investigation. The investigative staff was reminded they need to advise the OLES monitor when the interviews are taking place, this will allow them the opportunity to attend the interview.

Case Details	Description
Incident Date	10/08/2018
OLES Case Number	2018-01072MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 8, 2018, a psychiatric technician assistant

	allegedly struck 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 Details	Description
Incident Date	09/18/2018
OLES Case Number	2018-01078MA
Case Type	Abuse
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 September 18, 2018, staff members allegedly injured a patient while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**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 130 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 administrative investigation was opened on October 10, 2018. The investigative report was completed 130 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the Office of Law Enforcement Support (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 timeframe.

Case Details	Description
Incident Date	10/04/2018
OLES Case Number	2018-01079MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 4, 2018, staff members allegedly stepped on a patient's head while restraining the patient on the floor.
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 after determining there was no evidence of a crime or policy violation, and the OLES concurred with this decision.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2018
OLES Case Number	2018-01083MC
Case Type	Abuse

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 6, 2018, two officers and a senior psychiatric technician allegedly pushed a patient into the patient's room, causing the patient to fall.
Disposition	The department determined that 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 Special Investigations 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 did not review the senior psychiatric technician's prior statements before conducting his interview, did not notify the OLES prior to conducting the interview, thereby preventing the OLES from attending, and failed to reconcile the senior psychiatric technician's inconsistent statements in the investigative report.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? No. The investigator did not review the written statement provided by the senior psychiatric technician prior to conducting the interview, and therefore could not confront the senior psychiatric technician when the information provided during the interview differed from the written statement. 2. Was the final investigative report thorough and appropriately drafted? No. The investigative report did not attempt to reconcile the differing accounts provided by the senior psychiatric technician.

	3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not inform OLES when he interviewed the senior psychiatric technician or the officer, thus preventing OLES from attending the interviews.
Department Corrective Action Plan	OPS provided training to the investigator to ensure all relevant material related to the case is reviewed and continued consultation with the AIM prior to interviews being conducted to allow for OLES' participation. OPS provided training to the investigator to ensure continued collaboration with the AIMs during investigation to ensure all questions are answered throughout the investigation. In addition, the investigator has been reminded to re-interview any potential subjects or witnesses when discrepancies are discovered in the statements, as needed. OPS has provided training to the investigative staff to ensure continued consultation with the OLES AIM on all monitored cases. This will allow for the AIMs to participate in interviews if needed.

Case Details	Description
Incident Date	03/30/2018
OLES Case Number	2018-01084MA
Case Type	Broken Bone
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
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	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 Details	Description
Incident Date	10/10/2018
OLES Case Number	2018-01085MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 10, 2018, a psychiatric technician allegedly psychologically abused a patient by making false statements about 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 Office of Protective Services failed to timely notify the OLES, and the investigation was not completed until 143 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 discovered the incident on October 10, 2018, at 2222 hours; however, the OLES was not notified until October 11, 2018, at 0222 hours, approximately four hours later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 10, 2018; however, the investigation was not completed until

	March 1, 2018, 143 days later.
Department Corrective Action Plan	OPS provided training to all OPS supervisors on OLES reporting guidelines. The command staff provided roll call training to their staff. Department will ensure all investigative phases are conducted in a timely manner. Chief/OPS will meet on a weekly basis to discuss active cases.

Case Details	Description
Incident Date	10/11/2018
OLES Case Number	2018-01088MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 11, 2018, staff members allegedly assaulted a patient. The patient sustained multiple injuries, including a fractured hip and broken 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:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The initial responding officer failed to provide the required legal admonishment to a suspect before beginning the interview. The investigation was not completed until 145 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The initial responding officer failed to provide the required legal admonishment to a suspect before beginning the interview. 2. Was the pre-disciplinary/investigative phase

	conducted with due diligence? No. The incident was discovered on October 11, 2018; however, the investigation was not completed until March 5, 2019, 145 days later.
Department Corrective Action Plan	The responding has been reminded to issue the Beheler admonishment prior to interviewing the suspect/subject of any administrative investigation. 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 log and develop a solution to ensure timely reporting.

Case Details	Description
Incident Date	04/04/2018
OLES Case Number	2018-01094MA
Case Type	Sexual Assault
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On April 4, 2018, a psychiatric technician allegedly inappropriately touched 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 complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/29/2018
OLES Case Number	2018-01095MA
Case Type	Sexual Assault
Allegations	1. Other failure of good behavior
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 29, 2018, a psychiatric technician allegedly sexually assaulted a patient.
Disposition	The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES in a timely manner regarding the sufficiency of the investigation, and the investigative findings.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. Although the investigation was completed on January 17, 2019, the hiring authority did not receive the completed report until May 29, 2019. The hiring authority consulted with the OLES on June 3, 2019, 138 days after the investigation was completed.
Department Corrective Action Plan	In the future, the Chief/OPS will ensure all administrative cases have been properly input into the case management/tracking system and identified as monitored or nonmonitored, to prevent future confusion and delays.

Case Details	Description
Incident Date	09/21/2018
OLES Case Number	2018-01109MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 21, 2018, a psychiatric technician allegedly struck a patient in the head with a clipboard.
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 Details	Description
Incident Date	01/01/2015
OLES Case Number	2018-01117MA
Case Type	Sexual Assault
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
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 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 Details	Description
Incident Date	10/14/2018
OLES Case Number	2018-01130MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 14, 2018, and October 21, 2018, a nurse allegedly struck a patient with a flashlight.
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 126 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 22, 2018; however, the final investigative report was not completed until February 25, 2019, 126 days later.
Department Corrective Action	Department will ensure all investigative phases are conducted in a timely manner. Chief/OPS will meet on a

Plan	weekly basis to discuss active cases.

Case Details	Description
Incident Date	10/24/2018
OLES Case Number	2018-01134MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 24, 2018, a senior psychiatric technician allegedly grabbed 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:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The initial report prepared by the hospital police department was not completed until 84 days from the date of discovery. The investigation was not completed until 134 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 24, 2018; however, the investigation was not completed until March 7, 2019, 134 days later. It is noted that the initial report prepared by the hospital police department was not completed until January 16, 2019, 84 days from the date of discovery.
Department Corrective Action Plan	On December 19, 2018, the Lieutenants discussed with the Sergeants the importance of the investigative staff completing the incident reports in a timely manner. This will ensure the timeliness of the reporting is met. The Chief and Office of Special Investigations (OSI) will meet to discuss and implement a process to streamline the

	reporting process to ensure it is within the reporting guidelines. Until this process is developed and implemented, on a weekly basis the Lieutenants will audit the reports to ensure they are complete 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 Details	Description
Incident Date	10/24/2018
OLES Case Number	2018-01138MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 24, 2018, a psychiatric technician allegedly rubbed his hand against a patient's buttocks.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/05/2018
OLES Case Number	2018-01145MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 5, 2018, a unit supervisor allegedly grabbed a patient by the arm, thereby bruising 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 the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/25/2018
OLES Case Number	2018-01148MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On October 25, 2018, a senior psychiatric technician and a psychiatric technician allegedly kicked and choked a patient, while attempting to restrain 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 the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/22/2018
OLES Case Number	2018-01156MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 22, 2018, a staff member allegedly failed to document information about a patient's fall which resulted in an 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:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with the department's policies and procedures governing the investigative process. The department failed to notify the assigned investigator that the OLES was monitoring the investigation, thus preventing the OLES' participation in the investigation.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The department did not advise the assigned investigator that the OLES was monitoring the investigation.

	2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The department did not advise the assigned investigator that the OLES was monitoring the investigation; therefore, the OLES was prevented from participating during the investigation.
Department Corrective Action Plan	A tracking system has been implemented to ensure timely and proper notification of all OLES monitored cases. Training has been provided to the Supervising Special Investigator on reviewing cases to ensure the OLES monitored cases are timely and properly assigned. Also, the administrative tracking system will be reviewed on a regular bases to ensure all OLES monitored cases are completed in a timely manner as well as proper notification is provided.

Case Details	Description
Incident Date	02/28/2018
OLES Case Number	2018-01162MA
Case Type	Abuse
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
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 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 OLES was not notified of the administrative investigation once the related criminal investigation was completed and the investigator did not consult with the OLES during

	the investigation. The administrative investigation was opened on June 19, 2018; however, the investigation was not completed until 151 days later.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The matter was not identified as an OLES-monitored case; therefore, the OLES was not informed that an administrative investigation had been opened nor consulted with during the investigation. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator was unaware the matter was an OLES-monitored investigation; therefore, he did not consult with the OLES. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The administrative investigation was opened on June 19, 2018; however, the investigation was not completed until November 16, 2018, 151 days later.
Department Corrective Action Plan	In the future, the Chief/OPS will insure all administrative cases have been properly input into the case management/tracking system and identified as monitored or non- monitored, to prevent future confusion and delays. The Investigator was retrained on how to prioritize their cases to ensure deadlines are met. A tracking system has been implemented to ensure timeliness of the investigations and to prevent further delays. OPS is in the process of hiring two additional investigators to assist with the increased caseload.

Case Details	Description
Incident Date	11/07/2018
OLES Case Number	2018-01191MC
Case Type	Abuse
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 7, 2018, a patient was allegedly assaulted by three individuals. The patient was unable to identify his assailants.
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 Details	Description
Incident Date	09/09/2018
OLES Case Number	2018-01193MA
Case Type	Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 9, 2018, a patient was found nonresponsive in his room. Emergency life-saving measures were initiated by responding staff. The patient was transported to an outside hospital where he was pronounced dead. The coroner was unable to establish the cause of death.
Disposition	The hiring authority determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and

	procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/20/2018
OLES Case Number	2018-01198MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 20, 2018, a registered nurse allegedly inappropriately touched 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 Details	Description
Incident Date	11/09/2018
OLES Case Number	2018-01206MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 9, 2018, a psychiatric technician allegedly threw baby powder on an asthmatic patient's face.
Disposition	The Office of Protective Services conducted an investigation and found insufficient evidence for a

	probable cause referral to the district attorney's office. The OLES did not concur 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:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator did not adequately prepare for the interview of a potential suspect, failed to consider that a witness was a potential suspect and provide the appropriate admonishment prior to the interview, and inappropriately determined there was no probable cause to believe a crime occurred. In addition, the investigation was not completed until 157 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator did not properly evaluate whether a psychiatric technician trainee was a potential suspect. 2. Were all of the interviews thorough and appropriately conducted? No. The investigator was unfamiliar with the required admonishment to be provided to a suspect making a voluntary statement to police, wherein the suspect is informed that he is not under arrest, he is not in custody, and that he is free to go at any time. 3. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution? No. The Office of Protective Services inappropriately determined there was no probable cause to believe a crime was committed when probable cause existed that the psychiatric technician physically and emotionally abused a patient.

	4. Was the investigation thorough and appropriately conducted? No. The investigation did not properly consider a psychiatric technician trainee as a suspect after learning he failed to report seeing a psychiatric technician physically and emotionally abuse a patient. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 10, 2018; however, the investigative report was not completed until April 16, 2019, 157 days later.
Department Corrective Action Plan	Training has been provided to the Investigator to ensure continued collaboration with the AIMS to ensure review of all relevant materials related to the case, which includes relevant violations of the laws and elements of the crimes being investigated. The Investigator has been retrained on all admonishments related to criminal investigations. Training has been provided to the investigative staff to ensure continued consultation with the Office of Law Enforcement (OLES) AIM on all monitored cases to further explain or clarify any issues with the elements of a crime to ensure the investigation is completed appropriately. In the future the investigator will make sure they interview all involved subjects/suspects/witnesses regardless if they are going to provide witness testimony. The Investigator will be retrained on how to prioritize their cases to ensure deadlines are met. To prevent further delays, an electronic tracking system has been implemented to ensure timeliness of investigations. OPS is in the process of hiring two additional investigators to assist with the increased caseload.

Case Details	Description
Incident Date	11/11/2018
OLES Case Number	2018-01208MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty

	2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 11, 2018, a psychiatric technician allegedly injured a patient's thumb while the patient was being placed 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	11/11/2018
OLES Case Number	2018-01210MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 11, 2018, a registered nurse allegedly sexually assaulted a patient during a medical examination.
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 Details	Description
Incident Date	11/06/2018
OLES Case Number	2018-01219MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 6, 2018, a staff member allegedly 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/08/2018
OLES Case Number	2018-01234MA
Case Type	Broken Bone
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change

Incident Summary	On November 8, 2018, a patient was diagnosed with a broken nose.
Disposition	The hiring authority determined there was no evidence of any staff misconduct and found 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 132 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 14, 2018; however, the investigation was not completed until March 26, 2019, 132 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 log and develop a solution to ensure timely reporting.

Case Details	Description
Incident Date	11/13/2018
OLES Case Number	2018-01247MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 13, 2018, a psychiatric technician allegedly struck 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 Details	Description
Incident Date	11/04/2018
OLES Case Number	2018-01249MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 4, 2018, a registered nurse allegedly struck and forcefully placed a patient on the floor.
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 Details	Description
Incident Date	11/26/2018
OLES Case Number	2018-01276MC
Case Type	Abuse
Allegations	1. Criminal Act

Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 26, 2018, staff members allegedly twisted a patient's wrist and forced her head to the floor while attempting to restrain the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/30/2018
OLES Case Number	2018-01290MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 30, 2018, a psychiatric technician allegedly struck a patient multiple times in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's recommendation.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/01/2010
OLES Case Number	2018-01295MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	During 2010, a psychiatric technician allegedly had sexual intercourse with a patient multiple times which allegedly resulted in a pregnancy and childbirth.
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 Details	Description
Incident Date	11/30/2018
OLES Case Number	2018-01302MC
Case Type	Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 30, 2018, a psychiatric technician allegedly refused to change a patient's clothes after the patient urinated on himself.
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:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services provided a draft report that conflated two separate incidents in one report. Furthermore, the investigator did not advise the suspect of his constitutional rights during the initial investigation.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? No. The investigator did not advise the suspect of his constitutional rights prior to the interview during the initial investigation. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report did not appropriately address the incident. The draft investigative report conflated two separate incidents into the report.
Department Corrective Action Plan	OPS provided training to all OPS staff on the requirements of the Miranda warning according to OPS policy. The Chief/OPS discussed the importance of identifying and interviewing all subjects and suspects of an allegation. Also, discussed was the importance to keep all incidents/allegations separate in the report.

Case Details	Description
Incident Date	12/04/2018
OLES Case Number	2018-01307MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed

	Final: No Change
Incident Summary	On December 4, 2018, a registered nurse allegedly pushed a patient, causing the patient to hit her head on a wall.
Disposition	The hiring authority determined there was no evidence of any staff misconduct and found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not notify the Office of Law Enforcement Support with complete information regarding the incident within two hours of discovery 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 hiring authority did not notify the Office of Law Enforcement Support with complete information regarding the incident within two hours of discovery of the incident.
Department Corrective Action Plan	The OPS have been reminded of the priority 1 and 2 reporting requirements for OLES as well as the use of the reporting template.

Case Details	Description
Incident Date	12/02/2018
OLES Case Number	2018-01308MC
Case Type	Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 2, 2018, a psychiatric technician allegedly failed to prevent a patient from physically assaulting another 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 Details	Description
Incident Date	12/05/2018
OLES Case Number	2018-01312MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 5, 2018, a staff member allegedly struck a patient with a stick while the patient was showering.
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 Details	Description
Incident Date	04/01/2018
OLES Case Number	2018-01313MC

Case Type	Sexual Assault
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 April 1, 2018, a registered nurse allegedly assaulted a patient with a pair of scissors. On August 1, 2018, the registered nurse allegedly exposed himself to the patient.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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 Details	Description
Incident Date	11/27/2018
OLES Case Number	2018-01318MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 27, 2018, a psychiatric technician and registered nurse allegedly struck a patient multiple times while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

Assessment	**Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services did not fully question the patient after she appeared to recant her original allegation that she had been assaulted. The Office of Protective Services did not inform the psychiatric technician of the scope of his legal rights prior to obtaining his statement.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The Office of Protective Services did not adequately question the patient when she appeared to recant her original allegation. The Office of Protective Services did not provide the psychiatric technician with the appropriate legal admonitions before his interview.
Department Corrective Action Plan	OPS provided the officers with a series of follow up questions to ask in the event a patient recants their original allegation(s) and/or statements. Also, OPS will continue to brief the officers and remind them utilize proper admonishments for the focus subjects of their investigations, if warranted.

Case Details	Description
Incident Date	12/04/2018
OLES Case Number	2018-01319MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 4, 2018, a registered nurse allegedly slapped a patient's hand and pulled the patient's hair.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's recommendation.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Insufficient

	The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services failed to provide the registered nurse with the required legal admonition before obtaining the registered nurse's statement.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The Office of Protective Services failed to provide the registered nurse with the proper legal admonition before obtaining the registered nurse's statement.
Department Corrective Action Plan	The investigative staff have been reminded to issue the Beheler admonishment to the "focus" of any admin investigation. The watch commanders reminded their staff of the legal requirement to administer the Beheler admonishment during their interviews.

Case Details	Description
Incident Date	12/01/2018
OLES Case Number	2018-01322MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 1, 2018, a physician allegedly failed to properly treat a patient with a broken finger.
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 Details	Description
Incident Date	06/10/2018
OLES Case Number	2018-01325MA
Case Type	Abuse
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On or about June 10, 2018, a senior psychiatric technician allegedly pushed a patient in the chest.
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 Details	Description
Incident Date	12/15/2018
OLES Case Number	2018-01344MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 15, 2018, a psychiatric technician allegedly pushed a patient, causing the patient's head to strike the 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 after determining there was no evidence of a crime or policy violation, and the OLES concurred with this decision.

Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The department failed to timely notify the OLES of the incident, and the investigator failed to consult with the OLES prior to interviewing the subject, thereby preventing the OLES from providing real-time monitoring.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The department learned of the misconduct on September 15, 2018, at 0216 hours, but the department did not refer the matter to the OLES until September 15, 2018, at 0835 hours, over six hours after the time of discovery. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not contact the OLES prior to conducting the psychiatric technician's interview, thereby prevent the OLES from providing real-time monitoring.
Department Corrective Action Plan	The law enforcement staff have been reminded of the priority one and two reporting guidelines. This is to ensure timely notification of all priority one and two reporting. Training has been provided to include the created OLES intake sheet and will be attached to all assigned cases to prevent this from happening in the future.

Case Details	Description
Incident Date	12/16/2018
OLES Case Number	2018-01345MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change

Incident Summary	On December 16, 2018, a psychiatric technician allegedly struck a patient multiple times while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/12/2018
OLES Case Number	2018-01351MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 12, 2018, a registered nurse 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 the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/18/2018
OLES Case Number	2018-01353MA

Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 18, 2018, a psychiatric technician allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	06/01/2000
OLES Case Number	2018-01356MA
Case Type	Misconduct
Allegations	1. Other failure of good behavior 2. Immorality
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between 2000 and 2001, an officer allegedly committed a lewd act with a child.
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's pre-disciplinary process sufficiently complied with policies and procedures.

Case Details	Description
Incident Date	12/06/2018
OLES Case Number	2018-01357MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 6, 2018, a psychiatric technician allegedly grabbed, struck, and pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	12/19/2018
OLES Case Number	2018-01362MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 19, 2018, a registered nurse allegedly pushed 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. Level

	of care staff failed to timely notify hospital police of the allegation. Hospital police failed to provide the registered nurse with the required legal admonishment before obtaining the registered nurse's statement.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. Unit staff were aware of the allegation of physical abuse on December 19, 2018; however, did not report it to the Office of Protective Services until December 20, 2018. A registered nurse was not provided with the required legal admonishment prior to obtaining the nurse's statement.
Department Corrective Action Plan	Department staff will complete the necessary documentation (SIR, SOC 341, Allegation checklists) when they observe or receive information of alleged patient neglect per AD 15.13 reporting guideline. The Department Coordinator and OPS Command Staff was consulted and concurred. Also, additional training has been provided to the OPS investigative staff to ensure they follow the proper policies/procedures when interviewing the focus of an investigation by giving the Beheler admonishment.

Case Details	Description
Incident Date	12/21/2018
OLES Case Number	2018-01365MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 21, 2018, a health care staff member allegedly drugged and 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 the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/13/2018
OLES Case Number	2018-01366MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 13, 2018, a unit supervisor allegedly grabbed and forcefully placed a patient on the floor.
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 Details	Description
Incident Date	12/01/2018
OLES Case Number	2018-01367MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed

	Final: No Change
Incident Summary	On December 1, 2018, a psychiatric technician allegedly grabbed and twisted a patient's wrist.
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 Details	Description
Incident Date	12/24/2018
OLES Case Number	2018-01371MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 24, 2018, a psychiatric technician allegedly had periodically tapped a patient on the back of the head and then used profane language.
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 Details	Description
Incident Date	04/06/2018
OLES Case Number	2018-01374MA
Case Type	Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	Between April 6, 2018, and April 12, 2018, a senior psychiatric technician allegedly physically and sexually assaulted a patient, while another staff member video-recorded the assault.
Disposition	The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/10/2018
OLES Case Number	2018-01375MA
Case Type	Misconduct
Allegations	1. Insubordination
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 10, 2018, an officer allegedly discussed her knowledge of a pending criminal investigation of a second officer, and inappropriately used a state-issued computer and internet web-browser to access the second officer's criminal case records.
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 employee relations officer did not provide the OLES with the required documentation reflecting the hiring authority's review of the investigation, despite repeated requests.
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. The employee relations officer did not provide the OLES with the required forms reflecting the hiring authority's review of the investigation, despite repeated requests.
Department Corrective Action Plan	A check list is being developed to assist in ensuring that these critical steps are not overlooked in the future.

Case Details	Description
Incident Date	01/04/2019
OLES Case Number	2019-00011MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 4, 2019, a unit supervisor allegedly struck 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 Overall, the department sufficiently complied with

	policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/02/2019
OLES Case Number	2019-00013MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 2, 2019, a psychiatric technician allegedly struck a patient and forcefully placed her against a wall. During the incident, a registered nurse also allegedly used excessive force to place the patient against a wall.
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 Details	Description
Incident Date	01/04/2019
OLES Case Number	2019-00017MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 4, 2019, a licensed vocational nurse allegedly

	struck a patient after the patient grabbed a syringe from the licensed vocational nurse.
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 Details	Description
Incident Date	01/04/2019
OLES Case Number	2019-00024MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 4, 2019, two psychiatric technicians allegedly grabbed a patient, forcefully placed him on a bed, and threatened to medicate him.
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:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to notify the OLES regarding the scheduling of the victim's interview. Additionally, the investigator failed to identify a suspect

	during the investigation.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator failed to identify a staff member as a suspect, but rather interviewed the staff member as a witness. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report did not include all appropriate interviews. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services failed to notify OLES regarding the scheduling of the victim interview.
Department Corrective Action Plan	OPS provided training to all OPS staff on the requirements of effectively interviewing all subjects and suspects according to OPS policy. The Chief/OPS discussed with the entire investigative staff the importance of providing a draft copy of the report to OLES for review and consultation prior to submitting the final draft. Also discussed was the importance of identifying and interviewing all subjects and suspects of an allegation. The Chief/OPS discussed with the entire investigative staff the importance of providing continual real-time consultation to OLES during the course of the investigation. This will allow for the input/suggestions of the OLES monitor.

Case Details	Description
Incident Date	01/04/2019
OLES Case Number	2019-00029MA
Case Type	Broken Bone
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed

	Final: No Change
Incident Summary	On January 4, 2019, a patient who had been medically assessed as a fall-risk was on an enhanced level of observation when he fell, resulting in a fractured hip. The registered nurse who was monitoring the patient allegedly failed to appropriately intervene to prevent the fall.
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 Details	Description
Incident Date	12/24/2017
OLES Case Number	2019-00044MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 24, 2017, three staff members allegedly struck a restrained patient after covering his face with a bedsheet.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's recommendation.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was not completed until 449 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 27, 2017; however, the investigation was not completed until March 21, 2019, 449 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 log and develop a solution to ensure timely reporting.

Case Details	Description
Incident Date	01/17/2019
OLES Case Number	2019-00058MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 17, 2019, a registered nurse allegedly refused to help a patient who suffered a seizure.
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. Level of care staff failed to fully document the incident and make timely notifications.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. The incident occurred on January 11, 2019; however, level of care staff did not fully document or report the allegation until January 17, 2019; six days later.
Department	The department staff will complete the necessary

Corrective Action Plan	documentation (SIR, SOC 341/Allegation checklist) when they receive information of alleged patient neglect as per AD 15.13 reporting guidelines.

Case Details	Description
Incident Date	01/16/2019
OLES Case Number	2019-00059MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty 2. Willful disobedience 3. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Salary Reduction **Final:** To be determined in disciplinary phase
Incident Summary	On January 16, 2019, a nurse allegedly refused to medically assess a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a five percent salary reduction for 12 months. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/26/2019
OLES Case Number	2019-00090MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior
Findings	1. Sustained 2. Sustained

Penalty	**Initial:** Salary Reduction **Final:** To be determined in disciplinary phase
Incident Summary	On January 26, 2019, a senior psychiatric technician allegedly failed to document a patient's injury.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a five percent salary reduction for three months. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/30/2019
OLES Case Number	2019-00098MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 30, 2019, a psychiatric technician allegedly told a patient he killed a member of the patient's family before pulling the patient to the ground and scratching the patient's arms with a set of keys.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	01/31/2019
OLES Case Number	2019-00101MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 31, 2019, a health care staff member 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 the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/02/2019
OLES Case Number	2019-00108MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 2, 2019, an identified person 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/04/2019
OLES Case Number	2019-00122MC
Case Type	Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 4, 2019, a patient was discovered locked in a seclusion room without authorization or medical necessity.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The department 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 Details	Description
Incident Date	01/01/2015
OLES Case Number	2019-00126MA
Case Type	Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	During 2015, a senior psychiatric technician allegedly had a sexual relationship with a patient.
Disposition	The senior psychiatric technician resigned prior to the completion of the investigation; therefore, disciplinary findings were not made. A letter indicating the senior psychiatric technician resigned under adverse circumstances was placed in her official personnel file.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	11/26/2018
OLES Case Number	2019-00129MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 26, 2018, staff members allegedly used unnecessary force while attempting to restrain a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/10/2019
OLES Case Number	2019-00137MC

Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 10, 2019, a psychiatric technician allegedly assaulted a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 123 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, 2019; however, the investigation was not completed until June 13, 2019, 123 days later.
Department Corrective Action Plan	The Chief/OPS discussed with DPS supervisors and the investigative staff the importance of meeting the OLES notification time frame and investigations criteria. In addition, it was explained to use the extension memo and notify OLES monitor if the investigation report is going to go beyond the 120- day time frame.

Case Details	Description
Incident Date	02/06/2019
OLES Case Number	2019-00142MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred

Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 6, 2019, a psychiatric technician assistant allegedly held a patient against a wall for an extended period of time.
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 Details	Description
Incident Date	02/14/2019
OLES Case Number	2019-00156MC
Case Type	Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 14, 2019, a patient was found nonresponsive in his bed. Health care staff performed life-saving measures until paramedics arrived. The patient was pronounced dead. The patient was being treated for end stage cirrhosis of the liver and other chronic medical conditions.
Disposition	There was no evidence of staff misconduct; therefore, the incident was not referred to the district attorney's office. The OLES concurred with this determination. The Office of Special Investigations also opened an administrative investigation into potential policy violations, which the OLES accepted for monitoring.
Investigative	**Procedural Rating:** Sufficient

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

Case Details	Description
Incident Date	02/14/2019
OLES Case Number	2019-00158MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 14, 2019, an unidentified staff member 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 Details	Description
Incident Date	02/15/2019
OLES Case Number	2019-00161MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 15, 2019, an unidentified assailant allegedly

	raped a patient while the patient was sleeping.
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 Details	Description
Incident Date	02/02/2019
OLES Case Number	2019-00172MC
Case Type	Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	Between February 2 and February 17, 2019, two psychiatric technicians allegedly sexually assaulted a patient on multiple occasions.
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 Details	Description
Incident Date	02/22/2019
OLES Case Number	2019-00201MA
Case Type	Sexual Assault
Allegations	1. Criminal Act 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** To be determined in disciplinary phase
Incident Summary	On February 22, 2019, a psychiatric technician allegedly raped a patient. The psychiatric technician also allegedly failed to properly document the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the rape allegation; however, found there was sufficient evidence to sustain the allegation the psychiatric technician failed to properly document the incident. The hiring authority imposed a 5 percent salary reduction for six months. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident occurred on February 20, 2019; however the initial investigation, level of care documentation, and notifications were not made until February 25, 2019, five days later. The notification to OLES was not made unit five days after the allegation.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. The incident occurred on February 20, 2019. Level of care staff along with two hospital police officers were aware of the allegation; however, failed to properly document the incident and make all appropriate notifications. 2. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident?

	No. The hiring authority did not notify OLES until five days after the initial allegation. 3. Was the hiring authority's response to the incident appropriate? No. The responding officers failed to conduct an investigation. Level of Care staff failed to properly document the incident and make all appropriate notifications. 4. Did the OPS adequately respond to the incident? No. The initial responding officers to the incident failed to conduct an investigation into the incident, preserve the scene, gather the names and statements of witnesses, or write a report. 5. Was the incident properly documented? No. The initial responding officers did not document the incident.
Department Corrective Action Plan	The department staff will complete the necessary documentation (SIR, SOC 341, Allegation checklists) when they observe or receive information of alleged patient neglect per AD 15.13 reporting guideline. Department staff will complete the necessary documentation (SIR, SOC 341, Allegation checklists) when they observe or receive information of alleged patient neglect per AD 15.13 reporting guideline.

Case Details	Description
Incident Date	02/25/2019
OLES Case Number	2019-00205MC
Case Type	Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change

Incident Summary	On February 25, 2019, a psychiatric technician allegedly did not intervene and stop a fight between two patients.
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 Details	Description
Incident Date	10/19/2018
OLES Case Number	2019-00217MA
Case Type	Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 19, 2018, an officer allegedly left a patient unsupervised while at an outside hospital.
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 investigative process.

Case Details	Description
Incident Date	03/02/2019
OLES Case Number	2019-00224MC
Case Type	Abuse

Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 2, 2019, staff members allegedly pushed a patient onto his bed, which caused an injury to the patient's back.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/05/2019
OLES Case Number	2019-00229MA
Case Type	Death
Allegations	1. Other
Findings	1. Unsubstantiated
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 5, 2019, a psychiatric technician discovered a non-responsive patient. Responding staff initiated life-saving measures; however, the patient was pronounced dead. The patient had a terminal illness and died from cardiopulmonary arrest.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

	The department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	03/04/2019
OLES Case Number	2019-00234MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 4, 2019, a psychiatric technician allegedly bent a patient's finger and forcefully held the patient on the ground.
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 Details	Description
Incident Date	01/01/2019
OLES Case Number	2019-00239MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	Between January 1, 2019, and January 31, 2019, a

	registered nurse allegedly sexually assaulted 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 the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/13/2019
OLES Case Number	2019-00265MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 13, 2019, a psychiatric technician allegedly 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:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/01/2007
OLES Case Number	2019-00267MA
Case Type	Significant Interest - Other
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned in Lieu of Dismissal
Incident Summary	During April 2007, a psychiatric technician allegedly provided a patient with personal information, began a relationship with the patient, resided with the patient following his release, and failed to notify her supervisor of her relationship with the patient. The psychiatric technician allegedly failed to notify her supervisor of her continued relationship and residing with a former patient. On April 4, 2019, the psychiatric technician was allegedly dishonest during her interview with the Office of Special Investigations.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	03/20/2019
OLES Case Number	2019-00288MC
Case Type	Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 20, 2019, a patient was discovered non-responsive. Responding staff initiated emergency life saving measures, until the patient was pronounced dead. The coroner determined the patient died from natural causes.
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 Details	Description
Incident Date	03/19/2019
OLES Case Number	2019-00290MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 19, 2019, a registered nurse allegedly struck 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 Details	Description
Incident Date	10/13/2018
OLES Case Number	2019-00293MA
Case Type	Misconduct
Allegations	1. Other
Findings	1. Sustained
Penalty	**Initial:** Other **Final:** To be determined in disciplinary phase
Incident Summary	On October 13, 2018, an officer allegedly threatened to commit suicide and the officer was held in a mental health facility for a 72-hour period, resulting in the officer's loss of ability to own or possess firearms.
Disposition	The hiring authority found sufficient evidence that the officer lost the ability to own and possess firearms, and determined that a non-punitive termination was appropriate. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/06/2018
OLES Case Number	2019-00310MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On August 6, 2018, a senior psychiatric technician allegedly pushed a patient, causing the patient to fall.
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 Details	Description
Incident Date	10/11/2018
OLES Case Number	2019-00333MA
Case Type	Misconduct
Allegations	1. Dishonesty 2. Insubordination 3. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** To be determined in disciplinary phase
Incident Summary	Between July 1, 2018, and October 11, 2018, a communications operator and an officer allegedly engaged in excessive public displays of affection while on duty. On October 11, 2018, they allegedly engaged in sexual relations while on duty. Between January 8, 2019, and January 10, 2019, they allegedly discussed the

	investigation with each other after being admonished not to. On January 10, 2019, they were allegedly dishonest during their interviews with the OLES.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty for both employees. The OLES concurred with the determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	08/01/2018
OLES Case Number	2019-00338MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	Between August and December, 2018, health care staff members allegedly injected a substance into a patient's foot, which caused the patient pain and injury.
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 Details	Description
Incident Date	04/02/2019
OLES Case Number	2019-00347MC
Case Type	Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On April 2, 2019, a senior psychiatric technician allegedly grabbed and forcibly held a registered dietician, forced his hand into her pants and attempted to touch her genitals, and forcibly placed her hands on his genitals.
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 Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/24/2019
OLES Case Number	2019-00408MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On April 24, 2019, two staff members allegedly forced a patient to take medication.
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 Details	Description
Incident Date	05/06/2019
OLES Case Number	2019-00453MC
Case Type	Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On May 6, 2019, a psychiatric technician assistant allegedly failed to properly monitor a patient on an enhanced level of supervision, during which time the patient suffered a head 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 Details	Description
Incident Date	05/09/2019
OLES Case Number	2019-00470MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On May 9, 2019, a psychologist allegedly sexually harassed and molested a patient while the patient showered.
Disposition	The Office of Protective Services conducted an investigation and found insufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Appendix B2 Pre-Disciplinary Phase Cases - DDS

Case Details	Description
Incident Date	01/05/2018
OLES Case Number	2018-00045MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 5, 2018, seven psychiatric technicians allegedly struck, kicked, and choked a resident.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services did not open an administrative investigation after the district attorney's review. 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 162 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. Although the investigator timely completed the majority of the investigation, the investigative report was not completed until 162 days after the incident was discovered.
Department Corrective Action Plan	To ensure investigations are completed in a timely fashion, the OPS investigative supervisor will closely monitor the status of investigations on a weekly basis. During their weekly review, the OPS investigative supervisor will ensure cases are prioritized and completed in a timely fashion, by following an investigative timeline. The investigative

	supervisor will notate the inspection on the investigation control log.

Case Details	Description
Incident Date	01/29/2018
OLES Case Number	2018-00124MC
Case Type	Abuse
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 removed a blanket from a resident who was asleep. The psychiatric technician was also allegedly verbally abusive to the resident on an ongoing basis.
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 Details	Description
Incident Date	02/02/2018
OLES Case Number	2018-00140MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 2, 2018, a psychiatric technician allegedly forcefully placed a resident on the floor, struck the

	resident, and forced the resident's head onto the floor. A senior psychiatric technician allegedly failed to intervene and failed to report the incident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. 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 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 February 3, 2018; however, the final investigative report was not completed until June 26, 2018, 144 days later.
Department Corrective Action Plan	To ensure investigations are completed in a timely fashion, the OPS investigative supervisor will closely monitor the status of investigations on a weekly basis. During their weekly review, the OPS investigative supervisor will ensure cases are prioritized and completed in a timely fashion, by following an investigative timeline. The investigative supervisor will notate the inspection on the investigation control log.

Case Details	Description
Incident Date	03/24/2018
OLES Case Number	2018-00333MA
Case Type	Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On March 24, 2018, two psychiatric technicians allegedly

	failed to maintain adequate supervision of a resident on suicide watch, who subsequently died.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against both psychiatric technicians and issued a letter of instruction against one psychiatric technician. The second psychiatric technician resigned prior to the completion of the investigation; therefore, disciplinary action was not taken. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in the second psychiatric technician's official personnel file. The OLES concurred with the hiring authority's determinations.
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 completed on December 14, 2018; however, final investigative findings and penalty determinations were not made until June 20, 2019, 188 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The investigation was completed on December 14, 2018; however, final investigative findings and penalty determinations were not made until June 20, 2019, 188 days later.
Department Corrective Action Plan	Staff separations and re-assigning of investigations caused a deficiency in case timeline management. This issue has been resolved through attrition and the relocation of clients, due to the closure of the facility.

Case Details	Description
Incident Date	06/11/2018
OLES Case Number	2018-00625MC
Case Type	Abuse
Allegations	1. Criminal Act

Findings	1. Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On June 11, 2018, a psychiatric technician allegedly slapped, scratched, and choked a resident while the resident was restrained. A pre-licensed psychiatric technician and a second psychiatric technician allegedly failed to intervene and report the incident.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 141 days after the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on June 15, 2018; however, the investigation was not completed until November 2, 2018, 141 days later.
Department Corrective Action Plan	To ensure investigations are completed in a timely fashion, the OPS investigative supervisor will closely monitor the status of investigations on a weekly basis. During their weekly review, the OPS investigative supervisor will ensure cases are prioritized and completed in a timely fashion, by following an investigative timeline. The investigative supervisor will notate the inspection on the investigation control log.

Case Details	Description
Incident Date	03/20/2018
OLES Case Number	2018-00715MC
Case Type	Death
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	**Initial:** Other **Final:** No Change
Incident Summary	On March 20, 2018, a resident was found unresponsive in his bed. Two psychiatric technicians performed life saving measures and resuscitated the resident. On March 24, 2018, the resident died at an outside hospital.
Disposition	The Office of Protective Services conducted an investigation and referred the case to the district attorney for review. The OLES concurred with the 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 Office of Protective Services conducted an investigation and referred the case to the district attorney for review. The OLES concurred with the determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.

Case Details	Description
Incident Date	01/29/2018
OLES Case Number	2018-00814MA
Case Type	Abuse
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Unfounded 2. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Change

Incident Summary	On January 29, 2018, a psychiatric technician allegedly removed a blanket from a resident who was asleep. The psychiatric technician was also allegedly verbally abusive to the resident on an ongoing basis.
Disposition	The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to timely consult with the OLES regarding the sufficiency of the investigation, and investigative findings.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. Although the investigation was completed on October 4, 2018, the hiring authority did not receive notice of the completed report until January 7, 2019. The hiring authority consulted with the OLES on February 25, 2019, 50 days later.
Department Corrective Action Plan	The administrative lieutenant will conduct weekly checks of the investigation control log to ensure communication with the hiring authority is being properly conducted. The investigative supervisor will notate the inspection on the investigation control log.

Case Details	Description
Incident Date	04/16/2018
OLES Case Number	2018-00890MA
Case Type	Abuse
Allegations	1. Other failure of good behavior
Findings	1. Unfounded
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 up a resident by kicking the resident.
Disposition	The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	09/07/2018
OLES Case Number	2018-00950MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 7, 2018, a psychiatric technician assistant allegedly kicked 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 this determination. The Office of Special Investigations opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/10/2018
OLES Case Number	2018-00955MC
Case Type	Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 10, 2018, a psychiatric technician allegedly pulled down a resident's pants, and threatened to sexually assault the 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:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to adequately consult with the OLES during the investigation.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not consult with the OLES during the investigation; therefore, the OLES was unable to monitor any interviews the investigator conducted. The OLES was only able to review the draft investigative report.
Department Corrective Action Plan	The OPS investigative supervisor will conduct weekly checks of the investigation control log to ensure OPS investigations, containing an OLES case number, are being investigated according to OLES investigative guidelines. The investigative supervisor will notate the inspection on the investigation control log.

Case Details	Description
Incident Date	11/19/2018
OLES Case Number	2018-01254MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** Other **Final:** Other
Incident Summary	On November 19, 2018, a senior psychiatric technician allegedly repeatedly slapped a resident's knee while she was restrained, and a psychiatric technician allegedly failed to prevent or report the incident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/21/2018
OLES Case Number	2018-01270MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On November 21, 2018, a psychiatric technician allegedly failed to prevent a resident from ingesting two metal screws, while the resident was under an enhanced level of observation.
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 investigative process.

Case Details	Description
Incident Date	07/29/2017
OLES Case Number	2018-01288MA
Case Type	Misconduct
Allegations	1. Misuse of state property 2. Discourteous treatment
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** No Change
Incident Summary	Between July 29, 2017, and June 30, 2018, an officer allegedly sent inappropriate text messages to a colleague. In addition the officer allegedly conducted an unlawful patrol stop for the purpose of flirting with the colleague.
Disposition	The hiring authority sustained the allegation regarding the text messages but not the patrol stop and issued a letter of instruction. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigative findings conference was not timely conducted.
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 delivered to the hiring authority

	on December 5, 2018; however, the hiring authority did not conduct the investigative findings conference until March 14, 2019, 99 days later.
Department Corrective Action Plan	The OPS investigative supervisors will inspect all investigative plans to ensure all investigators file written notice timelines. The investigative supervisor will notate the inspection on the investigative control log.

Case Details	Description
Incident Date	12/11/2018
OLES Case Number	2018-01332MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 11, 2018, a psychiatric technician allegedly kicked 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 Details	Description
Incident Date	12/11/2018
OLES Case Number	2018-01338MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Penalty	**Initial:** Other

	Final: Other
Incident Summary	On December 11, 2018, a staff member allegedly slapped a 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 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 sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/14/2018
OLES Case Number	2018-01341MC
Case Type	Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 14, 2018, a resident was found unresponsive in his bedroom. Staff provided emergency life saving measures until a doctor pronounced the resident dead. An autopsy determined the patient died as a result of respiratory arrest, aspiration, seizure disorder, and extrapyramidal disorder.
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 sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/23/2018
OLES Case Number	2018-01377MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On December 23, 2018, a psychiatric technician allegedly struck a resident multiple times.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with 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 Details	Description
Incident Date	01/29/2019
OLES Case Number	2019-00096MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On January 29, 2019, a psychiatric technician allegedly struck 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 Details	Description
Incident Date	02/04/2019
OLES Case Number	2019-00116MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 4, 2019, a senior psychiatric technician allegedly pressured a resident to withdraw an allegation the resident had made against a psychiatric technician.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/11/2019
OLES Case Number	2019-00146MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 11, 2019, a psychiatric technician allegedly grabbed and bruised a resident's arms.
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 Details	Description
Incident Date	09/07/2018
OLES Case Number	2019-00166MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On September 7, 2018, a psychiatric technician assistant allegedly kicked a resident.
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 Details	Description
Incident Date	02/17/2019
OLES Case Number	2019-00186MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 17, 2019, a psychiatric technician allegedly slapped a resident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to insufficient evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/01/2018
OLES Case Number	2019-00192MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	During December 2018, a psychiatric technician allegedly slapped a resident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to insufficient

	evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/25/2019
OLES Case Number	2019-00204MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On February 25, 2019, a psychiatric technician allegedly struck a resident multiple times.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/11/2018
OLES Case Number	2019-00263MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** No Change

Incident Summary	On December 11, 2018, a psychiatric technician assistant allegedly slapped a resident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Details	Description
Incident Date	03/22/2019
OLES Case Number	2019-00296MC
Case Type	Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Penalty	**Initial:** No Penalty Imposed **Final:** No Change
Incident Summary	On March 22, 2019, a senior psychiatric technician allegedly struck a resident on the head and neck.
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 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 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 Details	Description
Incident Date	02/03/2017
OLES Case Number	2017-00682MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	On February 3, 2017, a psychiatric technician 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.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the

	sufficiency of the investigation and the investigative findings? No. The investigation was completed on September 19, 2017, and the findings and penalty conference was held on January 10, 2018; however, the hiring authority did not consult with the OLES until March 20, 2018. 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 provide real-time consultation with OLES concerning the findings and penalty conference. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was completed on September 19, 2017; however, the findings and penalty conference was not held until January 10, 2018, 113 days later. Furthermore, the hiring authority did not consult with the OLES until March 20, 2018, 69 days later.
Disciplinary Assessment	**Procedural Rating:** Insufficient **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 with the psychiatric technician wherein he agreed to resign in lieu of dismissal. The psychiatric technician also agreed not to seek future employment with the department and to withdraw his appeal. The OLES concurred with the settlement. The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority did not consult with the OLES regarding disciplinary determinations prior to making a final decision. The disciplinary action was not served until 233 days from the date the hiring authority made findings and penalty determinations.
Disciplinary Assessment	1. Did the hiring authority consult with OLES and the department attorney (if applicable) regarding disciplinary

Questions	determinations prior to making a final decision? No. The hiring authority did not consult with the OLES regarding disciplinary determinations prior to making a final decision. An attorney was not assigned at the time disciplinary determinations were made. 2. Was the disciplinary phase conducted with due diligence by the department? No. The decision to take disciplinary action was made on January 10, 2018; however, the disciplinary action was not served until August 31, 2018, 233 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 meetings, either in person or via teleconference. This will allow for real-time consultation between all parties. A tracking system has been implemented to ensure timely notification and serving of all disciplinary actions. 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 meetings, either in person or via teleconference. This will allow for real-time consultation between all parties.

Case Details	Description
Incident Date	09/28/2017
OLES Case Number	2017-01155MA
Case Type	Significant Interest - AWOL
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** Dismissal **Final:** No Change
Incident Summary	On September 28, 2017, three psychiatric technicians allegedly failed to properly supervise a patient during a

	court appearance. She left the courthouse and traveled by bus to a relative's residence where she cut her neck and wrists with a knife.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the first psychiatric technician and determined dismissal was the proper penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the other two psychiatric technicians. The OLES concurred.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on December 28, 2017; however, the findings and penalty conference was not completed until April 5, 2018, 97 days later.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The employee filed an appeal with the State Personnel Board. Prior to State Personnel Board proceedings, the department entered into a settlement agreement with the employee wherein the employee agreed to resign in lieu of dismissal and not seek future employment with the department. The employee agreed to withdraw his appeal. The OLES concurred. The department did not comply with policies and procedures governing the disciplinary process. Disciplinary determinations were made on February 8, 2018; however, the disciplinary action was not served on the employee until August 17, 2018, 187 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. Disciplinary determinations were made on February 8, 2018; however, the disciplinary action was not served on the employee until August 17, 2018, 187 days later.
Department Corrective Action Plan	Refresher training has been provided to the supervisors and manager. Also, a tracking system has been implemented to ensure all disciplinary actions are served in a timely manner.

Case Details	Description
Incident Date	06/01/2018
OLES Case Number	2018-00590MA
Case Type	Neglect
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 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.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician wherein the psychiatric technician resigned in lieu of dismissal and agreed to never seek employment with the department again. The psychiatric technician 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 penalty conference took place on August 20, 2018; however, the disciplinary action was not served until November 19, 2018, 81 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The findings and penalty conference took place on

	August 20, 2018; however, the disciplinary action was not served until November 19, 2018, 81 days later.
Department Corrective Action Plan	A tracking system has been implemented to ensure timely notification of all disciplinary actions. In the future, the hiring authority will consult with OLES as required.

Case Details	Description
Incident Date	06/22/2018
OLES Case Number	2018-01047MA
Case Type	Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Demotion **Final:** Demotion
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.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The lieutenant filed an appeal with the State Personnel Board. At the hearing, the department entered into a settlement agreement whereby the lieutenant agreed to voluntarily demote to an officer for 12 months after which time he would become a sergeant. In exchange, the lieutenant agreed to withdraw his appeal. The OLES concurred because demotion remained the penalty and it was still a significant penalty. The department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix C2 DDS Discipline Phase Cases - DDS

Case Details	Description
Incident Date	08/30/2017
OLES Case Number	2017-01042MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Unfounded
Penalty	**Initial:** Salary Reduction **Final:** No Change
Incident Summary	On August 30, 2017, a senior psychiatric technician and a teacher allegedly failed to monitor and account for a missing resident. The resident was left unattended for approximately 40 minutes.
Disposition	The hiring authority sustained the allegation against the senior psychiatric technician and imposed a 10 percent salary reduction for six months. The hiring authority determined the allegation against the teacher was unfounded. The OLES concurred with the hiring authority's determinations.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient Due to the pending closure of the facility and departure of witnesses, the hiring authority reduced the penalty to a five-working-day suspension. The OLES concurred. The senior psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the senior psychiatric technician wherein the penalty was reduced to a letter of reprimand and the senior psychiatric technician agreed to waive back pay for the suspension that had already been served. The senior psychiatric technician 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 initial disposition meeting was February 22, 2018; however, the disciplinary action was

	not served until August 10, 2018, 169 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The date of the initial disposition meeting was February 22, 2018; however, the disciplinary action was not served until August 10, 2018, 169 days later.
Department Corrective Action Plan	The penalty deliberation took considerably longer than expected, due to the complicated medical nature of the client's case. Deliberations involved the department's labor, legal, personnel and administrative management levels of the department, causing the case to exceed expected timelines.

Appendix D: Combined Pre-Disciplinary and Discipline Phase Cases

On the following pages are cases that, in this reporting period, OLES monitored in both their pre-disciplinary phase as well as the discipline phase. Each phase was rated separately.

Investigations and other activities conducted by the departments during the pre-disciplinary phase are rated for procedural and substantive sufficiency.

- Procedural sufficiency includes the notifications to OLES, consultations with 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.

The disciplinary phase is rated for procedural and substantive sufficiency.

- Procedural sufficiency includes, among other things, whether 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 Details	Description
Incident Date	11/23/2017
OLES Case Number	2018-00165MA
Case Type	Misconduct
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** No Change
Incident Summary	On November 23, 2017, an officer allegedly told a

	coroner that a recently deceased patient could have been saved but they chose not to save him.
Disposition	The hiring authority sustained the allegation and imposed a salary reduction of 5 percent for seven months. The OLES concurred with the hiring authority's determination. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The decision to take disciplinary action was made on March 13, 2018; however, the disciplinary action was not served until July 16, 2018, 125 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The decision to take disciplinary action was made on March 13, 2018; however, the disciplinary action was not served until July 16, 2018, 125 days later.
Department Corrective Action Plan	A tracking system has been implemented to ensure timely notification and service of all disciplinary actions.

Case Details	Description
Incident Date	10/19/2018
OLES Case Number	2018-01127MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	On October 19, 2018, a pre-licensed psychiatric

	technician allegedly failed to maintain enhanced supervision of a patient.
Disposition	The hiring authority sustained the allegation and imposed a 5 percent salary reduction for nine months; however, the pre-licensed psychiatric technician resigned before disciplinary action could be taken. A letter indicating the pre-licensed psychiatric technician resigned under adverse circumstances was placed in his official personnel file. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department 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.

Case Details	Description
Incident Date	11/01/2018
OLES Case Number	2018-01182MA
Case Type	Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On November 1, 2018, and November 2, 2018, a senior psychiatric technician allegedly failed to conduct required safety checks on a patient and falsified documentation of the checks.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. However, the senior psychiatric technician separated

	from state service before the disciplinary action could be served. In the event the senior psychiatric technician returns to state service, the hiring authority will serve the disciplinary action.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The draft investigative report failed to incorporate allegations that the senior psychiatric technician falsified official documentation.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report did not include any reference that the senior psychiatric technician allegedly falsified documentation.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The Chief/OPS discussed the importance of incorporating all employee allegations into the report.

Case Details	Description
Incident Date	12/08/2017
OLES Case Number	2018-01274MA
Case Type	Misconduct
Allegations	1. Discourteous treatment 2. Discourteous treatment 3. Other 4. Inexcusable neglect of duty 5. Dishonesty 6. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained

	4. Sustained 5. Sustained 6. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On December 8, 2017, an officer allegedly sent harassing text messages to a second officer. On December 23, 2017, the first officer allegedly sent nude photographs of the second officer and sexually explicit text messages to a third officer. On January 3, 2018, and October 18, 2018, the first officer was allegedly dishonest during investigative interviews.
Disposition	The hiring authority sustained the allegations and dismissed the officer. The OLES concurred. The officer did not file an appeal with the State Personnel Board.
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.

Case Details	Description
Incident Date	06/28/2018
OLES Case Number	2019-00227MA
Case Type	Abuse
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Other 4. Other
Findings	1. Sustained 2. Sustained 3. Sustained 4. Not Sustained
Penalty	**Initial:** Dismissal

	Final: Dismissal
Incident Summary	On June 28, 2018, a psychiatric technician allegedly became frustrated with a patient and pushed the patient's head and neck in a downward motion. On July 11, 2018, the psychiatric technician allegedly placed the patient in a chokehold and did not adequately monitor the patient, who was at risk for falls. On March 12, 2019, the psychiatric technician was allegedly dishonest during his interview with the Office of Special Investigations.
Disposition	The hiring authority sustained the allegations that the psychiatric technician placed a patient in a chokehold, failed to adequately monitor the patient, and was dishonest during his administrative interview, but found insufficient evidence to sustain the allegation that he pushed a patient's head and neck. The hiring authority determined dismissal was the appropriate penalty. 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. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, 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.

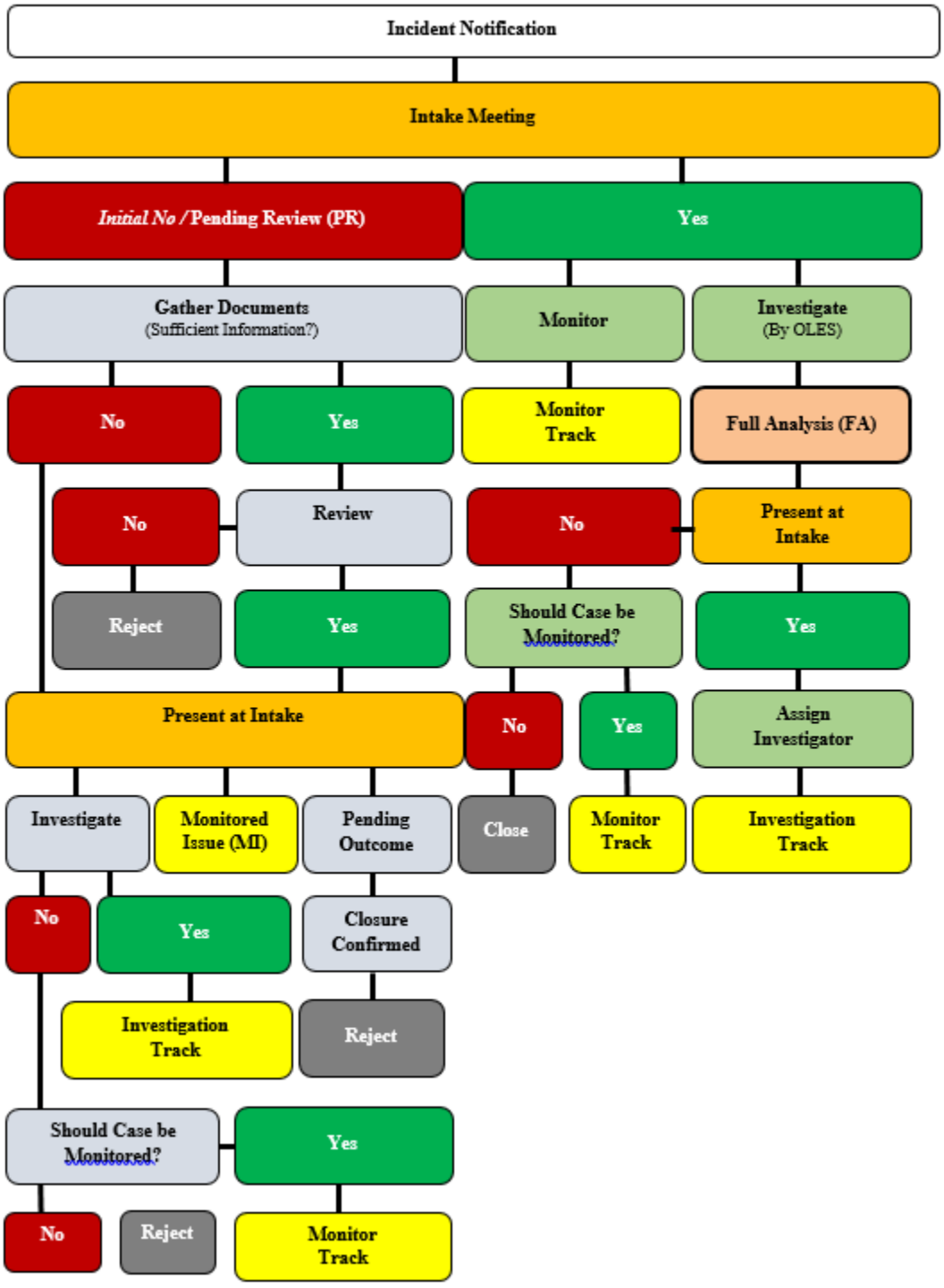
(d) Unreasonable physical constraint, or prolonged or continual deprivation of

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 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, OLES begins monitoring the disciplinary phase. This is handled by a monitoring attorney (AIM) at 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[8], 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

[8] 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.

    a. Develop investigation plan
    b. Determine statute of limitations
3. Critical witness interviews
    a. Primary subject(s) recorded
4. Investigation draft proposal

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[9]. It is recommended that the Skelly due process meeting be completed within 30 days.

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

30 Days

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

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

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