



Office of Law Enforcement Support

# Semiannual Report

January 1, 2017–June 30, 2017

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

Promoting a safe, secure and therapeutic environment

This report is prepared and distributed per California Welfare and Institutions Code Section 4023.8 et seq.

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# Introduction

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I am pleased to present this third report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency detailing the oversight and monitoring conducted at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Per its statutory authority, the OLES is responsible for real-time oversight of the DSH and DDS employee discipline process. The OLES further is focused on law enforcement programs and conducted internal investigations of DSH and DDS police personnel.

The OLES accomplished a great deal during our first year and a half of oversight as evidenced by our three Semi-Annual Reports. This was achieved by the many efforts of my team, the departments' staff, and our stakeholders to accomplish my office's guiding vision -- Promoting a Safe, Secure and Therapeutic Environment. However, much work remains if we are to help the departments obtain excellence in their internal affairs investigations, disciplinary processes and law enforcement best practices.

The OLES team, during its oversight duties and while conducting investigations, has identified several systemic issues we define as observed patterns of shortcomings in policy, procedures and protocols. The OLES provided to the departments a survey of the observed issues along with our recommendations that are labeled in the report as "Monitored Issues." This report highlights the status of several ongoing monitored issues and areas in which the departments are making systemic improvements. One example highlighted in this report includes the OLES' recommendation for both departments to establish a statewide panel of subject matter experts to review and provide a recommendation regarding incidents where the standard of care provided was in question. The OLES recommended the panel be composed of seasoned medical experts with no ties to the facility where the standard of care was in question. The DSH has presented a proposal to the OLES that would provide the necessary medical opinions during the investigative process.

This report further provides the status, as of June 30, 2017, of 30 recommendations that the OLES presented to the departments in 2016 and that the departments continue to address. These recommendations – 16 at DSH and 14 at DDS -- are for best practices in law enforcement, employee discipline processes and the tracking and management analysis of employee misconduct cases. One recommendation is departments' law enforcement must understand the population they serve, specifically those with mental health and developmental disabilities. For example, the OLES recommendation was to include mental health topics being taught to new police officers along with

ongoing professional development of longstanding personnel. The DSH developed a 24-hour mental health training program to be taught by highly qualified mental health experts.

Other recommendations were removed from the listing because DSH and DDS management informed the OLES that the recommendations were fully implemented before the start of the reporting period. For example, both DSH and DDS finished putting all law enforcement procedures for their facilities into their respective digital policy manuals, and they agreed to notify the OLES before any procedure is changed. The DDS also verified that all law enforcement equipment called for in the department's policies and procedures is available and accessible to personnel. Further, the DDS implemented a centralized discipline tracking system.

This is the final report showing the OLES providing oversight and monitoring at three psychiatric treatment facilities that reside on the grounds of California Department of Corrections and Rehabilitation (CDCR) prisons. Effective July 1, 2017, the psychiatric facilities in Stockton, Salinas Valley and Vacaville were transferred from DSH to CDCR, and this move ended the OLES monitoring duties at these facilities.

During the first six-month reporting period of 2017, the OLES continued to build the skills of its staff to accomplish the organization's goal of helping DSH and DDS provide safe, secure environments for the patients and residents under the departments' care. I am especially thankful to the Association of Regional Center Agencies for providing training to the OLES staff in June 2017.

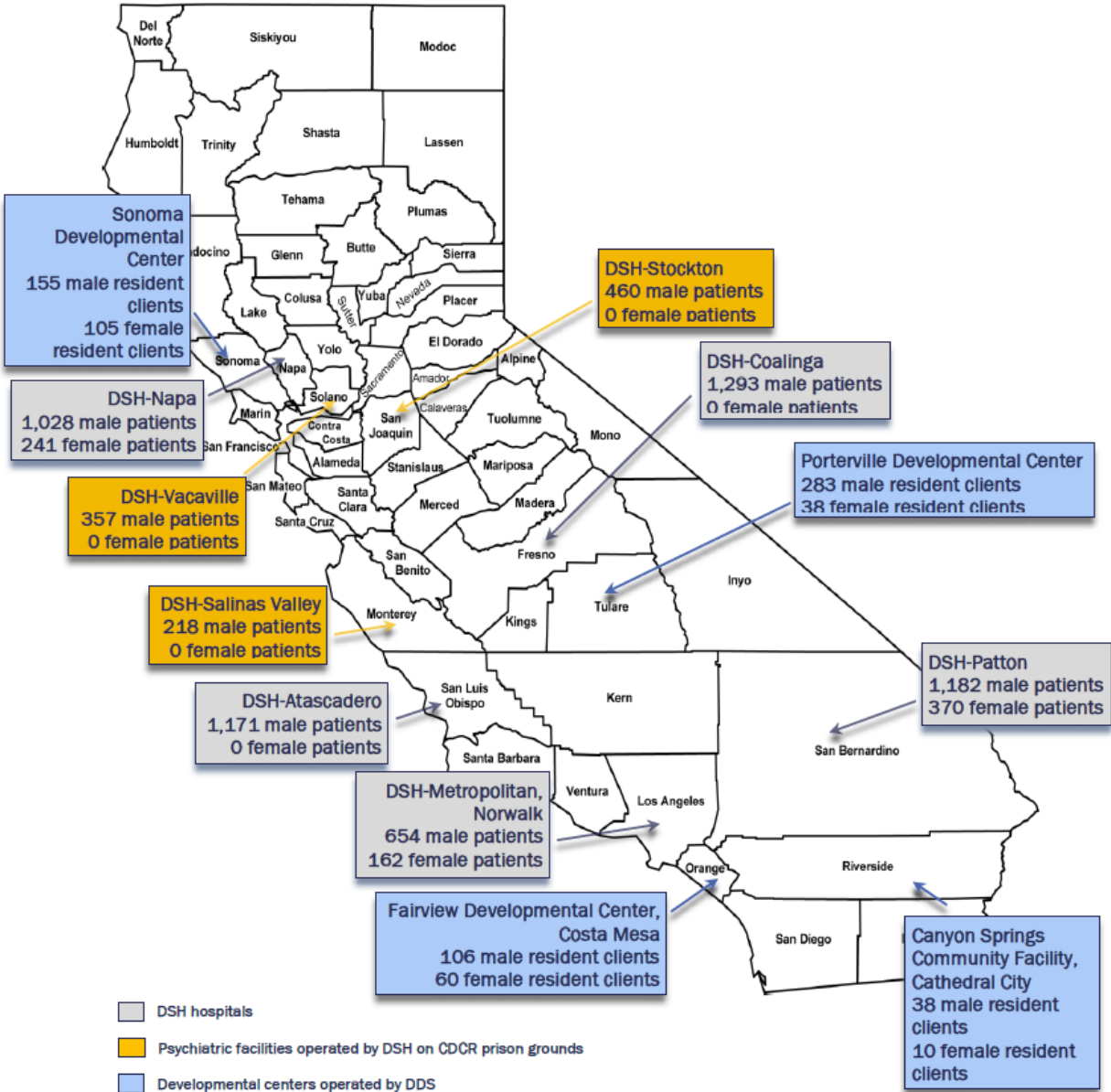
I welcome your comments and questions. Please visit the OLES website at [www.oles.ca.gov](http://www.oles.ca.gov) to contact us.

*Ken Baird*  
*Chief, Office of Law Enforcement Support*



# Facilities

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



Note: Population numbers as of June 30, 2017, were provided by the departments. The DSH total decreased by three patients compared with December 31, 2016. The DDS total declined by 101 residents, or 12.7 percent, compared with the end of 2016.

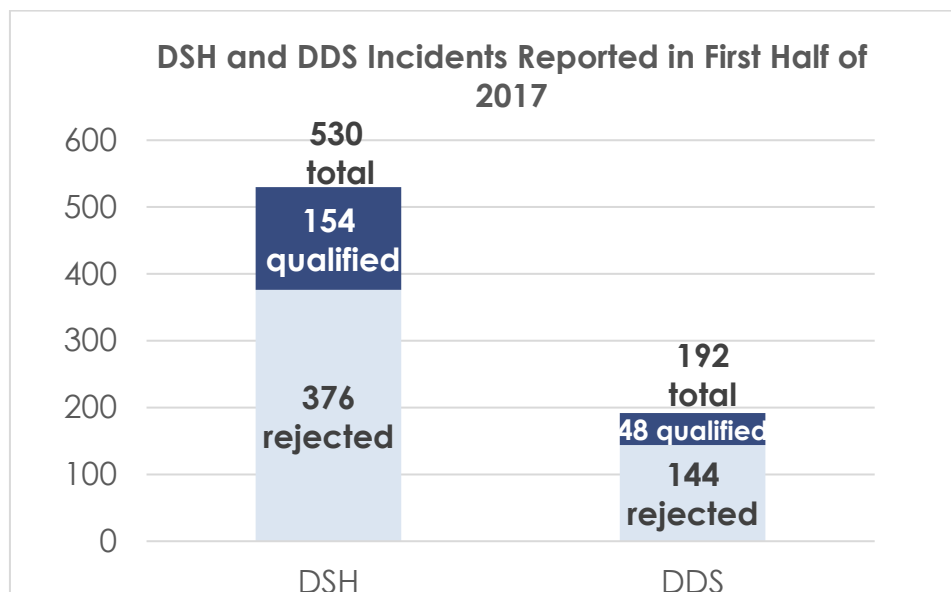
## DSH and DDS Facility Population Chart

Facility	Number of Male Residents/Patients	Number of Female Residents/Patients
DSH-Atascadero	1,171	0
DSH-Coalinga	1,293	0
DSH-Metropolitan	654	162
DSH-Napa	1,028	241
DSH-Patton	1,182	370
DSH-Salinas Valley	218	0
DSH-Stockton	460	0
DSH-Vacaville	357	0
Fairview	106	60
Porterville	283	38
Sonoma	155	105
Canyon Springs	38	10

# Executive Summary

From January 1, 2017, through June 30, 2017, the Office of Law Enforcement Support (OLES) received and processed 722 reports of prescribed incidents<sup>1</sup> at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Prescribed incidents included alleged misconduct by state employees, serious offenses between facility residents and patients, resident and patient deaths and other occurrences. The 722 reports marked a 13.0 percent decline from the 830 incident reports that the OLES received in the same six-month period a year earlier.

At both departments, the number of incidents reported to the OLES decreased. The DDS had the largest decline – from 252 incidents reported in the first half of 2016 to 192 this year, for a 23.8 percent drop. The DSH incident numbers decreased from 578 in the first half of 2016 to 530 this year, for an 8.3 percent decline. It is important to note that the developmental centers operated by DDS had 795 residents on June 30, 2017, which was 16.1 percent fewer than the facilities had on the same date in 2016. Meantime, the number of reported DSH incidents decreased even as the DSH population increased 2.2 percent, to 7,136 patients as of June 30, 2017, compared with the same date in 2016.<sup>2</sup>



As shown in the chart above, only 28.0 percent, or 202 of the total incident reports at the departments in the first six months of 2017 met the criteria to qualify for an OLES investigation, OLES monitoring and/or led to OLES research into a systemic

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

<sup>2</sup> Patient and resident population numbers as of June 30, 2017, were provided by DSH and DDS.

departmental issue.<sup>3</sup> This compares with 34.3 percent, or 285, of the 830 incident reports that came to the OLES in the year-earlier period. To ensure the OLES is meeting its legislative mandate and to safeguard an independent assessment of whether an allegation meets the OLES monitoring and/or investigation criteria, the OLES requires the departments to report allegations of misconduct broadly. It is best practice of an oversight entity to independently determine if an allegation meets its criteria. Further, by analyzing these allegations, the OLES discovered three systemic issues at DSH and one systemic issue at DDS that have been addressed with the departments through monitored issues. As of the end of June 2017, the OLES continued to investigate, monitor and research issues involving more than 140 incidents – some from the first half of 2017 reporting period and some that carried over from 2016 that had not yet concluded.

## Types of incidents

In contrast to the first half of 2016 when the single largest category of DSH incident reports received by the OLES involved allegations of patient abuse, the single largest category in the January through June 2017 period involved patient allegations of sexual assault. The total 147 reports of allegations of sexual assault in the period accounted for 27.7 percent of all DSH incidents that were reported to the OLES and marked a significant increase of 65.2 percent from the 89 reports received in the first six months of 2016.

### Most Frequent DSH Incidents Jan. 1, 2017, through June 30, 2017

Incident Categories	2017 Number of Reports	Change Compared With Year-Ago Period	2017 Number Meeting OLES Criteria
<b>Sexual Assault</b>	147	+65.2%	24*
<b>Abuse</b>	121	-45.0%	79
<b>Head/Neck Injury</b>	49	-25.8%	1
<b>Broken Bone**</b>	45	+309.1%	4
<b>Neglect</b>	34	-40.3%	14

\* Rose by only 2 even though the total reported sexual assaults increased by 65.2%.

\*\* The OLES changed the reporting criteria after the first reporting period in 2016 from requiring the reporting of only unknown broken bones to all broken bones.

The second largest category of incidents reported at DSH in the first half of 2017 was patient abuse allegations that did not involve sexual assault. Abuse had been the top incident category at DSH in the year-ago period. But the number of incidents reported this year fell by 45 percent – from 220 in the 2016 reporting period to 121

<sup>3</sup> Initial reports were descriptions of allegations. During its intake process, the OLES determined, for the purposes of OLES investigation and monitoring, whether the described allegations met the statutory requirements in California Welfare and Institutions Code Section 4023.6 et. seq. (see Appendix F). In addition, the OLES Chief determined at any point in a case whether an issue in DSH or DDS appeared to be systemic and, if so, he directed OLES staff to research the matter. The OLES labeled such matters “monitored issues” and added them to the final DSH and DDS incident counts for the reporting period.

this year.

Reports of head and/or neck injury were the third largest incident category at DSH, totaling 49 in the first six months of 2017. This number was down 25.8 percent from the 66 reports in the year-earlier period. The OLES required notification of all head/neck injuries that required treatment beyond first aid because such injuries can cause lasting health impairment or lead to death and may be indicative of assault, battery or neglect.

At DDS, allegations of abuse that did not involve sexual assault remained the top incident category as it was in the first half of 2016. However, the 76 abuse reports in the period this year were a 36.7 percent decline from the 120 abuse incident reports at DDS that the OLES received in the first half of 2016.

### **Most Frequent DDS Incidents Jan. 1, 2017, through June 30, 2017**

<b>Incident Categories</b>	<b>2017 Number of Reports</b>	<b>Change Compared With Year-Ago Period</b>	<b>2017 Number Meeting OLES Criteria</b>
<b>Abuse</b>	76	-36.7%	31
<b>Head/Neck Injury</b>	26	-31.6%	1
<b>Broken Bone</b>	23	-4.2%	3
<b>Sexual Assault</b>	22	+144.4%	7
<b>Genital Injury</b>	11	+175%	0

Following abuse, head and/or neck injuries ranked second as the most common incident at DDS to be reported to the OLES. The DDS, whose population includes residents with developmental disabilities, was required to report to the OLES all head and neck injuries if they required treatment beyond first aid. The 26 reports of head/neck injuries in the first half of 2017 were down 31.6 percent from the 38 reports the OLES received in the same period in 2016.

The third most common incident at DDS involved broken bones. These incidents decreased by one, from 24 in the first six months of 2016 to 23 in the same period in 2017, even though OLES changed the reporting requirement from reporting only unknown broken bones to all broken bones.

## **Results of OLES investigations**

Per the statute,<sup>4</sup> an OLES investigation commenced after the OLES was notified of an allegation that a DSH or DDS law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents.<sup>5</sup> From January 1, 2017, through June 30, 2017, the OLES completed 43 investigations, which was an increase of 207.1 percent from the 14 completed investigations in the same period a year earlier when the OLES

<sup>4</sup> Welfare and Institutions Code Section 4023.6 (2). (See Appendix F).

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

had just started operating. Of the 43 completed OLES investigations in early 2017, 22 were criminal cases and 21 were administrative. All were at DSH.

Appendix A of this report provides results of the 43 OLES investigations. Twenty-two of the investigations involved incidents that occurred in 2016, and 21 investigations focused on incidents in 2017. Only one investigation resulted in probable cause for referral to a prosecuting agency, and the agency declined to prosecute the case. Twenty-nine of the closed OLES investigations determined there was insufficient evidence to support the allegations, and summaries of the investigatory findings were provided to the department. Another 13 completed investigations were submitted to the hiring authorities at the facilities for disposition.

## **Results of OLES monitored cases**

In this report's Appendices B, C and D, the OLES provides information on 231 monitored incident cases that, by June 30, 2017, had reached completion. Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct. Seventy-three percent, or 169 of the 231 cases, were at DSH. The OLES found that 101 monitored cases at the two departments, combined, were insufficient either procedurally, substantively or both. Procedural sufficiency assesses the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency assesses the quality, adequacy and thoroughness of the investigative interviews and reports. During the January through June 2017 period, 39 monitored administrative cases at DSH and DDS had sustained allegations. Another seven criminal investigations conducted by DSH and DDS law enforcement in the period resulted in referrals to prosecuting agencies.

## **Monitored Issues**

In the course of its work, the OLES identified systemic issues -- observed patterns of misconduct and shortcomings in policy, procedures and protocol -- at the departments. The OLES labeled these items "monitored issues" and brought them to the attention of the departments along with a request for a response back to the OLES, often requesting the response within a specific time. In most instances, the OLES also asked the departments for corrective action plans. Appendix E contains the four monitored issues that were resolved during the January through June 2017 reporting period. Three of these monitored issues were at DSH and one was at DDS.

## **OLEs recommendations for best practices**

In the first two reports to the Legislature that the OLES produced for 2016, the OLES included the status of recommendations that the OLES had made to the departments for best practices in law enforcement and employment discipline. For this report, the OLES followed up with the departments on the unresolved recommendations. The departments' responses are provided verbatim in the boxes entitled "Status as of Dec. 31, 2016" and "Status as of June 30, 2017" in the OLES

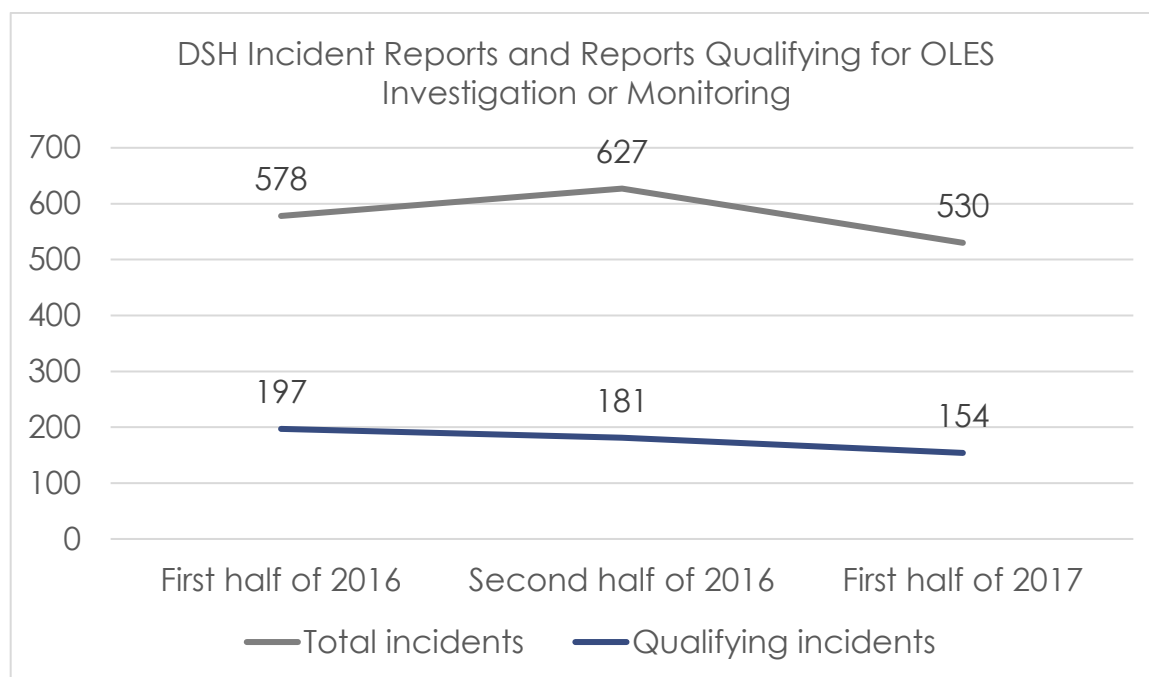
Recommendations section starting on page 47.

# DSH Incidents

Every OLES case started with a report of an incident. Reports of incidents – alleged, inferred or actually witnessed at the facilities – can arrive at the OLES from many sources 24/7. In the January through June 2017 reporting period, virtually all incident reports came from the departments.

## Decline in reported DSH incidents this period

Overall, the number of DSH incidents reported to the OLES from January 1, 2017, through June 30, 2017, decreased 8.3 percent, from 578 in the first half of 2016 to 530. Allegations of abuse, neglect and death reports all declined at DSH compared with the same period a year earlier.



As shown in the adjacent chart, only 154, or 29.1 percent of the 530 DSH incidents reported in the first half of 2017 qualified for OLES investigation or monitoring or led to OLES research into a systemic departmental issue.<sup>6</sup> This marked the third straight period where the number of reported incidents at DSH that met the criteria for OLES action decreased. The 154 incidents in the first half of 2017 were 21.8 percent fewer than the 197 incidents that qualified in the first half of 2016 and 14.9 percent fewer than the 181 incidents that qualified in the last half of 2016.

<sup>6</sup> The OLES Chief determined whether an issue in DSH or DDS appeared to be systemic and, if so, directed OLES staff to research the matter. The OLES labeled such matters “monitored issues” and added them to the final DSH and DDS incident counts for the reporting period.



## Most frequent DSH incidents this period

For the first time since the OLES began oversight and monitoring duties at DSH at the start of 2016, allegations of sexual assaults topped all other reported incidents. In the January through June 2017 period, the total 147 sexual assault allegations represented a 65.2 percent increase from the 89 reports the OLES received in the first six months of 2016. Also for the first time, sexual assault allegations at DSH accounted for more than a quarter – 27.7 percent -- of all incident reports to the OLES in a reporting period.

Abuse allegations that did not involve sexual assault ranked second in reported incidents at DSH in the first six months of 2017. But the 121 reports of abuse allegations received were down 45.0 percent from the 220 reports in the first half of 2016. They also were 26.2 percent less than the 164 abuse incidents reported in the final six months of 2016. Nonetheless, in the first half of 2017, more abuse allegations – 79 -- qualified for OLES investigation and/or monitoring or led to OLES research into systemic departmental issues than any other kind of incident, as the chart below shows.

### All Reported DSH Incidents

Incident Categories	Number Reported Jan. 1- June 30, 2017	Number Reported Jan. 1- June 30, 2016	Change	Number Meeting OLES Criteria Jan. 1-June 30, 2017	Number Meeting OLES Criteria Jan. 1-June 30, 2016
<b>Sexual Assault</b>	147	89	+65.2%	24	22
<b>Abuse</b>	121	220	-45.0%	79	100
<b>Head/Neck Injury</b>	49	66	-25.8%	1	6
<b>Broken Bone</b>	45	11	+309.1%	4	3
<b>Neglect</b>	34	57	-40.3%	14	25
<b>Misconduct*</b>	33	25	See note	15	13
<b>Significant-Other</b>	29	11	+163.6%	4	1
<b>Death</b>	24	32	-25.0%	11	7
<b>Child Pornography**</b>	19	2	+950.0%	0	0
<b>AWOL</b>	14	14	0%	1	0
<b>Attempted Suicide</b>	8	3	+166.7%	1	1
<b>Attack on Staff***</b>	3	3	0%	0	0
<b>Burn</b>	2	2	0%	0	0
<b>Genital Injury</b>	2	1	+100%	0	0
<b>Pregnancy</b>	0	4	-400%	0	3
<b>Riot</b>	0	1	-100%	0	0

<b>Non-Resident Assault</b>	0	0	-	0	0
<b>Law Enforcement*</b>	NA	17	See note	NA	8
<b>Use of Force</b>	NA	19	See note	NA	7
<b>Professional Board Violation****</b>	NA	1	See note	NA	1
<b>Totals</b>	530	578	-8.3%	154	197

\* To more clearly present all reports of alleged misconduct, the OLES eliminated two categories from the year-earlier period – “law enforcement” and “use of force” – and included these incidents in other categories including the general “misconduct” category. Eighteen of the incidents reported in the first half of 2016 under “law enforcement” and “use of force” would now be categorized as “misconduct.” As a result, the 33 misconduct incident reports in the first half of 2017 compare with 43 misconduct incident reports in the first half of 2016. The result is a 23.3 percent decline in the misconduct category at DSH in 2017 from a year earlier.

\*\* During the period of January 1st through June 30, 2016, the department was not reporting all child pornography cases to the OLES. As a result, the OLES clarified that all child pornography cases must be reported.

\*\*\* The number of attacks on staff reported to the OLES is a small percentage of all staff attacks. The department only reports to the OLES the attacks that resulted in serious injury to the employee.

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

Note that while “abuse” was how certain incidents were described when they arrived at the OLES, the determination of whether each incident met the threshold for the OLES’s purposes of investigation and/or monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.<sup>7</sup> It is critical that every incident reported by

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<sup>7</sup> Welfare and Institutions Code section 15610.63, states, in pertinent part: “Physical abuse” means any of the following: (a) Assault, as defined in Section 240 of the Penal Code. (b) Battery, as defined in Section 242 of the Penal Code. (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code. (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water. (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code. (2) Rape, as defined in Section 261 of the Penal Code. (3) Rape in concert, as described in Section 264.1 of the Penal Code. (4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code. (6) Sodomy, as defined in Section 286 of the Penal Code. (7) Oral copulation, as defined in Section 288a of the Penal Code. (8) Sexual penetration, as defined in Section 289 of the Penal Code. (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code. (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment. (2) For a period

patients be given a thorough and objective review.

As the OLES began its operations in early 2016, incident reports alleging misconduct by state employees were separated into categories specific to the type of allegation. One type of misconduct – the unnecessary use of force by DSH law enforcement personnel -- went into a “use of force” category. All other allegations of misconduct by law enforcement personnel went into a “law enforcement” category. The OLES used a third general category – “misconduct”– to capture incident reports of general misconduct by all other state employees and contractors when the allegation did not specifically meet the definition of other more specific categories. To simplify and more clearly present misconduct incident reports at DSH, the OLES in 2017 eliminated the “use of force” and “law enforcement” categories and included these incidents in more appropriate categories. This is reflected in the chart on the previous page. Under the new methodology, 18 of the 36 “use of force” and “law enforcement” incidents in the first half of 2016 would now be categorized as “misconduct.” Therefore, the 33 misconduct incidents reported from January 1, 2017, through June 30, 2017, compare with 43 misconduct incidents from the year-earlier period, and misconduct as a whole declined 23.3 percent from the period a year ago.

### **Distribution of DSH incidents this period**

With 530 incidents reported from January through June 2017, DSH accounted for the majority, or 73.4 percent, of the reports the OLES received in the period. This was not unexpected since DSH's eight facilities held 7,136 patients, which is nine times as many people as the 795 residents at the four DDS facilities as of June 30, 2017.

The DSH-Coalinga hospital had the highest number of reports – 117. This translated into a rate of nine incidents per 100 patients at Coalinga and compares with an incident rate of 7.41 incidents per 100 patients that the OLES reported for Coalinga for the first half of 2016. But Coalinga's 2017 incident rate still was lower than the 13.60 incidents per 100 patients for DSH-Metropolitan in Norwalk during the 2017 reporting period.

The DSH-Salinas Valley psychiatric program facility on the grounds of the California Department of Corrections and Rehabilitation (CDCR) Salinas Valley State Prison in Monterey County had the fewest incidents reported at 10, which was a decrease from 16 in the first half of 2016. The chart below shows the distribution of reported incidents at all eight DSH facilities.

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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.

## All Reported DSH Incidents By Facility

Facility	Number of Patients*	Incidents Reported Jan. 1-June 30, 2017	Incidents Per 100 Patients Jan. 1-June 30, 2017	Incidents Per 100 Patients Jan. 1-June 30, 2016
<b>DSH-Coalinga</b>	1,293	117	9.0	7.41
<b>DSH-Metropolitan</b>	816	111	13.60	14.88
<b>DSH-Patton</b>	1,552	103	6.64	6.95
<b>DSH-Atascadero</b>	1,171	72	6.15	6.59
<b>DSH-Napa</b>	1,269	57	4.49	6.37
<b>DSH-Vacaville</b>	357	32	8.96	19.06
<b>DSH-Stockton</b>	460	28	6.09	6.42
<b>DSH-Salinas Valley</b>	218	10	4.59	8.08
<b>Totals</b>	7,136	530	7.42	8.37

\* The DSH provided patient population numbers as of June 30, 2017

## DSH sexual assault allegations this period

For the first time since the OLES began monitoring DSH facilities in early 2016, reports of alleged sexual assaults were the largest single category of incident that the OLES received for a reporting period. The 147 alleged sexual assault incidents reported from January 1, 2017, through June 30, 2017, accounted for 27.7 percent of all DSH incident reports. But only 16.3 percent of the alleged sexual assaults, or 24 incidents out of the 147, met the OLES criteria for investigation, monitoring and/or research into systemic department issues. As shown in the chart on the next page, the DSH-Patton hospital had the most reports – 38 - and accounted for 25.8 percent of all alleged sexual assault incident reports in the period.

The largest segment of alleged sexual assaults -- 54 of the total 147 -- involved allegations of patients assaulting other patients. The chart on the next page shows three DSH facilities – Patton, Atascadero and Metropolitan – together accounted for 74.1 percent of these patient-assaulting-another-patient incident reports.

The second largest segment of alleged sexual assaults – 32.0 percent - was defined by the OLES as “unknown” because allegations made by patients did not implicate DSH employees or contactors. This “unknown” category included allegations that implicated family or friends in incidents that occurred when patients were not in a DSH facility. In addition, this category included allegations made by patients that sexual assaults may have occurred but they were unsure if another person was involved.

Reports of non-law enforcement hospital employees allegedly sexually assaulting patients accounted for 23.1 percent of all the reports, while law enforcement personnel were alleged to be involved in fewer than 10 percent of the incidents during the six-month period. All reports of alleged sexual assaults that the OLES received during the reporting period are shown in the chart below. It is important to note that the OLES takes every allegation seriously and closely reviews every case per the statutes.

### All Reported DSH Sexual Assault Allegations

Facility	Patient on Patient Incidents	Unknown* on Patient Incidents	Non-Law Enforcement Staff on Patient Incidents	Law Enforcement on Patient Incidents	Totals
DSH-Patton	20	8	10	0	38
DSH-Atascadero	10	14	5	0	29
DSH-Metropolitan	10	8	5	1	24
DSH-Napa	8	7	3	0	18
DSH-Vacaville	1	5	1	9	16
DSH-Coalinga	5	2	4	2	13
DSH-Stockton	0	2	5	0	7
DSH-Salinas Valley	0	1	1	0	2
<b>Totals</b>	54	47	34	12	147

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

### DSH patient deaths this period

There were 24 patient deaths – of 23 men and one woman – reported to the OLES at five DSH facilities during the first half of 2017. This number is down 25.0 percent from the 32 deaths reported in the same January through June period in 2016. Ages in the 2017 period ranged from 25 to 85, with 61 the average age of the deceased. The reported causes of death are shown in the chart below.

### Reported Causes of Death of DSH Patients

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

<b>DSH-Patton</b>	0	1	0	0	3	4
<b>DSH-Atascadero</b>	1	1	0	0	0	2
<b>Totals</b>	11	5	2	1	5	24

\* Other deaths were those that were not accounted for in the top four categories. These included a death attributed to sepsis, another attributed to suicide, a death that followed a patient-on-patient fight and others awaiting coroner reports.

Just over 70 percent of the DSH deaths were classified by facility medical directors or coroners as “expected”<sup>8</sup> due to underlying health conditions, such as cancer and kidney disease. Seven other deaths were classified as “unexpected,” and each of these deaths received two levels of reviews within DSH, per department policy. The OLES also reviewed the deaths and monitored the departmental investigations into the unexpected deaths at DSH. One of the unexpected deaths was a suspected homicide and the suspect is pending prosecution by the district attorney. A second was a suicide. A third was due to dilated cardiomyopathy due to hypertensive cardiovascular disease. A fourth death was due to unknown causes and is pending an autopsy report. The OLES continues to monitor all four of these cases. The remaining three deaths were due to a subdural hematoma after the patient fell, Huntington’s disease, and chronic obstructive pulmonary disease. The OLES closed these cases after it was determined that no staff misconduct was identified.

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<sup>8</sup> Per department policy, medical directors at DSH facilities made the determination of whether a death was “expected” or “unexpected.” The department also requires staff to follow DSH policy for standardized death investigations and “mortality reviews.”

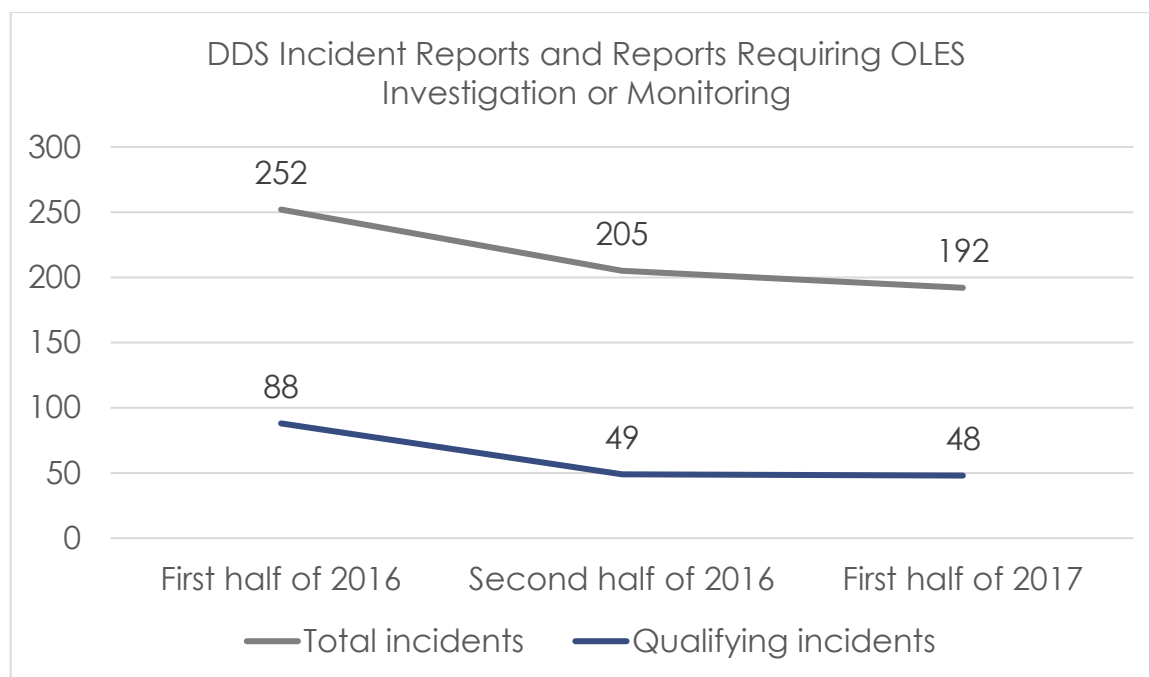
# DDS Incidents

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

## Decline in reported DDS incidents this period

Overall, the number of DDS incidents reported in the period declined 23.8 percent, from 252 in the first half of 2016 to 192 in the first half of 2017. Abuse allegations, head/neck injuries, neglect allegations and death reports all decreased at DDS.

Of the 192 reported DDS incidents in the first half of 2017, only 25.0 percent, or 48 incidents, met the criteria for OLES investigation or monitoring or led to OLES research into a systemic departmental issue. As the graph shows, the first half of 2017 marked the third straight reporting period where the number of DDS incidents reported to the OLES and the number of incidents qualifying for OLES action decreased. It should be noted that the DDS population also declined during each period.



## Most frequent DDS incidents this period

Alleged abuse was the most frequent DDS incident reported in the first half of 2017. The 76 abuse allegations from January through June 2017 accounted for 39.6 percent of all DDS incidents received in the period. The 76 reports, however, were down 36.7 percent from the 120 abuse incidents reported in the same period in 2016. While "abuse" was how certain incidents were described when they arrived at the OLES, the determination of whether each incident met the threshold for the OLES's purposes of investigation and/or monitoring was based on the statutory

definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63.<sup>9</sup> At the OLES, it is critical that every incident reported by patients and residents be given a thorough and objective review. At DDS, reports of head and/or neck injuries constituted the second most frequent incident received by the OLES. The OLES required notification of all head/neck injuries from DDS that required treatment beyond first aid because such injuries can cause lasting health impairment or lead to death and may be indicative of assault, battery or neglect. The 26 reported injuries in the first half of 2017 were a 31.6 percent drop from the head/neck injury reports received in the year-earlier period. Only one 2017 incident met the OLES criteria for further action.

Broken bone reports during the January 1, 2017, through June 30, 2017, reporting period accounted for the third most frequent incidents at DDS and were on par with the first half of 2016. Information on all the incident reports is in the chart below.

### **All Reported DDS Incidents**

<b>Incident Categories</b>	<b>Number Reported Jan. 1- June 30, 2017</b>	<b>Number Reported Jan. 1- June 30, 2016</b>	<b>Change</b>	<b>Number Meeting OLES Criteria Jan. 1-June 30, 2017</b>	<b>Number Meeting OLES Criteria Jan. 1-June 30, 2016</b>
<b>Abuse</b>	76	120	-36.7%	30	55
<b>Head/Neck Injury</b>	26	38	-31.6%	1	3
<b>Broken Bone</b>	23	24	-4.2%	3	8
<b>Sexual Assault</b>	22	9	+144.4%	7	2
<b>Death</b>	17	20	-15.0%	3	4

<sup>9</sup> Welfare and Institutions Code section 15610.63, states, in pertinent part: “Physical abuse” means any of the following: (a) Assault, as defined in Section 240 of the Penal Code. (b) Battery, as defined in Section 242 of the Penal Code. (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code. (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water. (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code. (2) Rape, as defined in Section 261 of the Penal Code. (3) Rape in concert, as described in Section 264.1 of the Penal Code. (4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code. (6) Sodomy, as defined in Section 286 of the Penal Code. (7) Oral copulation, as defined in Section 288a of the Penal Code. (8) Sexual penetration, as defined in Section 289 of the Penal Code. (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code. (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment. (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given. (3) For any purpose not authorized by the physician and surgeon.



<b>Genital Injury</b>	11	4	+175.0%	0	1
<b>Neglect</b>	6	18	-72.2%	2	12
<b>Significant Interest – Other*</b>	5	1	+400.0%	1	0
<b>AWOL</b>	3	4	-25.0%	1	0
<b>Misconduct**</b>	2	3	See note	0	1
<b>Attempted Suicide</b>	1	1	0%	0	0
<b>Use of Force**</b>	NA	3	See note	NA	0
<b>Law Enforcement**</b>	NA	1	See note	NA	1
<b>Burn</b>	0	3	-300.0%	0	0
<b>Attack on Staff</b>	0	1	-100.0%	0	0
<b>Non-Resident Assault</b>	0	1	-100.0%	0	0
<b>Professional Board Violation***</b>	NA	1	See note	NA	1
<b>Totals</b>	192	252	-23.8%	48	88

\* Any incident of significant interest to the public, e.g., escapes, “AWOL,” commission of serious crimes by a resident or patient off facility grounds, attempted suicide (requiring treatment beyond first aid), etc.

\*\* To more clearly present all reports of alleged misconduct, the OLES eliminated two categories from the year-earlier period – “law enforcement” and “use of force” – and included these incidents in other categories including the general “misconduct” category. Three of the incidents reported in the first half of 2016 under “law enforcement” and “use of force” would now be categorized as “misconduct.” As a result, the two misconduct incident reports in the first half of 2017 compare with six misconduct incident reports in the first half of 2016. The result is a 66.6 percent decline in overall law enforcement misconduct incident reports at DDS in 2017 from a year earlier.

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

## Distribution of DDS incidents this period

The 192 DDS incidents reported from January through June 2017 accounted for 26.6 percent of all reports the OLES received. Overall, the 192 reports were down 23.8 percent from the 252 received in the same period a year earlier. The rate of incidents per 100 residents at DDS also declined.

As shown in the chart below, the DDS facility in Porterville, which had the most

residents, had the most incident reports – 66 -- from January 1, 2017, through June 30, 2017. But this was a decrease of 15.4 percent from the 78 incidents reported during the year-ago period. The DDS Fairview facility in Costa Mesa and the Sonoma Developmental Center each reported 51 incidents in the period, which was a decrease for each facility compared with the same period in 2016.

**All Reported DDS Incidents By Facility**

<i>Facility</i>	<i>Number of Residents*</i>	<i>Incidents Reported Jan. 1-June 30, 2017</i>	<i>Incidents Per 100 Residents Jan. 1-June 30, 2017</i>	<i>Incidents Per 100 Residents Jan. 1-June 30, 2016</i>
<b>Porterville</b>	321	66	20.56	22.35
<b>Fairview</b>	166	51	30.72	34.91
<b>Sonoma</b>	260	51	19.62	16.11
<b>Canyon Springs</b>	48	24	50.00	74.47
<b>Totals</b>	795	192	24.15	25.51

\* The DDS provided population numbers as of June 30, 2017. Porterville included general treatment area and Secure Treatment Program

**DDS sexual assault allegations this period**

The OLES received 22 incident reports alleging sexual assault at DDS during the first half of 2017, which amounted to 11.5 percent of all incident reports at the department. Half of the sexual assault reports alleged DDS staff members assaulted residents. Allegations that residents sexually assaulted other residents accounted for eight of the 22 sexual assault incident reports, or 36.4 percent. The OLES categorized the remaining three reported incidents as “unknown” because the allegations made by residents did not implicate DDS employees or contractors. The OLES included in this category allegations made by residents that sexual assaults may have occurred but they were unsure if another person was involved. None of the allegations involved law enforcement personnel

**All Reported DDS Sexual Assault Incidents**

<i>Facility</i>	<i>Non-Law Enforcement Staff on Resident Incidents</i>	<i>Resident on Resident Incidents</i>	<i>Unknown* on Resident Incidents</i>	<i>Totals</i>
<b>Canyon Springs</b>	5	4	0	9
<b>Porterville</b>	3	2	2	7
<b>Fairview</b>	2	2	0	4
<b>Sonoma</b>	1	0	1	2
<b>Totals</b>	11	8	3	22

\* The OLES defined “unknown” sexual assaults as assaults that did not implicate DDS employees or contractors or where residents said they were unsure if another person was involved.

## DDS resident deaths this period

There were 17 DDS residents who died at four facilities, according to reports that the OLES received during the first six months of 2017. This compared with 20 deaths in the same period a year earlier. Fourteen of the deceased in 2017 were men and three were women. Ages of the deceased ranged from 33 to 88, with 63 being the average age.

All but one of the deaths at DDS were classified by the department as “expected” due to underlying health conditions such as cancer and kidney failure. The OLES reviewed all deaths that were reported and monitored the investigation into the one DDS death that was classified as “unexpected.” This unexpected death was determined to be due to pneumonia and sepsis and no staff misconduct was identified. The chart below shows the reported causes of death of the residents.

### Reported Causes of Death of DDS Residents

Facility	Cardiac/Respiratory	Cancer	Renal/Bowel	Sepsis	Totals
Sonoma	6	0	2	3	11
Fairview	1	2	0	1	4
Porterville	1	0	0	0	1
Canyon Springs	0	1	0	0	1
Totals	8	3	2	4	17

# Notification of Incidents

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

## **Priority 1 Threshold Incidents**

<b>PRIORITY 1 NOTIFICATIONS- 2-HOUR NOTIFICATION</b>
<ul style="list-style-type: none"><li>• Any death of a resident or patient</li><li>• Any allegation of sexual of a resident or patient</li><li>• An assault with a deadly weapon or an assault with force likely to produce great bodily injury to a resident or patient</li><li>• Any report of physical abuse of a resident or patient implicating a staff member</li><li>• Any injury to the genitals of a resident or patient when the cause of injury is undetermined</li><li>• A broken bone of a resident or patient</li><li>• Any use of deadly force by staff</li></ul>

## **Priority 2 Threshold Incidents**

<b>PRIORITY 2 NOTIFICATIONS- 1-DAY NOTIFICATION</b>
<ul style="list-style-type: none"><li>• A pregnancy involving a resident or patient</li><li>• Any injury to the head or neck of a resident requiring treatment beyond first aid</li><li>• Any burns of a resident or patient, regardless of whether the cause is known</li><li>• Any incident of significant interest to the public including, but not limited to, "AWOL", suicide attempt requiring treatment beyond first aid, commission of serious crimes by a resident or patient, riot and any incident which may potentially draw media attention</li><li>• Any incident involving a staff member requiring notification to professional licensing or certification boards</li><li>• Any allegations of peace officer misconduct, whether on-duty or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties</li><li>• Any staff action or inaction that resulted in, or reasonably could have</li></ul>

resulted in, a resident or patient injury requiring treatment beyond first aid or a resident or patient death

## Timeliness of notifications this period

In the first half of 2017, both DSH and DDS continued to improve the timeliness<sup>10</sup> of their notifications of incidents to the OLES. The DDS achieved the greatest improvement, going from a department-wide 78.6 percent rate of timely notifications in the first six months of 2016 to an overall 97.9 percent in the first half of 2017. At one DDS facility – the Fairview Developmental Center – every incident that was reported to the OLES in 2017 was timely. The DSH timeliness rating also improved, from 73.5 percent in the first half of 2016 to 92.8 percent in the first six months of 2017.

### Timely Notifications at DSH – Jan. 1-June 30, 2017

Rank	DSH Facility	Number of Patients*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	DSH-Vacaville	357	32	31	96.9%
2	DSH-Atascadero	1,171	72	69	95.8%
3	DSH-Patton	1,552	103	97	94.2%
4	DSH-Metropolitan	816	111	103	92.8%
5	DSH-Napa	1,269	57	53	93.0%
6	DSH-Coalinga	1,293	117	107	91.5%
7	DSH-Stockton	460	28	24	85.7%
8	DSH-Salinas	218	10	8	80.0%
	DSH Totals	7,136	530	492	92.8%

\* The department provided population numbers as of June 30, 2017.

### Timely Notifications at DDS – Jan. 1– June 30

Rank	DDS Facility	Number of Residents*	Number of Incidents Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Fairview	166	51	51	100%
2	Sonoma	260	51	50	98.0%

<sup>10</sup> Whenever it was reasonably believed that employee misconduct may have occurred, it was the responsibility of the hiring authority (department facility) to report the conduct in a timely manner, per the notification schedules on this and the previous page, to the OLES for investigation or monitoring. Each reported incident was reviewed by the OLES during a daily intake meeting where it was determined if the report was timely and contained adequate information.

<b>3</b>	Porterville**	321	66	64	97.0%
<b>4</b>	Canyon Springs	48	24	23	95.8%
	DDS Totals	795	192	188	97.9%

\* The department provided population numbers as of June 30, 2017. Porterville included general treatment area and Secure Treatment Program.

### **A comparison and analysis of DSH vs. DDS allegations**

After publication of the OLES 2016-2 SAR, the differences between the number of allegations reported by DSH and DDS were questioned, especially when the per capita rate was considered. For example, during the last SAR period, July 1, 2016 through December 31, 2016, DSH patients reported 164 allegations of abuse. At the close of that SAR period, the DSH population was 7,070 patients. This equates to 2.3 percent of the population on average, reporting an allegation of abuse. For the same time period, the DDS resident population was 921, and reported 91 allegations of abuse. DDS residents overall, were over 4 times more likely to make allegations. Specifically, 9.9 percent of the population on average made an allegation of abuse against staff.

During this SAR period, January through June 2017, the DSH population was 7,136 and patients made 121 allegations of abuse (1.6 percent) compared to the DDS population of 795 and 76 allegations of abuse (9.5 percent). Further analysis shows of the 121 allegations at DSH, there were just two patients with more than two allegations of abuse. Conversely, at DDS there were 72 unsubstantiated complaints in the same period, and 58 percent of these allegations of abuse were made by 13 individuals.

The OLES asked DDS management to research the issue and prepare a probable explanation for the disparity. The DDS provided the following likely reasons for the differences in the per capita rate of allegations between DSH patients and DDS residents, which are presented verbatim from DDS:\*

The reporting practice of the Developmental Centers Division (DCD) is intended to exceed the requirement of Welfare and Institutions Code 15610 (b) (1). The W&I Code requires the reporting of an incident that reasonably appears to be physical abuse. When an incident of mistreatment is reported by a resident, DCD documents all such incidents as an allegation of abuse – regardless of the reliability of the allegation. Examples: An allegation of assault by a public official who was known to not be present; an individual who alleged being shot in the head, with no apparent physical evidence.

Some individuals admitted to Developmental Centers have severe behavioral or psychiatric conditions and may have histories of making untrue statements. Of the 72 complaints noted in the January to July 2017 reporting period, 58 percent of the allegations were made by 13 individuals.

**Unsubstantiated Allegations at DDS This Period Attributed to Behavioral/Psychiatric Conditions**

<b>Type of Condition</b>	<b>Number</b>
Attempt to Gain or Avoid an Outcome	51
Cognitive Impairment	3
Relationship Related	5
Psychiatric/mood disorder	9
Substance use/seeking	3
Post Traumatic Stress related	1
<b>Total</b>	<b>72</b>

Interdisciplinary teams develop Individual Program Plans and Behavior Support Plans to assist individuals in building their capacities and capabilities. Plans include interventions with training steps, such as training the individual to communicate wants and needs appropriately and promote healthy social interaction with others. At each facility, there are various programs and strategies to further assist in addressing the root cause for these types of behaviors. These programs build social skills as well as elicit positive resolution to conflicts between parties.

Interdisciplinary teams work to identify different reasons why individuals make untrue statements, including completing a functional behavioral assessment by a behavior specialist or psychologist to determine the function of behavior.

Examples of the function of these behaviors include:

- Attempt to gain or avoid an outcome -- Individuals make false reports to deflect responsibility for action or divert attention in order to control or avoid a situation. Examples include not being able to gain or obtain what they want in a timeframe satisfactory to the person, making an allegation against a staff member to get them replaced with a preferred staff member or to seek attention from facility staff.
- Cognitive impairment -- Some individuals' cognitive impairment result in them misunderstanding or misinterpreting situations, such as names, places or orientation to time.
- Relationship related -- Individuals become frustrated or anxious with a conversation or interaction with a family member or peer and make an allegation against staff about themselves or about another person.
- Psychiatric and mood disorder -- Active psychiatric or neuropsychiatric disorder that results in individuals perceiving situations inaccurately. They may be predisposed to believing and making repeated, frequent or stereotyped statements.
- Substance use/seeking -- People who have severe substance dependency (for example drug-seeking behavior) but do not have ready access to the substance become frustrated and make false reports.
- Post-traumatic stress related -- Historical events or experiences, particularly involving trauma or abuse, can contribute to an individual's behavior of

making false reports.

\* The OLES had not independently verified this DDS information.

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

These investigations also are required by the California Welfare and Institutions Code Section 15630 which mandates that DSH and DDS facility law enforcement investigate and notify local law enforcement of allegations of abuse and neglect in state mental hospitals and developmental centers. Likewise, the OLES is mandated by the Welfare and Institutions Code Section 4023.6 et. seq. to monitor all DSH and DDS investigations into allegations of physical and sexual abuse in which a staff member who is not a law enforcement officer is implicated. When a DSH or DDS law enforcement officer is implicated, the OLES is required to conduct the investigation, per the statute.



# Intake

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All incidents received by the OLES during the six-month period were reviewed at a daily intake meeting by a panel of assigned OLES staff members. Based on statutory requirements, the panel determined whether allegations against law enforcement officers warranted an internal affairs investigation by the OLES. If the allegations were against other DSH or DDS staff members and not law enforcement, the panel determined whether the allegations warranted OLES monitoring of the departmental investigation. A flowchart of all the possible OLES outcomes from intake is shown in Appendix G.

## Rejections

In the first half of 2017 reporting period, 520 of the total 722 DSH and DDS incidents that the OLES received were rejected because they did not meet the criteria for the OLES to undertake investigation and/or monitoring. This amounted to 72.0 percent of all the incidents that were reported to the OLES. To ensure the OLES is independently assessing whether an allegation meets its criteria, the OLES requires the departments to broadly report misconduct allegations. It is best practice of an oversight entity to independently determine if an allegation meets its criteria. By analyzing a wide range of allegations, the OLES was able to discover three systemic issues at DSH and one systemic issue at DDS that have been addressed with the departments through monitored issues.

The DSH accounted for 376 of the 520 rejected incidents, or 72.3 percent of the total rejected incidents. Sexual assault allegations were the single largest DSH category where reported incidents did not meet the OLES criteria; therefore, the vast majority of these sexual assault cases – 123 out of 147 – were rejected. The DDS component of the total 520 rejected incidents during the six-month period totaled 144. This amounted to 27.7 percent of all rejected incidents. Abuse allegations accounted for nearly a third of the 144 DDS rejected incidents.

Every incident that was rejected by the OLES received a preliminary review – an extra step to ensure that incidents that initially appeared to not fit the criteria<sup>11</sup> for OLES involvement were being properly rejected. Sometimes, allegations were unclear, and additional information needed to be obtained to finalize an initial intake decision, which could involve significant delays. As an example, an alleged abuse case could require the OLES to review video files or digital recordings of a particular hallway, day room or staff area where a patient or resident was located. It could take time for the OLES to get the recordings from a facility and view them. Once the additional material/information was obtained and scrutinized by the OLES staff, the decision to initially reject an incident for not meeting the OLES criteria was reviewed again and could be reversed. The charts on the next page show the

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<sup>11</sup> Welfare and Institutions Code Section 4023.6 et. seq. (See Appendix F).

outcomes of all incidents the OLES received in the January 1, 2017, through June 30, 2017, reporting period.

**Disposition of DSH Cases**

<b>OLES Categories</b>	<b>Jan. 1 – June 30, 2017 Number</b>	<b>Percentage of Reported Incidents</b>	<b>Jan. 1-June 30, 2016 Number</b>	<b>Percentage of Reported Incidents</b>
<b>Rejected</b>	329	61.7%	381	65.9%
<b>Monitored, Administrative</b>	38	7.1%	117	20.2%
<b>Monitored, Criminal</b>	82	15.4%	45	7.8%
<b>OLES Investigations, Administrative</b>	9	1.7%	21	3.6%
<b>Monitored Issues*</b>	3	0.6%	8	1.4%
<b>OLES Investigations, Criminal</b>	25	4.7%	6	1.0%
<b>Outside Jurisdiction**</b>	47	8.8%	NA	NA
<b>Totals</b>	533	100%	578	100%

**Disposition of DDS Cases**

<b>OLES Categories</b>	<b>Jan. 1 – June 30, 2017 Number</b>	<b>Percentage of Reported Incidents</b>	<b>Jan. 1-June 30, 2016 Number</b>	<b>Percentage of Reported Incidents</b>
<b>Rejected</b>	144	74.6%	164	65.1%
<b>Monitored, Administrative</b>	6	3.1%	46	18.3%
<b>Monitored, Criminal</b>	41	21.2%	38	15.1%
<b>Monitored Issues*</b>	1	0.5%	3	1.2%
<b>OLES Investigations, Administrative</b>	0	0%	1	0.4%
<b>OLES Investigations, Criminal</b>	0	0%	0	0%
<b>Outside Jurisdiction**</b>	1	0.5%	NA	NA
<b>Totals</b>	193	100%	252	100%

\* Monitored issues are general concerns under review by the OLES and are not

reported incidents.

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

# Investigations and Monitoring

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

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

## OLES-conducted investigations

During the January through June 2017 period, the OLES completed 43 investigations – 22 were criminal cases and 21 were administrative. All were at DSH. Twenty-one investigations involved incidents that occurred in 2017. Another 22 investigations involved incidents in 2016.

An investigation conducted by the OLES is just the start of the process. If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, the OLES submits the investigation to a prosecuting agency. During the first half of 2017, one criminal case from OLES investigators was referred to a prosecuting agency, and the agency declined to prosecute.

All completed OLES investigations into administrative wrongdoing/misconduct are forwarded to facility management for review. In the January through June 2017 period, 13 administrative cases were referred to management for possible discipline of state employees, and eight cases were closed for lack of evidence. If the facility management imposes discipline, the OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if necessary.

The chart on the next page shows the results of all the completed OLES

investigations in the reporting period. These investigations are in Appendix A along with two other cases that were deferred. One of the incidents needing OLES investigation occurred in June 2017 shortly before the DSH facility – a psychiatric center on the grounds of a CDCR prison – was transferred to the authority of CDCR. Thus, the OLES forwarded the information to CDCR. In the other case, the OLES learned DSH had conducted and completed an unauthorized investigation into allegations against a facility police officer, thereby precluding the OLES from doing the investigation. The OLES did monitor the investigation and ultimately concurred with the recommended findings. DSH has put steps in place to ensure this does not occur in the future.

### **Results of Completed OLES Investigations – All at DSH**

<b>Type of Investigation</b>	<b>Total completed Jan. 1- June 30, 2017</b>	<b>Referred to prosecuting agency</b>	<b>Referred to facility management</b>	<b>Closed without referral*</b>
<b>Criminal</b>	22	1	-	21
<b>Administrative</b>	21	-	13	8
<b>Totals</b>	43	1	13	29

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

### **OLES-monitored departmental investigations**

In this report, the OLES provides information on the 231 monitored cases that, by June 30, 2017, had reached resolution. Just over half of these cases - 57.6 percent or 133 of the 231 total – involved allegations of administrative misconduct by departmental staff, such as failing to maintain one-on-one supervision, as required, for a patient. The results are summarized in the chart below, and synopses of the cases are in Appendices B, C and D.

### **Results of Completed Monitored Cases at DSH and DDS**

<b>Type of Case/Result</b>	<b>DSH</b>	<b>DDS</b>	<b>Totals</b>
<b>Criminal/Not Referred</b>	50	41	91
<b>Criminal/Referred to Prosecuting Agency</b>	4	3	7
<b>Total Criminal</b>	54	44	98
<b>Administrative/Without Sustained Allegations</b>	82	12	94
<b>Administrative/With Sustained Allegations</b>	33	6	39
<b>Total Administrative</b>	115	18	133
<b>Grand Totals</b>	169	62	231

In the January through June 2017 period, 39 of the 133 DSH and DDS monitored administrative investigations, or 29.3 percent, were sustained, meaning sufficient evidence was found to exist for discipline to be considered. This compares with 12 of 54 monitored cases at the departments, or 22.2 percent, in the first half of 2016. In addition, seven of the 98 criminal investigations that the OLES monitored, or 7.1

percent, were referred to prosecuting agencies in the first half of 2017. This compares with one out of 16 monitored criminal investigations, or 6.2 percent, a year earlier.

The OLES provides assessments of the completed monitored cases. At DSH, 78 of the departmental investigations, also known as pre-discipline phase cases, were deemed insufficient by the OLES – 74 were procedurally insufficient and four were procedurally as well as substantively insufficient.

Procedural sufficiency assesses the notifications to the OLES, consultations with the OLES and investigation activities for timeliness. Substantive sufficiency assesses the quality, adequacy and thoroughness of the investigative interviews and reports. At DDS, 13 of the departmental investigations, also known as pre-discipline phase cases, were assessed as insufficient by the OLES– 10 were procedurally insufficient, one was substantively insufficient and two were insufficient both procedurally and substantively.

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

## **Monitoring the discipline phase**

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

Appendix C provides assessments of 20 discipline phase-only cases monitored by the OLES that reached resolution during the reporting period. Sixteen of these 20 cases were at DSH and four were at DDS. The OLES assesses every discipline phase case for both procedural and substantive sufficiency. At DSH, five of the discipline phase cases were deemed insufficient by the OLES, and all five were procedurally insufficient. Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion. At DDS, each of the four discipline cases was assessed as insufficient. Three were procedurally insufficient and one was both procedurally and substantively insufficient. Substantive sufficiency assesses the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges

and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

## **Update on the discipline phase**

Since 2015, the OLES has recommended to both DSH and DDS that they implement comprehensive disciplinary policies to ensure that all DSH hospitals and DDS operated developmental centers have the same assessment of the quality of investigations and that the imposition of discipline is consistent and equitable. Specifically, the OLES advocated for the creation of a comprehensive disciplinary policy that would provide a framework for decision making in three major areas: 1) Determining whether allegations of misconduct should be sustained; 2) Instituting a flexible penalty matrix that adjusts for aggravating and mitigating circumstances, and 3) Establishing a collaborative process that allows for a higher level of review when a consensus on discipline cannot be reached at lower levels of the department.

The DSH has made significant efforts to create a comprehensive disciplinary policy. First, in 2016, DSH issued an Administrative Letter that established a process on how to proceed to a higher level of review when there is a lack of consensus among the stakeholders over the outcome of an investigation. Second, in May 2017, DSH presented the OLES with a working draft of their Objective Disciplinary Tool. The stated aim of the Objective Disciplinary Tool is to promote consistency, uniformity and fairness in employee discipline, and identifies penalty levels and aggravating and mitigating factors for hiring authorities to consider when imposing discipline. The draft Objective Disciplinary Tool is a strong step forward toward developing a comprehensive disciplinary policy. The OLES has made several recommendations to DSH, specifically, that they identify categories of employee misconduct and assign each category of misconduct to a penalty range level. This step is essential to ensuring consistency within each DSH facility and across facilities statewide because it provides hiring authorities with a starting point for the penalty analysis. The OLES presented these recommendations to DSH in June 2017, and are encouraged that DSH is open to making additional adjustments to the Objective Disciplinary Tool.

Recently, DDS provided the OLES with a draft policy memorandum that outlines the relationship between the OLES monitors and DDS personnel in the investigation of employee misconduct and throughout the disciplinary process. Although the draft policy is a good starting point, it does not include guidelines for hiring authorities to assist them in making decisions on allegations and the imposition of penalties. The OLES is nonetheless hopeful that once the DSH disciplinary policy is finalized, DDS will adopt that policy, as it is imperative that the disciplinary process throughout DDS is consistent, uniform and fair.

## **Perspective on departments imposing discipline**

Neither department processes or serves disciplinary actions on employees in a

consistent and timely manner. Neither DSH nor DDS has a policy or procedure that establishes a standard of when to serve a disciplinary action after the hiring authority has made a decision to impose discipline. The only operative limits are the California Government Code's one- and three-year statutes of limitations for peace officers and non-sworn employees, respectively.<sup>12</sup>

Delays in serving disciplinary actions are detrimental to the employee, unnecessarily defer discipline or prosecution and in many cases may ultimately have the effect of weakening a case's evidentiary posture. The best practice is to have uniform policies and procedures, which delineate the departments' disciplinary timelines and expectations for service of disciplinary actions. The OLES recommends that disciplinary actions be served on employees within 60 days of the decision to take disciplinary action.

The OLES reviewed the time it took the departments to serve 31 disciplinary actions. Most of the cases analyzed were those that were in the disciplinary phase in this Semi-Annual report as well as cases that were previously pre-disciplinary phase cases where the decision was made to impose discipline and the actions had not yet been served.

Of the 11 cases reviewed at DDS, six disciplinary actions were served on employees between 36 and 286 days after facility management made its disciplinary determinations. The average length of time to serve an action was 213 calendar days. However, Canyon Springs served an action in 36 days. Without this case, the average at DDS was 248 days.

The remaining five cases at DDS had been pending service of disciplinary action for up to 409 days. Sonoma had two cases that were pending for 269 and 180 days, respectively. Fairview had one case that had been pending service of the action for 409 days and Porterville had one case that has been pending for 85 days.

One Sonoma case typified the seriousness of the issue. The case involved neglect of a client by a psychiatric technician, which caused serious harm to the client. It took Sonoma management 286 days to serve the disciplinary action where the penalty was dismissal. A case from Fairview was particularly concerning. On May 17, 2016, the hiring authority sustained allegations that a psychiatric technician failed to properly monitor a client who was on a direct observation level of supervision during the evening shift and where the resident swallowed a mobile phone battery. The hiring authority determined the penalty should be a two-day suspension without pay. As of June 30, 2017, the disciplinary action had not been served on the employee, amounting to a delay of 409 days.

In this reporting period, DDS dedicated an attorney to write and process disciplinary

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<sup>12</sup> California Government Code Section 3304; see also California Government Code Section 19635.



actions. The OLES will continue to monitor and report on the effectiveness of this effort to expedite service of disciplinary actions.

At DSH, 15 of the 20 disciplinary actions had been served on employees between six and 264 days after the hiring authority made disciplinary determinations. The average length of time to serve an action was 118 days. Notably, Napa State Hospital had four disciplinary actions and the average time to serve them was 45 days. Coalinga served three disciplinary actions in 154, 214, and 216 days. Metropolitan, Patton, and Atascadero each had one disciplinary action which were served in 264, 148, and 111 days, respectively. The five remaining disciplinary actions were served at the psychiatric facilities co-located with California Department of Corrections that the OLES no longer monitors. As of June 30, 2017, there were five disciplinary actions that had been pending service for between 14 and 284 days.

The Coalinga State Hospital case that took 216 days to serve the employee involved a notice of dismissal. The employee was a food service technician who kissed and engaged in an inappropriate relationship with a patient. In this case, where the hiring authority sustained serious allegations against the employee who posed a threat to hospital security and to the patient, there should have been some imperative to expedite the disciplinary process.

The OLES recommends that the departments identify the cause of the delays and develop timeliness standards for the service of disciplinary actions. A standard of 60 days from the date of the disposition and penalty conference to the date of service would work to streamline and expedite the disciplinary process. If the hiring authority has sustained allegations of misconduct and decided on discipline, it is incumbent on the departments to serve the disciplinary action in a timely manner. The OLES has been working with DDS and DSH to increase the efficiency of serving disciplinary actions. The OLES will continue to monitor and report on these efforts.

# Additional Mandated Data

The OLES is required by statute to put into its semi-annual reports specific data about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where patients or resident clients are the perpetrators. All the mandated data for the first six months of 2017 came directly from DSH and DDS and are presented in the following tables.

## DSH Mandated Data – Adverse Actions Against Employees

DSH Facilities	Formal administrative investigations/actions completed*	Adverse action taken (Formal investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/retired pending adverse action****
DSH-Atascadero	28	1	25	1	1
DSH-Coalinga	54	4	25	23	2
DSH-Metropolitan	74	8	63	3	0
DSH-Napa	24	5	19	0	0
DSH-Patton	55	1	46	6	2
DSH-Salinas Valley	10	1	8	0	1
DSH-Stockton	22	1	20	1	0
DSH-Vacaville	13	7	6	0	0
<b>Totals</b>	<b>280</b>	<b>28</b>	<b>212</b>	<b>34</b>	<b>6</b>

## DDS Mandated Data – Adverse Actions Against Employees

DDS Facilities	Administrative investigations completed*	Adverse action taken**	No adverse action taken***	Resigned/retired pending adverse action****
Fairview	18	3	15	0
Porterville	29	6	18	5
Sonoma	12	7	3	2
Canyon Springs	26	3	23	0
<b>Totals</b>	<b>85</b>	<b>19</b>	<b>59</b>	<b>7</b>

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

adverse action against an employee.

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

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

\*\*\*\* Resigned or retired pending 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 while DDS reports these as completed investigations.

### DSH Mandated Data – Criminal Cases Against Employees\*

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
DSH-Atascadero	7	0	7	0
DSH-Coalinga	0	0	0	0
DSH-Metropolitan	30	4	26	2
DSH-Napa	79	0	79	0
DSH-Patton	12	8	4	7
DSH-Salinas Valley	0	0	0	0
DSH-Stockton	0	0	0	0
DSH-Vacaville	0	0	0	0
<b>Totals</b>	<b>128</b>	<b>12</b>	<b>116</b>	<b>9</b>

### DDS Mandated Data – Criminal Cases Against Employees\*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Fairview	4	1	3	0
Porterville	13	0	10	3
Sonoma	1	0	0	1
Canyon Springs	15	0	15	0
<b>Totals</b>	<b>33</b>	<b>1</b>	<b>28</b>	<b>4</b>

\*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/Resident Criminal Cases\*

DSH Facilities	Total cases	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies*** *
DSH-Atascadero	302	171	131	119
DSH-Coalinga	292	109	183	22
DSH-Metropolitan	324	30	294	2
DSH-Napa	386	8	378	0
DSH-Patton	352	210	142	135
DSH-Salinas Valley	0	0	0	0
DSH-Stockton	0	0	0	0
DSH-Vacaville	0	0	0	0
<b>Totals</b>	1,656	528	1,128	278

### DDS Mandated Data – Patient/Resident Criminal Cases\*

DDS Facilities	Total Cases	Referred to prosecuting agencies**	Not Referred***	Rejected by prosecuting agencies****
Fairview	12	3	3	6
Porterville	26	12	6	8
Sonoma	5	0	5	0
Canyon Springs	4	0	4	0
<b>Totals</b>	47	15	18	14

\* Patient/resident criminal cases include criminal investigations involving patients or 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	Pharmacy	Public Health	Behavioral Science	Psychology
DSH-Atascadero	2	1	0	0	0	0	0
DSH-Coalinga	0	1	0	0	0	0	0
DSH-Metropolitan	0	2	0	0	0	0	0
DSH-Napa	1	1	0	0	0	0	0
DSH-Patton	0	0	0	0	0	0	0
DSH-Salinas Valley	0	0	0	0	0	0	0
DSH-Stockton	0	2	0	0	0	0	0
DSH-Vacaville	0	0	0	0	0	0	0
<b>Totals</b>	<b>3</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

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

DDS Facilities	Registered Nursing	Vocational Nursing	Medical Board	Pharmacy	Public Health
Fairview	0	0	0	0	13
Porterville	0	2	0	0	22
Sonoma	0	0	0	0	0
Canyon Springs	0	1	0	0	0
<b>Totals</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>35</b>

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

# Monitored Issues

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

From January 1, 2017, through June 30, 2017, the departments resolved four monitored issues. Three were at DSH and one was at DDS. The departments were assessed by the OLES as “sufficient” in how they addressed the matters. One issue was the need for a policy for proper cell extractions in compliance with regulations at the three psychiatric facilities that DSH had on CDCR prison grounds. Another issue was instituting the best practice of mandatory audio/video recording for all interviews conducted by law enforcement, which DDS readily put into policy. All four completed monitored issues are in Appendix E.

## Update on monitored issues

The OLES is encouraged by the resources and diligence that the departments have put into addressing monitored issues. It is worth noting that in the first 18 months that the OLES had been operating, the departments addressed 14 monitored issues. The OLES is reporting this period on the following six open monitored issues:

### **1. Physician Review Panel**

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

On June 24, 2016, a meeting was convened that included medical directors from each DSH facility, OLES leadership and monitors and OPS leadership to discuss interests and goals as well as the barriers to implementation and resources needed to establish a meaningful process. Over the last year, DSH clinicians have participated in several cases brought forward by the Chief of OLES, Chief of OPS and facility hiring authorities. DSH indicated this participation provided valuable experience and information that enabled them to fine-tune their consultative process and policy development. The DSH reported the draft

policy is currently in the formal policy approval stage but upon finalization, the policy will establish a process by which clinical consultation will be provided by DSH to the OPS, as well as the OLES. These DSH investigative support processes include consultation upon intake, informal clinical consultation during the investigative process, and/or formal consultation via the establishment of an independent Subject Matter Expert (SME) panel.

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

The consultant or the panel will review, discuss, and offer a written, professional opinion regarding the standards of clinical care addressed and identified in the investigation either being conducted by OPS or the OLES or an investigation being monitored by the OLES. As with the informal consultations, the consultant and the assigned panel members for a formal consultation shall not be assigned to the facility where the investigation is taking place, and if a designee is appointed, they shall be a senior-level clinician or have specialized knowledge in the area being reviewed. The SME consultant(s) may consult with the Chief of OLES or DSH Chief of Law Enforcement and may meet with OPS and/or the OLES investigator or OLES monitor as needed.

The DSH also agreed to assist DDS by providing access to their SME panel.

## **2. Cell Phones**

The OLES discussed with DSH the lack of statewide policies and procedures to prohibit DSH staff from having and using personal electronic devices at their workstations and screening staff and visitors, so they do not bring these devices into DSH facilities. These devices can distract staff, thereby compromise the care of residents, and even violate patient privacy.

DSH has formed a workgroup comprised of hospital executive directors to

develop a draft policy on the use of cell phones at hospital facilities. The draft policy is currently undergoing revision and will be sent to various leadership committees for review and input. Once the leadership committees vet the draft policy, it will be forwarded to the OLES to evaluate and provide input before DSH finalizes and implements the policy.

### **3. DSH patient pregnancies**

In keeping with the requirement that DSH and DDS notify the OLES of every pregnancy involving a DSH or DDS resident, DSH reported three pregnancies in 2016 and DDS reported none. All three pregnancies occurred at Patton and reportedly stemmed from relations among patients. The OLES assigned an attorney monitor to observe how DSH managed the discovery of the patient pregnancies.

The OLES also asked Napa, Metropolitan and Patton as well as DSH headquarters in Sacramento to provide their policies on patient pregnancies. After reviewing pregnancy data and the policies that were provided by the department and after monitoring the DSH process on the three 2016 pregnancies, the OLES determined that there was no statewide policy at DSH requiring that patient pregnancies be reported to facility law enforcement, no statewide policy governing the investigation of patient pregnancies by facility law enforcement, no statewide policy governing notification to county Child and Family Services, and no statewide policy for ensuring that patients who demonstrate sexual aggression and/or sexually harmful behavior are promptly removed from DSH co-ed housing units.

The OLES recommends that DSH:

1. Establish a statewide policy requiring that every pregnancy be reported to facility law enforcement.
2. Establish a statewide policy requiring that every pregnancy be investigated by law enforcement. Complete investigations should determine, among other things, whether there was any staff misconduct, whether threats, force or bribes were used for sex, whether the patients could understand the nature or condition of the act and thereby legally give consent and whether patients were disabled or medicated such that they could not legally give consent.
3. Coordinate with county Child and Family Services for placement of newborns.
4. Establish a statewide policy that ensures that patients with demonstrated sexual aggression and sexually harmful behavior are not in DSH coed units.

As of June 30, 2017, the OLES was informed that DSH had convened a workgroup of departmental social workers and DSH legal staff to draft a statewide policy on placement of children who are born to patients. The OLES also was informed that a second workgroup, of DSH clinical and legal staff, was developing statewide policies on patient sexual relations and the care and treatment of pregnant patients. The DSH advised the OLES that draft policies would be reviewed by leadership committees in the department and then shared with the OLES. The



OLES will report in subsequent Semi-Annual Reports on DSH's progress in implementing these safeguards as well as the OLES recommendations regarding the reporting and investigation of patient pregnancies on a statewide basis.

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

During an investigation involving a patient allegation of sexual abuse against staff, the OLES identified a systemic issue involving DSH employees who are accused of physical or sexual abuse of patients. At the Metropolitan hospital in Norwalk, the DSH policy allowed clinical staff to decide whether an employee who was accused of abuse by a patient could be reinstated to a patient-care position without consultation with facility law enforcement and before facility law enforcement completed an investigation of the abuse allegation. Best practice in law enforcement is to keep alleged perpetrators and alleged victims separate through the completion of the investigation if there is a reasonable belief that a crime was committed.

After discussion with the OLES, Metropolitan this year changed its process so clinical staff now consult with facility law enforcement when determining if an accused staff member can be returned to patient care, even if the law enforcement investigation has not yet concluded. But as of June 30, 2017, not all DSH facilities had made the change. The DSH is in the process of developing a statewide policy.

The OLES is aware that some DSH patients make false allegations, which can be a product of their mental illness. DSH must handle each case individually on its merits and ensure every allegation is thoroughly investigated and not dismissed or disregarded. To ensure that accused staff members are not prematurely returned to patient care, the OLES recommends that facility law enforcement be consulted in these situations at every facility. The DSH reports they are in the process of developing a state-wide policy. The OLES will report on DSH's progress in implementing this safeguard to their patients on a statewide basis.

#### **5. Recording of DSH, DDS investigatory interviews**

A monitored issue the OLES discussed with DSH and DDS pertains to the departments' use of portable audio/video recording devices for investigatory interviews. Policies in both departments give law enforcement employees access to portable recorders, either audio or video or both, for use during the performance of their duties. The OLES observed that investigators in the detectives unit and the Office of Special Investigations at DSH and DDS record most interviews conducted during their investigations. But police officers at DSH and DDS facilities were not consistently recording their investigatory interviews. The OLES recommends that departmental policy require mandatory recording of investigatory interviews by officers, as the benefits certainly outweigh any potential burden of recording the interviews.

The recording of interviews protects staff against allegations that a patient or

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

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

After discussion with the OLES, DDS implemented a policy that requires every law enforcement employee to possess a department-issued portable recorder, which they are to activate any time they believe it would be appropriate or valuable to record. Activation can occur during interviews about allegations or events that would require a Priority 1 notification to the OLES, Special Investigation Unit interviews when a prior allegation is recanted by the individual who made the allegation, or any other contact that escalates or becomes adversarial to the point of meeting the recording requirement. The DDS policy allows an exception in cases where the recording of the interview would make a resident anxious or uncomfortable or causes the resident to not participate in the interview or when the resident is non-verbal. In cases where officers or investigators do not record the interview, the reason for not recording the interview is to be documented in the report.

The DSH is in the process of evaluating issues pertaining to the mandatory recording of investigatory interviews by its officers. The DSH has drafted policy and is in the process of procuring the technology to fully implement the OLES recommendation.

#### **6. DSH extraction policy, training**

The OLES identified a systemic issue concerning room and area extractions during an investigation into an allegation of excessive force against a peace officer. As a result, the OLES requested DSH furnish all policies and procedures governing the use of force in room and area extractions. At times, it is necessary to remove a patient from his/her room when the patient is uncooperative and there is a potential of self-harm or harm to others. The OLES discovered that facility law enforcement may not be evaluating the circumstances of events to determine if exigency exists or if calculated intervention would be a better and a safer option to remove a patient from an area. The DSH does have a policy within its Use of Force Section that defines calculated interventions as "Instances

where time and circumstances permit a planned response to a pending or current conflict scenario involving a patient.” But there is no policy or procedure outlining how officers are to conduct a calculated intervention. Further, there is no policy defining exigent room/area extraction and how officers should proceed if the situation arises.

For investigatory purposes and documentation, it is best practice to videotape extractions if time allows to document what occurred. The incidents of room/area extractions that the OLES reviewed indicated facility law enforcement did not video record these incidents despite having ample time to do so. There is a DSH policy on videotaping room extractions. It is contained in a section reserved for the collection of biological samples from patients and does not appear to be adapted to a mental hospital environment since the content refers to “cell” extractions and DSH houses patients in rooms, rather than cells. The policy states “the extraction shall be video recorded, including audio.” The OLES also reviewed DSH training plans and learned facility law enforcement personnel are not taught techniques to perform a room/area extraction involving an uncooperative patient.

Best practice in law enforcement crisis intervention calls for law enforcement to de-escalate situations involving the mentally ill and seek alternatives to force if at all possible. Sometimes, this involves waiting out a situation and allowing a patient to “cool off.” However, when it is necessary to remove a patient from a room/area, facility law enforcement must have guidelines to assist in determining when a situation calls for an immediate exigent response or if a more planned calculated intervention is the better option.

The OLES recommends DSH develop and provide to the OLES for review a statewide policy regarding calculated and exigent room and area extractions. Exigent extractions should be defined as life or death events where a measured, calculated extraction would not be prudent. The OLES further recommends that the policy specify mandatory documented training for officers, the equipment they are to use, procedures they are to follow and the documentation they are to have when conducting extractions. Additionally, the OLES recommends DSH require all calculated extractions to be video recorded, with audio, and all extractions – calculated and exigent – be subject to documented administrative reviews.

The DSH had advised the OLES that it was developing policy, procedures and training to address concerns identified. The OLES will continue to monitor and report in subsequent Semi-Annual Reports on DSH’s progress in implementing these safeguards on a statewide basis.

# OLES Recommendations

As required by statute,<sup>13</sup> the OLES in March 2015 provided the Legislature with a report that described the challenges faced by DSH and DDS law enforcement and the OLES recommendations. Additionally, in the OLES reports to the Legislature released October 1, 2016, and March 1, 2017, the OLES updated the recommendations for best practices in law enforcement and employee discipline that the OLES made to the departments. Below are the 30 unfinished recommendations –16 at DSH and 14 at DDS –and their June 30, 2017, status as provided verbatim by DSH and DDS.

## DSH law enforcement organizational structure

OLES Recommendation of best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p style="text-align: center;"><b>A</b></p> <p>Legislation should be drafted and enacted to consolidate all DSH law enforcement under the department's chief of law enforcement. This would upgrade the chief from consultant to supervising manager, speed up standardization and centralize the fragmented law enforcement authority at DSH.</p>	<p>Not yet implemented. No legislation has been enacted to effect this change. DSH has implemented Policy Directive 8000 – DSH Law Enforcement Reporting Structure in December 1, 2015, which clarifies under the existing statute the structure, authority and responsibilities of the DSH Chief of Law Enforcement, Office of Protective Services, and roles and reporting relationships of DSH law enforcement personnel.</p>	<p>Not yet implemented. No legislation has been enacted to effect this change. DSH has implemented Policy Directive 8000 – DSH Law Enforcement Reporting Structure in December 1, 2015, which clarifies under the existing statute the structure, authority and responsibilities of the DSH Chief of Law Enforcement, Office of Protective Services, and roles and reporting relationships of DSH law enforcement personnel.</p>

OLES comment: In its previous Semi-Annual Reports, the OLES recommended DSH draft and pursue a proposal to consolidate all DSH law enforcement under the responsibility of the department's chief of law enforcement. Since then, the DSH worked collaboratively with the California Statewide Law Enforcement Association (CSLEA), which represents law enforcement employees at DSH, to meet the intent of the OLES recommendation. The proposal elevates the responsibilities of the DSH chief to that of a departmental deputy director, which makes the position a voting

<sup>13</sup> Penal Code Section 830.38(c) and Welfare and Institutions Code Section 4023.5(a).

member of the DSH governing body and increases the position's authority. The draft also elevates the responsibilities of the chiefs of police at each DSH facility and changes their reporting structure so they report to the facility executive director, who is the top facility manager. Currently, chiefs of police report to the hospital administrators at each facility, and the hospital administrators report to the executive directors. The OLES is supportive of the proposed direction.

## DSH law enforcement policies and procedures

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>B</b></p> <p>By December 1, 2016, DSH should decide on one police baton statewide, excluding specialized and tactical police teams, and begin to phase out the other baton. Standardized tools reduce on-the-job confusion about which tools to use and when to use them and reduces complexity of training.</p>	<p>DSH has approved the use of the Rapid Containment Baton. Policy is currently being written. An official letter was sent to OLES on October 26, 2016.</p>	<p>In process. DSH approved the use of the Rapid Containment Baton. It is fully implemented at Patton, Metropolitan and Coalinga for current officers and at the DSH law enforcement academy for newly hired police officers. Hospitals at Atascadero and Napa will phase out all other batons in conjunction with retraining their officers. Full implementation is expected by June 30, 2019.</p>
<p><b>C</b></p> <p>DSH should ensure that all equipment needed for law enforcement personnel is available to staff so they can follow policy/procedure that calls for the use of the equipment.</p>	<p>Video and audio recording equipment is currently being installed at all facilities. Once installed the equipment will begin to be utilized.</p>	<p>In process. A workgroup has been formed to select and implement a recording program for DSH. Implementation is anticipated in October 2017.</p>
<p><b>D</b></p> <p>By December 31, 2016, DSH should have a computerized Early Intervention System in operation at every facility that is sending alerts to management about problematic law</p>	<p>The computerized Early Intervention System (Blue Team) will start on December 31, 2016, at 2359 hours. Training for Blue Team was completed at all facilities by December 9, 2016.</p>	<p>Fully implemented. DSH implemented the computerized Early Intervention System (Blue Team) on December 31, 2016, at 2400 hours. All use of force reports, citizen complaints and vehicle accident reports</p>

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p>enforcement behavior for monthly management action. Early intervention systems are designed to help managers pinpoint troubling behavior and address it before serious misconduct occurs.</p>		<p>are recorded in Blue Team and shared with the appropriate facility executive staff and reviewed with them monthly by DSH law enforcement. The same reports are also provided to the OLES.</p>

## DSH standardized training

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>E</b> By December 1, 2016, DSH should compile and submit to the OLES standardized lesson plans for statewide training of new law enforcement personnel. Standardized lesson plans help ensure consistency in the initial training of new law enforcement personnel before they are deployed at facilities statewide.</p>	<p>In process. DSH is in the process of finalizing lesson plans. Plans will be submitted to the OLES. DSH expects to fully implement for the next law enforcement Academy in 2017.</p>	<p>Fully implemented. Standardized lesson plans were submitted to the OLES and implemented in the DSH academy as of June 1, 2017.</p>
<p><b>F</b> By December 31, 2016, DSH should compile and submit to the OLES standardized lesson plans for continued professional training of law enforcement personnel. Standardized lesson plans help ensure consistency in ongoing training of DSH law enforcement personnel at all facilities statewide.</p>	<p>Not yet implemented. Once work is completed for the academy lesson plans for the initial training of new law enforcement personnel, DSH will begin to standardize the continued professional training.</p>	<p>Not yet implemented. Once the Envisage Training software is fully deployed at the DSH law enforcement academy on September 1, 2017, law enforcement will begin working on standardizing the lesson plans for continued professional training.</p>
<p><b>G</b> DSH should include mental health topics in its ongoing professional development training, and mental health</p>	<p>In process. Draft lesson plans are under development by DSH mental health professionals. DSH is</p>	<p>In progress. Draft lesson plans are under development by DSH mental health professionals. DSH is</p>

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p>professionals should be trainers for new and longstanding law enforcement personnel. The specialized environment at DSH facilities necessitates ongoing professional development training.</p>	<p>securing a vendor to help facilitate this training. DSH expects to provide this training for new law enforcement personnel in the next Academy in 2017. DSH will also provide this training to its existing law enforcement personnel by December 31, 2017.</p>	<p>securing a vendor to help facilitate this training. DSH expects to provide this training for new law enforcement personnel in the next academy in 2017. DSH will also provide this training to its existing law enforcement personnel by December 31, 2017.</p>

### **Implementation of Mental Health Training**

OLES comment: Every day, DSH and DDS law enforcement officers interact with DSH patients and DDS residents who have significant mental illnesses and cognitive impairments. These unique populations present extra challenges for law enforcement personnel as they are called upon to investigate allegations of patient/resident abuse. In the case of mentally ill patients, allegations of abuse can stem from persecutory delusions, maladaptive behavior or the inability to cope with stressors in the environment. Similarly, residents at DDS facilities may report abuse as an expression of their anxieties or in an effort to get their needs met. And, of course, allegations of abuse can be grounded in fact. Despite a mental illness or cognitive impairment, patients and residents can be accurate reporters of abuse.

The OLES made recommendations to DSH and DDS that they should develop comprehensive training curricula for law enforcement personnel that includes mental health topics, with mental health professionals as the trainers. Not only would the training help law enforcement personnel understand the dynamics of mental illness and cognitive impairment effects on behavior, but the training should include instruction on how to conduct interviews with patients and residents who present unique challenges to law enforcement.

On June 30, 2017, DSH presented the OLES with an outline for mental health training entitled "Crisis Intervention Team (CIT)." This proposed 24-hour course for new and long-term law enforcement personnel included training topics such as mental illness symptoms, interventions, body language, impulse control, patient's rights and building patient rapport. Mental health professionals will teach the training.

### **Obtaining Credible Recantations**

OLES comment: The CIT training is a strong and positive step forward to provide law enforcement personnel with the necessary tools and specialized skills to work successfully with the patient population. The OLES would simply recommend that DSH create procedures and add a training section on best practice interviewing

techniques for mentally ill patients with special attention to the area of allegation recantations.

The OLES and other stakeholders have a particular interest in ensuring the veracity of recantations by DSH patients and DDS residents. Since the OLES began monitoring the departments 18 months ago, the OLES has discovered several recantations that raise concerns. Some facilities did not audio record recantations. The OLES already brought to the attention of both departments that the best practice is to record all interviews. The DDS implemented a policy to do so, and DSH agreed to do the same but was still working on implementing it as of June 30, 2017.

Some of the recantations may have been the result of some level of coercion. For example, a law enforcement officer at DDS reported telling a resident he was “the boy who cried wolf.” Another officer told a resident that they could be charged with a crime and taken to jail for making false allegations. One officer suggested he could provide a resident with physical therapy in exchange for “the truth,” while other officers repeatedly prompted the resident to “tell the truth.” Further, the OLES has found that oftentimes, after a resident states, “I made it up” or words to that effect, the interview is immediately terminated and no follow up questions asked. These instances suggest coercion - subtle and overt - and do not provide sufficient assurances that the recantation was freely and voluntarily made. If the recantation is not credible, the possibility that the resident was, in fact, abused remains.

The OLES recommends DSH and DDS law enforcement establish forensic interviewing protocols to ensure that patient/resident recantations are credible and reliable. Below are some guidelines used by law enforcement agencies across the country when interviewing mentally ill and cognitively impaired individuals:

- Always audio record the interview
- Conduct the interview in a private setting without distractions
- Treat the patient/resident with dignity and respect
- Respect the patient/resident's personal space
- Talk slowly and quietly
- Identify yourself and others present and explain your intentions
- Keep actions slow and give prior warning if you intend to move around the room
- Explain in a firm but gentle voice that you are there to help
- Establish a rapport and ask the patient/resident for help in understanding what is going on with him/her
- Ask for a narrative and don't interrupt
- After the narrative is complete, invite additional information with opened ended questions
- Don't challenge, threaten, tease or belittle the patient/resident
- Don't make promises to the patient/resident in exchange for the recantation
- Once the patient/resident recants, ask followup questions to test the credibility of the recantation such as, Did anyone tell you to recant? Why are



you recanting? Ask specific questions such as, “Are you now saying that staff member Jones did not pull your hair? Are you now saying that staff member Jones did not punch your back?”

- End the interview with closure questions such as, Is there anything else you want to tell me?

The proper conduct of forensic interviewers is critical to the safety of patients and the protection of staff. The OLES encourages DSH and DDS to develop their own protocols and training curricula for forensic interviews with special attention to the difficult issue of recantations. The OLES commends DSH for its efforts in creating the CIT training course and recommends that DDS use the CIT curriculum from DSH as a starting point for developing a similar training course at DDS.

### DSH standardized training (cont’d)

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>H</b></p> <p>DSH should complete and submit to the OLES for approval the policy and procedures for consistent law enforcement field training for newly deployed law enforcement personnel, including objectives, evaluation methods and passing standards, across the department. Consistent training and evaluation in the field after initial new-hire training, ensures that initial standardized training is retained and reinforced.</p>	<p>In process. DSH is designing a standard officer Field Training Manual that will include general law enforcement training modules, on-duty procedures, site-specific operational training and an evaluation rubric for universal measurement of competency levels. DSH anticipates completing the development of the manual by June 30, 2017. DSH anticipates full implementation by December 31, 2017.</p>	<p>In progress. DSH is designing a standard officer Field Training Manual that will include general law enforcement training modules, on-duty procedures, site-specific operational training and an evaluation rubric for universal measurement of competency levels. DSH anticipates completing the development of the manual by June 30, 2017. DSH anticipates full implementation by December 31, 2017.</p>
<p><b>I</b></p> <p>By December 31, 2017, all current law enforcement staff should complete professional development training on how best to handle patients in mental crises, and this training should be conducted by</p>	<p>In process. See Item I on training on mental health topics.</p>	<p>In progress. See Item I on training on mental health topics.</p>

<p>mental health staff. The specialized environment at DSH facilities necessitates regular professional development training on this topic.</p>		
<p><b>J</b></p> <p>DSH should centralize law enforcement training records at the department level. Centralized training data can be tracked and analyzed across the department and allows for department-wide budgeting for training.</p>	<p>Partially implemented. DSH is manually tracking information via spreadsheets pending implementation of a more robust solution. DSH will be implementing the Envisage software to centralize all DSH law enforcement training data. DSH anticipates full implementation by October 2017.</p>	<p>Partially implemented. DSH is manually tracking information via spreadsheets pending implementation of a more robust solution. DSH will be implementing the Envisage software to centralize all DSH law enforcement training data. DSH anticipates full implementation by October 2017.</p>

### DSH standardized assessments of investigations

<b>OLES Recommendation of Best Practice</b>	<b>Status as of Dec. 31, 2016</b>	<b>Status as of June 30, 2017</b>
<p><b>K</b></p> <p>By December 1, 2016, DSH should implement written, statewide, standardized policy and procedures for assessing investigation reports in a consistent fashion at all facilities and determine management personnel who should be involved in the evaluations. This provides consistent, fair and reasoned assessment of the quality of investigations and strives to equalize how results of investigations are handled across all state facilities.</p>	<p>In process. In conjunction with the development and implementation of the penalty matrix discussed in OLES recommendation N (below), DSH will develop and implement standardized policy and procedures for assessing investigation reports by April 2017.</p>	<p>In process. In conjunction with the development of the Objective Discipline tool discussed in OLES recommendation N (below), DSH has developed Policy Directive 5315, Objective Discipline Process, which incorporates a procedure for the hiring authority to assess investigation reports. DSH presented the draft policy directive to the OLES on May 15, 2017. On June 15, 2017, the OLES provided feedback to the policy directive. DSH will present a revised version to the</p>

		OLES with expected completion by December 31, 2017.
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### DSH standardized discipline process

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>L</b></p> <p>By December 1, 2016, DSH should implement comprehensive written, statewide policy and procedures involving standardized penalty matrices for all state employees who are found to be involved in misconduct. This helps provide formalized, consistent and fair imposition of discipline penalties across all state facilities.</p>	<p>In process. DSH has established a work group that is in the process of developing a standardized penalty matrix. This is expected to be completed, finalized and implemented by April 2017.</p>	<p>In progress. DSH established a workgroup that developed an Objective Discipline tool. DSH presented the draft tool to the OLES on May 14, 2017. The OLES provided feedback to the tool. The DSH workgroup will reconvene to incorporate the requested updates and will present a revised tool to the OLES. Expected completion by December 31, 2017.</p>
<p><b>M</b></p> <p>By December 31, 2017, DSH should assign departmental attorneys at the beginning of employee misconduct cases to assist in investigations and witness interviews and to provide counsel to facility management about potential employee discipline. This helps improve quality of investigations so they can serve as a solid foundation for potential legal proceedings.</p>	<p>Not yet implemented. Due to limited DSH Legal Services Division resources and competing legal priorities, DSH does not currently have the resources to fully implement this recommendation. DSH is evaluating on a case-by-case basis to identify high profile and/or complex cases and will assign legal resources to these cases as needed.</p>	<p>Not yet implemented. Due to limited DSH Legal Services Division resources and competing legal priorities, DSH does not currently have the resources to fully implement this recommendation. DSH is evaluating on a case-by-case basis to identify high profile and/or complex cases and will assign legal resources to these cases as needed.</p>

## DSH standardized discipline tracking

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>N</b></p> <p>DSH should implement department-wide policy and procedures for collecting, organizing, centralizing and keeping consistent records of all employee misconduct reports. This ensures consistent and centralized data collection and record-keeping department-wide.</p>	<p>Partially implemented. DSH facilities are now reporting to DSH Sacramento on a monthly basis all employee discipline cases, including action taken, Skelly hearings, settlements, actions taken by the State Personnel Board and reports made to health professional licensing boards. DSH will develop and implement policies and procedures for the collection, organization and centralization by April 30, 2017.</p>	<p>In process. DSH has developed and approved Policy Directive 5316 – Discipline Record Keeping and it will be implemented in concert with the Objective Discipline Tool by December 31, 2017.</p>
<p><b>O</b></p> <p>DSH should develop a centralized discipline tracking computer system similar to CDCR's to provide secure, efficient, real-time access to ongoing discipline cases and tracks delays and outcomes so they can be analyzed.</p>	<p>Not yet implemented. DSH will evaluate existing reporting tool and possible solutions and provide a recommendation to DSH executive management for consideration by April 30, 2017.</p>	<p>Not implemented. At this time, DSH is continuing to explore technological options to address this recommendation. In the meantime, DSH has created procedures to address the tracking of disciplinary actions and they have been implemented.</p>
<p><b>P</b></p> <p>DSH should establish department-wide policy and procedures for documenting and recording its analysis of trends and patterns of all DSH employee misconduct. This ensures that centralized data collection and records are used as a management</p>	<p>In process. DSH has selected the Blue Team software for tracking and analyzing law enforcement misconduct. Additionally, DSH will develop and implement policies and procedures by April 30, 2017,</p>	<p>In process. DSH drafted Policy Directive 5316 that was presented to DSH executives on June 15, 2017. After review by the OLES, this policy directive is expected to be completed by December 15, 2017.</p>

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
tool to identify and address patterns and trends of employee misconduct.	for documenting and recording its analysis of trends and patterns of all DSH employee misconduct data.	

### DDS standardized investigation reports

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>A</b></p> <p>DDS should implement standardized investigation report formats in calendar 2016 to help ensure consistency in reports and investigation facts and in how the facts are presented.</p>	<p>DDS has established a committee to standardize investigation formats in conjunction with the configuration of the new Records Management System. DDS anticipates the project to be completed in the spring of 2017.</p>	<p>DDS law enforcement has developed draft standardized formats that are in final review. Once finalized by August 2017, they will be routed to the OLES for review/input. Once approved, they will be implemented immediately.</p>

### DDS standardized assessments of investigations

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>B</b></p> <p>By December 1, 2016, should implement written, statewide, standardized policy and procedures for assessing investigation reports in a consistent fashion at all facilities and determine management personnel who should be involved in the evaluations. This provides formalized, consistent, fair and reasoned assessment of the quality of investigations and strives to equalize how results of investigations are handled across all state</p>	<p>DDS is preparing an investigation checklist to be used by supervisors and managers to assess the quality of investigations. The checklist will be similar to the Investigation Assessment Questions used by OLES. Once the checklist is completed and approved by DDS and OLES, DDS will establish policy by June 2017 requiring supervisors and managers to use</p>	<p>Policy was drafted and circulated; should be issued by August 2017.</p>

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
facilities.	<p>the checklist during their review of investigations.</p> <p>Additionally, as DDS works with a vendor to configure the Records Management System, DDS will attempt to have the system prompt investigators to provide answers to questions from the checklist. Those answers would then become part of the investigative report.</p>	

### DDS law enforcement recruitment

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>C</b></p> <p>DDS should expand its law enforcement outreach and recruitment efforts to more venues and websites, including law enforcement, military and general employment sites, and use social media on a regular basis to publicize job openings. Broader outreach can help boost the number of applicants, thereby helping to address persistently high DDS law enforcement vacancy rates.</p>	<p>DDS has expanded recruitment efforts to general employment job fairs and military outlets. DDS has also posted job openings on local developmental center Facebook pages.</p>	<p>During this reporting period, DDS law enforcement successfully hired the following new peace officers: One investigator and two officers at Sonoma, two officers at Porterville and one officer each at Fairview and Canyon Springs. In addition, the following 10 candidates are in the background process: Two supervising special investigator I candidates – one for headquarters and the other for Fairview – have anticipated hire in two months. One headquarters investigator is anticipated to be hired in two weeks. Seven</p>

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
		<p>peace officer I candidates – four at Porterville, two at Sonoma and one at Canyon Springs - are anticipated in three months. Also, in May 2017, DDS law enforcement hired an AGPA (analyst) as a recruitment coordinator whose duties include researching and posting vacancies at various website and venues. Current job openings are advertised with no cost on the CalHR and California Commission on Peace Officers Standards and Training (POST) sites. DDS law enforcement has acquired the commitment from two nonprofit organizations to expand our law enforcement outreach and recruitment efforts at no cost. DDS's information security officer is not in favor of the use of social media sites due to security concerns.</p>
<p><b>D</b>            DDS should update and upgrade its law enforcement recruitment materials to improve the department's image with applicants and draw more interest, potentially attracting more law enforcement hires.</p>	<p>DDS is updating its recruitment pamphlets and creating new recruitment posters for April 2017. In the meantime, DDS has created a computer-generated update which has been manually inserted into</p>	<p>In June 2017, DDS law enforcement entered into a contract with a graphic designer to design and brand recruitment materials including rack cards, banners, poster boards and table aprons. DDS law enforcement is</p>

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
	existing recruitment pamphlets.	currently collecting photographs from the various facilities to use in the flyers and other materials.
<p><b>E</b></p> <p>DDS should recruit at more California Police Officer Standards and Training (POST) academies to gain focused and ready access to the state's newly trained law enforcement personnel.</p>	<p>DDS has been providing Recruitment presentations at all local law enforcement academies. DDS is scheduled to attend every POST-certified academy in the state (except agency-specific academies such as CHP and LAPD). As a result of recruitment efforts, since July 1, 2016, DDS has placed 16 peace officer I candidates and give investigator candidates into the background investigation stage of the hiring process.</p>	<p>During the reporting period, DDS law enforcement made recruitment presentations at 12 POST academies. From these presentations, DDS law enforcement received seven applications, five of which passed a hiring interview and were placed into background investigations. One applicant failed the background, one was successfully hired and three remain in backgrounds.</p>
<p><b>F</b></p> <p>DDS should add a law enforcement cadet job classification similar to CHP's to provide an additional entry point into law enforcement and allow redistribution of law enforcement duties among cadets and senior staff.</p>	<p>DDS is in discussion with DSH to allow DDS to use DDS's hospital police officer classification at DDS as a limited-term cadet classification.</p>	<p>DDS had previously discussed the option of using DSH's Hospital Police Officer (HPO) classification as a cadet classification at DDS because the HPO classification is not POST-certified. However, in order to be eligible for hire at DDS, the HPO applicant would have to be on a DSH eligibility list as well as a DDS list. The applicant would also need to have 832 PC prior to appointment</p>



OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
		<p>which can be a difficult course to locate. It was decided this would not be operationally feasible for DDS, DSH or the applicants. The DDS decided this was not a viable solution and not to pursue this solution.</p>
<p><b>G</b>            DDS should work on a transition plan for DDS law enforcement staff who would be interested in moving to DSH law enforcement as the DDS development centers close by 2021. This may help DDS to attract more job applicants who would want information on future jobs.</p>	<p>DDS has been in discussion with DSH on a transition plan for Office of Protective Service (OPS) staff as DDS developmental centers close and will have a transition plan completed to share with OLES in December 2017.</p>	<p>DDS has had discussions with DSH regarding a possible transition plan. DDS Office of Protective Service employees can submit applications to DSH. However, by state rule, when changing departments, applicants have to go through the normal hiring process at DSH to get hired. There also are collective bargaining issues involved in this process. With the anticipated closures, except of the secured treatment unit at Porterville Developmental Center and Canyon Springs Community Facility, DDS has established career centers at the developmental centers to assist all staff in transitioning to other state employment.</p>

## DDS standardized training

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>H</b></p> <p>DDS should develop and submit to the OLES for approval the standardized curriculum for the 24-hour critical incident training course that DDS established at the DSH-Atascadero academy in the first half of 2016. A standardized curriculum helps ensure standardized training.</p>	<p>DDS has developed a standardized curriculum for Critical Incident Training and submitted it to the California Commission on Peace Officers Standards and Training (POST) for POST certification.</p>	<p>DDS developed a crisis intervention behavioral health training course that was submitted to the California Commission on Peace Officers Standards and Training (POST) in 2016 and certified by POST in March 2017. The course will be taught by law enforcement managers and DDS mental health professionals. All law enforcement employees will complete the training by fall of 2017, and DDS will open the course for attendance by local law enforcement.</p>
<p><b>I</b></p> <p>DDS should complete and submit to the OLES the policy and procedures for consistent law enforcement field training for newly deployed law enforcement personnel, including objectives, evaluation methods and passing standards, across the department. Consistent training and evaluation in the field, after initial, new-hire training, helps ensure that initial standardized training of new hires is retained and reinforced.</p>	<p>DDS has developed a Field Training Officer manual that is consistent with POST standards. The manual is in final review by management and will be submitted to OLES for review and recommendations before publishing the manual.</p>	<p>DDS has developed a field training manual that is in final review. Upon DDS approval, a draft will be presented to the OLES for review/input in September 2017 and then will be submitted to POST for approval. In the interim and in an effort to establish standardization, DDS law enforcement is using the draft manual to train new hires through the field training process.</p>

## DDS standardized discipline tracking

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>J</b></p> <p>By December 31, 2016, DDS should have a computerized Early Intervention System in operation in every facility. The system sends alerts to management about problematic law enforcement behavior for monthly management review and action. Early intervention systems are designed to help managers pinpoint troubling behavior and address it before serious misconduct occurs</p>	<p>DDS conducted a pilot at Porterville Developmental Center to beta test the IA Pro/Blue Team Early Intervention System. During 2016, DDS had only four qualifying incidents. Consequently, it was determined that the IA Pro portion of the Early Intervention System could be used alone at DDS headquarters rather than having each facility use Blue Team. When a qualifying incident occurs, DDS headquarters will put the information directly into IAPro and the DDS chief of law enforcement will work with law enforcement commanders at the facilities to review the incidents.</p>	<p>After review and input by the OLES, DDS issued its policy and the Early Intervention System was activated in June 2017.</p>
<p><b>K</b></p> <p>DDS should establish department-wide policy and procedures for documenting and recording of its analysis of trends and patterns of all DDS employee misconduct data. This ensures that centralized data collection and records are used as a management tool to identify and address</p>	<p>DCD Policy 323, Governing Body, requires each developmental center to report status of all allegations and investigations to headquarters which is tracked on a standardized report for analysis and trending as part of its risk management system</p>	<p>On March 19, 2017, the Developmental Centers Division (DCD) of DDS modified its "Policy Memorandum 323 "Governing Body" to require DCD to conduct periodic reviews of investigations and outcomes using the investigations data collected by the developmental centers.</p>

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p>patterns and trends of employee misconduct.</p>	<p>and reviewed quarterly as part of each facility's Governing Body meeting. Each development center has a risk management policy that tracks and trends all reportable incidents.</p>	<p>The Health and Direct Care Services (HDCS) section in DDS will use incident reporting data collected by the facilities to ensure proper tracking and trending of their analysis, with findings and recommendations forwarded to the deputy director. Beginning July 2017, law enforcement at headquarters updates the investigations and allegations report with employee misconduct outcomes. HDCS prepares from the law enforcement data a quarterly report which analyzes employee trend data.</p>

### DDS standardized discipline process

OLES Recommendation of Best Practice	Status as of Dec. 31, 2016	Status as of June 30, 2017
<p><b>L</b> By December 1, 2016, DDS should implement a comprehensive written, statewide policy and procedures involving standardized penalty matrices for all state employees assigned to facilities who are found to be involved in misconduct. This provides formalized, consistent and fair imposition of discipline penalties across all state facilities</p>	<p>DCD will write and implement statewide a Case Disposition policy involving review of case facts and justification for level of discipline applied in cases involving staff misconduct. The policy is expected to be drafted by February 1, 2017, and implemented shortly thereafter.</p>	<p>A draft policy and procedures involving standardized penalty matrices is in draft review. DDS anticipates it to be issued by December 2017.</p>

<p style="text-align: center;"><b>M</b></p> <p>By December 1, 2016, DDS should establish a written, statewide executive review process to address situations where facility executive directors, labor attorneys and/or OLES disagree about employee discipline decisions. This provides consistent and formalized review process of discipline penalties across all state facilities.</p>	<p>The DCD Case Disposition policy (in R above) will include an executive review process to address situations where facility executive directors, labor attorneys and/or OLES disagree about employee discipline decisions.</p>	<p>Policy was drafted and circulated; should be issued by August 2017.</p>
<p style="text-align: center;"><b>N</b></p> <p>By December 31, 2017, DDS should assign departmental attorneys at the beginning of employee misconduct cases to assist in investigations and witness interviews and to provide counsel to facility management about potential employee discipline. This helps improve quality of investigations so they can serve as a solid foundation for potential legal proceedings.</p>	<p>Given the closure of three developmental centers currently occurring, DDS will not be requesting the additional staffing needed at this point to provide such representation on every case. Incidents may be evaluated on a case-by-case basis, until DDS can assess the resources that would be needed post-closures.</p>	<p>DDS converted a position from the Developmental Centers Division and assigned it to the Legal Affairs unit. This position already implemented in this reporting period a system to process all disciplinary cases.</p>

# Appendix A: OLES Investigations

Investigation Detail	Section Content
<b>Incident Date</b>	02/26/2016
<b>OLES Case Number</b>	2016-00257A
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On February 26, 2016, a patient alleged a firefighter used excessive force on him while he was being treated for a left shoulder injury. Further, the patient alleged a sergeant used excessive force on him when the sergeant and other officers were attempting to place him in security restraints.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	05/21/2016
<b>OLES Case Number</b>	2016-00951A
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On May 21, 2016, a patient was allegedly being housed in a cell for several days that was covered with his feces. Allegedly, a unit supervisor and a senior psychiatric technician knew the patient's cell was not being cleaned, but failed to take action.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	04/01/2016
<b>OLES Case Number</b>	2016-01265A
<b>Case Type</b>	Sexual Assault
<b>Incident Summary</b>	In April 2016, a patient alleged all of the officers at the department sexually assaulted her. She further alleged she feared she was going to be sexually assaulted by someone. When the patient was interviewed, she stated that she was not sexually assaulted, but she imagined it in her mind. She further stated she imagined the whole world was sexually assaulting her.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided

	to the department.
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Investigation Detail	Section Content
<b>Incident Date</b>	09/21/2016
<b>OLES Case Number</b>	2016-01340A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On September 21, 2016, two officers responded to an alarm, which was activated after two patients began fighting one another. Allegedly, the officers failed to investigate, document, or report the incident to a supervisor. Further, one officer was allegedly dishonest during her investigatory interview.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	10/11/2016
<b>OLES Case Number</b>	2016-01345A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On October 11 and 12, 2016, a medical technical assistant allegedly documented a patient was asleep in his cell when the patient was not at the institution.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	10/16/2016
<b>OLES Case Number</b>	2016-01355A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On October 16, 2016, an officer allegedly pepper sprayed a patient in the face, while the patient was in full-bed restraints.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	02/26/2016
<b>OLES Case Number</b>	2016-01397A
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On February 26, 2016, a patient alleged a firefighter used excessive force on him while he was being treated for a left shoulder injury. Further, the patient alleged a sergeant used

	excessive force on him when the sergeant and other officers were attempting to place him in security restraints.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	11/11/2016
<b>OLES Case Number</b>	2016-01491C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On November 11, 2016, a patient alleged that a sergeant used excessive force when placing him on a wall containment, resulting in bruises to his arm and pain to his shoulder.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	12/12/2016
<b>OLES Case Number</b>	2016-01618C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On December 12, 2016, a patient alleged an officer used excessive force by kicking him in the leg while the officer was escorting him back to his residential unit.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	12/21/2016
<b>OLES Case Number</b>	2016-01671A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On December 21, 2016, a medical technical assistant was allegedly overly familiar with a patient.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority



	for disposition. However, the medical technical assistant resigned during the course of the investigation. A letter was placed in her official personnel file indicating she resigned under adverse circumstances.
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Investigation Detail	Section Content
<b>Incident Date</b>	12/28/2016
<b>OLES Case Number</b>	2016-01700C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On December 28, 2016, a patient alleged an officer searched him without cause. The patient further alleged the officer squeezed his genitals during the search.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	05/21/2016
<b>OLES Case Number</b>	2017-00015A
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On May 21, 2016, a patient was allegedly being housed in a cell for several days that was covered with his feces. Allegedly, a unit supervisor and a senior psychiatric technician knew the patient's cell was not being cleaned, but failed to take action.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	10/12/2016
<b>OLES Case Number</b>	2017-00016A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On October 12, 2016, a senior medical technical assistant allegedly failed to properly monitor wellness checks on patients conducted by a medical technical assistant. The wellness checks noted a patient who was not at the institution to be asleep.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	10/16/2016
<b>OLES Case Number</b>	2017-00025C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On October 16, 2016, an officer allegedly pepper sprayed a patient in the face, while the patient was in full-bed restraints.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney. The district attorney declined to file charges.

Investigation Detail	Section Content
<b>Incident Date</b>	01/04/2017
<b>OLES Case Number</b>	2017-00031A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On January 4, 2017, an officer allegedly surreptitiously audio recorded a conversation with a sergeant without authorization. Further, the officer allegedly used a personal recording device and retained the recording for personal, use in violation of department policy.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	09/21/2016
<b>OLES Case Number</b>	2017-00070A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On September 21, 2016, two officers responded to an alarm, which was activated after two patients began fighting one another. Allegedly, the officers failed to investigate, document, or report the incident to a supervisor. Further, one officer was allegedly dishonest during his investigatory interview.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	09/21/2016
<b>OLES Case Number</b>	2017-00071A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On September 21, 2016, an officer allegedly failed to respond to an alarm and assist staff members when two

	patients were fighting one another.
<b>Disposition</b>	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.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	10/11/2016
<b>OLES Case Number</b>	2017-00081A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On October 11, 2016, a senior medical technical assistant allegedly failed to properly monitor wellness checks on patients conducted by a medical technical assistant. The wellness checks noted a patient who was not at the institution to be asleep.
<b>Disposition</b>	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.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	12/15/2016
<b>OLES Case Number</b>	2017-00086C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On December 15, 2016, a patient alleged an officer pushed him on the chest, which caused the patient to push the officer's hand away, resulting in the patient being taken to the ground. The patient alleged the officer was overly aggressive when he taken down to the ground and another officer allegedly put his finger in the patient's left eye.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	01/19/2017
<b>OLES Case Number</b>	2017-00098C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On January 19, 2017, a patient alleged an officer used unnecessary force on him by grabbing his right hand, then grabbing his back with both hands, and forcefully throwing him on a bed across the room.
<b>Disposition</b>	The department conducted and completed an

	investigation into the allegations, thereby precluding the Office of Law Enforcement Support from conducting an investigation into this matter as mandated by the Welfare and Institutions Code section 4023.6. OLES monitored the investigation and concurred with the recommended findings. DSH implemented a process to ensure it does not occur in the future.
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Investigation Detail	Section Content
<b>Incident Date</b>	01/31/2017
<b>OLES Case Number</b>	2017-00131A
<b>Case Type</b>	Neglect
<b>Incident Summary</b>	On January 31, 2017, medical technical assistant allegedly failed to properly supervise a patient who was using shaving equipment. The patient allegedly took a part the equipment and swallowed a metal piece.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	02/05/2017
<b>OLES Case Number</b>	2017-00140C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On February 5, 2017, an officer allegedly punched a patient two to three times in the thigh during a containment.
<b>Disposition</b>	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 a full investigation. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	05/30/2016
<b>OLES Case Number</b>	2017-00217C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On May 30, 2016, a patient alleged an officer refused to photograph the injuries he received during transportation from an outside hospital to the department. The patient further alleged a medical staff member also refused to photograph his injuries.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the

	matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.
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Investigation Detail	Section Content
<b>Incident Date</b>	02/07/2017
<b>OLES Case Number</b>	2017-00218C
<b>Case Type</b>	Sexual Assault
<b>Incident Summary</b>	On February 7, 2017, a patient alleged an officer sexually assaulted him during a pat-down search.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	02/22/2017
<b>OLES Case Number</b>	2017-00225A
<b>Case Type</b>	Neglect
<b>Incident Summary</b>	On February 22, 2017, a medical technical assistant allegedly failed to perform fifteen minute wellness checks, but documented she had done so. Additionally, the medical technical assistant was allegedly dishonest during her investigatory interview.
<b>Disposition</b>	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Investigation Detail	Section Content
<b>Incident Date</b>	06/08/2016
<b>OLES Case Number</b>	2017-00265C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On June 8, 2016, an officer allegedly assaulted patients and hid contraband in patients' rooms.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	03/03/2017

<b>OLES Case Number</b>	2017-00266C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On March 3, 2017, a patient alleged another patient assaulted him on at least two different occasions. In addition, the patient alleged the police chief failed to protect him from the second patient who continued to stalk him and assault his friends.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	03/10/2017
<b>OLES Case Number</b>	2017-00286C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On March 10, 2017, a patient alleged staff members and officers were urinating and defecating in food served to patients, engaging in sexual activity in the presence of patients, and making inappropriate comments towards patient; including sexually suggestive statements. In addition, the patient alleged officers were falsifying documents.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	03/10/2017
<b>OLES Case Number</b>	2017-00299C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On March 10, 2017, two patients were involved in a physical altercation, which required officers to intervene. One patient alleged officers used excessive force on him, resulting in fractured ribs.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	03/11/2017
<b>OLES Case Number</b>	2017-00303C
<b>Case Type</b>	Sexual Assault
<b>Incident Summary</b>	On March 11, 2017, a patient alleged a medical technical assistant sexually assaulted him during a pat-down search.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	03/14/2017
<b>OLES Case Number</b>	2017-00311C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On March 14, 2017, a patient alleged officers used excessive force on him, staff provided him stale food, and refused to provide him pain medications. The patient also alleged a sexual assault occurred in another facility that was not properly investigated.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	03/10/2017
<b>OLES Case Number</b>	2017-00325A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On March 10, 2017, officers allegedly injured a patient during a struggle. The patient suffered a laceration to his eyelid requiring sutures.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	03/07/2017

<b>OLES Case Number</b>	2017-00340C
<b>Case Type</b>	Sexual Assault
<b>Incident Summary</b>	On March 7, 2017, a patient alleged an officer sexually assaulted him while being searched prior to going into a visiting room. The patient alleged the officer grabbed his buttocks and genitals during the search.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	09/17/2016
<b>OLES Case Number</b>	2017-00412A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On September 17, 2016, a sergeant allegedly failed to handle a situation properly when a person suspected of committing domestic violence entered onto departmental grounds. Allegedly, the person coming on to departmental grounds threatened to his spouse, a staff member of the department. The sergeant did not arrest the person, but instead issued the person a trespassing citation and allowed him to leave. Additionally, on January 18, 2017, a second sergeant allegedly conducted an illegal traffic stop and search of a staff member's vehicle on departmental grounds. Allegedly, a staff member reported another staff member was coming on to departmental grounds with a loaded weapon in her vehicle. The sergeant conducted a stop and search of the vehicle; however, a weapon was not located.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

<b>Investigation Detail</b>	<b>Section Content</b>
<b>Incident Date</b>	02/07/2017
<b>OLES Case Number</b>	2017-00450C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On February 7, 2017, a patient alleged a psychiatric technician choked him when he was being removed from his cell as part of a therapeutic strategic intervention.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was



	insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.
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Investigation Detail	Section Content
<b>Incident Date</b>	11/14/2016
<b>OLEs Case Number</b>	2017-00462A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On November 14, 2016, a medical technical assistant was allegedly dishonest in a written report. Allegedly, the medical technical assistant indicated a senior medical technical assistant was involved in a use-of-force incident, when he was not.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	04/10/2017
<b>OLEs Case Number</b>	2017-00490C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On April 10, 2017, a patient alleged medical technical assistants used excessive force during a cell extraction. Allegedly, numerous medical technical assistants punched the patient in the face after he was restrained.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	04/26/2017
<b>OLEs Case Number</b>	2017-00519C
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On April 26, 2017, two officers allegedly used unnecessary and excessive force on a civilian who was exiting the facility property. In addition, the officers allegedly failed to initially document the incident and then allegedly generated a fabricated report of the incident.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an

	inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.
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Investigation Detail	Section Content
<b>Incident Date</b>	04/22/2017
<b>OLES Case Number</b>	2017-00521C
<b>Case Type</b>	Sexual Assault
<b>Incident Summary</b>	On April 22, 2017, and on April 28, 2017, a medical technical assistant allegedly touched a patient's penis through the food port of his cell door, while removing his waist restraints.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	04/15/2017
<b>OLES Case Number</b>	2017-00522A
<b>Case Type</b>	Sexual Assault
<b>Incident Summary</b>	On April 15, 2017, a patient alleged a medical technical assistant stared at him while he was grooming himself in his cell. Further, the patient alleged another medical technical assistant grabbed his buttocks during an application of waist restraints.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	04/11/2017
<b>OLES Case Number</b>	2017-00536C
<b>Case Type</b>	Sexual Assault
<b>Incident Summary</b>	On April 11, 2017, a patient alleged an officer touched his genitals inappropriately during a search.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the

	matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.
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Investigation Detail	Section Content
<b>Incident Date</b>	05/03/2017
<b>OLES Case Number</b>	2017-00537A
<b>Case Type</b>	Misconduct
<b>Incident Summary</b>	On May 3, 2017, private security transport officers' alleged officers conducted illegal searches and touching of their persons, illegal searches of their transport vehicle, and left one private security transport officer sitting in hot weather for a prolonged period during the searches. The alleged misconduct was reported following a criminal investigation of the private security transport officers for unlawful possession of weapons and ammunition on facility grounds.
<b>Disposition</b>	The Office of Law Enforcement Support conduct an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	05/13/2017
<b>OLES Case Number</b>	2017-00572C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On May 13, 2017, an officer observed a patient urinating on an outside restroom door. The officer approached the patient to redirect him, when the patient allegedly began yelling obscenities at the officer and started hitting himself with both of his fists. The patient stopped hitting himself after several orders to "stop" were given, and he was escorted back to his unit. While under escort, the patient allegedly grabbed a fence and refused orders to let go. The patient was forcibly removed, placed in handcuffs, and escorted to the unit. The patient received a cut on this finger and his right eye. While being treated for his injuries, the patient alleged officers beat him, sexually assaulted his wife, and a male officer hit a female officer with a baton.
<b>Disposition</b>	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' office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	05/25/2017
<b>OLES Case Number</b>	2017-00621C
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On May 25, 2017, a patient alleged a medical technical assistant used excessive force by closing the food port door on his arm, causing an injury.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Investigation Detail	Section Content
<b>Incident Date</b>	06/05/2017
<b>OLES Case Number</b>	2017-00656C
<b>Case Type</b>	Significant Interest - Other
<b>Incident Summary</b>	On June 5, 2017, a medical technical assistant allegedly left her four-year-old child unattended in a locked vehicle in the institution parking lot for over 15 minutes. The child was in a child's car seat and unable to loosen the strap to unlock the door for the responding officers. The medical technical assistant arrived on scene and identified herself as the child's parent. Allegedly, she stated she had only been gone for five minutes and was at the institution visiting someone. The medical technical assistant allegedly proceeded to get into her vehicle and drive away from the area, despite pleas for her to stop. The patrol sergeant conducted a traffic stop on the vehicle; upon contacting the medical technical assistant, she provided her employee identification.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into this matter, but was unable to conduct an investigation due to a transfer of the program and employees to California Department of Corrections and Rehabilitation. The findings were forwarded to the California Department of Corrections and Rehabilitation, Office of Internal Affairs with a recommendation to conduct a criminal investigation.

# Appendix B: Pre-Disciplinary Cases Monitored by the OLES

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

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

## Appendix B1 – DSH Pre-Disciplinary Cases

Case Table Section	Section Content
<b>Incident Date</b>	12/30/2015
<b>OLES Case Number</b>	2016-00046MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 30, 2015, a patient alleged he had been punched in the head several times by two psychiatric technicians.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's decision.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES concerning disciplinary determinations and the investigation was not completed until approximately 309 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.  2. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding

	<p>the sufficiency of the investigation and the investigative findings?</p> <p>No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation.</p> <p>3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?</p> <p>No. The hiring authority did not consult with the OLES regarding disciplinary determinations.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident occurred on December 30, 2015; however, the investigative report was not completed until November 3, 2016, 309 days later.</p>
<b>Department Corrective Action Plan</b>	<p>The Hiring Authority will be diligent and consult with OLES regarding the sufficiency of the investigation and investigative findings. The hiring authority will consult with OLES regarding the disciplinary determination. 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 and report is going to go beyond the 75-day time frame was explained to the investigator.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/26/2016
<b>OLES Case Number</b>	2016-00103MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Other failure of good behavior</li> <li>2. Inexcusable neglect of duty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Not Sustained</li> <li>2. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: No Penalty Imposed</p> <p>Final: No Change</p>
<b>Incident Summary</b>	<p>On January 26, 2016, an off-duty officer allegedly pushed his wife during an argument at their home.</p>
<b>Disposition</b>	<p>The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.</p>
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient</p> <p>Substantive Rating: Insufficient</p>

	<p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The first subject interview did not address all allegations and the OLES was not appropriately consulted. Also, the investigator was unsure about what admonishments to use during the interview. Prior to the second subject interview, the investigator provided a confidential investigative report to the subject and scheduled the subject's interview before the alleged victim's interview. In addition, the investigation was not completed until approximately 128 days after being opened and the hiring authority did not make a determination on the findings until approximately 193 days after the investigative report was finalized.</p>
<p><b>Pre-Disciplinary Assessment</b></p>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident? <p>No. The department's legal office was not notified.</p> </li> <li>2. Was the investigator properly trained to conduct the investigation? <p>No. The investigator was uncertain about which rights advisement or admonishment should be issued to the subject. He was also unsure about what information could be disclosed to the subject. This confusion caused the investigator to provide a confidential investigative report from outside law enforcement to the subject, and to deliberately schedule the subject's second interview before the alleged victim's interview because the investigator mistakenly believed all information and statements from the alleged victim's interview had to be disclosed to the subject before the subject's interview.</p> </li> <li>3. Were all of the interviews thorough and appropriately conducted? <p>No. The investigator did not ask the subject any questions about the subject's alleged failure to report his contact with outside law enforcement. A second interview of the subject was required due to the investigator's failure to adequately address this issue.</p> </li> <li>4. Did the OPS investigator appropriately enter case activity in the Records Management System?</li> </ol>

No. The investigator did not enter activity in the Records Management System.

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

No. The investigator concluded his first interview of the subject without first consulting with the OLES; thereby, preventing the OLES from providing any real-time recommendations. The investigator failed to adequately consult with the OLES prior to releasing to the subject a confidential investigative report from outside law enforcement that the investigator and the OLES previously agreed did not need to be provided to the subject prior to his interview.

6. Was the investigation thorough and appropriately conducted?

No. The investigator provided a confidential investigative report from outside law enforcement concerning the alleged incident to the subject prior to the subject's second interview. The investigator deliberately scheduled the subject's second interview before the alleged victim's interview.

7. 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 final report was approved on October 24, 2016; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation and investigative findings until May 4, 2017, 193 days later.

8. Was the pre-disciplinary/investigative phase conducted with due diligence?

No. The administrative investigation commenced on May 18, 2016; however, the investigation was not completed until September 22, 2016, 128 days later. The hiring authority did not make determinations regarding the sufficiency of the investigation, and the



	investigative findings until 193 days after the final report was approved.
<b>Department Corrective Action Plan</b>	Training has been provided to the investigator on the proper usage of the Advisement and Admonishment prior to a subject/witness interview. Training has also been provided on the disclosure requirements for the subject/witness interviews. Training has been provided to the investigator on the importance of completing an investigative plan and questions prior to interviewing subjects and witnesses. Training has been provided to the investigator on the importance of keeping OLES apprised of the ongoing investigation and incorporating their suggestions. Training has been provided to the investigator on the importance of not providing confidential information to the subject or witness. The Hiring Authority will consult with OLES regarding the investigative findings. OPS will insure timely consultation with OLES during the pre-disciplinary conference.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/26/2016
<b>OLES Case Number</b>	2016-00104MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Unsubstantiated 2. Unsubstantiated
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On January 26, 2016, a patient alleged three weeks prior, she observed a male staff leaving the female shower room and inside the room was a partially naked female patient. The reporting patient also alleged that another male staff was taking pictures of the naked female patient while she was dressing.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's decision.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 246 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?

	<p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on January 26, 2016; however, the final investigative report was not completed until September 28, 2016, 246 days later.</p>
<b>Department Corrective Action Plan</b>	The OPS has established guidelines to ensure reports are completed in the required timeframe.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/25/2015
<b>OLES Case Number</b>	2016-00156MA
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On June 25, 2015, it was discovered that a patient was pregnant. The patient had been committed to the department since 2006.
<b>Disposition</b>	No staff misconduct was identified; however, the investigation highlighted systemic issues that are being addressed by the department
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/14/2015
<b>OLES Case Number</b>	2016-00157MA
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On October 14, 2015, it was discovered a patient was pregnant. The patient gave birth on March 3, 2016. The patient had been housed at the department since May 6, 2010, and she advised the father of the baby was another patient.

<b>Disposition</b>	No staff misconduct was identified; therefore, the matter was not referred for additional investigation. However, systemic issues were identified that are being addressed by the department.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OLES regarding the incident. The OLES concurred with the hiring authority's decision not to refer the matter for further investigation.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/06/2016
<b>OLES Case Number</b>	2016-00166MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On February 6, 2016, a registered nurse allegedly grabbed a patient's arms, pushed the patient to the floor and dragged the patient by his ankle to his room. Once in his room, the patient alleged the registered nurse pushed him onto his bed.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 420 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on February 10, 2016; however, the investigation was not completed until April 5, 2017, 420 days later.</li> </ol>

<b>Department Corrective Action Plan</b>	The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/23/2016
<b>OLES Case Number</b>	2016-00230MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On February 23, 2016, a physician allegedly failed to properly provide care to a patient which resulted in the patient's death.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/01/2016
<b>OLES Case Number</b>	2016-00260MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On March 1, 2016, a patient alleged she was sexually assaulted by a psychiatric technician. A second patient alleged the same psychiatric technician sexually assaulted a third patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and

	procedures governing the pre-disciplinary process. The incident was discovered on March 2, 2016; however, the investigation was not completed until November 28, 2016, 271 days later.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames required by law?</p> <p>No. The OPS did not notify outside law enforcement of the incident.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The legal department was not notified.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on March 2, 2016; however, the investigation was not completed until November 28, 2016, 271 days later.</p>
<b>Department Corrective Action Plan</b>	On July 7, 2017, all Office of Protective Services (OPS) command staff have been instructed to notify outside law enforcement immediately for such instances. The OPS command staff will note the time of notification and outside law enforcement staff they made the notification to. This information is to be included in the police report. The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/21/2016
<b>OLEs Case Number</b>	2016-00337MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On March 21, 2016, a patient alleged two psychiatric technicians inappropriately looked at him while he showered and one psychiatric technician touched him in an inappropriate manner.
<b>Disposition</b>	The hiring authority determined there was insufficient

	evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The draft copy of the investigative report was not provided prior to closing the investigation, nor did the hiring authority consult with the OLES regarding investigative findings. In addition, the investigation was not completed until approximately 196 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?  No. The OPS did not provide the OLES a draft copy of the investigative report before the report was finalized. The OLES sought a higher level of review to obtain the report.</li> <li>4. Did OPS cooperate with and provide continued real-time consultation with OLES?  No. The OPS failed to initially provide the OLES with a draft copy of the investigative report prior to closing the investigation.</li> <li>5. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?  No. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and</li> </ol>

	<p>investigative findings.</p> <p>6. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?</p> <p>No. The hiring authority did not consult with the OLES concerning investigative findings.</p> <p>7. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on March 21, 2016; however, the investigation was not completed until October 3, 2016, 196 days later.</p>
<b>Department Corrective Action Plan</b>	<p>Human Resources and the Hiring Authority will consult with OLES regarding the investigative findings of each case. The Hiring Authority will consult with OLES concerning the investigative findings. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/28/2016
<b>OLEs Case Number</b>	2016-00361MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Inexcusable neglect of duty</li> <li>2. Other failure of good behavior</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Letter of Instruction</p> <p>Final: No Change</p>
<b>Incident Summary</b>	<p>On March 28, 2016, a nurse allegedly failed to conduct a nursing assessment and obtain a physician's order to keep a patient in full-body restraints. A psychiatric technician also failed to notify staff that the patient was still in full-body restraints.</p>
<b>Disposition</b>	<p>The hiring authority sustained allegations against the nurse and the psychiatric technician for violating policy regarding full-body restraints, and issued letters of instruction to both employees. The nurse retired before the corrective action was issued; however, a memo was placed in her official personnel file. The hiring authority determined there was insufficient evidence to sustain the</p>

	remaining allegations. The OLES concurred with the hiring authority's determinations.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/26/2016
<b>OLES Case Number</b>	2016-00366MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Not Sustained 3. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On March 26, 2016, a patient alleged three psychiatric technicians stripped him of his clothing and punched him three times in the ribs, while giving him forced medication.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on March 29, 2016; however, the investigation was not completed until November 26, 2016, 242 days later.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on March 29, 2016; however, the investigation was not completed until November 26, 2016, 242 days later.
<b>Department</b>	The Chief/OPS meet bi monthly with investigative staff to



<b>Corrective Action Plan</b>	review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/29/2016
<b>OLES Case Number</b>	2016-00367MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 29, 2016, a patient alleged while she was sleeping a staff member touched her breasts and genitals.
<b>Disposition</b>	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 a lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Insufficient  The department did not comply with policies and procedures governing the investigative process. The level of care staff did not timely notify the hospital police of the incident and also did not protect the crime scene. The investigation was not conducted in a timely manner. The incident was discovered on March 29, 2016; however, the investigation was not completed until April 5, 2017, 372 days later.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority respond timely to the incident?  No. The level of care staff learned of the allegation at 0815 hours; however, did not report the incident to hospital police until approximately 1200 hours, a delay of almost 4 hours later.</li> <li>Was the Hiring Authority's response to the incident appropriate?  No. The crime scene was not properly preserved and items containing potential evidence, such as clothing and bedding, were not secured by the level of care staff.</li> <li>Was the notification made to outside law</li> </ol>

	<p>enforcement recorded in the report?</p> <p>No. The notification to outside law enforcement was not recorded in the report.</p> <p>4. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified of the incident.</p> <p>5. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on March 29, 2016; however, the investigation was not completed until April 5, 2017, 372 days later.</p>
<b>Department Corrective Action Plan</b>	<p>Training has been provided to staff concerning the required reporting time frames to ensure OLES is notified as required. The staff was provided the policy, procedure and administrative directives for proper handling of evidence for a crime scene. On July 7, 2017, all OPS command staff have been instructed to notify outside law enforcement immediately for such instances. The OPS command staff will note the time of notification and outside law enforcement staff they made the notification to. This information is to be included in the police report. Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/31/2016
<b>OLES Case Number</b>	2016-00386MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	A patient alleged that on March 31, 2016, a psychiatric technician grabbed her arms and pushed her against a wall.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative</b>	Procedural Rating: Insufficient

<b>Assessment</b>	<p>Substantive Rating: Sufficient</p> <p>The department inadequately complied with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 313 days from the date of the incident was discovered.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The department learned of the alleged incident on April 2, 2016; however, the final investigative report was not completed until February 9, 2017; 313 days later. The hospital police completed its report within 19 days.</p>
<b>Department Corrective Action Plan</b>	<p>The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/08/2016
<b>OLES Case Number</b>	2016-00417MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 8, 2016, a patient alleged a psychiatric technician squeezed his arm five times. The patient also alleged the psychiatric technician abused a second patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not comply with policies and procedures because it did not timely complete the investigation. The department learned of the alleged</p>

	incident on April 11, 2016, however, the final investigative report was not completed until February 17, 2017, 312 days later.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The hiring authority did not timely notify the OLES, nor did the hiring authority notify the OLES in the proper manner. The hiring authority emailed the OLES three days after the initial report of physical abuse.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The department learned of the alleged incident on April 11, 2016; however, the final investigative report was not completed until February 17, 2017, 312 days later. The hospital police completed the initial report in three days</li> </ol>
<b>Department Corrective Action Plan</b>	The OPS command staff have been reminded of the reporting guidelines and the proper reporting format. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/12/2016
<b>OLES Case Number</b>	2016-00423MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On April 12, 2016, a patient alleged an unidentified person came into his room while he was sleeping and orally copulated him.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The

	<p>OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.</p>
<p><b>Investigative Assessment</b></p>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 392 days from the date of the incident</p>
<p><b>Pre-Disciplinary Assessment</b></p>	<p>1. Was the notification made to outside law enforcement recorded in the report?</p> <p>No. The notification to outside law enforcement was not recorded in the report.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on April 12, 2016; however, the investigation was not completed until May 9, 2017, 392 days later.</p>
<p><b>Department Corrective Action Plan</b></p>	<p>On July 7, 2017, all Office of Protective Services (OPS) command staff have been instructed to notify outside law enforcement immediately for such instances. The OPS command staff will note the time of notification and outside law enforcement staff they made the notification to. This information is to be included in the police report. The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.</p>

Case Table Section	Section Content
<b>Incident Date</b>	04/10/2016
<b>OLES Case Number</b>	2016-00426MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed

	Final: No Change
<b>Incident Summary</b>	On April 10, 2016, a patient alleged staff members threw him to the ground and kicked him in the back.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The department learned of the alleged incident on April 12, 2016; however, the final investigative report was not completed until February 17, 2017, 311 days later.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The department learned of the alleged incident on April 12, 2016; however, the final investigative report was not completed until February 17, 2017, 311 days later. The hospital police completed the initial report in one day.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/13/2016
<b>OLES Case Number</b>	2016-00437MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 13, 2016, a patient alleged a supervising psychiatric technician had been touching her breasts since August 2015. The patient further alleged that on one occasion, the supervising psychiatric technician forced her to touch his genitals.

<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 216 days from the date the incident was discovered. The hiring authority did not consult with the OLES concerning investigative findings.</p>
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>2. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?  No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and investigative findings.</li> <li>3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?  No. The hiring authority did not consult with the OLES concerning investigative findings.</li> <li>4. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on April 13, 2016; however, the investigation was not completed until November 15, 2016, 216 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Hiring Authority will consult with OLES regarding the investigative findings. Human Resources and the Hiring Authority will consult with OLES regarding the investigative findings of each case. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the

	OLES monitor if the investigation and report is going to go beyond the 75-day time frame.
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Case Table Section	Section Content
<b>Incident Date</b>	04/11/2016
<b>OLES Case Number</b>	2016-00442MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 11, 2016, a patient alleged a psychiatric technician twisted her arm behind her back, aggressively placed her on the ground, and dragged her by her arm. The patient sustained a fractured arm.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to consult with the OLES concerning investigatory findings. Additionally, the investigation was not completed until approximately 231 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?  No. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings.</li> <li>Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?  No. The hiring authority did not consult with the OLES concerning investigative findings.</li> </ol>



	<p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on April 13, 2016; however, the investigation was not completed until November 30, 2016, 231 days later.</p>
<b>Department Corrective Action Plan</b>	<p>Human Resources and the Hiring Authority will consult with OLES regarding the investigative findings of each case. Human Resources and the Hiring Authority will consult with OLES regarding the predisciplinary/ investigative phase. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/02/2015
<b>OLES Case Number</b>	2016-00444MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Inexcusable neglect of duty</li> <li>2. Inexcusable neglect of duty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Unfounded</li> <li>2. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: No Penalty Imposed</p> <p>Final: No Change</p>
<b>Incident Summary</b>	<p>On November 2, 2015, two psychiatric technicians allegedly failed to assist a patient when the patient was battered by a second patient.</p>
<b>Disposition</b>	<p>The hiring authority determined the allegation was unfounded as to one psychiatric technician, and there was insufficient evidence to sustain the allegation as to the other psychiatric technician. The OLES concurred with the hiring authority's determinations.</p>
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department generally complied with policies and procedures governing the pre-disciplinary process, however the investigation was not completed in a timely manner. The investigation was not completed until over 255 days from the date the investigation began.</p>
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?</li> </ol>

	<p>No. The department's legal office was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The investigation began on April 14, 2016 and a draft report was not completed until January 5, 2017; over 255 days later.</p>
<b>Department Corrective Action Plan</b>	<p>This case was assigned to a Retired Annuitant (RA) investigator at a time when the Office of Special Investigations (OSI) was staffed with only 1 full-time investigator and 3 RA investigators. As a result of the staffing shortage in OSI, the caseloads on each investigator were demanding. As of July 1, 2016, a Lieutenant was assigned to supervise OSI, relieving the Lead Investigator of those duties and allowing him to focus on an investigative caseload. Additionally, in August 2016 OSI filled another full time investigator vacancy to further alleviate the case load of the OSI Investigators.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/16/2016
<b>OLES Case Number</b>	2016-00453MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 16, 2016, a patient alleged a senior psychiatric technician pinched the back of her neck and shoulder, pulled her hair, and forced her right arm behind her back.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Insufficient</p> <p>The Office of Protective Services failed to comply with the department's policies and procedures governing the pre-disciplinary process due to an untimely investigation. Due to the delay of 271 days, the subject of the investigation had limited recall of the alleged incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. The hiring authority failed to telephonically notify the OLES of the incident.</p>

	<p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Was the investigation thorough and appropriately conducted?</p> <p>No. The investigation was not timely conducted and the delay had a negative impact due to the faded memory of the subject.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on April 17, 2016; however, the investigation was not completed until January 13, 2017, 271 days later.</p>
<b>Department Corrective Action Plan</b>	<p>Training has been provided to staff concerning the required reporting time frames to ensure OLES is notified as required. The Chief/OPS meet bi-monthly with investigative staff to review cases and to establish due dates for better compliance on the time frame criteria. OSI administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/13/2016
<b>OLES Case Number</b>	2016-00455MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 13, 2016, a patient alleged a psychiatric technician pushed her face into the floor two times causing a laceration to her eyebrow.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's decision.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The</p>

	investigation was not completed until approximately 304 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on April 16, 2016; however, the final report was not completed until February 14, 2017, 304 days later. The initial hospital police report was completed in 19 days.</li> </ol>
<b>Department Corrective Action Plan</b>	The Watch Commanders have been reminded of the reporting guidelines and the proper reporting format. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/24/2016
<b>OLES Case Number</b>	2016-00503MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 24, 2016, two psychiatric technicians allegedly used excessive force while restraining a patient, which caused the patient to sustain a chipped tooth.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The department did not timely notify the OLES of the incident

	and the investigation was not completed until approximately 367 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on April 26, 2016; however, the investigation was not completed until April 28, 2017, 367 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/24/2016
<b>OLES Case Number</b>	2016-00504MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 24, 2016, a patient alleged that two staff members grabbed the back of his pants as he exited the restroom and forcefully walked him back to his room.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not comply with policies and procedures because investigation was not completed in a timely manner. The department discovered the alleged incident on April 26, 2016; however, the final investigative report was not completed until February 17, 2017, 297 days</p>

	later.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The department discovered the alleged incident on April 26, 2016; however, the final investigative report was not completed until February 17, 2017, 297 days later. The hospital police completed the initial investigation in 14 days.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/26/2016
<b>OLES Case Number</b>	2016-00507MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 26, 2016, a patient alleged he was choked by a psychiatric technician.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation took 237 days to complete. Additionally, the hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p>

	<p>2. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The final report was completed on or about December 22, 2016; however, the consultation with the hiring authority did not take place until March 13, 2017, 81 days later.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The department learned of the incident on April 27, 2016; however, the investigative report was not completed until December 20, 2017, 237 days later. The initial report was completed by hospital police in 19 days.</p>
<p><b>Department Corrective Action Plan</b></p>	<p>The Hiring Authority will consult with the OLES monitor regarding the disposition of findings as soon as possible after the IRC meetings are held. HR personnel will complete and forward the "Hiring Authority Review of Investigation" and the "Justification of Penalty" form to the Hiring Authority for the consultations with the OLES Monitor. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

Case Table Section	Section Content
<b>Incident Date</b>	04/24/2016
<b>OLES Case Number</b>	2016-00514MA
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 24, 2016, it was discovered a patient was pregnant. The patient had been housed at the department since 2014, and advised that the father of the baby was another patient.
<b>Disposition</b>	No staff misconduct was identified, therefore the matter was not referred for additional investigation. However, systemic issues were identified that are being addressed by the

	department.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OLES regarding the incident. The OLES concurred with the hiring authority's decision not to refer the matter for further investigation.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/24/2016
<b>OLES Case Number</b>	2016-00549MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Inexcusable neglect of duty</li> <li>2. Inexcusable neglect of duty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Not Sustained</li> <li>2. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: No Penalty Imposed Final: No Change</p>
<b>Incident Summary</b>	On May 2, 2016, a patient alleged that on April 24, 2016, a registered nurse and a psychiatric technician asked the patient to touch their genitals and offered to touch his genitals.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The Office of Protective Services did not comply with policies and procedures governing the pre-disciplinary process. The OPS did not report the incident to outside law enforcement as required by law and the investigation was not completed in a timely manner. The investigation was not completed until 226 days after the allegations were made.</p>
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames required by law?  No. Outside law enforcement was not notified of the sexual assault allegation.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's</li> </ol>



	<p>legal office of the incident.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The alleged incident was discovered on May 2, 2016; however, the final investigative report was not completed until December 14, 2016, 226 days later.</p>
<b>Department Corrective Action Plan</b>	All sexual assault allegations must be reported to outside law enforcement. The employee, who did not make the call, has been counseled and retrained. The criminal matter was presented to the IRC on January 10, 2017, prior to the administrative investigation, which delayed the initiation of the administrative investigation. This procedural process has been corrected to prevent the delay of the initiation of administrative investigation in the future.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/26/2016
<b>OLES Case Number</b>	2016-00568MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On April 26, 2016, a patient alleged that a unit supervisor and two psychiatric technicians used excessive force on him during a floor containment procedure.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the investigative process. The patient made an allegation of abuse, however the department determined the actions of the staff did not rise to the level of abuse and closed the matter without an investigation. On the recommendation of the OLES the department conducted an investigation. Although the investigation commenced on May 10, 2016, it was not completed until approximately 207 days later.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. The OLES was not timely notified.</p>

	<p>2. Was the Hiring Authority's response to the incident appropriate?</p> <p>No. The hiring authority initially determined the matter did not rise to the level of abuse and closed the case.</p> <p>3. Did the Hiring Authority adequately consult with OLES regarding the incident?</p> <p>No. The hiring authority did not consult with the OLES prior to determining the matter should be closed.</p> <p>4. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>5. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The investigation into this allegation did not begin until May 10, 2016. The draft report was not completed until December 7, 2016, approximately 207 days later.</p>
<b>Department Corrective Action Plan</b>	The facility has established additional review procedures and will review incidents with OLES prior to closing the investigation.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/09/2016
<b>OLES Case Number</b>	2016-00587MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Inexcusable neglect of duty</li> <li>2. Inexcusable neglect of duty</li> <li>3. Dishonesty</li> <li>4. Other failure of good behavior</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Sustained</li> <li>3. Sustained</li> <li>4. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Salary Reduction</p> <p>Final: No Change</p>
<b>Incident Summary</b>	On May 9, 2016, a psychiatric technician assistant allegedly pulled on a patient's wheelchair and scratched the patient's back. Additionally, it was alleged the psychiatric technician

	assistant failed to complete interdisciplinary notes and she was less than truthful during her investigatory interview.
<b>Disposition</b>	The hiring authority sustained allegations against the psychiatric technician assistant for being less than truthful and failing to correctly date interdisciplinary notes; however, the hiring authority did not sustain an allegation for patient abuse. The hiring authority imposed a salary reduction of 5 percent for six months. The OLES concurred in the determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/10/2016
<b>OLES Case Number</b>	2016-00599MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	A patient alleged that on May 10, 2016, a psychiatric technician grabbed his arm and pushed him.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation took 252 days to complete. Additionally, the hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>2. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</li> </ol>

	<p>No. The investigative report was completed on January 18, 2017; however, the hiring authority did not consult with the OLES until March 13, 2017, 54 days later.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The department discovered the incident on May 11, 2016; however, the final report was not completed until January 18, 2017, 252 days later. The hospital police completed the initial report in 16 days.</p>
<b>Department Corrective Action Plan</b>	<p>The Hiring Authority will consult with the OLES monitor regarding the disposition of findings as soon as possible after the IRC meetings are held. HR personnel will complete and forward the "Hiring Authority Review of Investigation" and the "Justification of Penalty" form to the Hiring Authority for the consultations with the OLES Monitor. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/13/2016
<b>OLES Case Number</b>	2016-00615MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 13, 2016, a patient alleged a psychiatric technician pushed in her the chest.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 293 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?

	<p>No. The incident was discovered on May 13, 2016; however, the OLES was not notified until May 14, 2016.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The department learned of the allegation on May 13, 2016; however, the investigation was not completed until March 2, 2017, 293 days later. The initial report was completed by the hospital police in eight days.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/13/2016
<b>OLES Case Number</b>	2016-00621MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Dishonesty</li> <li>2. Inexcusable neglect of duty</li> <li>3. Inexcusable neglect of duty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Sustained</li> <li>3. Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Dismissal</p> <p>Final: Other</p>
<b>Incident Summary</b>	On May 13, 2016, a recreational therapist was allegedly in possession of a personal letter from a patient, non-prescribed medication, five hundred dollars and photos from a second patient. The first patient was found in possession of a greeting card and the psychiatric technician's mobile phone and office phone numbers.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain all of the allegations and determined that dismissal was the appropriate penalty. The OLES concurred. However, the recreational therapist resigned

	prior to the completion of the investigation; therefore disciplinary action was not taken. A letter indicating the recreational therapist resigned under adverse circumstances was placed in her official personnel file.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 334 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on May 13, 2016; however, the investigative report was not completed until April 12, 2017, 334 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/18/2016
<b>OLES Case Number</b>	2016-00644MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 18, 2016, a patient alleged several psychiatric technicians entered his room, slammed him on the ground, punched him, and then forcibly held him on the ground while his property was removed.
<b>Disposition</b>	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 290 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the OPS adequately respond to the incident?</p> <p>No. The OPS did not assign an investigator to this case for over 60 days after the incident was reported.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The legal department was not notified.</p> <p>3. Did the OPS investigator appropriately enter case activity in the Records Management System?</p> <p>No. The OPS investigator did not have access to the Records Management System.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident occurred on May 18, 2016; however, the final investigative report was not completed until March 8, 2017, 290 days later.</p>
<b>Department Corrective Action Plan</b>	The OPS has hired additional full time investigative staff to ensure cases are assigned in a timely manner, and a discussion was held with the investigator regarding the process for requesting an extension and using the extension memo if the assigned investigation is going to go beyond the 75 calendar days.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/13/2016
<b>OLES Case Number</b>	2016-00651MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 13, 2016, a patient alleged a psychiatric technician assaulted her and used excessive force while placing her on the floor after she refused to return a towel.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.

<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 340 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The incident was discovered on May 20, 2016, at 1813; however, the hiring authority did not notify the OLES of the incident until 2115, approximately three hours later.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on May 20, 2016; however, the investigation was not completed until April 25, 2017, 340 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	<p>The Hiring Authority will be diligent and consult with OLES regarding the sufficiency of the investigation and investigative findings. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/12/2016
<b>OLES Case Number</b>	2016-00653MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 12, 2016, a patient alleged a unit supervisor slammed him on to a bed, climbed on top of him, and administered unnecessary medication.



<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on May 19, 2016; however, the final investigative report was not completed until March 23, 2017, 306 days later.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on May 19, 2016; however, the OPS did not complete the final investigative report until March 23, 2017, 306 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS meet bi-monthly with investigative staff to review cases and to establish due dates for better compliance on the time frame criteria. OSI administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/19/2016
<b>OLES Case Number</b>	2016-00654MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 19, 2016, a psychiatric technician allegedly used unnecessary force when he jumped on a patient as the patient was walking away from him.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and

	<p>procedures governing the pre-disciplinary process. The investigation was not completed until approximately 124 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. The hiring authority did not timely notify the OLES of the incident. The incident was not report telephonically as required.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on May 19, 2016; however, the investigation was not completed until September 20, 2016, 124 days later.</p>
<b>Department Corrective Action Plan</b>	<p>Training has been provided to staff concerning the required reporting time frames to ensure OLES is notified as required. The Chief/OPS meet bi-monthly with investigative staff to review cases and to establish due dates for better compliance on the time frame criteria. OSI administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/22/2016
<b>OLES Case Number</b>	2016-00660MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 22, 2016, a patient alleged a psychiatric technician twisted his arm behind his back and pushed him against a wall.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 340 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on May 22, 2016; however, the investigation was not completed until April 28, 2017, 340 days later.</p>
<b>Department Corrective Action Plan</b>	Chief/OPS meet bi-monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/26/2016
<b>OLEs Case Number</b>	2016-00674MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 26, 2016, a psychiatric technician allegedly punched a patient while intervening in a fight between the patient and another patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on May 26, 2016; however, the final investigative report was not completed until March 15, 2017, 293 days later.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The legal department was not notified.</p>

	<p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on May 26, 2016; however, the OPS did not complete the final investigative report until March 15, 2017, 293 days later.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS meet bi-monthly with investigative staff to review cases and to establish due dates for better compliance on the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/26/2016
<b>OLES Case Number</b>	2016-00684MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 26, 2016, a psychiatric technician allegedly pushed a patient onto a bed and grabbed the patient by the throat.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not comply with policies and procedures governing the pre-investigative process. The investigation was not completed until approximately 319 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on May 27, 2016; however, the investigation was not completed until April 11, 2017, 319 days later.</p>
<b>Department</b>	The Chief/OPS discussed with the entire Investigative staff

<b>Corrective Action Plan</b>	the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/27/2016
<b>OLES Case Number</b>	2016-00688MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 27, 2016, two psychiatric technicians allegedly pushed a patient, held the patient down on the ground, twisted the patient's arm, and pushed the patient's head into the ground. Two officers also allegedly twisted the patient's arm.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/02/2016
<b>OLES Case Number</b>	2016-00711MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On June 2, 2016, a patient alleged that she was sexually and verbally abused by a recreational therapist, unit supervisor, and psychiatrist.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The

	investigation was not completed until approximately 301 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on June 2, 2016; however, the investigation was not completed until March 30, 2017, 301 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	OPS staff have been reminded of the reporting requirements for priority 1 notification to OLES. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/06/2016
<b>OLES Case Number</b>	2016-00716MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On June 6, 2016, a psychiatric technician allegedly hit a patient on the leg and called the patient a derogatory name.
<b>Disposition</b>	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority delayed approximately seven months before</p>

	consulting with the OLES regarding the investigative findings.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>2. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The investigative report was completed on August 5, 2016; however, the hiring authority did not consult with the OLES regarding the sufficiency of investigation, and investigative findings until March 6, 2017, seven months later.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The hiring authority did not timely consult with the OLES regarding the sufficiency of the investigation and investigative findings. The investigation was completed on August 5, 2016; however, the disposition conference was delayed until March 6, 2017.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. The Hiring Authority will insure to consult with OLES regarding disciplinary determinations.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/07/2016
<b>OLES Case Number</b>	2016-00723MA
<b>Allegations</b>	<p>1. Inexcusable neglect of duty</p> <p>2. Other failure of good behavior</p>
<b>Findings</b>	<p>1. Sustained</p> <p>2. Not Sustained</p>
<b>Penalty</b>	<p>Initial: Training</p> <p>Final: No Change</p>
<b>Incident Summary</b>	On June 7, 2016, a nurse allegedly yelled at a patient. On June 8, 2016, a second nurse allegedly poked the same patient's fingertip with an opened paper clip to test for numbness after the patient's recent surgery.
<b>Disposition</b>	The hiring authority sustained an allegation against the first nurse for yelling at the patient, and ordered training for the

	nurse. The hiring authority determined there was insufficient evidence to sustain the remaining allegations against the first and second nurse. The OLES concurred with the hiring authority's determinations.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The department failed to timely notify the OLES and the investigation was not completed until approximately 245 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. The department learned of the alleged misconduct on June 8, 2016, at 1143hrs, but did not notify the OLES until June 8, 2016, at 2100hrs, over nine hours after the Office of Protective Services discovered the incident.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on June 8, 2016; however, the investigation was not completed until February 7, 2017, 245 days later.</p>
<b>Department Corrective Action Plan</b>	The OPS provided training to all OPS supervisors on OLES reporting guidelines in January 2017. The command staff provided roll call training to their staff. The facility will ensure timely consultation with OLES during the pre-disciplinary conference.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/14/2016
<b>OLES Case Number</b>	2016-00728MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Other failure of good behavior</li> <li>2. Inexcusable neglect of duty</li> <li>3. Discourteous treatment</li> <li>4. Dishonesty</li> <li>5. Inexcusable neglect of duty</li> </ol>



<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Sustained</li> <li>3. Sustained</li> <li>4. Sustained</li> <li>5. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Suspension Final: No Change</p>
<b>Incident Summary</b>	<p>On May 14, 2016, a nurse was allegedly less than alert while on duty, and confronted the patient who reported the nurse's inattentiveness to a supervising nurse. The supervising nurse allegedly failed to intervene when the first nurse confronted the patient. Additionally, a licensed vocational nurse was allegedly less than alert while assigned to enhanced observation duties over a patient. The licensed vocational nurse was also allegedly dishonest during the investigation.</p>
<b>Disposition</b>	<p>The hiring authority sustained the allegations against the first nurse, and imposed a 10 percent salary reduction for six months. The hiring authority also sustained the allegations against the licensed vocational nurse, and imposed a 12-working-day suspension. The OLES concurred with the hiring authority's determinations. The hiring authority determined there was insufficient evidence to sustain the allegation against the supervising nurse. The OLES concurred.</p>
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 328 days from the date of the incident was discovered.</p>
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on June 9, 2016; however, the investigation was not completed until May 2, 2017, 328 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	<p>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</p>

	investigation and report is going to go beyond the 75-day time frame.
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Case Table Section	Section Content
<b>Incident Date</b>	06/09/2016
<b>OLES Case Number</b>	2016-00730MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Sustained
<b>Penalty</b>	Initial: Training Final: No Change
<b>Incident Summary</b>	On June 9, 2016, a psychiatric technician allegedly administered medication against a patient's will. Additionally, a psychiatric technician apprentice allegedly failed to report the alleged misconduct to a supervisor in a timely manner.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation of improper medication administration. The hiring authority determined there was sufficient evidence to sustain the allegation of failure to timely report suspected misconduct and provided training to the psychiatric technician apprentice. The OLES concurred with the hiring authority's determinations.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	06/17/2016
<b>OLES Case Number</b>	2016-00774MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On June 17, 2016, a psychiatric technician allegedly slapped a patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's decision.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The department failed to comply with procedures governing the pre-disciplinary process. The department failed to timely notify OLES about the incident and failed to timely consult with the OLES regarding investigative findings.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. On June 17, 2016, at 1810 hours, the Office of Protective Services discovered the incident; however, the Office of Protective Services did not notify OLES until June 18, 2016, at 1338 hours, which is beyond the two-hour notification requirement.</p> <p>2. Was a department attorney assigned to assist with the case development?</p> <p>No. A department attorney was not assigned during the investigation.</p> <p>3. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The final investigative report was completed on August 5, 2016; however, the hiring authority did not consult with OLES regarding the investigative findings until March 6, 2017, seven months later.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>The final investigative report was completed on August 5, 2016; however, the hiring authority did not consult with OLES regarding the investigative findings until March 6, 2017, seven months later.</p>
<b>Department Corrective Action Plan</b>	The OPS provided training to all OPS supervisors on OLES reporting guidelines in January 2017. The command staff provided roll call training to their staff. The facility will ensure timely consultation with OLES during the pre-disciplinary conference.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/19/2016
<b>OLES Case Number</b>	2016-00776MA

<b>Allegations</b>	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty
<b>Findings</b>	1. Not Sustained 2. Sustained 3. Sustained 4. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: No Change
<b>Incident Summary</b>	On June 19, 2016, a psychiatric technician allegedly threatened to injure a patient, allegedly shared personal information with the patient, and failed to report the patient's inappropriate interactions. The psychiatric technician was allegedly dishonest during the investigation.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain allegations that the psychiatric technician shared personal information with the patient, failed to report the patient's inappropriate interactions, and was dishonest during the investigation. The hiring authority did not sustain an allegation for abuse. The hiring authority imposed a salary reduction of 10 percent for 12 months. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/18/2016
<b>OLES Case Number</b>	2016-00777MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained 2. Not Sustained
<b>Penalty</b>	Initial: Training Final: No Change
<b>Incident Summary</b>	On June 18, 2016, a psychiatric technician allegedly tapped the protective head helmet a patient was wearing.
<b>Disposition</b>	The hiring authority sustained an allegation against the psychiatric technician for violating therapeutic strategic intervention policy, but determined there was insufficient evidence to support an allegation of abuse. The OLES concurred with the hiring authority's determinations. The hiring authority determined training was the appropriate

	penalty. Although the OLES ultimately concurred with the hiring authority's decision, the OLES was not consulted during disciplinary determinations.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to consult with the OLES regarding disciplinary determinations.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. The hiring authority did not notify the OLES in the proper or timely manner.</p> <p>2. Did the Hiring Authority adequately consult with OLES regarding the incident?</p> <p>No. The hiring authority did not use a proper method of notification to notify the OLES of the incident.</p> <p>3. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>4. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?</p> <p>No. The hiring authority failed to consult with the OLES regarding disciplinary determinations.</p>
<b>Department Corrective Action Plan</b>	OPS provided re-training to all OPS supervisors and staff on OLES reporting guidelines in January 2017. The Hiring Authority will insure to consult with OLES regarding disciplinary determinations.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/10/2016
<b>OLES Case Number</b>	2016-00823MA
<b>Allegations</b>	<p>1. Discourteous treatment</p> <p>2. Other failure of good behavior</p> <p>3. Inexcusable neglect of duty</p>
<b>Findings</b>	<p>1. Not Sustained</p> <p>2. Not Sustained</p>

	3. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On June 10, 2016, a psychiatric technician allegedly pushed a patient in the chest when the patient leaned into the nurses' station.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/27/2016
<b>OLES Case Number</b>	2016-00838MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On June 27, 2016, six psychiatric technicians and a sergeant allegedly slammed a patient's head into the ground.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain allegations against the six psychiatric technicians and the sergeant. The OLES concurred with the hiring authority's decision.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	07/03/2016
<b>OLES Case Number</b>	2016-00866MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On July 3, 2016, a patient alleged a psychiatric technician attempted to have sexual contact with him.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred

	with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 203 days from the date of the incident. Additionally, the hiring authority did not timely consult with the OLES concerning the sufficiency of the investigation.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the OPS adequately respond to the incident?</p> <p>No. The initial report indicates the staff member suspected of misconduct was interviewed without providing her with the proper admonition.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>The investigative report was finalized on January 24, 2017; however, the hiring authority did not consult with the OLES until March 13, 2017, 48 days later.</p> <p>4. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The alleged incident was discovered on July 5, 2016, however the final investigative report was not completed until January 24, 2017; 203 days later. The hospital police completed the initial report in 24 days.</p>
<b>Department Corrective Action Plan</b>	<p>The OPS will provide staff with training to staff and the Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

Case Table Section	Section Content
<b>Incident Date</b>	07/15/2016
<b>OLES Case Number</b>	2016-00897MA
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On July 15, 2016, a unresponsive patient was found in his room by staff. Emergency medical care was provided until the patient was declared deceased.
<b>Disposition</b>	The patient died of cardiac arrest and no staff misconduct was identified; therefore, the case was not referred to the Office of Protective Services for further investigation.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
<b>Incident Date</b>	07/19/2016
<b>OLES Case Number</b>	2016-00914MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On July 19, 2016, a patient alleged he was having sexual relations with a psychiatric technician. In addition, the patient alleged the psychiatric technician was having sexual relations while on duty with a former patient and two other staff members.
<b>Disposition</b>	The hiring authority determined the allegation to be unfounded. The OLES was not consulted.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The OPS did not provide the OLES with a copy of the draft investigative report. Additionally, the hiring authority did not consult with the OLES concerning investigative findings.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.



	<p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES was not provided with a draft copy of the investigative report.</p> <p>4. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS did not provide the OLES with a draft copy of the investigative report.</p> <p>5. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.</p> <p>6. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?</p> <p>The hiring authority did not consult with the OLES concerning investigative findings.</p>
<p><b>Department Corrective Action Plan</b></p>	<p>OPS staff have been reminded of the reporting requirements for notification to OLES. The Chief/OPS discussed with the investigative staff the importance of providing the draft report to OLES prior to finalizing the report. The Chief/OPS discussed with the investigative staff the importance of consulting with OLES regarding the investigation and providing the draft report before finalization. The Hiring Authority will consult with OLES regarding the sufficiency of the investigation and the investigative findings. The Hiring Authority will consultation</p>

	with OLES regarding the investigative findings.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	07/28/2016
<b>OLES Case Number</b>	2016-00944MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On July 28, 2016, a patient alleged a psychiatric technician scratched her while medication was being administered.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 242 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not notified of the incident within the required two hours.</li> <li>Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The investigation was not completed until approximately 242 days from the date of the incident. The incident occurred July 28, 2016, and the investigation was completed March 28, 2017.</li> </ol>
<b>Department Corrective Action Plan</b>	Training has been provided to staff concerning the required reporting time frames to ensure OLES is notified as required. The Chief/OPS meet bi-monthly with investigative staff to review cases and to establish due dates for better compliance on the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	07/25/2016
<b>OLES Case Number</b>	2016-00957MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	From July 25, 2016, to July 28, 2016, staff members allegedly failed to clean a patient who had soiled himself, leaving the patient in his own urine and feces for three days.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/03/2016
<b>OLES Case Number</b>	2016-00998MA
<b>Allegations</b>	1. Other failure of good behavior 2. Discourteous treatment 3. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Unfounded 3. Inexcusable neglect of duty
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On August 3, 2016, a nurse allegedly poked a patient in the chest, told the patient it was permissible for another staff member to sexually assault the patient, and failed to report the patient's allegation of sexual assault.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/08/2016
<b>OLES Case Number</b>	2016-01004MA
<b>Allegations</b>	1. Inexcusable neglect of duty

<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On August 8, 2016, a patient alleged that a staff member came into his room and scratched him with a sharp object.
<b>Disposition</b>	The hiring authority determined that the investigation proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 125 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The legal department was not notified.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on August 10, 2016; however, the investigative report was not completed until December 15, 2016, 125 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The OPS has established guidelines to ensure reports are completed in the required timeframe.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/08/2016
<b>OLES Case Number</b>	2016-01016MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On August 8, 2016, a patient alleged a psychiatric technician touched his genitals.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient

	<p>The department failed to comply with policies and procedures governing the investigative process. The incident was discovered on August 8, 2016; however, the investigation was not completed until April 7, 2017, 242 days later.</p>
<p><b>Pre-Disciplinary Assessment</b></p>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified of the incident.</li> <li>2. Was the notification made to outside law enforcement recorded in the report?  No. The notification to outside law enforcement was not recorded in the report.</li> <li>3. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>4. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on August 8, 2016; however, the investigation was not completed until April 7, 2017, 242 days later.</li> </ol>
<p><b>Department Corrective Action Plan</b></p>	<p>On July 7, 2017, all Office of Protective Services (OPS) command staff have been instructed on the requirements for Priority 1 and Priority 2 OLES notifications. Command staff are to make the OLES notification within the required timeframes and note the time of the notification in the 24 Hour Watch Commander Log. Additionally, the OPS has hired an Associate Government Program Analyst who will act as the OLES Liaison. This staff was hired as of June 1st, 2017 and will coordinate for all OLES cases. On July 7, 2017, all Office of Protective Services (OPS) command staff have been instructed to notify outside law enforcement immediately for such instances. The OPS command staff will note the time of notification and outside law enforcement staff they made the notification to. This information is to be included in the police report. The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log</p>

	of scheduled due dates to keep Chief/OPS informed.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/13/2016
<b>OLES Case Number</b>	2016-01019MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On August 13, 2016, a patient alleged a registered nurse forced her onto the floor, sat on her chest, grabbed her hair, and stepped on her chest.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral tot he district attorney. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 229 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not notified of the incident within the required two hours.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The investigation was not completed until approximately 229 days from the date of the incident. The incident occurred August 13, 2016, and the investigation was completed March 31, 2017.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS meet bi-monthly with investigative staff to review cases and to establish due dates for better compliance on the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled

	due dates to keep Chief/OPS informed.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/10/2016
<b>OLES Case Number</b>	2016-01022MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On August 10, 2016, a patient's mother alleged the patient was pushed to the ground by a staff member.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The incident was discovered on August 12, 2016; however, the investigation was not completed until April 29, 2017, 260 days later.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The legal department was not notified.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on August 12, 2016; however, the investigation was not completed until April 29, 2017, 260 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	On July 7, 2017, all Office of Protective Services (OPS) command staff have been instructed on the requirements for Priority 1 and Priority 2 OLES notifications. Command staff are to make the OLES notification within the required timeframes and note the time of the notification in the 24 Hour Watch Commander Log. Additionally, OPS has hired

	an Associate Government Program Analyst who will act as the OLES Liaison. This staff was hired as of June 1, 2017 and will coordinate for all OLES cases. The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/15/2016
<b>OLES Case Number</b>	2016-01036MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On August 15, 2016, a patient alleged a psychiatric technician hit him.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The incident was discovered on August 15, 2016; however, the investigation was not completed until May 2, 2017, 260 days later.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The legal department was not notified.</li> <li>3. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on August 15, 2016; however, the investigation was not completed until May 2, 2017, 260 days later.</li> </ol>



<b>Department Corrective Action Plan</b>	On July 7, 2017, all Office of Protective Services (OPS) command staff have been instructed on the requirements for Priority 1 and Priority 2 OLES notifications. Command staff are to make the OLES notification within the required timeframes and note the time of the notification in the 24 Hour Watch Commander Log. Additionally, OPS has hired an Associate Government Program Analyst who will act as the OLES Liaison. This staff was hired as of June 1, 2017 and will coordinate for all OLES cases. The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/10/2016
<b>OLES Case Number</b>	2016-01043MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On August 10, 2016, a patient alleged a psychiatric technician pulled his hair and called him a derogatory name.
<b>Disposition</b>	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/19/2016
<b>OLES Case Number</b>	2016-01061MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On August 19, 2016, a patient alleged that three unknown staff members picked him up by his arms and legs, carried him to his room, threw him on his bed and forcefully

	administered an injection.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 182 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The department learned of the alleged incident on August 19, 2016; however, the final report was not completed until February 17, 2017, 182 days later. The hospital police completed the initial report in 13 days.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/17/2016
<b>OLES Case Number</b>	2016-01062MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On August 17, 2016, a patient alleged a psychiatric technician grabbed him by the shirt and arm, dragged him to a medication room, where he was forcibly given medication.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient

	The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 132 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on August 19, 2016; however, the investigative report was not completed until December 29, 2016, 132 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/22/2016
<b>OLES Case Number</b>	2016-01077MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On August 22, 2016, a patient was transported from a hospital to county jail. At the jail, the patient alleged that prior to leaving the hospital, an unidentified hospital staff "jammed" him against a wall causing pain to his chest and difficulty breathing.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	08/20/2016
<b>OLES Case Number</b>	2016-01079MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On August 20, 2016, a nurse and a psychiatric technician allegedly grabbed a patient's arms, and stepped on the patient's feet while escorting the patient to a seclusion room. In addition, three other psychiatric technicians allegedly continuously knocked on the door and called out the patient's name in order to deprive the patient of sleep.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/05/2016
<b>OLES Case Number</b>	2016-01107MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Unsubstantiated
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 5, 2016, a patient alleged he was forcibly held on the ground by psychiatric technicians while they removed property from his cell. He further alleged that one psychiatric technician held him in a "head lock" while a registered nurse repeatedly punched him in the head.
<b>Disposition</b>	The hiring authority determined the allegations were unsubstantiated. The OLES concurred in the determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 100 days from the date the investigation was opened.
<b>Pre-Disciplinary</b>	1. Did the Hiring Authority timely notify the department's

<b>Assessment</b>	<p>legal office of the incident?</p> <p>No. The legal department was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The investigation into this matter was opened on August 26, 2016; however, the draft report was not completed until December 7, 2016, 100 days later. Also, the final report was not completed until January 17, 2017, over 30 days later.</p>
<b>Department Corrective Action Plan</b>	<p>The allegations in this case were very serious and the investigation was complex and involved a significant number of witnesses, thus the investigation was not completed within the 75-day timeline. The department has implemented a notification protocol for cases that will take longer than 75 calendar days to investigate, the facility will utilize this process going forward to ensure that OLES is aware in the future when a case is likely to take longer than 75 days to investigate.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	08/28/2016
<b>OLES Case Number</b>	2016-01123MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Other failure of good behavior</li> <li>2. Inexcusable neglect of duty</li> <li>3. Inexcusable neglect of duty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Not Sustained</li> <li>2. Not Sustained</li> <li>3. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Training</p> <p>Final: No Change</p>
<b>Incident Summary</b>	<p>On August 28, 2016, a licensed vocational nurse allegedly slapped a patient's face during enhanced observation of the patient. Two nurses allegedly failed to report the incident. One of the nurses also allegedly failed to accurately sign the night shift sign-in sheet.</p>
<b>Disposition</b>	<p>The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the determination.</p>
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>Overall, the department complied with policies and procedures governing the pre-disciplinary process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/05/2016
<b>OLES Case Number</b>	2016-01138MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On September 5, 2016, a patient alleged a psychiatric technician aggressively placed him against the wall, causing a small laceration to his forehead.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 183 days from the date of the incident, and the hiring authority did not consult with the OLES concerning the investigative findings.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?  No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.</li> <li>Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?  No. The hiring authority did not consult with the OLES concerning the sufficiency of the investigation and investigative findings.</li> <li>Was the pre-disciplinary/investigative phase</li> </ol>

	<p>conducted with due diligence?</p> <p>No. The incident was discovered on September 5, 2016; however, the investigation was not completed until March 7, 2017, 183 days later.</p>
<b>Department Corrective Action Plan</b>	<p>The Hiring Authority will be diligent and consult with OLES regarding the sufficiency of the investigation and investigative findings. The hiring authority will consult with OLES regarding the investigation and investigative findings. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/08/2016
<b>OLES Case Number</b>	2016-01164MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On September 8, 2016, two psychiatric technicians allegedly stabilized a patient against a wall even though the patient was allegedly compliant, then threw the patient on the ground.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 231 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on September 9,</p>

	2016; however, the investigation was not completed until April 27, 2017, 231 days later.
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/06/2016
<b>OLES Case Number</b>	2016-01165MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 6, 2016, a psychiatric technician allegedly used excessive force while restraining a patient on a bed.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 273 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on September 6, 2016; however, the investigation was not completed until June 5, 2017, 273 days later.
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day



	time frame.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/09/2016
<b>OLES Case Number</b>	2016-01170MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On September 9, 2016, a patient alleged a psychiatric technician battered another patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES was not consulted.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES concerning investigative findings.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The hiring authority did not timely notify the OLES.</li> <li>2. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>3. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?  No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings.</li> <li>4. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?  No. The hiring authority did not consult with the OLES</li> </ol>

	concerning investigative findings.
<b>Department Corrective Action Plan</b>	OPS staff have been reminded of the reporting requirements for priority 1 notification to OLES. The Hiring Authority will be diligent and consult with OLES regarding the sufficiency of the investigation and investigative findings. Human Resources and the Hiring Authority will consult with OLES regarding pre-disciplinary/investigative phase.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/08/2016
<b>OLES Case Number</b>	2016-01176MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 8, 2016, a senior psychiatric technician allegedly told a patient to take off her pants, then inappropriately touched the patient.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 247 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames required by law?  No. There is no information that the Office of Protective Services timely notified outside law enforcement.</li> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>Was the pre-disciplinary/investigative phase conducted with due diligence?</li> </ol>

	No. The incident was discovered on September 12, 2016; however, the investigative report was not completed until May 16, 2017, 247 days later.
<b>Department Corrective Action Plan</b>	OPS provided re-training to all OPS supervisors and staff on OLES reporting guidelines in January 2017. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/08/2016
<b>OLES Case Number</b>	2016-01180MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On September 8, 2016, a patient alleged that a psychiatric technician grabbed his arm and pulled him, causing him to feel anxious and embarrassed.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 182 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on September 12, 2016; however, the investigation was not completed until April 12, 2017, 182 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the

	extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.
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Case Table Section	Section Content
<b>Incident Date</b>	07/27/2016
<b>OLES Case Number</b>	2016-01189MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On July 27, 2016, a psychiatric technician allegedly punched the back of a patient's head while the patient was being contained on the patient's bed.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department complied with policies and procedures governing the investigatory process.

Case Table Section	Section Content
<b>Incident Date</b>	09/14/2016
<b>OLES Case Number</b>	2016-01192MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained 2. Sustained
<b>Penalty</b>	Initial: Counseling Final: No Change
<b>Incident Summary</b>	On September 14, 2016, a patient was allegedly neglected when a psychiatric technician fell asleep while conducting a one-to-one observation.
<b>Disposition</b>	The hiring authority sustained the allegation the psychiatric technician fell asleep during her one-to-one observation. The hiring authority imposed a letter of counseling. The OLES concurred with the determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies

	and procedures governing the pre-disciplinary process.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/19/2016
<b>OLES Case Number</b>	2016-01224MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 19, 2016, a psychiatric technician allegedly pushed his own knees into the back of a patient's knees, put his body weight on the back of the patient's calf as the patient knelt, and allegedly punched the patient's ribs several times.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 259 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on September 20, 2016; however, the investigation was not completed until June 5, 2017, 259 days later.
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	09/24/2016
<b>OLES Case Number</b>	2016-01237MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 24, 2016, a psychiatric technician allegedly inappropriately touched a patient's groin area while the patient slept. On September 25, 2016, two other psychiatric technicians allegedly sexually assaulted the same patient as he slept.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 222 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on September 24, 2016; however, the investigation was not completed until May 3, 2017, 222 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/22/2016
<b>OLES Case Number</b>	2016-01283MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred

<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 22, 2016, a psychiatric technician allegedly gave incorrect medication to a patient, then attempted to retrieve the medication by attempting to pull the patient's arm through the medication window port.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 159 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident occurred on October 3, 2016; however, the investigation was not completed until March 14, 2017, 159 days later
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/19/2016
<b>OLES Case Number</b>	2016-01377MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On October 19, 2016, a registered nurse allegedly slammed a door on a patient's fingers.
<b>Disposition</b>	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 Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/23/2016
<b>OLES Case Number</b>	2016-01386MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On October 23, 2016, a psychiatric technician assistant allegedly pushed and struck a patient.
<b>Disposition</b>	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 did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/18/2016
<b>OLES Case Number</b>	2016-01400MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On September 18, 2016, a patient alleged that a psychiatric technician pushed her against a wall which caused her to hit her head.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the investigative process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/18/2016
<b>OLES Case Number</b>	2016-01402MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On October 18, 2016, a psychiatric technician allegedly used excessive force while restraining a patient. A second psychiatric technician allegedly used a chokehold on the patient, then slammed the patient's head into a wall.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 203 days from the date of the incident was discovered.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on October 26, 2016; however, the investigation was not completed until May 16, 2017, 203 days later.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day

	time frame.
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Case Table Section	Section Content
<b>Incident Date</b>	10/23/2016
<b>OLES Case Number</b>	2016-01410MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On October 23, 2016, a patient alleged that he was pushed and grabbed by a psychiatric technician assistant.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing investigative process.

Case Table Section	Section Content
<b>Incident Date</b>	11/03/2016
<b>OLES Case Number</b>	2016-01436MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 3, 2016, a nurse, a senior psychiatric technician, and a psychiatric technician allegedly failed to release a patient from restraints in a timely manner.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	11/04/2016
<b>OLES Case Number</b>	2016-01442MC
<b>Allegations</b>	1. Criminal Act

<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 4, 2016, a psychiatric technician assistant allegedly failed to properly monitor a patient, who was on a constant level of supervision status, thereby allowing the patient an opportunity to swallow a screw.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/24/2016
<b>OLES Case Number</b>	2016-01444MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On October 24, 2016, a patient alleged that a registered nurse hit her in the head with a plate. In addition, two psychiatric technicians who witnessed the incident allegedly laughed and failed to intervene.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's decision.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/04/2016
<b>OLES Case Number</b>	2016-01453MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change

<b>Incident Summary</b>	On November 4, 2016, a psychiatric technician allegedly asked a patient to masturbate.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/03/2016
<b>OLES Case Number</b>	2016-01461MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 3, 2016, a patient alleged that three staff members forcefully placed him against a wall while administering medication.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The OPS did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 146 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The investigation was not completed until approximately 146 days from the date of the incident. The incident occurred November 8, 2016,</li> </ol>

	and the investigation was concluded April 3, 2017.
<b>Department Corrective Action Plan</b>	The Chief/OPS meet bi-monthly with investigative staff to review cases and to establish due dates for better compliance on the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/13/2016
<b>OLES Case Number</b>	2016-01485MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 13, 2016, a staff member allegedly inappropriately touched a patient.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 212 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on November 14, 2016; however, the final investigative report was not completed until June 14, 2017, 212 days later.
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

Case Table Section	Section Content
<b>Incident Date</b>	11/13/2016
<b>OLES Case Number</b>	2016-01490MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 13, 2016, a patient alleged a psychiatric technician pushed her.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. An administrative investigation was not opened due to a lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
<b>Incident Date</b>	11/15/2016
<b>OLES Case Number</b>	2016-01497MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 15, 2016, a patient alleged a psychiatric technician aggressively placed him on the floor, banged his head on the floor, and slapped him repeatedly in the face.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 149 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the

	<p>department's legal office of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on November 15, 2016; however, the investigation was not completed until April 12, 2017, 149 days later.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/16/2016
<b>OLES Case Number</b>	2016-01498MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 16, 2016, a senior psychiatric technician allegedly hit a patient multiple times on his arm with a bag in an attempt to wake him.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 174 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on November 16, 2016; however, the investigation was not completed until May 9, 2017, 174 days later.</p>

<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/09/2016
<b>OLES Case Number</b>	2016-01508MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 9, 2016, a psychologist was allegedly involved in an overly familiar relationship with an inmate.
<b>Disposition</b>	The psychologist resigned while the investigation was on-going. The hiring authority placed a letter in the psychologist's official personnel file indicating she resigned under unfavorable circumstances.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/19/2016
<b>OLES Case Number</b>	2016-01530MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 19, 2016, a patient alleged that a psychiatric technician verbally and physically mistreated another patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 142 days after the incident was discovered.



<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. The hiring authority did not timely notify the OLES of the physical abuse.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on November 21, 2016; however, the investigation was not completed until April 12, 2017, 142 days later.</p>
<b>Department Corrective Action Plan</b>	<p>OPS staff have been reminded of the reporting requirements for priority 1 notification to OLES. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/21/2016
<b>OLES Case Number</b>	2016-01550MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Inexcusable neglect of duty</li> <li>2. Dishonesty</li> <li>3. Inexcusable neglect of duty</li> <li>4. Dishonesty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Sustained</li> <li>3. Sustained</li> <li>4. Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Dismissal</p> <p>Final: No Change</p>
<b>Incident Summary</b>	<p>On September 21, 2016, a patient alleged a psychiatric technician would not allow her to use the restroom. The psychiatric technician was also allegedly dishonest during an investigative interview. A registered nurse allegedly failed to report the allegation.</p>
<b>Disposition</b>	<p>The hiring authority determined there was sufficient</p>

	evidence to sustain the allegations against the psychiatric technician and dismissed the employee. The hiring authority also sustained the allegation against a registered nurse and ordered she receive corrective action. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on September 22, 2016; however, the investigation was not completed until March 27, 2017, 192 days later.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The legal office was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on September 22, 2016; however, the investigation was not completed until March 27, 2017, 192 days later.</p>
<b>Department Corrective Action Plan</b>	Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/29/2016
<b>OLES Case Number</b>	2016-01559MA
<b>Allegations</b>	<p>1. Inexcusable neglect of duty</p> <p>1. Insubordination</p>
<b>Findings</b>	<p>1. Not Sustained</p> <p>2. Not Sustained</p>
<b>Penalty</b>	<p>Initial: No Penalty Imposed</p> <p>Final: No Change</p>
<b>Incident Summary</b>	On November 29, 2016, a patient alleged a psychiatric technician punched him in the throat. In addition, the psychiatric technician allegedly failed to cooperate with the investigation into the allegation.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative</b>	Procedural Rating: Insufficient

<b>Assessment</b>	Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 147 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on November 29, 2016; however, the investigation was not completed until April 25, 2017, 147 days later.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/07/2016
<b>OLES Case Number</b>	2016-01595MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 7, 2016, a psychiatric technician allegedly allowed a patient to remain in soiled clothing and bedding for approximately 45 minutes while in full bed restraints.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	12/08/2016
<b>OLES Case Number</b>	2016-01597MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 8, 2016, a psychiatric technician allegedly used his personal mobile phone while assigned to provide direct and continuous observation of a patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 139 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on December 8, 2016; however, the investigation was not completed until April 25, 2017, 139 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/05/2016
<b>OLES Case Number</b>	2016-01598MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 5, 2016, a psychiatric technician assistant

	was allegedly sleeping while assigned to a one-to-one observation of patient. It was further alleged that on December 8, 2016, the same psychiatric technician assistant was using her personal cell phone while on a one-to-one observation of the same patient.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/09/2016
<b>OLES Case Number</b>	2016-01603MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 9, 2016, a patient alleged that a registered nurse punched him in the mouth.
<b>Disposition</b>	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 OPS also opened an administrative investigation, which the OLES accepted for monitoring.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/09/2016
<b>OLES Case Number</b>	2016-01605MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 9, 2017, a nurse allegedly sexually assaulted a patient. The patient recanted the allegation approximately one hour after making the initial allegation.

<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 187 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal department was not notified.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on December 10, 2016; however, the investigation was not completed until June 14, 2017, 187 days later.
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/10/2016
<b>OLES Case Number</b>	2016-01607MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 10, 2016, a patient alleged a physician digitally penetrated her rectum during an examination. The patient also alleged a health services specialist took pictures of her genitals. In addition, the patient alleged a registered nurse gave her a mixture of dishwater and milk of magnesia which she ingested.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred

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

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/08/2016
<b>OLES Case Number</b>	2016-01613MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 8, 2016, a patient alleged that a psychiatric technician punched and kicked him several times on the head.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 136 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on December 9, 2016; however, the investigation was not completed until April 24, 2017, 136 days later.</li> </ol>
<b>Department</b>	On July 7, 2017, all Office of Protective Services (OPS)

<b>Corrective Action Plan</b>	command staff have been instructed on the requirements for Priority 1 and Priority 2 OLES notifications. Command staff are to make the OLES notification within the required timeframes and note the time of the notification in the 24 Hour Watch Commander Log. Additionally, OPS has hired an Associate Government Program Analyst who will act as the OLES Liaison. This staff was hired as of June 1, 2017 and will coordinate for all OLES cases. The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/12/2016
<b>OLES Case Number</b>	2016-01616MA
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 12, 2016, a patient was discovered non-responsive in the day hall. Emergency life-saving measures were provided; however, the patient did not recover and was pronounced dead. An autopsy revealed the cause of death as Arteriosclerotic Cardiovascular Disease.
<b>Disposition</b>	No staff misconduct was identified; therefore, the case was not referred for additional investigation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OLES regarding the incident.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/30/2016
<b>OLES Case Number</b>	2016-01628MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 30, 2016, a doctor allegedly inappropriately touched a patient during a medical exam.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services failed to notify outside law enforcement about the incident, and the investigation was not completed until approximately 191 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames required by law?</p> <p>No. The Office of Protective Services did not notify outside law enforcement about the alleged sexual assault.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on December 13, 2016; however, the investigation was not completed until June 21, 2017, 191 days later.</p>
<b>Department Corrective Action Plan</b>	OPS provided re-training to all OPS supervisors and staff on OLES reporting guidelines in January 2017. OPS will insure the investigation is conducted in a timely manner.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/15/2016
<b>OLES Case Number</b>	2016-01652MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Dismissal Final: No Change
<b>Incident Summary</b>	On December 15, 2016, a registered nurse allegedly allowed a patient to self-administer medications without a doctor's order.

<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. The OLES concurred. However, the registered nurse resigned before disciplinary action could be imposed. A letter indicating the registered nurse resigned under adverse circumstances was placed in her official personnel file.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/22/2016
<b>OLES Case Number</b>	2016-01669MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 22, 2016, a patient reported that a rehabilitation therapist "put a baby in me."
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 124 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on December 22, 2016; however, the investigation was not completed until April 25, 2017, 124 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the

	extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/22/2016
<b>OLES Case Number</b>	2016-01670MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 22, 2016, a patient alleged a social worker pushed her.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to the lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on December 22, 2016; however, the investigation was not completed until May 8, 2017, 137 days later.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on December 22, 2016; however, the investigation was not completed until May 8, 2017, 137 days later.
<b>Department Corrective Action Plan</b>	Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/23/2016
<b>OLES Case Number</b>	2016-01674MA

<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 23, 2016, medical staff members allegedly failed to appropriately monitor a patient on suicide watch, resulting in the patient drinking a dangerously excessive amount of water.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/26/2016
<b>OLES Case Number</b>	2016-01678MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act
<b>Findings</b>	1. Not Referred 2. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 26, 2016, a psychiatric technician allegedly intentionally gave the wrong medication to a patient. It was further alleged the psychiatric technician tried to intimidate a nurse from reporting the incident.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/30/2016
<b>OLES Case Number</b>	2016-01682MA

<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 30, 2016, a psychiatric technician allegedly failed to properly supervise a patient, who was on a constant level of observation status. Allegedly, the patient was able to use a restroom without observation.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/28/2016
<b>OLES Case Number</b>	2016-01693MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 28, 2016, a psychiatric technician allegedly sexually assaulted a patient as the patient showered. The patient recanted approximately 15 hours after making the allegation.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 159 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.

	<p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on December 29, 2016; however, the investigation was not completed until June 5, 2017, 159 days later.</p>
<b>Department Corrective Action Plan</b>	The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/23/2016
<b>OLES Case Number</b>	2016-01699MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 23, 2016, a patient alleged a psychiatric technician grabbed her by her shirt collar, pulled her down onto a bed, and laid on top of her.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/15/2016
<b>OLES Case Number</b>	2016-01701MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 15, 2016, a psychiatric technician allegedly administered medication to a patient in an improper manner.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a

	probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The case was referred for review to determine if an administrative investigation will be conducted.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/21/2016
<b>OLES Case Number</b>	2016-01704MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 21, 2016, a registered nurse alleged a psychiatric technician improperly administered medication to a patient.
<b>Disposition</b>	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 administrative investigation.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/25/2016
<b>OLES Case Number</b>	2016-01706MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 25, 2016, a patient suffered an injury to his head from an undetermined cause.
<b>Disposition</b>	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.

<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 148 days from the date of the incident</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified of the incident.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on December 29, 2016; however, the investigation was not completed until May 25, 2017, 148 days later.</p>
<b>Department Corrective Action Plan</b>	<p>Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/03/2017
<b>OLES Case Number</b>	2017-00013MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 3, 2017, a registered nurse allegedly pushed a patient against a wall.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the investigative process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	01/06/2017
<b>OLES Case Number</b>	2017-00026MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 6, 2017, a patient alleged a psychiatric technician had assaulted him in the shower.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/06/2017
<b>OLES Case Number</b>	2017-00027MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 6, 2017, a patient alleged she was sexually assaulted by a registered nurse while she was sleeping. Subsequently, the patient stated she had only dreamt she was sexually assaulted.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	06/01/2016
<b>OLES Case Number</b>	2017-00037MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	A patient alleged that in June or July 2016, a psychiatric technician had allegedly taken him off the facility grounds and sexually assaulted him.
<b>Disposition</b>	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 Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/10/2017
<b>OLES Case Number</b>	2017-00051MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On January 10, 2017, a patient alleged a psychiatric technician punched her in the left arm, grabbed her by the neck, and called her a derogatory name.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/23/2016
<b>OLES Case Number</b>	2017-00062MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained

<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 23, 2016, a psychiatric technician allegedly slapped a patient on his head.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until approximately 166 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The legal department was not notified.  3. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The legal department was not notified.  4. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on September 23, 2016; however, the final investigation was not completed until March 8, 2017, 166 days later.  2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident was discovered on September 23, 2016; however, the final investigation was not completed until March 8, 2017, 166 days later.
<b>Department Corrective Action Plan</b>	The Chief/OPS meet bi monthly with investigative staff to review and establish due dates for better compliance in the time frame criteria. OPS administrative staff currently maintains a 75 day tracking log of scheduled due dates to keep Chief/OPS informed.

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	01/20/2017
<b>OLES Case Number</b>	2017-00083MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 20, 2017, a psychiatric technician allegedly grabbed a patient's jacket and hit him in the stomach.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/22/2017
<b>OLES Case Number</b>	2017-00089MA
<b>Allegations</b>	1. Other failure of good behavior 2. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On January 22, 2017, a psychiatric technician allegedly kicked a trash can lid, which was being held by a patient, causing injuries to the patient's hand and head.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations against the psychiatric technician. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	01/24/2017
<b>OLES Case Number</b>	2017-00091MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Penalty Imposed
<b>Incident Summary</b>	On January 24, 2017, a patient alleged staff members and other patients had repeatedly sexually assaulted her.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/19/2017
<b>OLES Case Number</b>	2017-00105MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On January 19, 2017, four psychiatric technicians allegedly unnecessarily restrained a patient for approximately 20 minutes. Allegedly, the four psychiatric technicians used their body weight to hold the patient down while they waited for the chemical restraint to take effect.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policy and procedure during the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/26/2017
<b>OLES Case Number</b>	2017-00106MC
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other

	Final: No Change
<b>Incident Summary</b>	On January 26, 2017, a patient died while at an outside hospital due to atherosclerotic cardio disease.
<b>Disposition</b>	The hiring authority reviewed this matter and determined no staff misconduct or policy violations were identified as part of a death review. The matter was not referred to district attorney's office. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/26/2017
<b>OLES Case Number</b>	2017-00110MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 26, 2017, a patient was discovered breathing, but otherwise unresponsive in his cell. The patient was taken to standby emergency services, where he continued to be unresponsive. The patient was taken to a local hospital and an emergency craniotomy was performed for drainage to a large epidural hematoma. The patient suffered a non-displaced skull fracture and a left transverse sinus laceration.
<b>Disposition</b>	The department conducted an inquiry into this matter and determined there was no evidence for a probable cause referral to the district attorney and no staff misconduct identified. A memorandum was submitted to the hiring authority and the matter was closed. The OLES concurred with the determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
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<b>Incident Date</b>	10/25/2016
<b>OLES Case Number</b>	2017-00115MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On October 25, 2016, a patient alleged she was battered by another patient in front of six staff members. The patient alleged the staff members laughed and failed to properly intervene.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department did not comply with policies and procedures governing the pre-disciplinary process. The level of care staff did not timely report the allegation to the Office of Protective Services. Additionally, the investigation was not completed until approximately 138 days from the date the incident was discovered.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority respond timely to the incident?  No. The incident occurred on October 25, 2016; however, was not reported to the hospital police until November 4, 2016, 10 days later.</li> <li>2. Was the Hiring Authority's response to the incident appropriate?  No. The hospital police did not conduct a thorough investigation and did not take steps to identify the alleged subjects until directed to do so by OSI.</li> <li>3. Was the incident properly documented?  No. The initial report did not document attempts by hospital police to locate potential subjects.</li> <li>4. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> </ol>

	<p>5. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The alleged incident was discovered on November 4, 2016; however, the investigation was not completed until March 21, 2017, 138 days later.</p>
<b>Department Corrective Action Plan</b>	<p>The Hiring Authority has been reminded of the reporting requirements for notification to Office of Law Enforcement Support (OLES). To prevent any delay in OPS responding to the incident the hiring authority will forward complaints received from Patient's Rights to OPS immediately. The Chief/OPS reminded the OPS staff of the importance to documenting all steps taken during their preliminary investigation in their reports. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/11/2017
<b>OLES Case Number</b>	2017-00132MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On February 11, 2017, a patient died as a result of a fall which caused a skull fracture.
<b>Disposition</b>	The hiring authority determined no staff misconduct, abuse, or neglect contributed to the patient's death and therefore did not sustain any allegations of misconduct. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/03/2017
<b>OLES Case Number</b>	2017-00133MC
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Not Referred



<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 3, 2017, a patient died while being treated at an outside hospital. The autopsy findings concluded the patient died due to natural causes.
<b>Disposition</b>	The hiring authority reviewed this matter and determined no staff misconduct or policy violations were identified as part of a death review. The matter was not referred to the district attorney's office. The OLES concurred with the determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/03/2017
<b>OLES Case Number</b>	2017-00136MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 3, 2017, a psychiatric technician allegedly slapped a patient on the back of the head and forcefully pulled the patient from his chair for failing to comply with a fire alarm drill. In addition, while escorting the patient, the psychiatric technician allegedly called the patient a derogatory term.
<b>Disposition</b>	The investigation 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 Special Investigations also opened an administrative investigation which the OLES accepted for monitoring.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigatory process sufficiently complied with policies and procedures.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/04/2016
<b>OLES Case Number</b>	2017-00170MA
<b>Allegations</b>	1. Inexcusable neglect of duty

<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 4, 2016, a psychiatric technician allegedly failed to properly maintain appropriate supervision of a patient on enhanced supervision status.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/18/2017
<b>OLES Case Number</b>	2017-00198MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On February 18, 2017, a registered nurse allegedly pushed a medication cart into a patient's leg three times.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/17/2017
<b>OLES Case Number</b>	2017-00199MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 17, 2017, a psychiatric technician allegedly engaged in a sexual relationship with a patient.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
<b>Incident Date</b>	01/27/2017
<b>OLES Case Number</b>	2017-00210MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On January 27, 2017, a psychiatric technician allegedly pushed a patient to the ground, and later, allegedly cleaned a wound on the patient's forearm in an unsanitary manner.
<b>Disposition</b>	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 Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	08/10/2016
<b>OLES Case Number</b>	2017-00237MA
<b>Allegations</b>	1. Other failure of good behavior 2. Discourteous treatment
<b>Findings</b>	1. Unfounded 2. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On August 10, 2016, a patient alleged a psychiatric technician pulled his hair and called him a derogatory name.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department complied with policies and procedures governing the pre-disciplinary process.</p>
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/06/2017
<b>OLES Case Number</b>	2017-00260MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 6, 2017, a psychiatric technician allegedly attempted to sexually assault a patient.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the investigative process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/07/2017
<b>OLES Case Number</b>	2017-00269MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 7, 2017, a patient alleged that she may have been sexually assaulted by a psychiatric technician.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department's investigative process sufficiently complied with policies and procedures.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/30/2017
<b>OLES Case Number</b>	2017-00287MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 30, 2017, a psychiatric technician allegedly used excessive force on a patient during a wall containment procedure. On February 7, 2017, the psychiatric technician allegedly twisted the same patient's arm during another wall containment procedure.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/19/2017
<b>OLES Case Number</b>	2017-00332MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Not Sustained 3. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On March 19, 2017, a patient alleged that a psychiatric technician and a registered nurse falsified his medical chart and that another psychiatric technician threatened to give him unnecessary medication.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and

	procedures governing the pre-disciplinary process.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/21/2017
<b>OLES Case Number</b>	2017-00373MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	Between March 21 and March 22, 2017, a psychiatric technician allegedly elbowed a patient twice in the neck. On March 25, 2017, the same psychiatric technician allegedly punched the same patient twice in the stomach.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/19/2016
<b>OLES Case Number</b>	2017-00407MA
<b>Allegations</b>	1. Unlawful discrimination 2. Unlawful retaliation 3. Dishonesty 4. Other failure of good behavior
<b>Findings</b>	1. Sustained 2. Sustained 3. Sustained 4. Sustained
<b>Penalty</b>	Initial: Dismissal Final: Dismissal
<b>Incident Summary</b>	On April 19, 2016, a supervising special investigator allegedly sexually harassed an investigator by leaning over a desk to say, "good morning" in an emphatic manner. The supervising special investigator also allegedly stared at the investigator's breasts. From May 10, 2016, to September 26, 2016, the supervising special investigator allegedly retaliated against the investigator after the investigator filed a complaint, by issuing corrective actions to the investigator, and by having the investigator removed from training so the supervising special investigator could attend

	<p>instead. The supervising special investigator also allegedly discriminated against the investigator. The supervising special investigator was also allegedly dishonest during the investigatory interview.</p>
<b>Disposition</b>	<p>The hiring authority sustained allegations against the supervising special investigator for sexual harassment, discrimination, retaliation, and dishonesty, and dismissed him. The OLES concurred with the hiring authority's determinations.</p>
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Insufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigator did not provide the OLES with sufficient time to review the draft investigative report. The report was submitted to the hiring authority 12 days before the deadline to take disciplinary action. The investigator failed to notify the OLES of several case interviews. The hiring authority failed to consult with the OLES regarding findings and penalty until after the hiring authority had already made his determinations and served the disciplinary action.</p>
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan?  No. The OLES was not consulted regarding an investigative plan.</li> <li>3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?  No. The investigator did not provide the draft investigative report to the OLES with sufficient time to review the report and provide input.</li> <li>4. 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?</li> </ol>

	<p>No. The deadline to take disciplinary action was April 19, 2017; however, the report was submitted to the hiring authority on April 7, 2017, 12 days before the deadline.</p> <p>5. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The investigator failed to notify the OLES of several interviews. Although the OLES did provide initial recommendations regarding the draft investigative report on April 6, 2017, and the investigator inquired April 10, 2017, about any other input from the OLES regarding the report, the investigator later advised on April 12, 2017, that the report was forwarded to the hiring authority on April 7, 2017, without any recommendations incorporated.</p> <p>6. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The hiring authority did not consult with the OLES regarding the sufficiency of the investigation, and investigative findings, until after the hiring authority had already made his determinations and the resulting disciplinary action was served.</p> <p>7. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?</p> <p>No. The hiring authority did not consult with the OLES prior to making findings determinations.</p>
<p><b>Department Corrective Action Plan</b></p>	<p>The Chief/OPS discussed with the investigative staff the importance of consulting with OLES regarding the investigative plan /process. The Chief/OPS discussed with the investigative staff the importance of the draft report to OLES prior to finalizing the report. The Chief/OPS discussed with the entire Investigative staff the importance of timely completion of subject interviews to allow for hiring authority to take disciplinary action. The Chief/OPS discussed with the investigative staff the importance of consulting with OLES regarding the investigation. The Hiring Authority will</p>



	consult with OLES regarding the investigation and the investigative findings prior to final determination and disciplinary action being served. The Hiring Authority will consult with OLES regarding the disciplinary process.
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Case Table Section	Section Content
<b>Incident Date</b>	05/02/2017
<b>OLES Case Number</b>	2017-00530MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act
<b>Findings</b>	1. Referred 2. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On May 2, 2017, a psychiatric technician allegedly hit a patient three times on the back of the head.
<b>Disposition</b>	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 OPS also opened an administrative investigation, which the OLES accepted for monitoring.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
<b>Incident Date</b>	05/14/2017
<b>OLES Case Number</b>	2017-00582MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On May 14, 2017, a patient alleged he had been sexually assaulted by staff members.
<b>Disposition</b>	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient

	Overall, the department sufficiently complied with policies and procedures governing the investigative process.
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Case Table Section	Section Content
<b>Incident Date</b>	05/17/2017
<b>OLES Case Number</b>	2017-00592MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 17, 2017, a patient died from cardiopulmonary failure after returning from an outside hospital where he had received medical care and treatment.
<b>Disposition</b>	The hiring authority determined no staff misconduct, abuse, or neglect contributed to the patient's death and therefore did not sustain any allegations of misconduct. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	08/10/2016
<b>OLES Case Number</b>	2017-00612MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On August 10, 2016, a psychiatric technician allegedly pushed a patient to the ground.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	02/17/2017
<b>OLES Case Number</b>	2017-00613MA
<b>Allegations</b>	1. Inexcusable neglect of duty

	2. Other failure of good behavior
<b>Findings</b>	1. Sustained 2. Sustained
<b>Penalty</b>	Initial: Dismissal Final: No Change
<b>Incident Summary</b>	On February 17, 2017, a psychiatric technician allegedly engaged in a long-term overly familiar relationship with a patient.
<b>Disposition</b>	The hiring authority sustained the allegations against the psychiatric technician and determined dismissal was the appropriate penalty. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/17/2017
<b>OLES Case Number</b>	2017-00614MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Other failure of good behavior
<b>Findings</b>	1. Sustained 2. Sustained
<b>Penalty</b>	Initial: Dismissal Final: No Change
<b>Incident Summary</b>	On February 17, 2017, a psychiatric technician allegedly engaged in a long-term overly familiar relationship with a patient.
<b>Disposition</b>	The hiring authority sustained the allegations against the psychiatric technician and determined dismissal was the appropriate penalty; however, the psychiatric technician resigned before the investigation concluded. A letter was placed in the psychiatric technician's official personnel file to document the psychiatric technician resigned under unfavorable circumstances. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/18/2016
<b>OLES Case Number</b>	2017-00710MA

<b>Allegations</b>	1. Unlawful retaliation
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	From May 18, 2016, to October 28, 2016, a lieutenant allegedly retaliated against an officer by giving the officer dirty looks, making inappropriate comments towards the officer, treating the officer differently regarding dispatch center calls, and taking video recordings of the officer. Additionally, from June 30, 2016, to October 17, 2016, the lieutenant allegedly retaliated against an investigator by staring at the investigator on several occasions, and mouthing an offensive word when the lieutenant looked at the investigator.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain all allegations against the lieutenant. The OLES concurred with the hiring authority's determinations.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

## Appendix B2 – DDS Pre-Disciplinary Cases

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/07/2016
<b>OLES Case Number</b>	2016-00266MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On March 7, 2016, a client alleged a psychiatric technician hit him in his eye.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegation against the psychiatric technician. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with the policies and procedures governing the pre-disciplinary process. The investigation was not completed in a timely manner. The

	investigation was opened on March 8, 2016 and was not completed until December 12, 2016: a delay of nine months.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The investigation was not completed in a timely manner. The investigation took nine months to be completed.</p>
<b>Department Corrective Action Plan</b>	The investigator and the supervisor have been counseled regarding completing investigations in a timely manner.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/11/2016
<b>OLES Case Number</b>	2016-00299MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On March 11, 2016, a psychiatric technician assistant discovered a lesion on a client's scrotum while bathing the client.
<b>Disposition</b>	The department conducted an investigation into this matter; however, there was insufficient evidence to indicate misconduct occurred and the matter was closed.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/10/2016
<b>OLES Case Number</b>	2016-00320MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 10, 2016, it was determined during an eye

	examination that a client had a detached retina
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/07/2016
<b>OLES Case Number</b>	2016-00322MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 7, 2016, a psychiatric technician allegedly punched and tried to choke a client.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. An administrative investigation was not opened due to lack of sufficient evidence. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Insufficient  The department failed to comply with procedures governing the investigatory process. The hiring authority did not timely notify the OLES. The draft investigative report and the final investigative report contained inaccuracies describing the OLES' role in the case. The investigation took over 120 days to complete, and finally, the OPS delayed in providing a copy of the final investigative report to the OLES.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The Office of Protective Services was notified of the incident on March 17, 2016; however, they did not notify the OLES until March 18, 2016.</li> <li>2. Did the Hiring Authority notify outside law enforcement of the incident within the specified time</li> </ol>

	<p>frames required by law?</p> <p>No. There is no documentation outside law enforcement was notified.</p> <p>3. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified of the incident.</p> <p>4. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?</p> <p>No. The draft investigative report included both criminal and administrative findings.</p> <p>5. Was the final investigative report thorough and appropriately drafted?</p> <p>No. Although the final investigative report was corrected to contain only criminal findings, the report incorrectly stated the recommendation to not open an administrative investigation was directed by the OLES.</p> <p>6. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The final investigative report was dated September 2, 2016; however, the OPS did not provide the OLES with a copy of the final report until January 9, 2017, four months later.</p> <p>7. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on March 17, 2016; however, the draft investigative report was not completed until August 8, 2016, over 120 days later. Also, the OLES did not receive a copy of the final investigative report until four months after completion.</p>
<p><b>Department Corrective Action Plan</b></p>	<p>All facility OPS managers and supervisors have been issued verbal and written instruction that they shall abide by the OLES Facility Reporting Guidelines, and rank and file OPS</p>

	<p>personnel have been briefed regarding the OLES Facility Reporting Guidelines and of their individual responsibilities to notify OPS managers and supervisors of priority 1 and 2 incidents. OPS personnel have also been instructed to provide facility employees (mandated reporters) with the necessary notification requirements to abide by Welfare and Institutions Section 15630 (mandated reporters). Progressive discipline has been issued to OPS personnel who have failed to abide by the OLES Facility Reporting Guidelines.</p>
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Case Table Section	Section Content
<b>Incident Date</b>	12/11/2015
<b>OLES Case Number</b>	2016-00391MA
<b>Allegations</b>	1. Incompetency
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 11, 2015, a client apparently died from natural causes. However, toxicology results could not rule out death from a possible drug overdose.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain any allegations of medical negligence. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	04/19/2016
<b>OLES Case Number</b>	2016-00551MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On April 19, 2016, a pre-licensed psychiatric technician allegedly punched a client after the client tried to bite staff.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. An administrative investigation was not opened because of



	insufficient evidence. The OLES concurred.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the investigative process. The department failed to timely notify the OLES, and the investigation was not completed until approximately 317 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?</p> <p>No. The OLES was not timely notified.</p> <p>2. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The department's legal office was not notified.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on May 3, 2016; however, the investigation was not completed until March 15, 2017, 317 days later.</p>
<b>Department Corrective Action Plan</b>	<p>OPS has provided officers with training to ensure timeliness of notifications to OLES and outside law enforcement and to document the notifications in their reports. SIU Investigators have been advised to immediately schedule their interviews with the assigned OLES Monitor in order to expedite the investigative process. OPS management will continue to closely monitor the status of all assigned SIU investigations.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/02/2016
<b>OLES Case Number</b>	2016-00560MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On May 2, 2016, a client allegedly punched a second client in his rib area. A psychiatric technician allegedly failed to report the incident.
<b>Disposition</b>	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES

	concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/18/2016
<b>OLES Case Number</b>	2016-00664MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On May 18, 2016, a client was receiving medical treatment when it was discovered he had a fractured rib.
<b>Disposition</b>	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/08/2016
<b>OLES Case Number</b>	2016-00726MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On June 8, 2016, a client allegedly did not receive proper medical care to treat cancer.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with this determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department complied with the policies and procedures governing the pre-disciplinary process. However, the OLES recommended the department obtain

	an objective and independent medical opinion from an expert outside the facility, to determine whether the care provided to the client was appropriate. Such an opinion was not obtained.
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Case Table Section	Section Content
<b>Incident Date</b>	06/21/2016
<b>OLES Case Number</b>	2016-00786MA
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On June 21, 2016, a client suffered cardiac arrest. Emergency medical services responded and were unable to revive the client.
<b>Disposition</b>	The hiring authority reviewed this matter and determined no staff misconduct or policy violations were identified as part of a death review. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	06/01/2016
<b>OLES Case Number</b>	2016-00875MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act 3. Criminal Act
<b>Findings</b>	1. Referred 2. Referred 3. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	From June 2016 to July 2016, a pre-licensed psychiatric technician allegedly had sex with a patient.
<b>Disposition</b>	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and

	<p>procedures governing the investigatory process. The Office of Protective Services failed to timely notify the OLES and outside law enforcement about the alleged misconduct. The investigator failed to consult with the OLES about draft search warrants before the search warrants were submitted to a judicial magistrate.</p>
<p><b>Pre-Disciplinary Assessment</b></p>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The department learned of the alleged misconduct on June 13, 2016, at 1515hrs, but did not notify the OLES until July 8, 2016, at 0710hrs, 25 days after the Office of Protective Services discovered the alleged misconduct.</li>   <li>2. Did the Hiring Authority notify outside law enforcement of the incident within the specified time frames required by law?  No. There is no documentation that the department timely notified outside law enforcement about the pre-licensed psychiatric technician's alleged misconduct.</li>   <li>3. Was the notification made to outside law enforcement recorded in the report?  No. There is no documentation that the department notified outside law enforcement.</li>   <li>4. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not timely notified about the alleged misconduct.</li>   <li>5. Did OPS cooperate with and provide continued real-time consultation with OLES?  No. The investigator did not allow OLES an opportunity to review and consult on search warrants before they were submitted to a judicial magistrate.</li> </ol>
<p><b>Department Corrective Action Plan</b></p>	<p>All OPS staff have been provided additional training regarding requirements to notify OLES. The OPS did notify local law enforcement in this case, but failed to document the notification in the report. The investigator has been</p>

	counseled. The investigator was not aware that OLES wanted to review search warrants before they were submitted to a judge. OPS staff is now aware and will consult with OLES on search warrants in the future.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	07/27/2016
<b>OLES Case Number</b>	2016-00941MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: No Change
<b>Incident Summary</b>	On July 27, 2016, a senior psychiatric technician allegedly failed to make required notifications after hearing a client's arm make a popping sound while the client was being moved. The client was later diagnosed with a fractured arm.
<b>Disposition</b>	The hiring authority sustained the allegation against the senior psychiatric technician and imposed a 5 percent salary reduction for 12 months. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 112 days from the date of incident. In addition, the final investigative report was approved on December 15, 2016; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings until approximately 113 days later.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The OLES was not timely notified.</li> <li>2. Was the notification made to outside law enforcement recorded in the report?  No. The report did not indicate notification was made to outside law enforcement.</li> <li>3. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> </ol>

	<p>4. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The final investigative report was approved on December 15, 2016; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation and the investigative findings until April 6, 2017, 113 days later.</p> <p>5. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on July 27, 2016; however, the investigation was not completed until November 15, 2016, 112 days later.</p>
<b>Department Corrective Action Plan</b>	OPS has provided officers with training to ensure timeliness of notifications to OLES and outside law enforcement and to document the notifications in their reports. SIU Investigators have been advised to immediately schedule their interviews with the assigned OLES Monitor in order to expedite the investigative process. OPS management will continue to closely monitor the status of all assigned SIU investigations.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	07/26/2016
<b>OLES Case Number</b>	2016-00942MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On July 26, 2016, a client was discovered to have sustained a fractured hand.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	08/27/2016
<b>OLES Case Number</b>	2016-01106MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Dismissal Final: No Change
<b>Incident Summary</b>	On August 27, 2016, a psychiatric technician allegedly failed to adequately maintain enhanced supervision of a client, which resulted in the client's escape from the facility.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 5 percent salary reduction for twelve months. The OLES concurred with the hiring authority's determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the pre-disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	09/03/2016
<b>OLES Case Number</b>	2016-01133MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 3, 2016, a client alleged she was hit in the head by a psychiatric technician.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department's investigative process sufficiently complied with policies and procedures.

Case Table Section	Section Content
<b>Incident Date</b>	09/09/2016
<b>OLES Case Number</b>	2016-01166MC
<b>Allegations</b>	1. Criminal Act

<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On September 9, 2016, a client alleged a psychiatric technician placed him in a chokehold and pulled him to the ground from behind.
<b>Disposition</b>	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/15/2016
<b>OLES Case Number</b>	2016-01197MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On September 15, 2016, a client alleged a psychiatric technician kicked his foot and aggressively threw a ball at him while the two played basketball.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The Office of Protective Services failed to comply with the department's policies and procedures governing the investigative process. The investigator did not provide the OLES with a draft investigative report for review.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office of the incident.</li> <li>Upon completion of the investigation, was a draft</li> </ol>



	<p>copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES was not provided with a draft copy of the investigative report.</p> <p>3. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>The OLES was not provided with a draft copy of the investigative report.</p>
<b>Department Corrective Action Plan</b>	The investigator was counseled to provide a draft copy of the investigative report to the OLES monitor.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/03/2016
<b>OLES Case Number</b>	2016-01281MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On October 3, 2016, a psychiatric technician allegedly handled a client in an aggressive manner, by forcibly removing a catheter and roughly pulling him into a seated position, while the client was receiving treatment at an outside hospital.
<b>Disposition</b>	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The district attorney's office filed criminal charges against the psychiatric technician. The OPS also opened an administrative investigation, which the OLES accepted for monitoring.
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 182 days from the date of the incident.</p>
<b>Pre-Disciplinary Assessment</b>	1. Did the Hiring Authority timely notify the department's legal office of the incident?

	<p>No. The department's legal office was not notified.</p> <p>2. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on October 3, 2016; however, the investigative report was not completed until April 3, 2017, 182 days later.</p>
<b>Department Corrective Action Plan</b>	Due to vacation, training, and temporary reassignment to another facility, the assigned investigator was unavailable for an extended time. In the future, investigations will be reassigned to another investigator when there are lengthy staff absences.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/02/2016
<b>OLES Case Number</b>	2016-01434MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 2, 2016, a health care staff member allegedly was physically abusive with a client during a transfer of the client from her bed to the shower, which resulted in a fractured right femur and a bruised forehead.
<b>Disposition</b>	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 did not open an administrative investigation, and the OLES concurred with this determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/03/2016
<b>OLES Case Number</b>	2016-01439MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 3, 2016, a staff member allegedly hit a client

	while on a bus during a field trip. A civilian witness reported the incident.
<b>Disposition</b>	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 OPS also opened an administrative investigation, which the OLES did not monitor.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/07/2016
<b>OLES Case Number</b>	2016-01454MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 7, 2016, a psychiatric technician allegedly grabbed a client, and used her fists to strike the client's head. The psychiatric technician also allegedly threatened to kill the client.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department complied with policies and procedures governing investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/07/2016
<b>OLES Case Number</b>	2016-01458MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 7, 2016, a client alleged that a psychiatric technician struck his head and another psychiatric

	technician struck him on the arm.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/14/2016
<b>OLES Case Number</b>	2016-01495MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 14, 2016, a senior psychiatric technician allegedly placed his forearm on a client's neck while holding the client down on a bed.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/19/2016
<b>OLES Case Number</b>	2016-01515MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 19, 2016, a psychiatric technician assistant discovered an elderly client was bleeding from her genital area. Some minor scratches were also noticed in the client's genital area.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/20/2016
<b>OLES Case Number</b>	2016-01518MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 20, 2016, a client was discovered with bruising to her breast and thighs.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/22/2016
<b>OLES Case Number</b>	2016-01527MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 22, 2016, a client died from cardiopulmonary arrest and respiratory failure while at an outside hospital, where she had been receiving treatment.
<b>Disposition</b>	The hiring authority determined no staff misconduct, abuse, or neglect contributed to the patient's death and therefore did not sustain any allegations of misconduct. The OLES concurred.
<b>Investigative</b>	Procedural Rating: Insufficient

<b>Assessment</b>	Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 141 days from the date of the incident.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> <li>2. Was the pre-disciplinary/investigative phase conducted with due diligence?  No. The incident occurred on November 22, 2016; however, the Investigation was not completed until April 11, 2017, 141 days later.</li> </ol>
<b>Department Corrective Action Plan</b>	This death investigation required extensive review of medical documents such as interdisciplinary notes, physician's orders, physician progress notes, physician's death summary, etc. During the course of the death investigation, interviews were conducted with multiple physicians, nurses, deputy coroner and other subject matter experts. However, OPS management will continue to closely monitor the status of all assigned SIU investigations.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/17/2016
<b>OLES Case Number</b>	2016-01535MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 17, 2016, a client alleged that a rehabilitation therapist pulled her hair.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Insufficient  The Office of Protective Services failed to comply with the department's policies and procedures governing the

	<p>investigative process. The investigation did not initially include an interview with the staff to which the client first recanted the allegation. Additionally, the interview of the client concerning the recantation was less than a minute in length and was conducted in a suggestive manner to insure the client agreed the recantation was given freely and voluntarily and not as the result of threats, duress, or tricks.</p>
<p><b>Pre-Disciplinary Assessment</b></p>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the department's legal office of the incident?  No. The hiring authority did not notify the department's legal office about the incident.</li> <li>2. Were all of the interviews thorough and appropriately conducted?  No. The interview of the client regarding the recantation of the allegations was approximately one minute in length and did not seek to determine if the recantation was freely and voluntarily given. Additionally, the investigation did not originally include an interview with the staff to whom the client initially recanted the allegation.</li> <li>3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?  No. The report did not include an interview with the staff to whom the client initially recanted.</li> <li>4. Was the investigation thorough and appropriately conducted?  No. The interview of the client regarding the recantation of the allegations was approximately one minute in length and did not seek to determine if the recantation was freely and voluntarily given. Additionally, the investigation did not originally include an interview with the staff to whom the client initially recanted the allegation.</li> </ol>
<p><b>Department Corrective Action Plan</b></p>	<p>The investigator has been provided direction regarding how to conduct proper interviews when a victim wants to recant their allegation.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/08/2016
<b>OLES Case Number</b>	2016-01612MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained 2. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On December 8, 2016, a psychiatric technician allegedly left a client, who was under constant supervision, unattended. In addition, a registered nurse allegedly failed to properly supervise another client, at the same time, and the two clients were involved in a fight.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegation against the psychiatric technician; however, the psychiatric technician resigned prior to the imposition of the penalty. A letter was placed in his official personnel file indicating he resigned under unfavorable circumstances. The hiring authority determined there was insufficient evidence to sustain the allegation against the registered nurse; however, the nurse received training as a result of this incident. The OLES concurred with the hiring authority's determinations.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/05/2016
<b>OLES Case Number</b>	2016-01615MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 5, 2016, four psychiatric technicians allegedly punched and kicked a client.
<b>Disposition</b>	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.
<b>Investigative</b>	Procedural Rating: Sufficient



<b>Assessment</b>	Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/12/2016
<b>OLES Case Number</b>	2016-01624MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 12, 2016, a unit supervisor and a psychiatric technician allegedly hit a client with either a lock or keys while the client was in the shower.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. An administrative investigation was not opened because of insufficient evidence.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the investigatory process. The Office of Protective Services did not identify the client's abuse allegation in a timely manner, failed to timely notify outside law enforcement, and the OLES of the allegation.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>1. Did the Hiring Authority timely notify the Office of Law Enforcement Support (OLES) of the incident?  No. The department learned of the alleged misconduct on December 12, 2016, at 0859hrs, but the department did not notify the OLES until December 13, 2016, at 0850hrs, almost 24 hours after the Office of Protective Services discovered the alleged incident.</li> <li>2. Did the OPS adequately respond to the incident?  No. The Office of Protective Services did not initially identify the client's allegation of abuse which would have required more immediate notification to the OLES.</li> <li>3. Did the Hiring Authority notify outside law</li> </ol>

	<p>enforcement of the incident within the specified time frames required by law?</p> <p>No. The department failed to timely notify outside law enforcement.</p> <p>4. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p>
<b>Department Corrective Action Plan</b>	The officer in this case was new to the department. He has been provided additional training regarding notification requirements.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/24/2016
<b>OLES Case Number</b>	2016-01639MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act
<b>Findings</b>	1. Not Referred 2. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On November 24, 2016, a psychiatric technician assistant allegedly kicked a client in the chest, and a psychiatric technician allegedly hit the client. The two staff members also allegedly choked the client.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation because of a lack of evidence. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/22/2016
<b>OLES Case Number</b>	2016-01668MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred

<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 22, 2016, a health care staff member allegedly was physically abusive with a client, which resulted in the client sustaining a broken arm.
<b>Disposition</b>	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 did not open an administrative investigation, and the OLES concurred with this determination.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	12/29/2016
<b>OLES Case Number</b>	2016-01703MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On December 29, 2016, a client died while at an outside hospital from undetermined causes. Later, the autopsy findings concluded the patient died due to complications from a brain tumor.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/01/2017
<b>OLES Case Number</b>	2017-00003MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred

<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 1, 2017, two health care staff were changing a nonverbal client's diaper when the client suddenly died.
<b>Disposition</b>	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/03/2017
<b>OLES Case Number</b>	2017-00012MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 3, 2017, a client alleged that she was raped by a senior psychiatric technician.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/03/2017
<b>OLES Case Number</b>	2017-00014MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 3, 2017, a client alleged that a psychiatric technician punched her in the eye.
<b>Disposition</b>	An investigation failed to establish sufficient evidence for a

	probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/08/2017
<b>OLES Case Number</b>	2017-00028MA
<b>Allegations</b>	1. Other
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 8, 2017, a client who was hospitalized due to a perforated bowel died. The client was not a candidate for surgery and had a do not resuscitate order in place at the time.
<b>Disposition</b>	The hiring authority reviewed this matter and determined no staff misconduct or policy violations were identified as part of a death review. The OLES concurred.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/11/2017
<b>OLES Case Number</b>	2017-00042MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On January 11, 2017, a psychiatric technician assistant allegedly choked a client.
<b>Disposition</b>	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.
<b>Investigative</b>	Procedural Rating: Sufficient

<b>Assessment</b>	Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/02/2017
<b>OLES Case Number</b>	2017-00137MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act
<b>Findings</b>	1. Not Referred 2. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 2, 2017, a client alleged he had been forcefully pushed by a senior psychiatric technician after a verbal altercation with another client.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/07/2016
<b>OLES Case Number</b>	2017-00149MA
<b>Allegations</b>	1. Other failure of good behavior 2. Discourteous treatment
<b>Findings</b>	1. Not Sustained 2. Not Sustained
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On November 7, 2016, a psychiatric technician allegedly grabbed a client, and used the client's fists to strike the client's head. The psychiatric technician also allegedly threatened to kill the client.
<b>Disposition</b>	The hiring authority determined there was insufficient evidence to sustain the allegations against the psychiatric technician. The OLES concurred with the hiring authority's determination.

<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.</p>
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/07/2017
<b>OLES Case Number</b>	2017-00160MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Suspension Final: No Change
<b>Incident Summary</b>	On February 7, 2017, a client alleged a psychiatric technician threatened to hit her.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 30-working-day suspension. The OLES concurred.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department's pre-disciplinary process sufficiently complied with polices and procedures.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/07/2017
<b>OLES Case Number</b>	2017-00161MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act
<b>Findings</b>	1. Not Referred 2. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 7, 2017, a client alleged a psychiatric technician pulled her hair and digitally penetrated her genitals.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Insufficient</p> <p>Although the investigation was generally adequate;</p>

	however, the interview of the complaining client was mishandled. The initial interview of the client was suggestive and manipulative to such a degree that the client had to be re-interviewed.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Were all of the interviews thorough and appropriately conducted?</p> <p>No. The interview of the client was not appropriately conducted. The investigator was leading, suggestive and somewhat manipulative in attempting to get the client to recant her allegation. The initial interview was so flawed that the client had to be re-interviewed.</p> <p>3. Was the investigation thorough and appropriately conducted?</p> <p>No. The interview of the alleged victim was not properly conducted.</p>
<b>Department Corrective Action Plan</b>	The investigator was issued a Letter of Instruction detailing his deficiencies and clearly outlining expectations.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/13/2017
<b>OLES Case Number</b>	2017-00180MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act
<b>Findings</b>	1. Not Referred 2. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 13, 2017, a client alleged a psychiatric technician used a padded defensive tool to push her to the ground.
<b>Disposition</b>	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.



<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department's investigative process sufficiently complied with policies and procedures.</p>
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/13/2017
<b>OLES Case Number</b>	2017-00184MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 13, 2017, a psychiatric technician allegedly punched a client in the stomach numerous times.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the investigative process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/13/2017
<b>OLES Case Number</b>	2017-00185MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 13, 2017, a client died from natural causes while at an outside hospital where she had been receiving end of life care.
<b>Disposition</b>	No staff misconduct was identified; therefore, the matter was not referred to the district attorney's office. The OPS did not open an administrative investigation due to lack of evidence. The OLES concurred with the determinations.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department complied with policies and procedures governing the investigative process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	02/23/2017
<b>OLES Case Number</b>	2017-00224MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On February 23, 2017, a client alleged that a psychiatric technician separated her from another client in an aggressive manner and called her derogatory name.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/01/2017
<b>OLES Case Number</b>	2017-00250MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 1, 2017, a client alleged a psychiatric technician dragged him across the floor.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

Case Table Section	Section Content
<b>Incident Date</b>	03/05/2017
<b>OLES Case Number</b>	2017-00256MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 5, 2017, a client alleged a psychiatric technician called her a derogatory name and then knocked her to the floor.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

Case Table Section	Section Content
<b>Incident Date</b>	03/05/2017
<b>OLES Case Number</b>	2017-00262MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 5, 2017, a psychiatric technician allegedly poked a client in the eyes.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the investigative process.

Case Table Section	Section Content
<b>Incident Date</b>	03/08/2017
<b>OLES Case Number</b>	2017-00276MC
<b>Allegations</b>	1. Criminal Act

<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Penalty Imposed
<b>Incident Summary</b>	On March 8, 2017, a client alleged a senior psychiatric technician and three psychiatric technicians pulled her hair.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. An administrative investigation was not opened due to insufficient evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/13/2017
<b>OLES Case Number</b>	2017-00304MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 13, 2017, a client alleged a psychiatric technician kicked her in the knee.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/13/2017
<b>OLES Case Number</b>	2017-00306MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 13, 2017, a staff member allegedly caused a

	fracture to a client's toe.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/17/2017
<b>OLES Case Number</b>	2017-00327MC
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 17, 2017, a client alleged a psychiatric technician kicked her in the legs.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The Office of Protective Services did not comply with policies and procedures governing the investigative process because the investigation and report were finalized without consultation with the OLES.
<b>Pre-Disciplinary Assessment</b>	<ol style="list-style-type: none"> <li>Did the Hiring Authority adequately consult with OLES regarding the incident?  No. The OPS investigator neither did not provide the OLES with the audio recording of the interviews, nor with the draft report until after the investigation was finalized.</li> <li>Did the Hiring Authority timely notify the department's legal office of the incident?  No. The department's legal office was not notified.</li> </ol>

	<p>3. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the Hiring Authority or prosecuting agency?</p> <p>No. The OLES was not provided with a draft copy of the report before the report was finalized and forwarded to the hiring authority.</p> <p>4. Did OPS cooperate with and provide continued real-time consultation with OLES?</p> <p>No. The OPS did not provide the OLES with neither audio recordings of the interviews, nor a draft report prior to the completion of the investigation.</p>
<b>Department Corrective Action Plan</b>	The investigator has been issued a Letter of Instruction.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/22/2017
<b>OLES Case Number</b>	2017-00364MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 22, 2017, a psychiatric technician allegedly kicked a patient's leg.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/30/2017
<b>OLES Case Number</b>	2017-00385MC
<b>Allegations</b>	1. Criminal Act
<b>Findings</b>	1. Not Referred

<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On March 30, 2017, a psychiatric technician and a psychiatric technician assistant allegedly punched and hit a client in the face and chest.
<b>Disposition</b>	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.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department complied with policies and procedures governing the investigative process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	04/02/2017
<b>OLES Case Number</b>	2017-00397MA
<b>Allegations</b>	1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained 2. Sustained 3. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: No Change
<b>Incident Summary</b>	On April 2, 2017, two psychiatric technicians allegedly failed to properly supervise clients who had engaged in sexual activity. One of the clients lacked the legal capacity to consent. Additionally, the psychiatric technicians allegedly falsified medical rounds documents.
<b>Disposition</b>	The hiring authority determined that the one of the psychiatric technicians falsified documents and failed to adequately supervise the clients and imposed a salary reduction of 5 percent for 12 months. The hiring authority determined the second psychiatric technician failed to properly complete documentation and likewise failed to adequately supervise the clients and imposed a salary reduction of 5 percent for 12 months.
<b>Investigative Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigator was not initially prepared to conduct a subject

	interview, thereby requiring a second interview of the subject.
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Did the investigator adequately prepare for all aspects of the investigation?</p> <p>No. The investigator did not prepare adequately for one of the subject interviews, requiring the subject to be interviewed a second time.</p> <p>3. Were all of the interviews thorough and appropriately conducted?</p> <p>No. The initial interview of one of the subjects was not thoroughly conducted because the investigator had not gathered all relevant documents prior to the interview.</p>
<b>Department Corrective Action Plan</b>	The Investigator was issued a memo of counseling outlining the deficiencies in this investigation and providing clear expectations for future investigations.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/03/2016
<b>OLES Case Number</b>	2017-00615MA
<b>Allegations</b>	<p>1. Dishonesty</p> <p>2. Inexcusable neglect of duty</p>
<b>Findings</b>	<p>1. Sustained</p> <p>2. Sustained</p>
<b>Penalty</b>	<p>Initial: Dismissal</p> <p>Final: No Change</p>
<b>Incident Summary</b>	On October 3, 2016, a psychiatric technician allegedly handled a client in an aggressive manner while at an outside hospital and was allegedly dishonest during the investigatory interview.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegations, and dismissed the employee. The OLES concurred.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient</p> <p>Substantive Rating: Sufficient</p> <p>The department sufficiently complied with policies and</p>



	procedures governing the pre-disciplinary process.
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<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/28/2017
<b>OLES Case Number</b>	2017-00625MC
<b>Allegations</b>	1. Criminal Act 2. Criminal Act
<b>Findings</b>	1. Not Referred 2. Not Referred
<b>Penalty</b>	Initial: Other Final: No Change
<b>Incident Summary</b>	On May 28, 2017, a senior psychiatric technician and two psychiatric technicians allegedly pushed a client to the ground and dragged her through the dirt. Additionally, one of the psychiatric technicians allegedly pulled her hair and the other psychiatric technician allegedly poured water over her face and head. The client also alleged the senior psychiatric technician sexually assaulted her.
<b>Disposition</b>	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
<b>Investigative Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's investigative process sufficiently complied with policies and procedures.

# Appendix C: Discipline Phase Cases

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

- Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion.
- Substantive sufficiency assesses the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

## Appendix C1- DSH Discipline Phase Cases

Case Table Section	Section Content
<b>Incident Date</b>	01/15/2016
<b>OLES Case Number</b>	2016-0063MA
<b>Allegations</b>	1. Other failure of good behavior 2. Other failure of good behavior
<b>Findings</b>	1. Sustained 2. Sustained
<b>Penalty</b>	Initial: Dismissal Final: Dismissal
<b>Incident Summary</b>	On January 15, 2016, a food service technician allegedly kissed and engaged in an inappropriate relationship with a patient.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegations and served a notice of dismissal on the food service technician. The OLES was not consulted. The food service technician did not file an appeal with the State Personnel Board.
<b>Disciplinary Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  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, and the disciplinary officer did not provide the draft disciplinary action to OLES for review. It also took seven months to draft the disciplinary action.
<b>Disciplinary Assessment</b>	1. Did the Hiring Authority consult with OLES and the department attorney (if applicable) regarding

<p><b>Questions</b></p>	<p>disciplinary determinations prior to making a final decision?</p> <p>No. The hiring authority did not consult with OLES regarding disciplinary determinations.</p> <p>2. Did the department attorney or human resources personnel provide to the Hiring Authority and OLES written confirmation of penalty discussion?</p> <p>No. The OLES received confirmation of the hiring authority's disciplinary determination from the hiring authority. No penalty forms had been created or were in use at this time.</p> <p>3. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES?</p> <p>No. The disciplinary officer did not provide OLES with a draft of the disciplinary action prior to being served.</p> <p>4. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. Although the department attorney regularly consulted with OLES, the disciplinary officer did not provide a draft copy of the disciplinary action to OLES.</p> <p>5. Was the disciplinary phase conducted with due diligence by the department?</p> <p>No. On May 13, 2016, the hiring authority decided to dismiss the food service technician; however, the disciplinary action was not served until December 15, 2016, seven months later.</p>
<p><b>Department Corrective Action Plan</b></p>	<p>The Hiring Authority has created a tracking system to track all Office of Law Enforcement monitored cases. In addition, Human Resources will review tracking system daily to flag any delays.</p>

Case Table Section	Section Content
<b>Incident Date</b>	02/02/2016
<b>OLES Case Number</b>	2016-00133MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Dismissal Final: Dismissal
<b>Incident Summary</b>	On February 2, 2016, a psychologist allegedly verbally threatened and physically abused a patient during a containment procedure.
<b>Disposition</b>	The hiring authority sustained the allegations and dismissed the psychologist. The OLES concurred with the determination. Following service of the disciplinary action, the psychologist attempted to file an appeal, however, it was untimely and the State Personnel Board did not accept it. No further action was taken by the psychologist.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department's disciplinary process sufficiently complied with policies and procedures.

Case Table Section	Section Content
<b>Incident Date</b>	03/26/2016
<b>OLES Case Number</b>	2016-00375MA
<b>Allegations</b>	1. Other failure of good behavior
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: No Change
<b>Incident Summary</b>	On March 26, 2016, a medical technical assistant was allegedly driving under the influence of an alcoholic beverage, while off-duty.
<b>Disposition</b>	The hiring authority sustained the allegation and imposed a salary reduction of five percent for three months. The OLES concurred.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	04/12/2016
<b>OLES Case Number</b>	2016-00441MA
<b>Allegations</b>	1. Discourteous treatment

	<ul style="list-style-type: none"> <li>2. Inexcusable neglect of duty</li> <li>3. Inexcusable neglect of duty</li> <li>4. Dishonesty</li> </ul>
<b>Findings</b>	<ul style="list-style-type: none"> <li>1. Sustained</li> <li>2. Not Sustained</li> <li>3. Not Sustained</li> <li>4. Not Sustained</li> </ul>
<b>Penalty</b>	<p>Initial: Salary Reduction Final: No Change</p>
<b>Incident Summary</b>	<p>On April 12, 2016, a senior psychiatric technician allegedly forcibly grabbed a patient by the arm and led her to a seclusion room. It was further alleged the senior psychiatric technician used inappropriate language towards the patient. Also, the senior psychiatric technician was allegedly less than truthful during her investigatory interview and she allegedly contacted a witness who was interviewed during the course of the investigation, after she was admonished to not discuss the investigation.</p>
<b>Disposition</b>	<p>The hiring authority determined there was sufficient evidence to sustain the allegations that the senior psychiatric technician was discourteous toward the patient and insubordinate by contacting a witness in the case and imposed a salary reduction of five percent for six months. The other allegations were not sustained. The OLES concurred. The senior psychiatric technician did not file an appeal with the State Personnel Board.</p>
<b>Disciplinary Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	11/21/2015
<b>OLES Case Number</b>	2016-00583MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	<p>Initial: Salary Reduction Final: Salary Reduction</p>
<b>Incident Summary</b>	<p>On November 21, 2015, a lieutenant allegedly failed to handle evidence properly. It was alleged that the lieutenant left the several boxes of evidence unattended while he walked into the office to get assistance in moving the boxes.</p>
<b>Disposition</b>	<p>The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a salary</p>

	reduction of 5 percent for six months. The OLES concurred. The lieutenant filed an appeal with the State Personnel Board. Prior to an evidentiary hearing the department entered into a settlement agreement with the lieutenant wherein the penalty was reduced to a 5 percent salary reduction for three months. The lieutenant agreed to withdraw his appeal. The OLES concurred with the settlement because it was not unreasonable.
<b>Disciplinary Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department generally complied with policies and procedures governing the disciplinary process. However, the action was not drafted and served on the lieutenant until approximately 90 days after a decision was made to impose discipline.
<b>Disciplinary Assessment Questions</b>	<ol style="list-style-type: none"> <li>1. Did a department attorney attend the Skelly hearing?  No. The department policy does not require an attorney to attend the Skelly hearing.</li> <li>2. Was the disciplinary phase conducted with due diligence by the department?  No. The department did not serve the action until over 90 days after the decision was made to impose discipline.</li> </ol>
<b>Department Corrective Action Plan</b>	OPS is working with Office of Law Enforcement Support to establish appropriate timeliness guidelines.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/07/2016
<b>OLES Case Number</b>	2016-01448MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Dishonesty</li> <li>2. Inexcusable neglect of duty</li> <li>3. Inexcusable neglect of duty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Sustained</li> <li>3. Not Sustained</li> </ol>
<b>Penalty</b>	Initial: Dismissal Final: Dismissal
<b>Incident Summary</b>	On March 7, 2016, a registered nurse allegedly left a patient in the shower for approximately two hours, then failed to properly document the incident in the patient's

	interdisciplinary notes. Also, it was alleged the registered nurse was dishonest in her investigatory interview.
<b>Disposition</b>	The hiring authority sustained the allegations the registered nurse failed to properly document her observations and was dishonest, however, the allegation of leaving the patient in the shower was not sustained. The hiring authority served the registered nurse with a notice of dismissal. The OLES concurred.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The registered nurse filed an appeal with the State Personnel Board. The litigation of the appeal was transferred to another department, therefore, the OLES concluded monitoring of the appeal. The department substantially complied with policy and procedures governing the disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/07/2016
<b>OLES Case Number</b>	2016-01449MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Not Sustained 2. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: Salary Reduction
<b>Incident Summary</b>	On March 7, 2016, a medical technical assistant allegedly left a patient in the shower for approximately two hours, and then failed to properly document the incident in the patient observation record.
<b>Disposition</b>	The hiring authority sustained the allegation that the medical technical assistant failed to properly document the incident, however, found insufficient evidence to sustain the allegation that the patient was left in the shower. The hiring authority imposed a salary reduction of 10 percent for six months. The OLES concurred with the determination. The medical technical assistant was served with his action and requested a Skelly hearing. Following the Skelly hearing, an appeal was filed with the State Personnel Board. Prior to State Personnel Board proceedings, the department and the medical technical assistant entered into a settlement agreement. The department modified the salary reduction to 5 percent for eight months and required further training. The medical technical assistant agreed to withdraw his appeal.

	<p>Following an executive review, the OLES concurred with the terms of the settlement agreement.</p>
<p><b>Disciplinary Assessment</b></p>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>Overall, the department failed to comply with policies and procedures governing the discipline process. The department failed to provide the draft disciplinary action to the OLES for review. Also, the Skelly officer improperly engaged in settlement discussions with the medical technical assistant. The disciplinary action was not served on the employee until approximately 120 days from the date when the decision to impose discipline was made.</p>
<p><b>Disciplinary Assessment Questions</b></p>	<ol style="list-style-type: none"> <li>1. Was a department attorney assigned to this case during the disciplinary phase?  No. A department attorney was not assigned to the case.</li> <li>2. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES?  No. A copy of the draft disciplinary action was not provided to the OLES.</li> <li>3. If there was a Skelly hearing, was it conducted properly?  No. The OLES was not notified of the Skelly hearing. The OLES was provided the Skelly officer's recommendation which indicated the Skelly officer engaged in settlement discussions with the subject.</li> <li>4. Was an executive review conducted to raise an issue to a higher level of management in this case?  Yes. An executive review was conducted in this matter.</li> <li>5. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</li> </ol>



	<p>No. The department did not consult with the OLES during the disciplinary phase until after the Skelly hearing.</p> <p>6. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. The hiring authority did not consult with the OLES prior to entering into settlement negotiations after the Skelly hearing.</p> <p>7. Was the disciplinary phase conducted with due diligence by the department?</p> <p>No. The adverse action was not completed and served for over 120 days after a decision was made to take disciplinary action.</p>
<b>Department Corrective Action Plan</b>	<p>The Hiring Authority reviewed the OLES procedures with the Employee Relations Officer to ensure complete familiarization with the new process. The OLES monitor will be provided the draft adverse action for review within the required time frames. The Hiring Authority reviewed the OLES and Skelly hearing requirements and procedures with the Skelly Officer. The OLES monitor will be included in any Skelly hearing involving an OLES employee misconduct investigation. The Hiring Authority reviewed the OLES procedures with the Employee Relations Officer to ensure complete familiarization with the new process. The OLES monitor will be included in any Skelly hearing involving an OLES employee misconduct investigation. The department was compliant with OLES policy with regard to entering into a settlement agreement. The department is committed to complying with the OLES requirements and procedures. OPS is working with OLES to develop appropriate timeliness guidelines.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	03/07/2016
<b>OLES Case Number</b>	2016-01450MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained 2. Sustained
<b>Penalty</b>	Initial: Salary Reduction

	Final: Salary Reduction
<b>Incident Summary</b>	On March 7, 2016, a medical technical assistant allegedly left a patient in the shower for approximately two hours, then failed to properly document the incident in the patient observation record.
<b>Disposition</b>	The hiring authority sustained the allegations and imposed a salary reduction of 10 percent for 13 months. The OLES concurred. The medical technical assistant filed an appeal with the State Personnel Board. The litigation of the appeal was transferred to another department; therefore, the OLES concluded monitoring of the appeal.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department substantially complied with policy and procedures governing the disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/27/2016
<b>OLES Case Number</b>	2016-01549MA
<b>Allegations</b>	1. Dishonesty 2. Inexcusable neglect of duty 3. Misuse of state property 4. Insubordination 5. Other failure of good behavior
<b>Findings</b>	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
<b>Penalty</b>	Initial: Dismissal Final: No Change
<b>Incident Summary</b>	On June 3, 2016, an acting sergeant allegedly engaged in an on-duty sexual relationship with another employee, on facility grounds, in an area accessible to employees only. It was further alleged the acting sergeant utilized departmental email and instant messaging, while on duty to engage in a personal relationship with another employee. Also, the acting sergeant allegedly discussed the investigation with another employee after being admonished not to do so. Additionally, the acting sergeant was allegedly dishonest in his investigatory interview.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the acting sergeant. The OLES concurred with the hiring authority's determination. Following the Skelly hearing, the

	acting sergeant resigned. A letter was placed in his official personnel file noting his resignation under adverse circumstances.
<b>Disciplinary Assessment</b>	Procedural Rating: Insufficient Substantive Rating: Sufficient  The department generally complied with policies and procedures governing the disciplinary process, however the department did not serve the disciplinary action in timely manner. The disciplinary action was not served until approximately 100 days after the determination was made to impose discipline.
<b>Disciplinary Assessment Questions</b>	1. Did a department attorney attend the Skelly hearing?  No. The department policy does not require an attorney to attend the Skelly hearing.  2. Was the disciplinary phase conducted with due diligence by the department?  No. The disciplinary action was not served for over 100 days after a decision was made to impose discipline.
<b>Department Corrective Action Plan</b>	Office of Protective Services will contact the legal department and consult with them prior to the final decision to impose discipline. Office of Protective Services is working with Office of Law Enforcement Support to develop appropriate timeliness guidelines.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/03/2016
<b>OLES Case Number</b>	2016-01563MA
<b>Allegations</b>	1. Dishonesty 2. Inexcusable neglect of duty 3. Other failure of good behavior
<b>Findings</b>	1. Sustained 2. Sustained 3. Sustained
<b>Penalty</b>	Initial: Dismissal Final: No Change
<b>Incident Summary</b>	On June 3, 2016, a psychiatric technician allegedly engaged in an on-duty sexual relationship, with another employee on facility grounds, in an area accessible to employees only. It was further alleged the psychiatric technician utilized departmental email and instant

	messaging, while on duty, to engage in a personal relationship with another employee. Also, the psychiatric technician was allegedly dishonest in her investigatory interview.
<b>Disposition</b>	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. The psychiatric technician resigned prior to the service of the disciplinary action. A letter was placed in her official personnel file indicating she resigned under adverse circumstances.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/21/2016
<b>OLES Case Number</b>	2017-00157MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Training Final: No Change
<b>Incident Summary</b>	On May 21, 2016, a patient was allegedly housed in a feces covered cell for several days. Allegedly, a unit supervisor knew the patient's cell was not being cleaned, but failed to take action.
<b>Disposition</b>	The hiring authority sustained the allegation and provided corrective training to the unit supervisor and all unit personnel. The OLES concurred.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	05/21/2016
<b>OLES Case Number</b>	2017-00158MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Training Final: No Change
<b>Incident Summary</b>	On May 21, 2016, a patient was allegedly being housed in

	a feces covered cell for several days. Allegedly, a senior psychiatric technician knew the patient's cell was not being cleaned, but failed to take action.
<b>Disposition</b>	The hiring authority sustained the allegation and provided corrective training to the senior psychiatric technician and all unit personnel. The OLES concurred.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the disciplinary process.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	10/11/2016
<b>OLES Case Number</b>	2017-00432MA
<b>Allegations</b>	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained 2. Sustained 3. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: Letter of Instruction
<b>Incident Summary</b>	On October 11, 2016, and October 12, 2016, a medical technical assistant allegedly documented a patient was asleep in his cell when the patient not at the institution. In addition, two senior medical technical assistants allegedly failed to properly monitor the wellness checks conducted by the medical technical assistant.
<b>Disposition</b>	The hiring authority sustained the allegations. The medical technical assistant was provided a letter of instruction and training. Both the senior medical technical assistants received a salary reduction of 5 percent for 12 months and training. However, following a Skelly hearing the disciplinary action was revoked and both senior medical technical assistants received letters of instruction. The OLES concurred with the determinations.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policy and procedures governing the disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	01/31/2017
<b>OLES Case Number</b>	2017-00499MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Unfounded
<b>Penalty</b>	Initial: No Penalty Imposed Final: No Change
<b>Incident Summary</b>	On January 31, 2017, a medical technical assistant allegedly failed to properly supervise a patient who was using shaving equipment. The patient allegedly disassembled the equipment and swallowed a metal piece.
<b>Disposition</b>	The hiring authority determined the allegation was unfounded. The OLES concurred.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Table Section	Section Content
<b>Incident Date</b>	02/22/2017
<b>OLES Case Number</b>	2017-00500MA
<b>Allegations</b>	1. Dishonesty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Dismissal Final: Dismissal
<b>Incident Summary</b>	On February 22, 2017, a medical technical assistant allegedly failed to perform fifteen minute wellness checks, but documented she had done so. Additionally, the medical technical assistant was allegedly dishonest during her investigatory interview.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the medical technical assistant. The OLES concurred with the determination.
<b>Disciplinary Assessment</b>	Procedural Rating: Sufficient Substantive Rating: Sufficient  The medical technical assistant an appeal with the State Personnel Board. The litigation of the appeal was transferred to another department, therefore, the OLES concluded monitoring of the appeal. The department substantially complied with policy and procedures governing the disciplinary process.

## Appendix C2 – DDS Discipline Phase Cases

Case Table Section	Section Content
<b>Incident Date</b>	01/01/2016
<b>OLES Case Number</b>	2016-00016MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Inefficiency</li> <li>2. Inefficiency</li> <li>3. Inefficiency</li> <li>4. Inefficiency</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Sustained</li> <li>3. Unfounded</li> <li>4. Unfounded</li> </ol>
<b>Penalty</b>	Initial: Suspension Final: Suspension
<b>Incident Summary</b>	<p>On January 1, 2016, a psychiatric technician allegedly failed to properly supervise a client during a period of direct observation. Allegedly, the client swallowed a mobile phone battery during that time. Furthermore, two other psychiatric technicians allegedly failed to properly supervise other clients because they were impermissibly using their mobile phones.</p>
<b>Disposition</b>	<p>The hiring authority determined there was sufficient evidence to sustain the allegations against the first psychiatric technician and imposed a two working-day suspension without pay. The hiring authority determined allegations against the other two psychiatric technicians were unfounded. The OLES concurred with the determinations.</p>
<b>Disciplinary Assessment</b>	<p>Procedural Rating: Insufficient            Substantive Rating: Sufficient</p> <p>The hiring authority modified the original penalty to a 5 percent salary reduction for two months. 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 penalty was modified to a letter of reprimand with no back pay. The psychiatric technician agreed to withdraw her appeal. The OLES concurred with the settlement because the penalty reduction was not significant and the salary reduction had already taken place. However, the department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was not served</p>

	on the employee until approximately 262 days from the date of the disposition meeting.
<b>Disciplinary Assessment Questions</b>	<p>1. Was a department attorney assigned to this case during the disciplinary phase?</p> <p>No. A department attorney was not assigned to this case during the disciplinary phase.</p> <p>2. Was the disciplinary phase conducted with due diligence by the department?</p> <p>No. The department failed to serve the disciplinary action within 30 days from the decision to take disciplinary action. The findings and penalty conference were held on April 27, 2017; however, the disciplinary action was not served until January 13, 2017, 262 days later.</p>
<b>Department Corrective Action Plan</b>	The Hiring Authority and Administrative Services Director will conduct monthly status reviews with the Facility's Labor Relations Analyst to monitor the timely completion and service of Disciplinary Actions. In cases where time delays are indicated, confer with all responsible reviewers of the Action will be completed in order to ensure the completion and service of the Disciplinary Action moves forward without extended delay.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	01/24/2016
<b>OLES Case Number</b>	2016-00182MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Dishonesty</li> <li>2. Incompetency</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Salary Reduction</p> <p>Final: Letter of Reprimand</p>
<b>Incident Summary</b>	On January 24, 2016, a psychiatric technician allegedly failed to properly supervise a client who was on a one to one level of supervision. The client was able to grab and insert a plastic spoon into her vagina while under the care of the psychiatric technician. It was further alleged that the psychiatric technician was dishonest during her investigatory interview.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a five percent salary reduction for six months. The OLES concurred.



<p><b>Disciplinary Assessment</b></p>	<p>Procedural Rating: Insufficient Substantive Rating: Insufficient</p> <p>After the psychiatric technician was served with a disciplinary action, she filed an appeal with the State Personnel Board. During the disciplinary process, the department failed to comply with policies and procedures. The department entered into a settlement agreement with the psychiatric technician wherein the department agreed to reduce the penalty from a 5 percent salary reduction for six months to a letter of reprimand. The psychiatric technician withdrew her appeal. The OLES was excluded from the settlement process and was precluded from elevating the matter through the Executive Review process. The OLES did not concur with the settlement because there were no changed circumstances or facts to warrant the reduction in penalty. The settlement was unreasonable given the seriousness of the sustained allegation, which included dishonesty, and potential for harm to the client.</p>
<p><b>Disciplinary Assessment Questions</b></p>	<ol style="list-style-type: none"> <li>1. Was a department attorney assigned to this case during the disciplinary phase?  No. A department attorney was not assigned to this case during the disciplinary phase.</li> <li>2. Was OLES provided with a draft of the pre-hearing settlement conference statement prior to it being filed?  No. The OLES was not provided with a draft of the pre-hearing settlement conference statement prior to it being filed.</li> <li>3. Did the Hiring Authority consult with OLES and the department attorney (if applicable) before modifying the penalty or agreeing to a settlement?  No. The hiring authority did not consult with the OLES before entering into a settlement, which modified the penalty.</li> <li>4. If the penalty was modified by department action or a settlement agreement, did OLES concur with the modification?  No. The OLES did not concur with the settlement, as it</li> </ol>

	<p>was unreasonable given the seriousness of the misconduct.</p> <p>5. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. The discipline officer failed to consult with the OLES regarding the change of penalty and settlement.</p> <p>6. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. The hiring authority did not consult with the OLES regarding the change of penalty and settlement.</p> <p>7. Was the disciplinary phase conducted with due diligence by the department?</p> <p>No. The disposition conference occurred on March 22, 2016; however, the adverse action was not served on the employee until October 7, 2016, 186 days later.</p>
<b>Department Corrective Action Plan</b>	The department's Office of Legal Affairs will now be handling all OLES cases going before the Board, and will be responsible for notifying the AIM of any settlement conferences.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/12/2016
<b>OLES Case Number</b>	2016-00756MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: No Penalty Imposed
<b>Incident Summary</b>	On June 12, 2016, a psychiatric technician allegedly failed to properly monitor an agitated client who was placed in a shower stall.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 10 percent salary reduction for six months. The OLES concurred

	with the hiring authority's determination.
<b>Disciplinary Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The disciplinary action was withdrawn following the Skelly hearing. The OLES concurred; however, the hiring authority failed to comply with the department's policies and procedures governing the disciplinary process. The department did not complete the disciplinary phase in a timely manner. The decision to take disciplinary action occurred on September 20, 2016; however, disciplinary action was not served until June 2, 2017, 255 days later.</p>
<b>Disciplinary Assessment Questions</b>	<ol style="list-style-type: none"> <li>1. Was a department attorney assigned to this case during the disciplinary phase?  No. A department attorney was not assigned during the disciplinary phase.</li> <li>2. Was the penalty upheld by the department after a Skelly hearing?  No. The penalty was not upheld by the department after a Skelly hearing.</li> <li>3. Did the department modify the penalty after service of the disciplinary action or Letter of Intent to take disciplinary action without a settlement agreement or SPB action modifying the penalty?  Yes. The department withdrew the disciplinary action without consulting the OLES.</li> <li>4. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?  No. The hiring authority withdrew the disciplinary action without consulting the OLES.</li> <li>5. Was the disciplinary phase conducted with due diligence by the department?  No. The disposition meeting with the hiring authority occurred on September 20, 2016; however, the disciplinary action was not served until June 2, 2017,</li> </ol>

	255 days later.
<b>Department Corrective Action Plan</b>	The Hiring Authority will ensure consultation with OLES when there is a recommended change in disciplinary action at the Skelly hearing.

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/03/2016
<b>OLES Case Number</b>	2016-01149MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Inexcusable neglect of duty</li> <li>2. Inexcusable neglect of duty</li> <li>3. Inexcusable neglect of duty</li> <li>4. Inexcusable neglect of duty</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Not Sustained</li> <li>3. Not Sustained</li> <li>4. Not Sustained</li> </ol>
<b>Penalty</b>	<p>Initial: Salary Reduction</p> <p>Final: Salary Reduction</p>
<b>Incident Summary</b>	<p>On September 3, 2016, a senior psychiatric technician and three psychiatric technicians allegedly left a client, who was restrained, alone in an unsecured room and failed to properly document the incident. It was further alleged the senior psychiatric technician failed to provide his direct supervisors with complete information about the incident, inappropriately removed himself from client contact and relieved one of the psychiatric technicians from her duties without authorization.</p>
<b>Disposition</b>	<p>The hiring authority sustained all of the allegations against the senior psychiatric technician and imposed a salary reduction of 5 percent for 12 months. The hiring authority did not sustain the allegations against the three psychiatric technicians, however served each with a letter of expectation concerning appropriate client care. The OLES concurred with the hiring authority's determinations.</p>
<b>Disciplinary Assessment</b>	<p>Procedural Rating: Insufficient</p> <p>Substantive Rating: Sufficient</p> <p>The senior psychiatric technician filed an appeal with the State Personnel Board. However, prior to hearing, the department entered into a settlement agreement the senior psychiatric technician. Due to a positive change in the senior psychiatric technician's performance, the hiring authority agreed to reduce the penalty from a salary reduction of 5 percent for 12 months to a salary reduction of 5 percent for six months. The senior psychiatric technician agreed to withdraw his appeal. The OLES</p>

	<p>concurred with the settlement because it reinforced the improved performance of the senior psychiatric technician. The department did not comply with policies and procedures governing the disciplinary process. A department attorney was not timely assigned to the case to consult with the hiring authority regarding disposition. The hiring authority did not notify the OLES of the Skelly hearing.</p>
<p><b>Disciplinary Assessment Questions</b></p>	<p>1. Did the Hiring Authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision?</p> <p>No. The department attorney was not yet assigned to the case at the time disciplinary determinations were made.</p> <p>2. If there was a Skelly hearing, was it conducted properly?</p> <p>No. The OLES was not notified of the Skelly hearing.</p> <p>3. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. The hiring authority did not inform the OLES of the Skelly hearing.</p>
<p><b>Department Corrective Action Plan</b></p>	<p>The Hiring Authority has redirected staffing to Legal Affairs to handle disciplinary cases. The Labor Relation Analyst has been directed to contact the assigned OLES Monitor of the date and time of Skelly hearings.</p>

# Appendix D: Combined Pre-disciplinary and Discipline Phase Cases

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

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

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

Discipline is rated for procedural and substantive sufficiency:

- Procedural sufficiency assesses, among other things, whether the OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion.
- Substantive sufficiency assesses the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

## Appendix D – DSH Combined Cases

Case Table Section	Section Content
<b>Incident Date</b>	07/12/2016
<b>OLES Case Number</b>	2016-00892MA
<b>Allegations</b>	1. Inexcusable neglect of duty
<b>Findings</b>	1. Sustained
<b>Penalty</b>	Initial: Salary Reduction Final: Letter of Instruction
<b>Incident Summary</b>	On July 12, 2016, a psychiatric technician was allegedly negligent while supervising a patient during an arts and crafts group. The patient who had a history of self-injurious behavior was on an enhanced level of observation status. During the arts and crafts group, the patient obtained a pair of scissors and cut himself multiple times.
<b>Disposition</b>	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a salary reduction of 5 percent for six months. The OLES concurred

	<p>with the hiring authority's initial determination. Subsequently, the hiring authority reduced the penalty to a letter of warning without consultation with the OLES. The OLES did not concur with the corrective action.</p>
<b>Investigative Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Sufficient</p> <p>The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until approximately 144 days from the date of the incident. Additionally, the hiring authority did not timely consult with the OLES regarding the sufficiency of the investigation.</p>
<b>Pre-Disciplinary Assessment</b>	<p>1. Did the Hiring Authority timely notify the department's legal office of the incident?</p> <p>No. The hiring authority did not notify the department's legal office of the incident.</p> <p>2. Did the Hiring Authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?</p> <p>No. The investigative report was completed on January 18, 2017; however, the hiring authority did not consult with the OLES until March 13, 2017, 54 days later.</p> <p>3. Was the pre-disciplinary/investigative phase conducted with due diligence?</p> <p>No. The incident was discovered on July 13, 2016; however, the final report was not completed until January 18, 2017, 189 days later.</p>
<b>Disciplinary Assessment</b>	<p>Procedural Rating: Insufficient Substantive Rating: Insufficient</p> <p>The department failed to comply with policies and procedures governing the disciplinary process. The department modified the original penalty, without consulting with the OLES, from a salary reduction to a non-disciplinary letter of warning. The OLES did not concur in the modified penalty, given the patient's history of self-injurious behavior; harm suffered by the patient, and the fact the psychiatric technician was assigned duties to protect the</p>

	patient from the very harm, which occurred.
<b>Disciplinary Assessment Questions</b>	<ol style="list-style-type: none"> <li>1. Was a department attorney assigned to this case during the disciplinary phase?  No. A department attorney was not assigned to the case during the disciplinary phase.</li> <li>2. Did the Hiring Authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision?  No. The hiring authority initially consulted with the OLES about the disciplinary decision; however, a final decision to withdraw the discipline and impose corrective action was made without consultation with the OLES.</li> <li>3. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES?  No. The discipline officer did not provide the OLES with a copy of the letter of warning.</li> <li>4. Did the Hiring Authority consult with OLES and the department attorney (if applicable) before modifying the penalty or agreeing to a settlement?  No. The hiring authority did not consult with the OLES when it reduced the original penalty to a letter of warning.</li> <li>5. If the penalty was modified by department action or a settlement agreement, did OLES concur with the modification?  No. The OLES did not concur with reduction of the penalty to corrective action due to the harm the patient sustained and there were no facts to warrant the reduction in penalty.</li> <li>6. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except</li> </ol>



	<p>for those related to a writ?</p> <p>No. The discipline officer did not consult with the OLES concerning the reduction in penalty and service of the corrective action.</p> <p>7. Did the Hiring Authority cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ?</p> <p>No. The hiring authority did not consult with the OLES concerning the reduction in penalty from adverse action to corrective action.</p>
<b>Department Corrective Action Plan</b>	<p>The Hiring Authority will consult with the OLES monitor regarding the disposition of findings as soon as possible after the IRC meetings are held. HR personnel will complete and forward the "Hiring Authority Review of Investigation" and the "Justification of Penalty" form to the Hiring Authority for the consultations with the OLES Monitor. The Chief/OPS discussed with the entire Investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation and report is going to go beyond the 75-day time frame.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	09/11/2016
<b>OLES Case Number</b>	2016-01215MA
<b>Allegations</b>	<ol style="list-style-type: none"> <li>1. Other failure of good behavior</li> <li>2. Other failure of good behavior</li> </ol>
<b>Findings</b>	<ol style="list-style-type: none"> <li>1. Sustained</li> <li>2. Unfounded</li> </ol>
<b>Penalty</b>	<p>Initial: Dismissal</p> <p>Final: Resigned In Lieu of Dismissal</p>
<b>Incident Summary</b>	<p>On September 11, 2016, a patient was allegedly involved in an overly familiar relationship with a psychiatric technician and a psychologist.</p>
<b>Disposition</b>	<p>The hiring authority sustained the allegation as to the psychiatric technician and served her with a notice of dismissal. The psychiatric technician filed an appeal with the State Personnel Board. The allegation against the psychologist was unfounded. The OLES concurred with determinations. Prior to the hearing, the department and the psychiatric technician entered into a settlement agreement whereby the psychiatric technician resigned in</p>

	lieu of dismissal. The OLES found the settlement to be reasonable.
<b>Investigative Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>The department sufficiently complied with policies and procedures during the pre-disciplinary phase.</p>
<b>Disciplinary Assessment</b>	<p>Procedural Rating: Sufficient Substantive Rating: Sufficient</p> <p>Overall, the department sufficient complied with policies and procedures during the disciplinary phase.</p>

# Appendix E: Monitored Issues

## Appendix E1 – DSH Monitored Issues

Case Table Section	Section Content
<b>Incident Date</b>	01/23/2016
<b>OLES Case Number</b>	2016-00097MI
<b>Case Type</b>	Use of Force
<b>Incident Summary</b>	On January 23, 2016, a patient was exhibiting behavioral issues necessitating a cell move. The patient refused to comply with orders to allow staff to move him. Six medical technical assistants assembled supervised by one senior medical technical assistant to perform a cell extraction. When the cell door was opened, the patient charged out of the cell and staff used physical force to place him in restraints. On January 25, 2016, the patient alleged the medical technical assistants used excessive force during the cell extraction.
<b>Disposition</b>	The OLES reviewed the use-of-force incident and discovered guidelines set forth in regulations were not followed. Specifically, the medical technical assistants did not appropriately document the incident and failed to capture the incident with video recordings. The OLES recommended the department follow regulations when controlled use-of-force incidents are performed.
<b>Overall Assessment</b>	Rating: Sufficient  The department appropriately responded to the concerns raised by the OLES. The department prepared a policy for cell extractions in compliance with regulations. The policy was in the review process by the impacted facility and labor unions, but was not implemented prior to the specific facility being transferred from the jurisdiction of the department.

Case Table Section	Section Content
<b>Incident Date</b>	04/18/2016
<b>OLES Case Number</b>	2016-00753MI
<b>Case Type</b>	Abuse
<b>Incident Summary</b>	On April 18, 2016, several patients alleged a doctor failed to provide them adequate medical care. Additionally, the patients' alleged inadequate medical care may have been a contributing factor in the death of two patients.
<b>Disposition</b>	The Office of Law Enforcement Support conducted an inquiry into the matter and determined the department did

	complete an adequate investigation in the death cases. However, it was discovered the department did not have sufficient policies in place directing investigators to interview medical examiners and/or coroner investigator in all death investigations.
<b>Overall Assessment</b>	<p>Rating: Sufficient</p> <p>The department appropriately responded to the concerns raised by the OLES. The department conducted a clinical practice audit of the assessment and care the doctor provided in the specific cases identified in the complaint and a random sampling of the doctor's entire caseload. In addition, the department implemented policy to require all death investigations to include an interview of the medical examiner and/or coroner investigator.</p>

<b>Case Table Section</b>	<b>Section Content</b>
<b>Incident Date</b>	06/04/2016
<b>OLES Case Number</b>	2016-01334MI
<b>Case Type</b>	Significant Interest - Other
<b>Incident Summary</b>	On June 4, 2016, a registered nurse was allegedly falsifying interdisciplinary notes in patients' medical charts. During a review of the allegations, it was determined that there was a lack of guidelines for staff to follow when making electronic clinical documentation.
<b>Disposition</b>	A thorough review of the issue was conducted. The OLES determined that the registered nurse had "cut and paste" to complete electronic clinical documentation. There was no indication that the documentation was false or inaccurate; however, it did appear as a common practice. During a review of the issue, the OLES apprised the department of their findings. Also, a written summary of the findings was sent to the department.
<b>Overall Assessment</b>	<p>Rating: Sufficient</p> <p>The OLES did not request the department take action based on its findings. During the review process, the department was kept informed of the findings and during that time, the department engaged in training to prevent potential for erroneous electronic clinical documentation.</p>

## Appendix E2 – DDS Monitored Issues

Case Table Section	Section Content
<b>Incident Date</b>	01/03/2017
<b>OLES Case Number</b>	2017-00273MI
<b>Case Type</b>	Significant Interest - Other
<b>Incident Summary</b>	On January 3, 2017, it was discovered that the department law enforcement officers were inconsistent in their use of portable audio/video recorders. Some investigators recorded interviews conducted during their investigations, while others did not. In addition, police officers, who are the first responders to an incident, were not consistently recording interviews.
<b>Disposition</b>	The OLES reviewed the department's policy on the use of portable audio/video recorders. The OLES found this policy to be inadequate because it did not require mandatory recording of investigatory interviews by hospital police officers. Advantages to recording interviews include protecting staff against accusations that a client was coerced or tricked into recanting their allegations, ensures accuracy in report writing, safeguards diminishing memories, and provides a means of preserving evidence. The OLES recommended that the department require mandatory recording of interviews conducted by hospital police officers for incidents involving sexual assault allegations, physical abuse allegations, felony allegations resulting in serious bodily injury, and circumstances surrounding deaths. Additionally, the OLES recommend recording any recantation by a client. The OLES further recommended that in cases where the hospital police officers do not record interviews based on the interview making a client anxious, uncomfortable, or result in the client's refusal to participate, the hospital police officers should document, in their report, the reasoning for not making the recording.
<b>Overall Assessment</b>	Rating: Sufficient  The department appropriately responded to the concerns raised by the OLES. The department prepared a policy for the mandatory recording of interviews by hospital police officers, which addressed all of the recommendations made by the OLES, including the mandatory documentation by hospital police officers when an interview was not recorded.

# Appendix F: Statutes

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## California Welfare and Institutions Code 4023.6 et seq.

### 4023.6.

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

### 4023.7.

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

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

**4023.8.**

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

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

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

## **California Welfare and Institutions Code 4427.5**

### **4427.5.**

- (a) (1) A developmental center shall immediately report the following incidents involving a resident to the local law enforcement agency having jurisdiction over the city or county in which the developmental center is located, regardless of whether the Office of Protective Services has investigated the facts and circumstances relating to the incident:
    - (A) A death.
    - (B) A sexual assault, as defined in Section 15610.63.
    - (C) An assault with a deadly weapon, as described in Section 245 of the Penal Code, by a nonresident of the developmental center.
    - (D) An assault with force likely to produce great bodily injury, as described in Section 245 of the Penal Code.
    - (E) An injury to the genitals when the cause of the injury is undetermined.
    - (F) A broken bone, when the cause of the break is undetermined.
  - (2) If the incident is reported to the law enforcement agency by telephone, a written report of the incident shall also be submitted to the agency, within two working days.
  - (3) The reporting requirements of this subdivision are in addition to, and do not substitute for, the reporting requirements of mandated reporters, and any other reporting and investigative duties of the developmental center and the department as required by law.
  - (4) Nothing in this subdivision shall be interpreted to prevent the developmental center from reporting any other criminal act constituting a danger to the health or safety of the residents of the developmental center to the local law enforcement agency.
- (b) (1) The department shall report to the agency described in subdivision (i) of Section 4900 any of the following incidents involving a resident of a developmental center:
    - (A) Any unexpected or suspicious death, regardless of whether the cause is immediately known.
    - (B) Any allegation of sexual assault, as defined in Section 15610.63, in which the alleged perpetrator is a developmental center or department employee or contractor.
    - (C) Any report made to the local law enforcement agency in the jurisdiction in which the facility is located that involves physical abuse, as defined in Section 15610.63, in which a staff member is implicated.



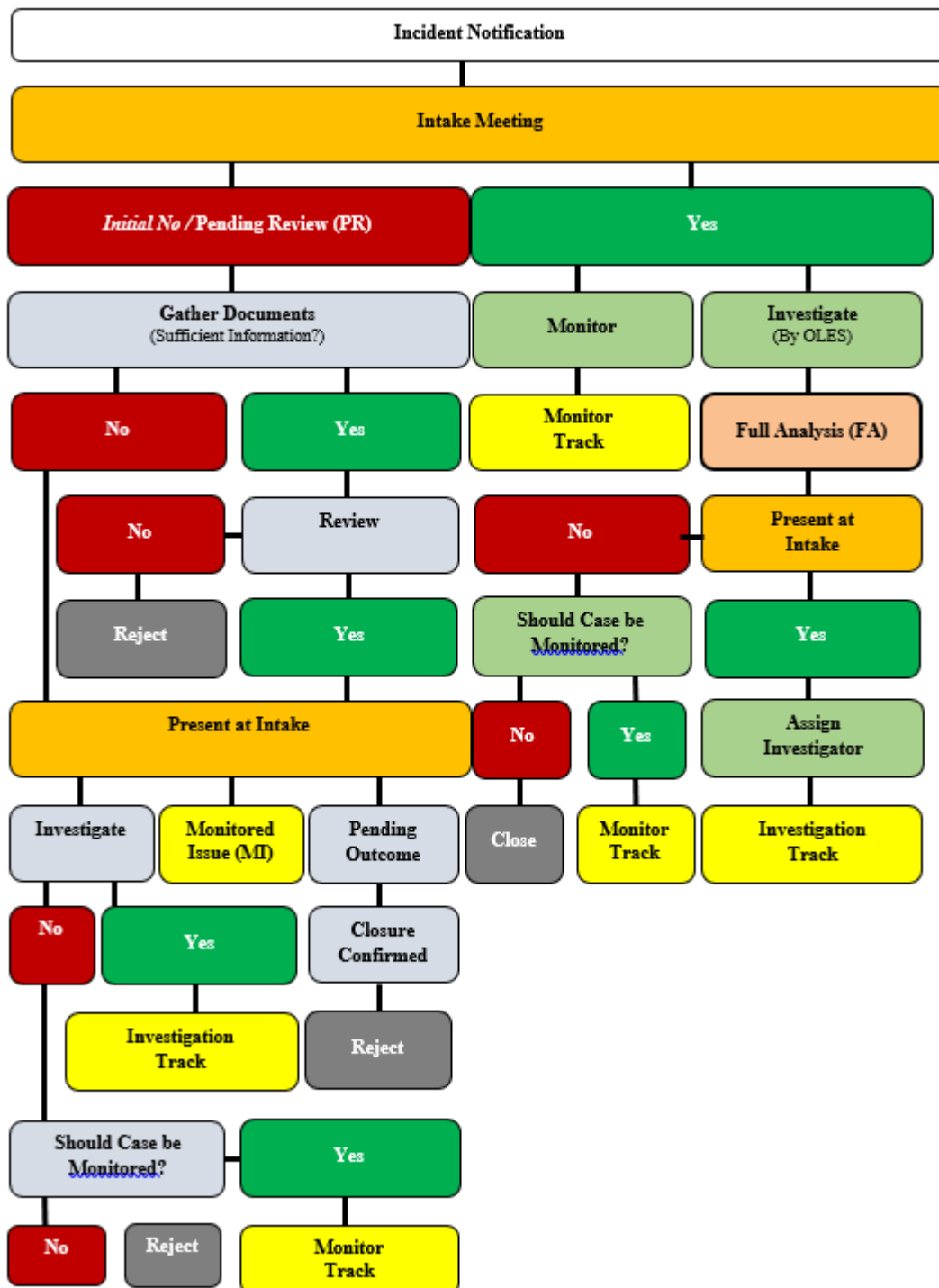
- (2) A report pursuant to this subdivision shall be made no later than the close of the first business day following the discovery of the reportable incident.

## **California Welfare and Institutions Code 4023**

### **4023**

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

# Appendix G: OLES Intake Flow Chart



## Outline Description

1. OLES receives a notification of an incident and discusses the incident during an intake meeting
2. The disposition of the incident case may be assigned to any of the following:
  - a. Initial No/Pending Review
  - b. OLES Monitored Case

c. OLES Investigation Case

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

# Appendix H: Guidelines for the OLES Processes

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

If, instead, an incident is investigated by DSH or DDS but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH or DDS investigator and the department attorney, if one is designated<sup>14</sup>, throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 75 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 75-day recommendation is followed. However, complex cases can take more time.

## Administrative Investigation Process

### *THRESHOLD INCIDENTS (75 Days)*

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

### *Critical Junctures*

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

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<sup>14</sup> The best practice is to have an employment law attorney from the department involved from the outset to guide investigators, assist with interviews and gathering of evidence, and to give advice and counsel to the facility management (also known as the hiring authority) where the employee who is the subject of the incident works. Neither DSH nor DDS had the resources in the six-month period to dedicate to this best practice.

It is recommended that within 30 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code 4023.8, subdivision (a)(2)(C), (D), and (E), the hiring authority shall consult with the AIM attorney on the discipline decision, including 1) the allegations for which the employee should be exonerated, the allegations for which the evidence is insufficient and the allegations should not be sustained, or the allegations that should be sustained; and 2) the appropriate discipline for sustained allegations, if any. If either the AIM attorney or the hiring authority believes the other party's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.

### 30 Days

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

Once a final determination is reached regarding the appropriate allegations and discipline in a case, it is recommended that a Notice of Adverse Action (NOAA) be finalized and served upon the employee within 30 days.

### 30 Days

1. Human resources unit at the facility completes NOAA and forwards to AIM 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<sup>15</sup>. It is recommended that the Skelly due process meeting be completed within 30 days.

### 30 Days

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

State employees who receive discipline have a right to challenge the decision by

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<sup>15</sup> Skelly v. State Personnel Board, 15 Cal. 3d 194 (1975)

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

### *Conclusion*

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