Office of Law Enforcement Support

Semiannual Report

July 1, 2020–December 31, 2020

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

Promoting a safe, secure and therapeutic environment

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

Contents

Introduction

I am pleased to present the tenth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency. This report details OLES's oversight and monitoring of the Department of State Hospitals (DSH) from July 1 through December 31, 2020.

In this report, the OLES provides details on 429 reported incidents and the results of completed investigations and monitored cases. In response to procedural and substantive insufficiencies OLES identified while monitoring cases, the DSH provided additional training on the OLES reporting guidelines, the importance of interviewing all involved parties during an investigation, and providing the appropriate admonishments to individuals prior to conducting interviews. Additionally, since DSH designated staff to act as OLES liaisons in May 2020, communication between DSH and OLES has greatly improved. The OLES liaisons track DSH's progress on OLES monitored cases and address questions on reported incidents.

In the previous semiannual report, the OLES highlighted key measures DSH took in response to COVID-19. The DSH had its first confirmed case of a patient positive for COVID-19 in May 2020. By June 30, 2020, a cumulative total of 107 patients tested positive for COVID-19. As of December 31, 2020, a cumulative total of 1,226 patients tested positive for COVID-19. During this reporting period, the DSH implemented additional preventative measures in response to the COVID-19 pandemic. For example, to ensure adequate bed space for treating patients, the DSH activated the Southern Youth Correctional Center in the city of Norwalk. The DSH began daily COVID-19 antigen testing of hospital staff who have contact with patients or work in patient care areas. The DSH required hospital staff who do not have patient contact to participate in weekly Polymerase Chain Reaction (PCR) testing. The DSH also began offering COVID-19 vaccinations to patients and staff in December 2020. A comprehensive list of preparation and preventative activities can be found on the DSH website.

The DSH continues to actively respond to the evolving pandemic to protect patients and staff. During this pandemic, the care and services provided to patients by DSH staff, law enforcement and management has continued to be a priority. As OLES enters its sixth year of oversight and monitoring, we remain committed to continuous quality improvement and instilling accountability at DSH.

We are grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DSH management and personnel. We welcome comments and questions. Please visit the OLES website at https://www.oles.ca.gov/.

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

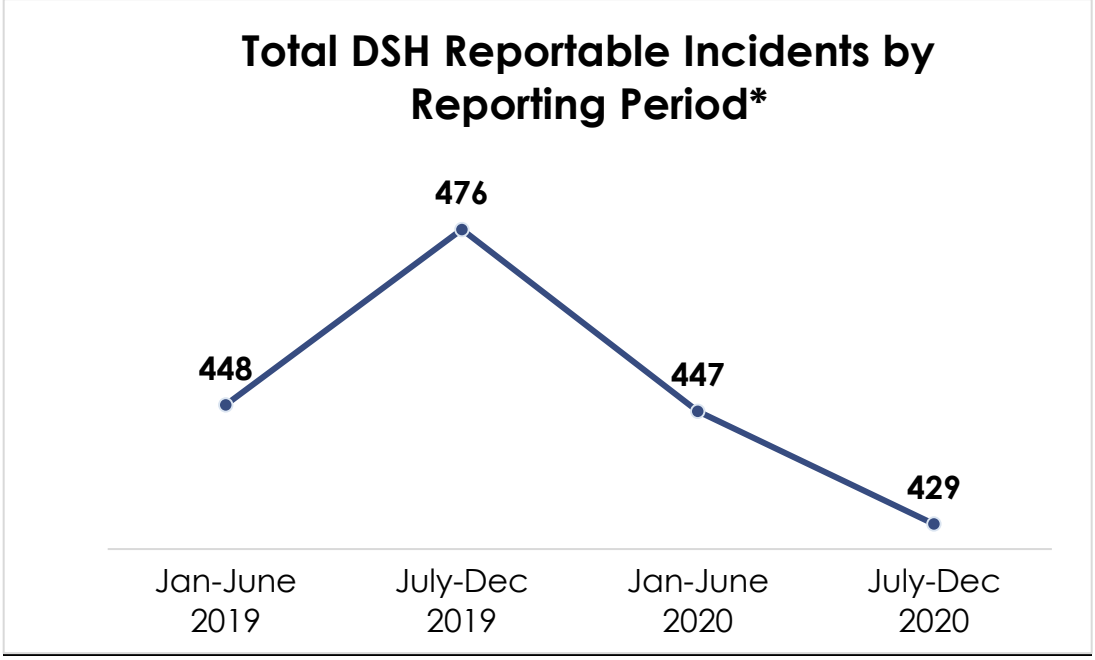
The OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers as of December 31, 2020, were provided by the department.

DSH Facility Population Table

Facility	Number of Male Patients	Number of Female Patients	Total
DSH-Atascadero	967	0	967
DSH-Coalinga	1,315	0	1,315
DSH-Metropolitan	643	199	842
DSH-Napa	872	204	1,076
DSH-Patton	880	372	1,252
Total	4,677	775	5,452

Executive Summary

During the reporting period of July 1, 2020, through December 31, 2020, the Office of Law Enforcement Support (OLES) received and processed 429 reportable incidents[1] from the California Department of State Hospitals (DSH). Reportable incidents include alleged misconduct by state employees, serious offenses between patients, patient deaths and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is a decrease of 18 incident reports compared to the prior reporting period which had 447 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



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

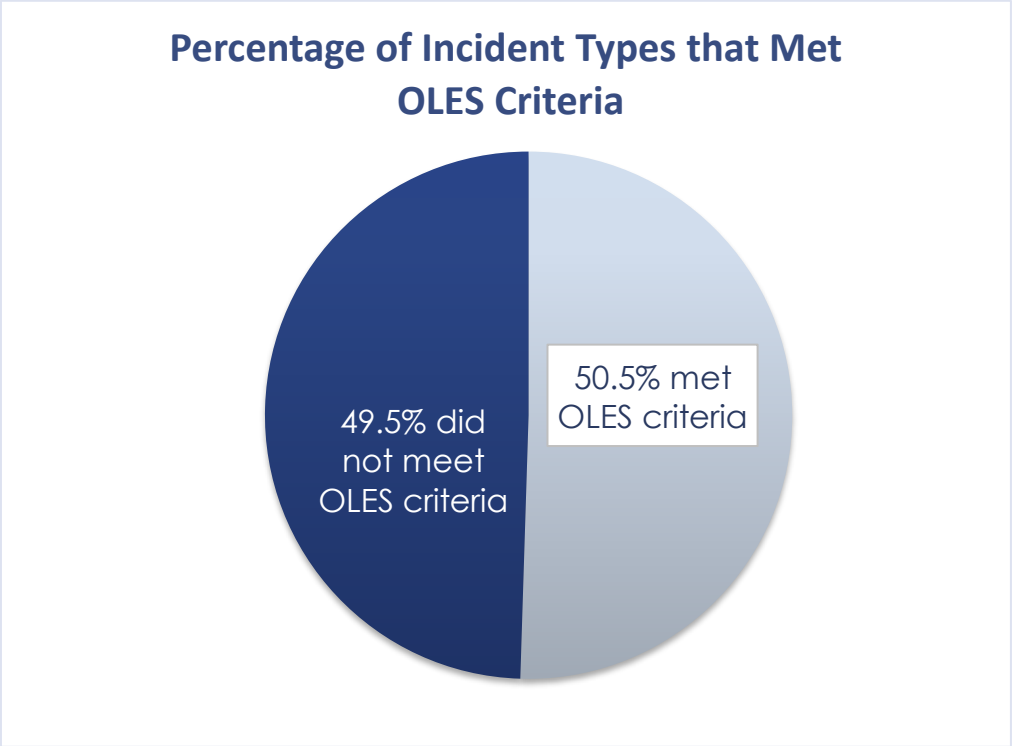
Incident Types Meeting OLES Criteria

The DSH reports to OLES any incidents and associated reportable incident types[2] listed in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. An incident type "meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for

[1] Reportable incidents are pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix F) and existing agreements between OLES and the department.

[2] The OLES defines an incident as an event in which allegations or occurrences meeting the OLES criteria may arise from or have taken place. Allegations or occurrences from incidents such as allegations of sexual assault or physical abuse, or an occurrence of a broken bone are referred to as incident types.

investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 429 reported incidents, the OLES identified 29 incidents with two or more incident types. The DSH reported a total of 465 incident types during this reporting period. Two hundred and thirty-five, or 50.5 percent of the 465 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported by DSH include: sexual assault, abuse, death, broken bone of unknown origin and head or neck injury. Allegations of sexual assault represented the single largest number of alleged incidents reported by DSH during this reporting period. The OLES received 104 reports of sexual assault, which accounted for 22.3 percent of all reported incident types by DSH. The DSH reported 94 incident types of abuse, making abuse the second most frequently reported incident type. Patient deaths were the third most reported incident type with 60 patient deaths reported, representing a 57.9 percent increase when compared to the 38 patient deaths reporting in the prior reporting period. The fourth most frequently reported incident type was reports of broken bone of unknown origin, which increased by 18.2 percent to 39 incident types. The DSH reported 30 head or neck injury incident types. Reports of head or neck injuries decreased by 31.8 percent when compared to the prior reporting period.

Patient Deaths

The number of patient deaths increased by 57.9 percent, from 38 deaths to 60 deaths during this reporting period. Twenty of the reported death incident types met the OLES

criteria for investigation or monitoring. Thirty-four of the 60 patient deaths were expected due to existing medical conditions or COVID-19. Twenty-six patient deaths were classified as "unexpected" and received two levels of review by DSH, per department policy. The OLES reviewed each unexpected death and monitored the cases that met OLES criteria. Nine of the 26 "unexpected" deaths were due to COVID-19, eight were due to cardiac or respiratory issues, one was due to sepsis, one was due to cancer, one was due to a cerebral issue and six are pending determination for the cause.

Coalinga State Hospital (CSH) and Patton State Hospital (PSH), reported the largest number of patient deaths with 17 patient deaths from each facility. At CSH, the most frequent cause of death reported was cardiac or respiratory issues or COVID-19. At PSH, COVID-19 and cancer were the two most frequently reported causes for patient deaths.

Patient Arrests

The OLES works collaboratively with DSH to ensure patients receive the best possible treatment and care at the local jurisdiction holding facility. The OLES also reviews each circumstance to safeguard patient rights and make certain there is strict compliance to the laws of arrest. The purpose of OLES oversight of patient arrests is twofold:

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

During this reporting period, DSH reported 11 patient arrests, five fewer arrests than in the prior reporting period. The patients were arrested for violations of the following statutes:

Statute	Description
Penal Code section 69	resisting an executive officer with threat or violence
Penal Code section 203	mayhem
Penal Code section 236	false imprisonment
Penal Code section 243(c)	battery on a peace officer
Penal Code section 243(d)	battery causing serious bodily injury
Penal Code section 245(a)(1)	assault with a deadly weapon
Penal Code section 245(a)(4)	assault with force likely to cause great bodily injury
Penal Code section 311.11 (a) and (b)	possession of child pornography
Penal Code section 368(b)(2)	elder abuse resulting in great bodily injury
Penal Code section 664/187(a)	attempted murder

Results of Completed OLES Investigations on DSH Law Enforcement

Per statute[3], an OLES investigation is initiated after OLES is notified of an allegation that a DSH law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents. As of December 31, 2020, DSH had approximately 737 sworn staff members.

Appendix A provides information on the 19 OLES investigations that were completed during this reporting period. These investigations involved allegations against at least 20 sworn staff members, which is approximately 2.7 percent of DSH sworn staff. Some allegations did not specify the number of officers involved. Thirteen investigations involved alleged incidents that occurred in 2020. Two investigations involved an alleged incident that occurred in 2019. Three investigations involved alleged incidents that occurred in 2018. One investigation involved an alleged incident that occurred in 2016.

The OLES submitted seven completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process. One administrative investigation was submitted to the State Auditor's office for review. The OLES conducted inquiries into five criminal allegations. The criminal cases were closed without referral to a district attorney's office due to a lack of probable cause. A summary of the review and decision for each case was provided to the department. In the remaining six administrative investigations, the OLES determined there was insufficient evidence that misconduct occurred and the matter was closed. The OLES provided a summary of the review and decision to the department.

Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct. In Appendices B, C, and D of this report, OLES provides information on 74 monitored administrative cases and 61 monitored criminal cases that, by December 31, 2020, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These monitored cases included allegations against psychiatric technicians, psychiatric technician assistants, officers, registered nurses, unit supervisors and several other types of staff members.

Ten pre-disciplinary administrative cases had sustained allegations and five criminal investigations resulted in referrals to prosecuting agencies.

The OLES monitored 127 pre-disciplinary phase cases; 120 of the pre-disciplinary phase cases are listed in Appendix B and seven are in Appendix D. Fourteen of the 127 pre-disciplinary phase cases were rated as procedurally insufficient only. Three cases were rated both procedurally and substantively insufficient. The DSH's failure to notify OLES of incidents in a timely manner was the most frequent procedural deficiency.

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

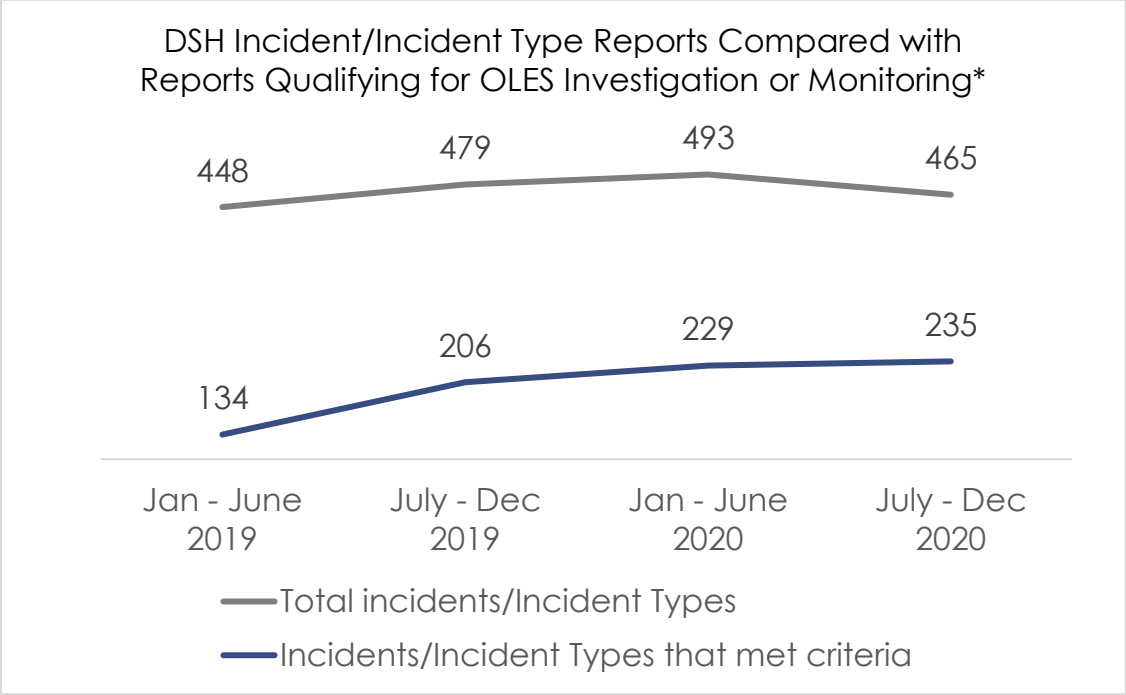
The OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in fifteen administrative cases; eight are listed in Appendix C and seven are in Appendix D. All disciplinary phase cases were rated procedurally and substantively sufficient.

Incidents and Incident Types

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

Increase in Reported Incident Types

The number of DSH incidents reported to OLES from July 1 through December 31, 2020, decreased 4.0 percent, from 447 during the prior reporting period to 429 in this reporting period. From the 429 reported incidents, the OLES identified 465 incident types, as 29 of the incidents featured two or more incident types. Two hundred and thirty-five of the 465 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic issue.



* Numbers are unadjusted and are provided as they were previously published. Beginning in the July through December 31, 2019 reporting period, the OLES switched from evaluating incidents to evaluating incident types for meeting OLES criteria.

Most Frequent Incident Types Reported

The most frequent incident types reported were sexual assault, abuse, death, broken bone of unknown origin and head or neck injury. These incident types accounted for 327 or 70.2 percent of all incident types reported by DSH. Of the 327 incident types, 185 met criteria for OLES to investigate or monitor. This is 78.7 percent of the 235 incident types that met criteria.

Allegations of abuse or sexual assault remain the two most frequently reported incident types at DSH. In this reporting period, allegations of sexual assault accounted for 22.3 percent of all incident types reported. The number of sexual assault allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period decreased by 20.9 percent, from 43 during the prior reporting period, to 34 in this reporting period.

Abuse allegations were the second most frequently reported incident type at DSH in this reporting period, totaling 94 incident types and accounting for 20.2 percent of all incident types reported. Of the 94 abuse allegations reported in this period, 89 allegations qualified for investigation, monitoring or consideration of a potential systemic issue. This is an increase of 4.7 percent or five qualifying reports from the prior reporting period, which had 85 incident types of abuse that met OLES criteria.

Reports of patient death increased 57.9 percent when compared to the number reported in the prior reporting period. COVID-19 was the primary cause of death for 23 of the 60 reported patient deaths.

Reports for broken bone of unknown origin and head or neck injuries continue to be frequently reported. Reports for broken bone of unknown origin increased 18.2 percent. Reports of head or neck injuries decreased 31.8 percent to 30 incident types. Fifteen head or neck injuries resulted from a physical altercation between patients. Twelve head or neck injuries resulted from a self-injury by the patient, an unwitnessed or witnessed fall or the patient losing balance. The remaining three head or neck injuries were due to an unknown cause or dental issues. The following table provides the most frequently reported incident types reported by DSH and the percent change from the previous reporting period.

Most Frequent Incident Types July 1 through December 31, 2020

Incident Type Category	Prior Period Incident Type Total – January 1 through June 30, 2020	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Sexual Assault	86	104	+20.9%	34
Abuse	93	94	+1.1%	89
Death	38	60	+57.9%	20
Broken Bone (Unknown Origin)	33	39	+18.2%	37
Head/Neck Injury	44	30	-31.8%	5
Neglect	18	20	+11.1%	17
Misconduct	30	19	-36.7%	17
Patient on Patient Assault/GBI	24	15	-37.5%	2

Incident Types by Reporting Period

The following table compares the total count of reported incident types during this reporting period to the total count from the two prior reporting periods.

Incident Categories	Prior Period July 1- December 31, 2019 (Reported)*	Prior Period July 1 - December 31, 2019 (Meets Criteria)*	Prior Period January 1 - June 30, 2020 (Reported)*	Prior Period January 1 - June 30, 2020 (Meets Criteria)*	Current Period July 1 - December 31, 2020 (Reported)	Current Period July 1 - December 30, 2020 (Meets Criteria)
Abuse	79	75	93	85	94	89
Broken Bone	77	26	-	-	-	-
Broken Bone (Known Origin)	-	-	27	1	12	1
Broken Bone (Unknown Origin)	-	-	33	29	39	37
Burn	3	0	3	0	2	0
Death	19	5	38	20	60	20
Genital Injury	2	0	-	-	-	-
Genital Injury (Known Origin)	-	-	3	1	1	0
Genital Injury (Unknown Origin)	-	-	2	1	8	3
Head/Neck Injury	23	2	44	8	30	5
Misconduct**	41	38	30	21	19	17
Neglect	19	19	18	11	19	16
Non-patient assault/GBI on Patient	1	1	0	0	0	0
Patient on Patient Assault/GBI	15	0	24	0	15	2
Pregnancy	0	0	0	0	1	1
Sexual Assault	102	34	86	43	104	34
Sexual Assault-OJ***	35	0	33	0	13	0
Significant Interest-Attack on Staff******	10	0	13	0	12	0

Incident Categories	Prior Period July 1- December 31, 2019 (Reported)*	Prior Period July 1 - December 31, 2019 (Meets Criteria)*	Prior Period January 1 - June 30, 2020 (Reported)*	Prior Period January 1 - June 30, 2020 (Meets Criteria)*	Current Period July 1 - December 31, 2020 (Reported)	Current Period July 1 - December 30, 2020 (Meets Criteria)
Significant Interest-Attempted Suicide	1	0	5	0	1	0
Significant Interest-AWOL	9	2	6	0	6	0
Significant Interest-Child Pornography	3	0	1	0	1	0
Significant Interest-Other***	13	1	9	1	7	1
Significant Interest-Over-Familiarity	-	-	9	8	10	9
Significant Interest-Patient Arrest	27	0	16	0	11	0
Significant Interest-Riot	0	0	0	0	0	0
Total	479	209	493	229	465	235

*Numbers in this column are unadjusted and provided as they were previously published.
**Beginning in the January 1, 2020, through June 30, 2020, reporting period, the OLES identified applicable incident types within each incident involving peace officer misconduct. For example, an allegation of abuse by a peace officer is recorded as one incident type for abuse and one incident type for misconduct.
***These incidents occurred outside the jurisdiction of DSH.
****The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department reported to OLES and therefore does not reflect all attacks on staff that may have occurred.
*****Any other incident of significant interest, e.g., civilian citation for a suspicious vehicle on facility grounds; and drugs found in a state hospital.

Incident Types by Facility

The following table provides the total reported incident types by facility.

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Abuse	9	17	38	11	19	94
Broken Bone (Known Origin)	2	5	3	1	1	12
Broken Bone (Unknown Origin)	3	11	10	6	9	39
Burn	1	0	1	0	0	2
Death	2	17	15	9	17	60
Genital Injury (Known Origin)	0	0	1	0	0	1
Genital Injury (Unknown Origin)	0	0	8	0	0	8
Head/Neck Injury	1	6	11	9	3	30
Misconduct*	5	6	3	4	1	19
Neglect	5	3	7	1	3	19
Non-Patient on Patient Assault/GBI	0	0	0	0	0	0
Patient on Patient Assault/GBI	1	3	4	2	5	15
Pregnancy	0	0	0	1	0	1
Sexual Assault	14	24	36	14	16	104
Sexual Assault-OJ**	4	1	6	2	0	13
Significant Interest- Attack on Staff***	10	0	1	1	0	12
Significant Interest-Attempted Suicide	0	1	0	0	0	1
Significant Interest-AWOL	0	0	1	5	0	6
Significant Interest-Child Pornography	0	1	0	0	0	1
Significant Interest-	1	1	1	1	3	7

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Other****						
Significant Interest-Over-Familiarity	2	2	1	2	3	10
Significant Interest-Patient Arrest	1	4	0	0	6	11
Significant Interest-Riot	0	0	0	0	0	0
Total	61	102	147	69	86	465

*Beginning in the January 1, 2020, through June 30, 2020, reporting period, the OLES identified applicable incident types within each incident involving peace officer misconduct. For example, an allegation of abuse by a peace officer is recorded as one incident type for abuse and one incident type for misconduct.

**These incidents occurred outside the jurisdiction of DSH.

***The OLES does not require facilities to report all incidents in which a staff member is attacked. These numbers represent the incidents that the department has reported to OLES and therefore does not reflect all attacks on staff that may have occurred.

*****Any other incident of significant interest, e.g., civilian citation for a suspicious vehicle on facility grounds; and drugs found in a state hospital.

Distribution of Incident Types

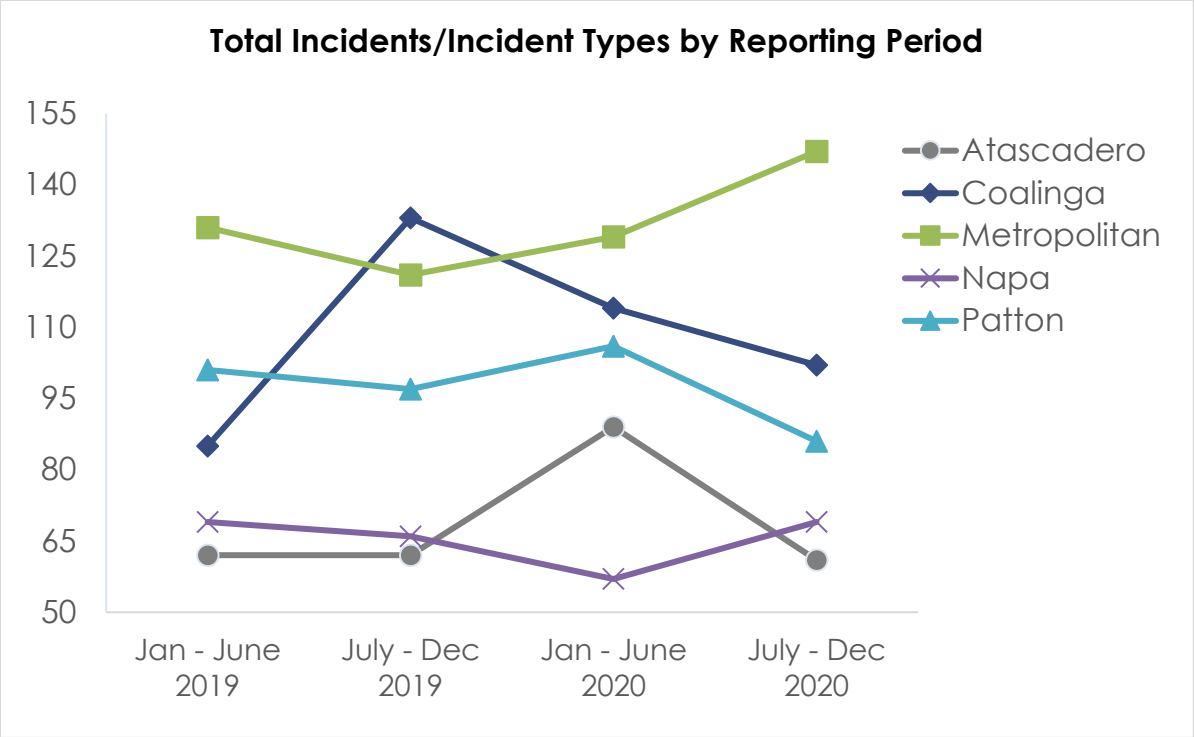
With 5,452 patients department-wide, this equates to 0.085 incident types per patient. The following table provides the population counts of DSH facilities for reference.

DSH Population and Total Incident Types

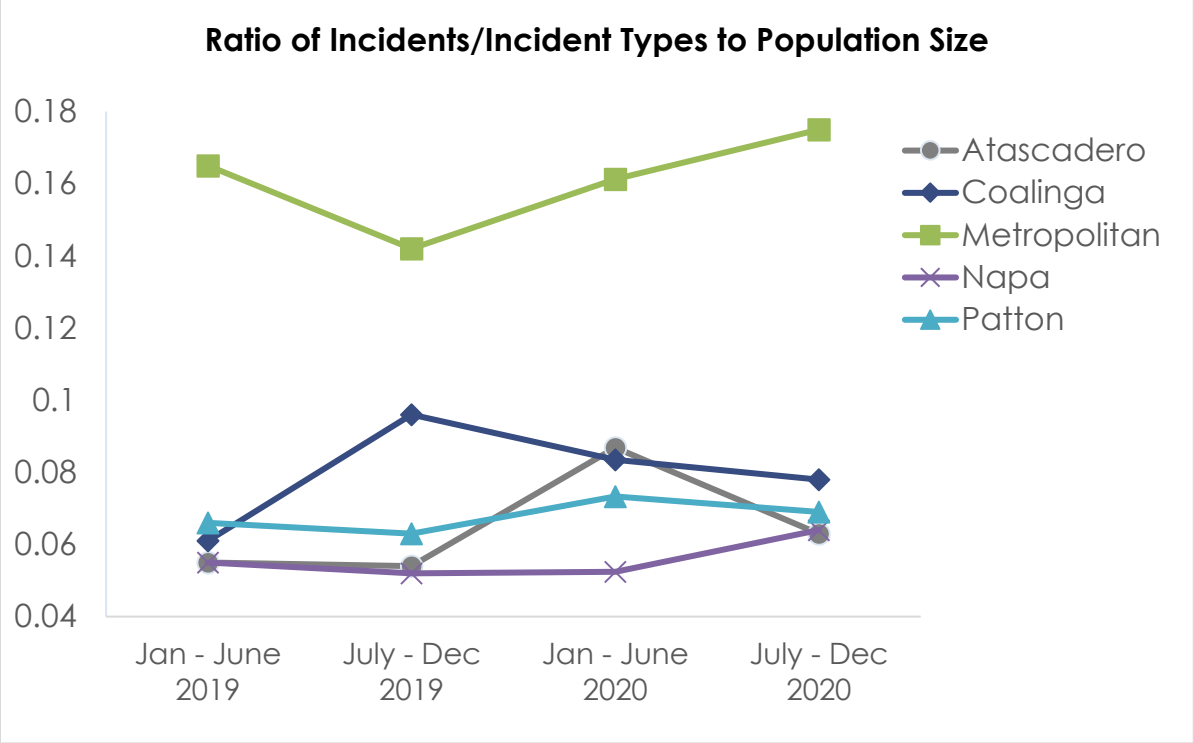
DSH Facility	Number of Patients*	Total Incident Types	Ratio of Incident Types to Population
Atascadero	967	61	0.063
Coalinga	1,315	102	0.078
Metropolitan	842	147	0.175
Napa	1,076	69	0.064
Patton	1,252	86	0.069
Total	5,452	465	0.085

* The department provided population numbers as of December 31, 2020.

With the exception of the July 1, 2019 through December 31, 2019, reporting period, Metropolitan State Hospital (MSH) consistently reports the highest number of incident types. The Atascadero State Hospital (ASH) and Napa State Hospital (NSH) report the fewest incident types. MSH and NSH reported more incident types compared to the prior reporting period. The following charts depict the total number of incidents or incident types for this reporting period and the prior three reporting periods as well as the ratio of incidents or incident types compared to the population size of each facility.



Despite having the smallest patient population, MSH consistently reports the highest number of incident types compared to the population size as shown in the chart on the following page.



Sexual Assault Allegations

Sexual assault was the most frequently reported incident type from July 1 through December 31, 2020. The 104 alleged sexual assault incident types reported in this reporting period accounted for 22.3 percent of all reported incident types from DSH. Thirty-four of the 104 reported incident types of alleged sexual assault, or 32.7 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 13 reported incident types under the sexual assault-OJ category, none of which met OLES criteria for investigation or monitoring.

MSH reported the highest number of incident types under the sexual assault incident type category. MSH reported 36 incident types, or 34.6 percent of all alleged sexual assault incident types reported during this reporting period. CSH reported 24 incident types under the sexual assault category, the second highest number of sexual assault incident type reports.

MSH also reported the highest number of alleged sexual assault-OJ incident types. In this reporting period, MSH reported six out of the 13 reported incident types under the alleged sexual assault-OJ. This category includes allegations that implicated family, friends, or others in incidents that occurred when patients were not in a DSH facility.

Allegations of sexual assault involving a patient assaulting other patient(s) were the most frequently reported, with a total of 68 incident types, or 65.4 percent of the alleged sexual assault incident types. The second most frequent type of alleged sexual assault involved non-law enforcement staff on a patient, with 32 incident types or 30.8 percent of the 104 alleged sexual assault incident types. There were four allegations pf sexual assault involving an unknown assailant on a patient. These include allegations made by patients that did not implicate DSH employees or contractors. DSH did not report any allegations of sexual assault on a patient by law enforcement personnel during this reporting period. All DSH reports of alleged sexual assaults received by OLES during the reporting period are shown in the following table.

Sexual Assault Allegations Reported July 1 through December 30, 2020

Facility	Patient on Patient	Non-Law Enforcement Staff on Patient	Unknown Person on Patient	OJ*	Totals
Atascadero	9	5	0	4	18
Coalinga	19	4	1	1	25
Metropolitan	23	11	2	6	42
Napa	8	5	1	2	16
Patton	9	7	0	0	16
Totals	68	32	4	13	117

*Sexual Assault-OJ is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH or outside the jurisdiction of the state hospital.

Patient Deaths

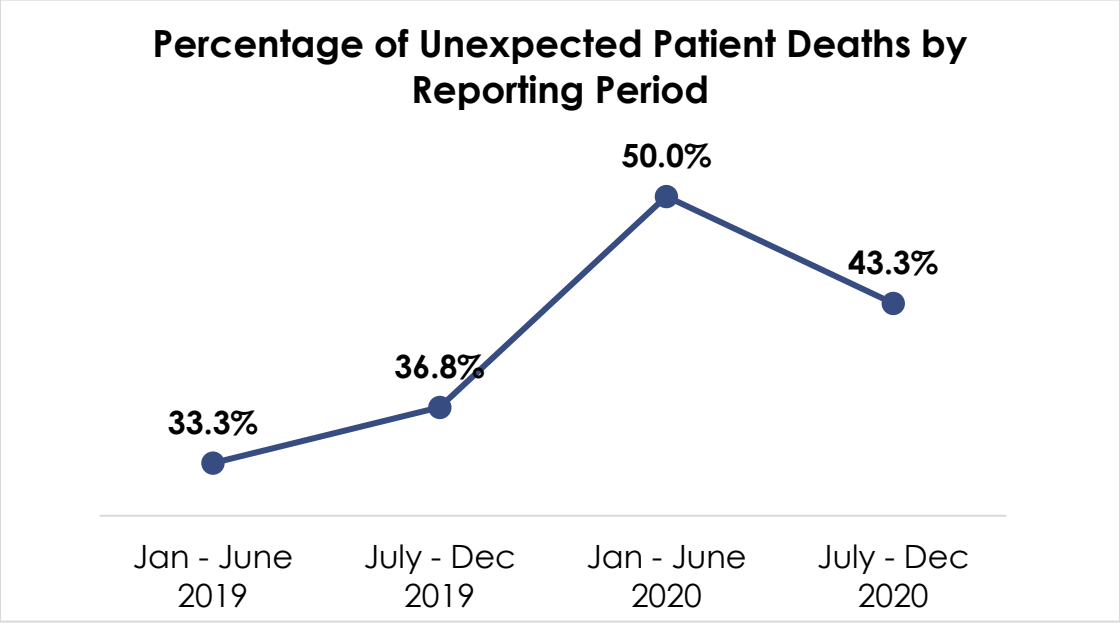
There were 60 patient deaths reported to OLES from DSH facilities during this reporting period. This number increased 57.9 percent from the 38 patient deaths reported in the

prior reporting period of January 1 through June 30, 2020. Of the 60 patient deaths, 55 were male patients and five were female. The patient age at the time of death ranged from 24 years to 100 years old. The following table provides the total number of patient deaths in each age group.

Patient Deaths by Age Group

Age Group (years)	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
15-24	0	0	0	1	0	1
25-34	0	0	1	0	0	1
35-44	1	0	0	0	0	1
45-54	0	2	1	1	1	5
55-64	0	5	4	2	7	18
65-74	1	8	2	5	8	24
75-84	0	2	3	0	1	6
85 and over	0	0	4	0	0	4
Total	2	17	15	9	17	60

Thirty-four of the patient deaths were classified as "expected" due to underlying health conditions, such as cancer and kidney disease. Twenty-six deaths were classified as "unexpected". Though there was a significant increase in patient deaths, the percentage of unexpected patient deaths decreased compared to the percentage in the prior reporting period. The following chart depicts the percentage of unexpected patient deaths in this reporting period and the three prior reporting periods.



Each unexpected patient death receives two levels of review within DSH, per department policy. The OLES reviewed each unexpected death and monitored the cases that met OLES criteria. In 20 of the 60 patient deaths, the OLES monitored the departmental investigations.

The final determination for the cause of death of reported patient deaths are provided in the following table.

Cause of Patient Deaths

Facility	Cancer	Cardiac/ Respiratory	Renal/Liver	Sepsis	COVID-19	Other	Totals
Atascadero	0	1	1	0	0	0	2
Coalinga	2	7	0	0	8	0	17
Metropolitan	1	4	0	1	7	2	15
Napa	2	2	0	3	0	2	9
Patton	4	1	1	0	8	3	17
Totals	9	15	2	4	23	7	60

COVID-19 was listed as the cause of death for 38.3 percent of the reported patient deaths. The second most frequently reported cause of death was cardiac or respiratory issues. Six patient deaths listed under the "Other" category are pending determination for the cause. One patient death from NSH was due to cerebral issues and was included under the "Other" category.

Reports of Patients Absent without Leave

In this reporting period, NSH reported five incident types under the significant interest-absent without leave (AWOL) category. At NSH, a forensic patient ran towards the sally port while being escorted to a dental appointment. Officers transported the patient back to his unit without incident. Another forensic patient attempted to escape from her housing unit by pushing past staff at an open doorway. Officers apprehended the patient at the intersection of Birch and Spruce Drive[4] and returned the patient to her housing unit without incident. On a separate date, the same forensic patient ran down the unit hallway and forcefully pushed open the door as another staff was opening the unit door. Officers and the Grounds Presence Team found the patient in front of the main entrance to the S-Complex on Spruce Drive and transported her back to the unit without incident. Another forensic patient pushed past a staff member who was unlocking a door to enter the housing unit. The patient ran approximately 100 feet away from the unit before staff and officers stopped her at the corner of Birch Drive and Spruce Drive. The patient was transported back to her home unit without further incident. In another incident, a non-forensic patient exited a secure area when a staff member opened a door to enter. The patient was redirected back to the secure area without incident.

There was one report from MSH. At MSH, a non-forensic patient ran away from an outside medical appointment and was returned to the Department three days later, after being detained by outside law enforcement. In all incidents described above, the patients did not require treatment beyond first aid.

[4] The intersection of Birch and Spruce Drive is within the Napa State Hospital campus and is not accessible to the public.

Notification of Incident Types

Different incident types require different kinds of notification to OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq., and agreements between OLES and the departments, certain serious incident types are required to be reported to OLES within two hours of their discovery. Notification of these "Priority One" incident types 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 within 24 hours of the time and date of discovery of the reportable incident. "Priority Two" threshold incidents require notification within 24 hours of the time and date of discovery. Priority One and Two threshold incident types are shown in the tables below.

Priority One Notifications – Two Hour Notification

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

Priority Two Notifications – 24 Hour Notification

Incident	Description
Broken Bone (K)	A broken bone of a patient when the cause of the break is known by staff.
Burns	Any burns of a patient. This does not include sunburns or mouth burns caused by consuming hot food or liquid unless blistering occurs.
Genital Injury (K)	An injury to the genitals of a patient when the cause of injury is known by staff.
Head/Neck Injury	Any injury to the head or neck of a patient requiring treatment beyond first-aid that is not caused by staff or law enforcement. Or any tooth injuries, including but not limited to, a chipped, cracked, broken, loosened or displaced tooth that resulted from a forceful impact, regardless of treatment.
Neglect	Any staff action or inaction that resulted in, or reasonably could have resulted in a patient death, or injury requiring treatment beyond first-aid.

Incident	Description
Patient Arrest	Any arrest of a patient.
Peace Officer Misconduct	Any allegations of peace officer misconduct, whether on or off-duty. This does not include routine traffic infractions outside of the peace officer's official duties.
Pregnancy	A patient pregnancy.
Significant Interest	Any incident of significant interest to the public, including, but not limited to: AWOL, suicide attempt (requiring treatment beyond first-aid), commission of serious crimes by patient(s) or staff, child pornography, riot (as defined for OLES reporting purposes), over-familiarity between staff and patients or any incident which may potentially draw media attention.

Timeliness of Notifications

In this reporting period, the OLES evaluated the timely reporting of incident types rather than incidents. DSH timely reporting of incident types was 91.9 percent. In the prior reporting period, an incident was considered untimely if it contained at least one incident type that was reported untimely. The DSH timely reporting of incidents in the prior reporting period was 90.7 percent.

Eighteen of the 465 reported incident types were excluded from DSH's total incident type count when calculating timeliness. These 18 incident types involved a patient attack on staff or were incidents reported directly to OLES by a patient, family member of a patient, facility staff member or by an outside law enforcement agency. Of the 447 incident types evaluated for timeliness, 411 were reported timely and 36 incident types were not timely. Four of the 36 untimely incident types were unreported and were discovered by OLES when reviewing the DSH facility daily incident logs or incident reports.

PSH had the highest percentage of timely notifications at 94.1 percent during this reporting period. ASH had the lowest percentage of timely notifications at 89.8 percent. When compared to the prior reporting period, CSH, NSH and PSH increased in the percentage of timely reports. ASH and MSH had a lower percentage of timely notifications this reporting period compared to the prior reporting period. The following table provides the percentage of timely notifications to OLES for each facility.

Rank	DSH Facility	Number of Incidents Types Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Patton	85	80	94.1%
2	Coalinga	99	91	91.9%
3	Metropolitan	146	134	91.8%
4	Napa	68	62	91.2%
5	Atascadero	49	44	89.8%
	Total	**447**	**411**	**91.9%**

Intake

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

For incidents that initially do not appear to fit the criteria[5] for OLES involvement, the OLES categorizes the incident under the "Pending Review" category and conducts an extra step to ensure the incident is properly categorized. When allegations are unclear and additional information is needed to finalize an initial intake decision, OLES may review video files or digital recordings of a particular hallway, day room, or staff area where a patient was located. Once OLES obtains and evaluates the additional materials or information, the decision to initially deem an incident as not meeting OLES criteria is reviewed again and may be reversed.

For the July 1 through December 31, 2020, reporting period, 185 of the total 476 cases opened for DSH incidents that occurred within DSH's jurisdiction or 38.9 percent were assigned a pending review. The OLES opened cases for 13 incidents that may have occurred while the patient was not housed within a DSH facility and assigned those cases a pending review. The OLES opened 12 administrative investigations and 4 criminal investigations. The OLES opened 179 monitored criminal cases and 83 monitored administrative cases.

The table on the following page provides the case assignments for incidents received by OLES during the reporting period. Please note that the table on the following page separates out the outside jurisdiction cases from the Pending Review cases.

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

Cases Opened in the Current Reporting Period

OLES Case Assignments	July 1 – December 31, 2020	Percentage of Opened Cases
Pending Review	185	38.9%
Monitored, Criminal	179	37.6%
Monitored, Administrative	83	17.4%
Outside Jurisdiction*	13	2.7%
OLES Investigations, Criminal	4	0.8%
OLES Investigations, Administrative	12	2.5%
Totals	476	~100%

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

Completed Investigations and Monitored Cases

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

OLES Investigations

During this reporting period, OLES completed 19 investigations. Five investigations were criminal cases and 14 were administrative.

If an OLES investigation into a criminal matter reveals probable cause that a crime was committed, OLES submits the investigation to the appropriate prosecuting agency. In this reporting period, the OLES did not refer any criminal investigations to a prosecuting agency. All completed OLES investigations into administrative wrongdoing or misconduct are forwarded to facility management for review. In this reporting period, seven administrative cases were referred to management for possible discipline of state employees. One administrative investigation was conducted at the request of the State Auditor's office and submitted to the State Auditor's office for review. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted. The OLES provided the department with summaries of the reviews and decisions of all administrative and criminal investigations in which the OLES determined there was a lack of probable cause.

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

Results of Completed OLES Investigations

Type of Investigation	Total completed July 1- December 31, 2020	Referred to prosecuting agency	Referred to facility management*	Closed without referral
Administrative	14	N/A	8	6
Criminal	5	0	N/A	5
Total	19	0	8	11

*The investigation submitted to the State Auditor's Office is included under this category.

OLES Monitored Cases

In this report, OLES provides information on 135 completed monitored cases. By the end of the reporting period, 61 monitored criminal cases had either been referred or not referred to a prosecuting agency. Five out of 61 criminal cases were referred to a prosecuting agency.

There were 66 completed monitored pre-disciplinary administrative cases that had allegations that were sustained or not sustained during this reporting period. Ten of the 66 cases had sustained allegations. Fifty-six cases had no sustained allegations. Eight of the monitored administrative cases had sustained allegations that OLES reported on in a prior reporting period. Results of OLES monitored cases are provided in the table below.

Type of Case/Result	DSH
Criminal-Referred to Prosecuting Agency	5
Criminal-Not Referred	56
Total Criminal	61
Administrative-With Sustained Allegations	10
Administrative- With Sustained Allegations Reported in the Prior Reporting Period	8
Administrative-Without Sustained Allegations	56
Total Administrative	74
Grand Total	135

Pre-Disciplinary Phase Cases

Of the 127 pre-disciplinary phase cases provided in Appendix B and D, the OLES rated 14 cases procedurally insufficient only and three cases procedurally and substantively insufficient. The following table provides the type of case and the corresponding number of cases rated procedurally or substantively insufficient.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	1	1
Criminal/Not Referred	9	2
Administrative/With Sustained Allegations	1	0
Administrative/Without Sustained Allegations	6	0
Total	17	3

Significant procedural deficiencies found in insufficient cases and their potential consequences include, but are not limited to following:

Procedural Deficiencies found in Insufficient Cases

Procedural Deficiency	Potential Consequence
Failure to complete investigations within 120 days	As investigations age, memories may fade, witnesses may become unavailable, patients may be discharged or transferred.
Failure to notify OLES of suspect interview	This prevents OLES from providing contemporaneous oversight of the interview.
Failure to notify OLES of incident within required timeframe	This prevents OLES from properly processing and classifying or assigning the case. Many reporting requirements are required by statute.
Failure to interview suspect prior to drafting investigative report.	This may result in an incomplete and inadequate investigation. The suspect may have provided a relevant explanation. It is important to provide the employee an opportunity to admit or deny the misconduct or provide otherwise relevant information.
Failure to audio record suspect or victim interview	This limits the department to have to rely upon notes and may affect the accuracy of investigative reports.
Failure to identify and interview witnesses	This increases the likelihood of missing or erroneous information.

The DSH's failure to notify OLES of the incident within the required timeframe was the most frequent procedural deficiency observed in pre-disciplinary phase cases. There were three investigations that were not completed within the 120 day timeframe.

Substantive Deficiencies found in Insufficient Cases

Substantive Deficiency	Potential Consequence
Failure to provide required legal admonition prior to taking a statement	This may compromise the integrity of the statement and render a statement

Substantive Deficiency	Potential Consequence
	inadmissible in court. In some cases, it may violate union contracts or the Public Safety Officer Bill of Rights.

Corrective action plans for procedural and substantive deficiencies in pre-disciplinary phase cases are provided in Appendix B and D.

Disciplinary Phase Cases

The OLES monitored the disciplinary action, *Skelly* hearings, settlements and State Personnel Board proceedings in fifteen administrative cases. All cases were rated both procedurally and substantively sufficient. Details regarding the monitoring of these cases are in Appendix C and D of this report.

Additional Mandated Data

In accordance with Welfare and Institutions Code section 4023.8, the OLES publishes data in its semiannual report about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where patients are the perpetrators. All the mandated data for this reporting period came directly from DSH and are presented in the following tables.

Adverse Actions against Employees

DSH Facilities	Formal administrative investigations/actions completed*	Adverse action taken (Formal investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/ retired pending adverse action****
Atascadero	27	9	10	6	2
Coalinga	34	4	16	13	1
Metropolitan	45	1	43	1	0
Napa	39	5	22	12	0
Patton	45	2	40	3	0
Totals	190	21	131	35	3

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

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

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

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

Criminal Cases against Employees

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	1	1	0	0
Coalinga	0	0	0	0
Metropolitan	43	0	43	0
Napa	19	0	19	0
Patton	4	4	0	3
Totals	67	5	62	3

* Employee criminal cases include criminal investigations of any employee. Numbers are for investigations which were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.

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

***Criminal cases not referred to prosecuting agencies due to a lack of probable cause.

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

Patient Criminal Cases

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	148	148	47	75
Coalinga	369	369	280	33
Metropolitan	373	373	371	0
Napa	199	199	192	5
Patton	193	193	105	72
Totals	1282	1282	995	185

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

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

*** Criminal cases not referred to prosecuting agencies due to a lack of probable cause.

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

Reports of Employee Misconduct to Licensing Boards

DSH Facilities	Registered Nursing	Vocational Nursing/ Psych Tech	CA Board of Pharmacy
Atascadero	2	13	1
Coalinga	0	0	0
Metropolitan	0	0	0
Napa	3	0	0
Patton	0	0	0
Totals	5	13	1

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

Monitored Issues

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

Recording of Investigatory Interviews

On January 10, 2017, the OLES issued a memorandum to the Department of State Hospitals (DSH) recommending that hospital police officers (HPO's) record investigatory interviews, except in cases where the recording would make a patient anxious, uncomfortable, or result in a patient's refusal to participate in the interview.

In response to the OLES memorandum, on March 1, 2018, DSH implemented California Department of State Hospitals' Policy 600, which sets forth guidelines and requirements pertaining to the handling and disposition of criminal and administrative investigations, including the mandatory recording of interviews, as recommended by the OLES memorandum.

Despite this policy, the OLES found multiple examples where DSH HPO's statewide are not properly recording interviews. As a result, multiple criminal and administrative cases document unrecorded interviews that cannot be verified and reviewed, possibly jeopardizing the outcome of the cases.

On July 30, 2020, the OLES issued a memorandum to the Chief of Law Enforcement at DSH, recommending statewide re-training on DSH Policy 600, to implement the appropriate recording of interviews by DSH HPO's. In response, on October 1, 2020, the Chief of the Office of Protective Services instituted protocols and re-training policies for DSH officers to ensure the appropriate recording of interviews as recommended by the OLES. The OLES will continue to monitor the department's adherence to its recording policies.

Enforcement of Employee Return to Patient Care Policy

As previously published in the semiannual report covering the period of January 1, 2018 through June 30, 2018, the OLES identified a systemic issue involving DSH employees who were accused of physical or sexual abuse of patients. Department policy allowed clinical staff to decide whether an employee who was accused of patient abuse 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.

DSH drafted PD 3101 in response to OLES concerns regarding the lack of consultation

with OPS in circumstances where an employee is returned to patient care despite the employee being the subject of a pending, open criminal investigation for allegations of physical abuse or sexual abuse of a patient. In September 2017, the OLES reviewed and agreed with the proposed draft of PD 3101. At the time, the department appropriately responded to the concerns and recommendations raised by OLES.

However, the OLES learned that DSH has not implemented the policy. The number of the policy changed from PD 3101 to PD 9500. PD 9500 was scheduled to be presented to DSH's executive team in February 2021.

Escape Prevention and Key Control at CSH

On April 7, 2020, the OLES initiated a monitored issue in response to a patient escaping through unsecured receiving and release (R&R) doors, gates or locks at CSH. The attempted escape was possible due to lack of supervision and communication by hospital police officers and lack of adequate control or accountability measures in issuing and inventorying keys.

The OLES recommended CSH implement the following 14 recommendations:

Receiving and Release Area

- Add signage in the R&R area prohibiting employees from propping doors open or other methods of circumventing security systems. CSH should reflect this prohibition in policy.
- Instruct field sergeants to make daily rounds of the R&R area, filling out a logbook indicating they have toured the area and found no security deficiencies and that all doors are operational and secured. CSH policy should include this as a required task for security personnel.
- The communications center should not be able to control a door they cannot visually see via camera. Install a camera that enables the communication center to monitor the door or assign control of the door to someone who can monitor the door.
- Develop post orders regarding handling escorts.
- Develop post orders for the Support Services Lieutenant (Lt.). Post orders should include that the Support Services Lt. is responsible for ensuring the Field Sergeants sign daily the logbook showing they have made their rounds of the R&R area and ensured there are no security deficiencies and that all doors are operational and secure.
- Vehicle sally port gates should never be open at the same time or left open.
- When the automatic feature of a vehicle sally port door is not functioning, staff must immediately close the gate manually after a person/vehicle passes through it. The appropriate post orders should reflect this requirement.
- Footage from video cameras at CSH should be DVR-recorded.

Key Control

- Repair or replace the key boxes in such a manner their security features function appropriately (this includes regular software updates).
- Assign a HPO or supervisor to monitor key activity at the beginning, during and

end of each shift to ensure keys are turned to the lock position and the key boxes are properly secured.
- Allow OPS access to the key computer system so an inventory of each box can be completed on each shift. Have policy in place to address next steps when a key is missing. (Lockdown, secure a given area etc.).
- Provide ongoing training to all staff regarding key control.
- All key box areas must be under DVR-video surveillance.
- Develop policy where officers are responsible for key inventory and security. The locksmiths should only be responsible for functioning keys and ensuring the lock box operates properly.

Per a memorandum from DSH in April 2020, DSH accomplished six out of the eight recommendations for the receiving and release area. Since the previous SAR, DSH completed all but two recommendations. The remaining two recommendations are for footage from video cameras at CSH should be DVR-recorded and for key box areas to be under DVR-video surveillance. The DSH obtained the cameras and DVR system. The DSH is in the process of hiring a contractor to install the cameras in large hallways to increase patient safety and monitor who enters the rooms in which the key boxes are located. The OLES will continue to monitor the department's progress.

Underutilization of Blue Team/IAPro

In March 2015, the OLES provided the Legislature with a report that described the challenges faced by law enforcement at DSH along with recommendations to address these challenges. One of the recommendations was for the departments to use an early intervention (EI) system to monitor incidents for selected performance indicators such as use of force and patient complaints. The intent was for the departments to use data to proactively identify potential performance problems with staff. The DSH selected the IAPro/Blue Team software for its EI system. BlueTeam is the interface of IAPro that allows officers and supervisors to input and manage incidents such as use of force, field-level discipline, complaints and vehicle accidents. The software also allows these incidents to be routed through the chain-of-command with review and approval at each step.

The OLES semiannual report covering the period of January 1 through June 30, 2016, recommended DSH OPS Chief review monthly reports from the system to ensure employees with the identified behavior or activities received prompt management attention. The OLES also recommended using the employee trends pinpointed in the system to review whether training was adequate or needed to be updated or supplemented. During the semiannual reporting period of July 1 through December 31, 2016, the DSH reported that DSH completed staff training at all facilities and that staff would begin using Blue Team/IAPro on December 31, 2016. DSH facilities were to enter incident data into the system and DSH-HQ would track eight incident-types: Use of Force, Patient Complaints, Citizens Complaints, Citizens Complaints-Other, Vehicle Accidents, Administrative Investigation, Censurable Incident Report, and Merit Salary Advance Denial. DSH-HQ would generate monthly reports to send to the DSH Police Chief at each facility for review.

On July 25, 2017, OLES initiated a monitored issue to assess DSH's implementation and usage of the Blue Team/IA Pro program at DSH. On January 24, 2018, the OLES received the year-end totals for IAPro from four of the five facilities. The OLES did not receive the totals from CSH until February 26, 2018.

The number of incidents inputted by the facilities are provided below:

DSH Facility	January 1- June 30, 2017	July 1 - December 31, 2017
ASH	12	11
CSH	41	51
MSH	12	24
NSH	3	6
PSH	4	7
Total	72	99

The OLES completed a comprehensive review of the data to determine whether the monthly reports submitted to the DSH Police Chiefs accurately reflected the number of reportable incidents, and to identify any potential systemic issues. The OLES determined IAPro did not accurately reflect the number of incidents that met the criteria as a reportable incident to both Blue Team and OLES. Also, some reportable use of force incidents were discovered in DSH'S Records Management System, but they were not in IAPro. The facilities did not accurately record facility case numbers in Blue Team; they used partial facility case numbers or case numbers previously used in an unrelated incident. Some monthly IA Pro reports DSH-HQ generated and sent to DSH Police Chiefs did not contain any incidents, which appeared to be the result of late reporting. There appeared to be a lack of responsibility to ensure monthly reports submitted with no reportable incidents are questioned and updated if appropriate. DSH-HQ did not contact the DSH Police Chiefs to question the accuracy of zero incidents before the monthly report was generated, and the DSH Police Chiefs did not question the accuracy of the monthly report they received.

On March 12, 2018, the interim OLES Chief, DSH OPS Chief and their respective staff discussed OLES' findings. The DSH OPS Chief advised additional training was scheduled to refresh staff knowledge of reporting requirements. The DSH OPS Chief was granted 60 days to address the issues. Discussions between OLES and DSH revealed additional training to refresh staff knowledge of reporting requirements and utilizing Blue Team did not occur.

On December 22, 2020, OLES received notification from the DSH OPS Chief, that Blue Team training had been completed, with an overall completion rate of 93.67 percent. Individually, the completion rates reflected, ASH-88.00%, CSH-90.00%, MSH-84.00%, NSH-100.00%, PSH-100.00%, and DSH-Headquarters-100.00%. The DSH OPS Chief advised a yearly refresher will be conducted to ensure staff remain current in their knowledge and understanding. The OLES will continue to monitor the issue to ensure DSH is utilizing Blue Team appropriately.

Untimely Investigations at PSH

Since March 2018, OLES reported that delays in completing investigations were the most prevalent procedural deficiency for pre-disciplinary phase cases at DSH facilities. To address this deficiency, DSH added additional staff to the investigative teams at several facilities and extended the required investigative timeframe from 75 days to 120 days. Furthermore, DSH implemented additional review and monitoring processes.

The OLES previously reported that PSH historically had a disproportionately high number of untimely monitored investigations. In response, PSH implemented several remedial measures, including but not limited to, a visual tracking system, additional supervisory review and assignment of a liaison for contact between the hospital police department and the Office of Protective Services. Since implementing these changes, PSH significantly reduced the number of untimely investigations. As shown in the following table, PSH had one untimely investigation in this reporting period.

Reporting Period	# of PSH Untimely Investigations	Total DSH Untimely Investigations	Percent of Untimely Investigations from PSH	PSH Range for Untimely Investigations (days)
January-June 2018	19	34	55.9%	134-588
July-December 2018	20	26	76.9%	131-358
January-June 2019	17	29	58.6%	132-674
July-December 2019	6	8	75.0%	149-484
January-June 2020	0	8	0%	N/A
July-December 2020	1	3	33.3%	158

The PSH resolved this monitored issue due to the significant improvement in the number of timely investigations during the last three reporting periods.

DSH Patient Pregnancies

In the semiannual report covering January 1 through June 30, 2017, OLES made several recommendations to DSH to minimize patient pregnancies. The OLES also made a recommendation on how to best manage patients who become pregnant while residing in a state hospital or if they are pregnant when they are admitted to a DSH facility.

The OLES' recommendations included the following:

- Establish a statewide policy requiring that every pregnancy be reported to facility law enforcement.

- 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.
- Coordinate with county Child and Family Services for placement of newborns.
- Establish a statewide policy that ensures that patients with demonstrated sexual aggression and sexually harmful behavior are not in DSH coed units.

In response to the OLES recommendations, the DSH drafted two policies titled "Child Placement" and "Patient Sexuality." The first policy titled PD 3108 Child Placement allows the pregnant patient to decide where and with whom her infant will be placed after birth. PD 3108 was fully implemented. The second policy titled "Patient Sexuality" identifies what must be considered when determining patient placement in co-ed living quarters. DSH renamed "Patient Sexuality" to *PD 3106 – Patient Sexual Behavior and Health.* PD 3106 was scheduled to be presented to DSH's executive team in February 2021.

DSH Extraction Policy and Training

As reported in previous semiannual reports, the OLES recognized that the DSH lacked a clear policy governing when and how to conduct extractions of patients from their rooms or other areas.

Sometimes it is necessary to remove patients from their room or other area when they are uncooperative and become a danger to themselves or to others. The OLES discovered that DSH facility law enforcement personnel lacked clear guidance in determining whether such events were exigent situations requiring immediate use of controlled force, or whether a calculated intervention might be a better and safer option by which to gain control and remove a patient from an area.

While the DSH, at that time, had in its Use of Force Policy a definition of calculated interventions as "Instances where time and circumstances permit a planned response to a pending or current conflict scenario involving a patient," it had no policy or procedure guiding officers in conducting such calculated interventions. More importantly, it had no policy defining exigent extractions, or guiding officers in their execution when such situations arose.

Accordingly the OLES recommended the DSH develop and provide to the OLES for review a statewide policy governing both calculated and exigent room and area extractions. The OLES further recommended that exigent extractions should be defined as life or death events where a measured, calculated extraction would not be practical. The OLES also recommended that the policy:

- Provide for mandatory documented training for officers
- Specify the equipment to be used in extractions
- Define the procedures to follow when conducting extractions
- Describe the documentation to be developed after extraction events

- Require all calculated extractions to be video- and audio-recorded
- Require all extractions, both calculated and exigent, be subjected to documented administrative review

In December 2017, the DSH provided the OLES with a draft policy and a proposed training plan. After receiving the OLES' comments on the draft policy, the DSH refined the policy into final form by July 2018 and provided training for those who would, in turn, train the staff at individual institutions system-wide by January 2019. In addition, by December 2018, the DSH had purchased the necessary equipment to be used in extractions.

The DSH's final policy, Policy 338, includes all of the items noted above, and additionally includes provisions for medical examination of patients after extraction events, decontamination procedures for patients when chemical agents are used, and a restriction against extractions being conducted by anyone but specifically-trained extraction teams.

The OLES is pleased to report that DSH has completed the majority of training for all sworn staff, and is now committed by policy to conduct annual refresher training on calculated intervention for patient extractions.

Child Pornography at Coalinga State Hospital

As reported in the July 1 through December 31, 2017 SAR, the OLES focused on what appeared to be a spike in reports of patients in possession of child pornography at Coalinga State Hospital (CSH). From January 1 through June 30, 2017, there were 19 reports of patients found in possession of child pornography within the hospital. In the early months of SAR period July 1 through December 31, 2017, another four incidents of child pornography were reported by CSH as part of the mandated reporting set up by the OLES.

CSH opened in 2005 and houses sexually violent predators, which made up 71 percent of the 1,315 patients as of December 31, 2020. The CSH is a self-contained psychiatric hospital constructed with a secure perimeter. The California Department of Corrections and Rehabilitation provides perimeter security as well as transportation of patients to outside medical services and court proceedings.

CSH has experienced a problem with patients gaining access to and storing child pornography. Contraband can enter the facility through the patient visiting program, the mail room, and staff circumventing hospital precautions and smuggling contraband into the facility. A catalyst that likely started the storage and distribution of electronic contraband started when CSH authorized Administrative Directive (AD) 654 in November 2006. This directive allowed patients to possess laptop computers and other gaming systems that were capable of accessing and storing electronic media outside the filters and reach of the hospital's digital network. As an unintended consequence, per a memorandum dated February 29, 2007, authored by the "Patient Computer Technology Committee," the program authorized in AD 654 was discontinued after seven months due to the "high rate of policy violations" including

"widespread distribution of pornographic material." The memorandum placed a moratorium on patients purchasing new computers but allowed patients to keep electronic devices approved under AD 654.

The OLES analyzed criminal reports and complaints where CSH patients and staff were arrested for possession of child pornography, some of which made statewide news. Examples include a patient and staff member being arrested in November 2016, for possession of child pornography. Eight patients and one staff member were arrested for possession of child pornography in February 2017.

OLES Investigators visited CSH in August and September 2017 to interview staff and study the problem of patient possession of child pornography CSH. During these visits, the OLES learned CSH Law Enforcement staff have submitted 44 cases to the Fresno County District Attorney's Office, and 18 patients pleaded guilty to 22 charges related to the possession of child pornography. OLES identified several policy and procedural issues and began to work with the DSH to eradicate, investigate and prevent possession of electronic contraband of all types at the hospital.

Eradication

In January 2018, DSH implemented California Code of Regulations, Title 9, Section 4350. The amendments provided clarity on what electronic devices were permitted within the DSH state hospitals and accounted for technological advances that had occurred which allowed patients to have more storage capacity and ways to access the Internet. DSH designed a three-phase process to remove the contraband devices from the facility.

- In the first phase, CSH worked with the Fresno County District Attorney's Office to create an amnesty program that would allow patients to turn over electronic devices.
    - Based on this program, the department received items from patients that have not been inventoried. These items are stored in one non-climate control storage shipping container at CSH. As per the agreement with the Fresno County District Attorney, these items will be destroyed.
- The second phase of the program included a voluntary turn-in, where patients submitted their items that violated Section 4350 with the understanding that the electronic devices would be searched with the patient's consent and mailed out of the facility.
    - In June 2018, the DSH CSH team began the process of reviewing the media storage devices turned in during the voluntary turn-in phase. During this time, the team worked with level of care staff to transfer legal data from a personal storage device to a state issued thumb drive. Each item had to be scanned and the patient was monitored while the transfer was being conducted. This team consisted of multiple officers and sergeants. The team has scanned:

        - 37,264 DVDs
        - 315 Thumb drives
        - 222 Hard drives

        - 216 SD cards
        - 115 MP3 players
        - 3 Laptops
    - Every item on this list was treated as unique and varied in size from Gigabyte removable media to multiple terabyte hard drives. As of December 24, 2020, the scanning of these items is now complete. As a result of this work, 30 crime reports of child pornography and four suspicious activity reports were produced.
- In the third phase, the Department of Police Services and facility staff conducted a thorough search of the hospital. In this phase, there was a comprehensive search of the facility and any items found that were not compliant with Section 4350 were confiscated.
    - During January 29, 2018 through January 31, 2018, CSH conducted a hospital wide search and seized an enormous amount of material now considered contraband under the new regulations. These items are currently stored in two large climate controlled shipping containers and consist of the following:

        - 108,089 Burnable DVD/CD
        - 5498 Games
        - 1163 USB thumb Drives
        - 736 Hard drives
        - 679 SD/Micro SD cards
        - 647 Micca/Media Players
        - 591 USB/HDMI Hubs
        - 504 SD/Micro SD card readers
        - 422 MP3 Players
        - 295 Gaming systems with WiFi
        - 280 Radios with recording capability
        - 210 DVD recorders
        - 176 Speakers with SD or USB slot
        - 139 Wireless keyboards
        - 132 Personal digital assistants
        - 123 Flashlights
        - 97 Dana word processors
        - 92 Tablets
        - 66 Wireless headphones
        - 23 Laptops
        - 21 Graphic calculators

    - Most of these contraband items would require a search warrant to exam. Ownership and possession is a concern. The department does not plan to conduct any further analysis. The items will be destroyed.

Outcome

The OLES entered into an agreement with CSH that monthly reports would be provided to the OLES on the progress of processing and adjudicating all illegal and contraband materials seized during the January 2018 implementation of the three phase

eradication plan. Materials discovered from processing this seized material were reported to the OLES on a monthly basis to reflect the progress being made for closure of the three phase plan. As of December 2020, the processing is now complete, and CSH will no longer report on a monthly basis.

DSH continues to report newly discovered "post sweep" contraband to the OLES, which is then documented in the appropriate SAR, according to the reported timeframe. The OLES continues to monitor and work collaboratively with DSH to increase compliance with the DSH regulations on contraband to improve the safety and security for all patients. The OLES commits to oversee the destruction of the seized contraband.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of July 1 through December 31, 2020.

Case Detail	Description
Incident Date	07/01/2018
OLES Case Number	2019-00945-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between July 1, 2018, and June 30, 2019, a hospital police officer allegedly worked unapproved and unnecessary overtime.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	01/01/2016
OLES Case Number	2019-01094-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	In 2016, a lieutenant allegedly sold high-capacity firearm magazines to non-sworn personnel and failed to report secondary employment.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	10/27/2018
OLES Case Number	2019-01179-2A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between October 27, 2018, and October 5, 2019, an officer allegedly failed to immediately report allegations of misconduct committed by another officer. On October 5, 2019, the officer allegedly made false or misleading statements in official documents.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	04/09/2018
OLES Case Number	2020-00023-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between April 9, 2018, and May 1, 2020, an officer allegedly failed to follow department policy regarding outside employment.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	10/27/2019
OLES Case Number	2020-00232-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 27, 2019, two officers allegedly failed to report their knowledge of an off-duty police supervisor operating a state vehicle while under the influence of alcohol.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	02/24/2020
OLES Case Number	2020-00301-1C
Case Type	Investigative
Incident Type	1. Sexual Assault
Incident Summary	Between February 24, 2020, and March 24, 2020, officers allegedly sexually assaulted a patient.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary was provided to the department.

Case Detail	Description
Incident Date	04/10/2020
OLES Case Number	2020-00376-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	On April 10, 2020, officers allegedly used excessive force while escorting a patient.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The case was not referred to

	the district attorney's office due to a lack of probable cause. A summary was provided to the department.

Case Detail	Description
Incident Date	04/25/2020
OLES Case Number	2020-00422-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On April 25, 2020, an officer allegedly falsely reported overtime hours.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES will monitor the disposition process.

Case Detail	Description
Incident Date	04/16/2020
OLES Case Number	2020-00432-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On April 16, 2020, an officer allegedly falsified a report by writing a patient had recanted an allegation of misconduct.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	05/07/2020
OLES Case Number	2020-00469-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On May 7, 2020, an officer allegedly suffered a drug overdose at his home.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	05/12/2020
OLES Case Number	2020-00492-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On May 12, 2020, an anonymous complainant notified the State Auditor's Office of alleged timesheet fraud committed by department retired annuitant investigators. The State Auditor's Office requested the OLES conduct an investigation.

Disposition	The investigation was completed by the OLES and submitted to the State Auditor's office for review.

Case Detail	Description
Incident Date	06/04/2020
OLES Case Number	2020-00576-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On June 4, 2020, a patient alleged that officers and other staff members ransacked his room, and that his personal documents were disturbed. The patient alleged that a senior psychiatric technician and a psychiatric technician intentionally placed odorous chemicals in his room and that a senior psychiatric technician and two psychiatric technicians used state computers for activities unrelated to their work.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that peace officer misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	06/14/2020
OLES Case Number	2020-00623-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On June 14, 2020, an officer allegedly used excessive force on a patient.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary was provided to the department.

Case Detail	Description
Incident Date	07/03/2020
OLES Case Number	2020-00685-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On July 3, 2020, an anonymous complaint was received by the Office of Law Enforcement Support alleging that hospital police staff were not required to follow hospital COVID-19 safety protocols, procedures, and guidelines.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided

	to the department.

Case Detail	Description
Incident Date	08/06/2019
OLES Case Number	2020-00732-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On August 6, 2019, an investigator allegedly violated an employee's constitutional rights during a criminal investigative interview.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	07/20/2020
OLES Case Number	2020-00744-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On July 20, 2020, an officer allegedly used excessive force on a patient.
Disposition	The OLES conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	09/02/2020
OLES Case Number	2020-00930-1C
Case Type	Investigative
Incident Type	1. Abuse 2. Neglect
Incident Summary	On September 2, 2020, an undetermined number of officers allegedly physically abused a patient while stabilizing him in a seclusion room.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary was provided to the department.

Case Detail	Description
Incident Date	08/17/2020
OLES Case Number	2020-00958-1A
Case Type	Investigative

Incident Type	1. Misconduct
Incident Summary	Between August 17, 2020, and August 28, 2020, an officer allegedly failed to report he tested positive for the novel coronavirus.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	03/19/2020
OLES Case Number	2020-00960-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between March 19, 2020, and September 17, 2020, an officer allegedly violated state quarantine orders.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The case was not referred to the district attorney's office due to a lack of probable cause. A summary was provided to the department.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by December 31, 2020, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. The OLES monitored each departmental investigation for both procedural and substantive sufficiency.

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

Criminal-Referred to Prosecuting Agency

Case Detail	Description
Incident Date	04/01/2020
OLES Case Number	2020-00421-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	On or about April 1, 2020, a nurse allegedly kissed a patient on two occasions, allowed the patient to rub her buttocks and breasts over her clothing, and sent pornographic photographs and letters to the patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to adequately confer with the OLES upon case initiation and prior to finalizing an investigative plan, failed to cooperate and consult with the OLES monitor, did not consult with the district attorney to determine if an administrative investigation should be conducted concurrently with the criminal investigation, failed to

	thoroughly conduct interviews, and refused to investigate a possible criminal charge against the nurse.
Pre-Disciplinary Assessment	1. Did OPS adequately consult with OLES and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation? No. The investigator did not consult with the district attorney to determine if an administrative investigation should be conducted concurrently with the criminal investigation. 2. Were all of the interviews thorough and appropriately conducted? No. The investigator failed to thoroughly question the nurse regarding information she allegedly provided to her husband, who is also a nurse with the department, about her relationship with a patient. In addition, the investigator failed to interview a psychologist or psychiatrist to assess whether the patient sustained any mental suffering as a result of the alleged relationship with the nurse. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to cooperate with the OLES monitor. The investigator was assigned to the case on April 21, 2020, but did not make contact with the OLES monitor until May 4, 2020, 13 days later. During that 13 day period, the investigator interviewed the suspect and two percipient witnesses, and executed searches of the patient's room and the suspect's automobile. The investigator also failed to communicate with the OLES monitor for 16 days between May 4, 2020, and May 20, 2020, during which time the investigator conducted a second interview of the suspect nurse and three interviews of percipient witnesses. The investigator's failures to cooperate prevented the OLES monitor from attending the interviews and providing real-time feedback. Also, the investigator did not provide the OLES monitor with recordings of the interviews he conducted until May 26, 2020, and May 27, 2020, despite receiving multiple requests for the recordings from the OLES monitor. The investigator did not advise the OLES monitor that the nurse resigned her employment on June 5, 2020, until June 16, 2020, 11 days later.
Department Corrective Action Plan	To ensure OPS complies with policies and procedures governing the investigative process, Investigators, upon

	request from OLES AIMs, will consult with the local District Attorney on a case by case basis to determine if an administrative investigation should be conducted concurrently with the criminal investigation. The investigators will make every effort possible to contact the AIMs prior to commencing the investigation of assigned cases. The investigators will also inform their Division Commander when disagreement is encountered with OLES AIMs to ensure OPS Command staff can participate with OLES AIMs and reach a mutual resolution. The investigators will make every effort possible to contact the AIMs prior to commencing the investigation of assigned cases. This will ensure OLES AIMs have the opportunity to provide input and participate in the investigation in real-time. Investigators will consult with the appropriate medical/clinical staff to rule out criminal neglect due to patient mental suffering when appropriate.

Case Detail	Description
Incident Date	06/22/2020
OLES Case Number	2020-00649-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On June 22, 2020, a patient was allegedly involved in a physical altercation with a second patient. The first patient sustained fractured ribs.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services did not open an administrative investigation as no staff misconduct was involved. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/12/2020
OLES Case Number	2020-00715-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin)
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred

	2. Referred
Incident Summary	On July 12, 2020, a patient allegedly assaulted a second patient. The second patient sustained orbital and nasal fractures. The first patient also allegedly assaulted two other patients.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office for charges against the first patient. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence of any staff misconduct. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/01/2020
OLES Case Number	2020-00840-1C
Case Type	Monitored
Incident Types	1. Sexual Assault 2. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	Between March 2020, and August 2020, a psychiatric technician allegedly was overly familiar with two patients.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/15/2020
OLES Case Number	2020-00883-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act

Findings	1. Referred 2. Referred
Incident Summary	On August 15, 2020, a psychiatric technician allegedly grabbed a patient by the neck and arm, while pushing the patient in a wheelchair.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. The Office of Protective Services will open an administrative investigation, after the district attorney's office's review, which the OLES will monitor.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Criminal-Not Referred

Case Detail	Description
Incident Date	01/02/2020
OLES Case Number	2020-00010-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 2, 2020, hospital staff found a patient unresponsive in his room and began life saving measures; however, the patient was declared dead. An autopsy determined the cause of death was complications from lung disease.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause, nor was an administrative investigation opened. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/01/2019
OLES Case Number	2020-00201-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act

	2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Between September 1, 2019, and November 30, 2019, a psychiatric technician allegedly kicked a patient's bed, and pushed the patient in the chest. The psychiatric technician also allegedly directed the patient go to the back of the line if the patient entered the dining area early. On February 25, 2020, the psychiatric technician again allegedly directed the patient to go to the back of the line.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/10/2020
OLES Case Number	2020-00251-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 10, 2020, a psychiatric technician allegedly slapped and kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 184 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 11, 2020; however, the final investigative report was not completed

	until September 11, 2020, 184 days later.
Department Corrective Action Plan	Since May 2020, we have a dedicated person (AGPA – OLES Liaison) tracking the progress of all OLES monitored cases to ensure future timeliness. Additionally, we conduct weekly case status meetings where Investigators update the team on the progress of their caseloads. Any issues that arise are identified and Investigators ask for assistance (if needed) to ensure that their cases close within our internal limit of 90 days (well in advance of the 120-day OLES limit). The process noted above, that has been implemented would have caught and corrected the issue with this late reported case. OPS is also providing on–going trainings for Investigative Staff to ensure they are familiar with the OLES reporting requirements as well as the process for submitting an extension if needed. Additional Investigators are being hired to better manage the case load. This case was assigned out to the Investigator in a timely manner.

Case Detail	Description
Incident Date	03/21/2020
OLES Case Number	2020-00289-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 21, 2020, a patient suffered a laceration above her eyebrow while she was on an enhanced level of supervision for self-injurious behavior.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/01/2020
OLES Case Number	2020-00344-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 1, 2020, a psychiatric technician allegedly injured a

	patient's back while restraining the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/13/2012
OLES Case Number	2020-00358-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between December 13, 2012, and January 31, 2013, a staff member allegedly engaged in a sexual relationship with a patient. A patient who allegedly witnessed the incident did not report it until April 4, 2020.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The department incorrectly categorized the incident, and failed to properly notify the OLES of the incident. Key interviews were not conducted nor documented in the draft investigative report. The investigation was not completed until 132 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services failed to properly notify the OLES within two hours of discovering the alleged incident. 2. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES?

	No. The Office of Protective Services initially categorized the incident as an alleged incident of staff overfamiliarity with a patient instead of alleged sexual abuse. 3. Were all of the interviews thorough and appropriately conducted? No. The investigator initially determined an interview of the alleged patient-victim and the program assistant were unnecessary, even though the patient and program assistant were both sufficiently identified as being involved in the reported alleged sexual misconduct. Ultimately, after repeated recommendations, both were interviewed. 4. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The initial draft investigative report did not include any interview of the alleged patient-victim or the program assistant. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 8, 2020; however, the investigative report was not completed until August 18, 2020, 132 days later.
Department Corrective Action Plan	This case was a topic in a weekly case update meeting with the Detective Sergeant, Investigations Lieutenant and Chief regarding the difference of opinion the Detective and OLES monitor were having on this case. After discussion regarding this matter, the detectives will strongly consider the suggestions or recommendations made by OLES. OPS felt that due to this patient being capable to give consent that this would constitute as an overfamiliarity case. The Sergeants have since been briefed on reporting all cases of this type as sexual abuse.

Case Detail	Description
Incident Date	04/01/2018
OLES Case Number	2020-00362-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between April 1, 2018, and April 30, 2020, a registered nurse

	allegedly has been repeatedly sexually assaulting a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/28/2020
OLES Case Number	2020-00392-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 28, 2020, a psychiatric technician allegedly pulled a patient by his shoulder.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/01/2019
OLES Case Number	2020-00409-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between September 2019, and April 2020, a psychiatric technician allegedly engaged in a sexual relationship with a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.

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

Case Detail	Description
Incident Date	04/29/2020
OLES Case Number	2020-00429-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 29, 2020, a psychiatric technician allegedly used an unauthorized headlock on a patient and forced the patient's head against a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/30/2020
OLES Case Number	2020-00436-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 30, 2020, a psychiatric technician allegedly struck a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/20/2020
OLES Case Number	2020-00447-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 20, 2020, a psychiatric technician allegedly forced a patient against a wall, thereby dislodging one of the patient's teeth.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/28/2020
OLES Case Number	2020-00452-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Unknown Origin) 3. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 28, 2020, a patient fell from her wheelchair. She received x-rays as a precautionary measure and on May 4, 2020, she was diagnosed with a fractured nose.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/24/2020
OLES Case Number	2020-00462-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 24, 2020, a patient complained of leg pain. She was sent to an outside hospital where she was diagnosed with a fractured femur.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/10/2020
OLES Case Number	2020-00481-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 10, 2020, a psychiatric technician assistant and a registered nurse allegedly kicked and struck a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/09/2020
OLES Case Number	2020-00482-1C
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 9, 2020, a psychiatric technician allegedly forcibly pulled a patient by the arm.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/14/2020
OLES Case Number	2020-00488-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 14, 2020, a senior psychiatric technician allegedly struck and bruised a patient's face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/07/2020
OLES Case Number	2020-00491-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 7, 2020, an unidentified person allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective

	Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/14/2020
OLES Case Number	2020-00502-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 14, 2020, a patient was diagnosed with a fractured wrist. The patient reported that she had fallen or injured her wrist by striking a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES did not accept for monitoring because the alleged misconduct did not fall within OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/17/2020
OLES Case Number	2020-00506-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 17, 2020, a psychiatric technician allegedly inappropriately touched a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	05/20/2020
OLES Case Number	2020-00521-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 20, 2020, a registered nurse allegedly scratched a patient's arm.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/02/2020
OLES Case Number	2020-00571-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 2, 2020, a staff member allegedly grabbed and pulled a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/03/2020
OLES Case Number	2020-00572-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 3, 2020, a staff member allegedly pushed a patient, causing an injury to the patient's eye.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES did not accept for monitoring because the alleged misconduct did not fall within OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/29/2020
OLES Case Number	2020-00574-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 29, 2020, a nurse allegedly shaved a patient's head without authorization.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/05/2020
OLES Case Number	2020-00581-1C
Case Type	Monitored
Incident Types	1. Sexual Assault

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 5, 2020, a staff member allegedly choked, sexually assaulted, and raped a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/12/2019
OLES Case Number	2020-00608-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between June 12, 2019, and September 30, 2019, an unidentified staff member allegedly grabbed a patient by the neck, forced the patient to the floor, and improperly restrained the patient. The patient did not sustain any injuries.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/12/2020
OLES Case Number	2020-00619-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 12, 2020, a psychiatric technician allegedly grabbed a patient by the neck, dragged the patient into a bathroom stall, and struck the patient multiple times.

Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES did not accept for monitoring because it did not meet OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/13/2020
OLES Case Number	2020-00620-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 13, 2020, a psychiatric technician allegedly inappropriately touched a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to timely notify the OLES of the alleged incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the alleged abuse on June 15, 2020, at 1056 hours; however, the OLES was not notified until 1500 hours, over four hours later.
Department Corrective Action Plan	Training will be provided to all OPS personnel to notify a supervisor if any staff member refuses to provide information on a confidential SIR. Keeping reporting time frames in mind, if OPS cannot get the required information the supervisor will notify OPS management up to the Chief of Police until the information is obtained enough to determine if the incident is an OLES reportable incident. OLES will be kept informed during this process.

Case Detail	Description
Incident Date	06/17/2020
OLES Case Number	2020-00630-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On June 17, 2020, two senior psychiatric technicians allegedly forced a patient onto the floor, hit the patient, and then kneeled on the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/18/2020
OLES Case Number	2020-00638-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 18, 2020, three psychiatric technicians allegedly pushed and choked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/25/2020
OLES Case Number	2020-00654-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 25, 2020, a psychiatric technician allegedly struck a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/29/2020
OLES Case Number	2020-00675-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Significant Interest - Attack on Staff
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 29, 2020, a senior psychiatric technician allegedly slapped a patient's hand when the patient reached for a lunch.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The department did not timely notify the OLES of the incident, and failed to provide complete information regarding the incident and allegation of abuse. Also, the responding patrol officer failed to question the senior psychiatric technician, the patient, or staff witnesses about the abuse allegation.
Pre-Disciplinary	1. Did the hiring authority timely notify the Office of Law

Assessment	Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on June 29, 2020 at 1157 hours, but did not notify the OLES until June 30, 2020, at 1229 hours, over 22 hours later. 2. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES? No. On June 30, 2020, the Office of Protective Services only notified the OLES that the patient allegedly choked the senior psychiatric technician. No information was provided regarding allegations of abuse. 3. Did the department adequately respond to the incident? No. The responding patrol officer did not question the senior psychiatric technician, the patient, or staff witnesses about the allegation that the senior psychiatric technician allegedly swatted the patient's hand when he reached for a lunch.
Department Corrective Action Plan	To ensure OPS does not fail to comply with policies and procedures governing the investigative process, OPS has provided training and also discussed the case with the officer to ensure the Officer understands the importance of interviewing all involved parties. OPS will also provide additional training to the Sergeant to ensure they identify the scope and nature of reporting guidelines in reporting cases to OLES in a timely manner. OPS will train and discuss the case with the officer to ensure the Officer will interview all parties to ensure patient abuse has not taken place.

Case Detail	Description
Incident Date	05/07/2020
OLES Case Number	2020-00678-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 7, 2020, a nurse allegedly discovered information that a second nurse, his wife, was having a relationship with a patient and failed to report that information to the department.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. 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 only because the manner in which the criminal investigation was conducted, precluded the discovery of information sufficient to justify the opening of administrative investigation.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The department did not timely respond to the incident, did not timely notify the OLES of the incident, and did not report the nurse's possible misconduct. The department also did not adequately or appropriately respond to the incident because it did not open an investigation until 40 days after learning of the alleged misconduct, and it did not adequately consult with the OLES regarding the allegations. The investigator failed to consult with the monitor regarding the investigative plan and the nurse's interview, and did not conduct a thorough or adequate investigation.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. The department learned of the nurse's possible misconduct on May 7, 2020, but did not open an investigation until June 16, 2020, 40 days later. 2. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The department learned of the nurse's possible misconduct on May 7, 2020, but did not notify OLES until May 28, 2020, 21 days later, when the investigator sent the monitor recordings of the interview of the nurse's spouse, during which she informed her husband that she was being investigated for being involved with a patient. 3. Did the hiring authority adequately consult with OLES regarding the incident? No. The department learned of the nurse's possible misconduct on May 7, 2020, but did not notify OLES until May 28, 2020, 21 days later, when the investigator sent the monitor recordings of the interview of the nurse's wife, during which she informed her husband that she was being investigated for an alleged involvement with a patient. The investigator never informed the monitor about the information learned during the wife's interview.

	4. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The investigator did not confer with OLES upon initiating the case nor provide an investigative plan. 5. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator did not adequately prepare for the interview of the nurse because he did not thoroughly question the nurse's wife, also a nurse, regarding the information she allegedly told her husband about her involvement with a patient. 6. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to notify OLES of the scheduling of the nurse's interview, thereby preventing the monitor from attending the interview and providing real-time feedback. 7. Was the investigation thorough and appropriately conducted? No. The investigator failed to initially recognize that the nurse may be a subject when he learned during the wife's interview that she allegedly told her husband about her involvement with the patient. When the monitor raised the issue of the possible misconduct to the investigator attention, the investigator initially refused to investigate the misconduct, claiming a reluctance to interfere with the nurses' marriage. Once he agreed to interview the nurse but failed to fully question the nurse regarding the details of when he learned about his wife's alleged involvement with a patient.
Department Corrective Action Plan	To ensure OPS complies with policies and procedures governing the investigative process, OPS will open alleged staff misconduct immediately and notify OLES of any delays that may arise during the course of the investigation. OPS will open alleged staff misconduct immediately and notify OLES. This will ensure OLES is given the opportunity to participate in the investigation and provide feedback in real time. The Investigator will be retrained by the Supervising Special Investigator in recognizing additional suspects throughout the course of a criminal investigation. The investigator will also make every effort possible to provide the OLES AIMs with

	an investigation plan prior to commencing interviewing parties involved. The investigators will also inform their Division Commander when disagreement is encountered with OLES AIMs to ensure OPS Command staff can participate with OLES AIMs and reach a mutual resolution. The investigator will also make every effort possible to provide the OLES AIMs with additional information that may justify the need for additional criminal charges. The Investigator will be retrained on keeping the lines of communication open with the assigned AIM and advising the AIM, through case consultation, a detailed suspect questioning plan.

Case Detail	Description
Incident Date	06/01/2020
OLES Case Number	2020-00706-2C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between June 1, 2020, and June 30, 2020, a psychiatric technician allegedly grabbed and forced a patient to the floor.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/13/2020
OLES Case Number	2020-00719-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On July 13, 2020, it was alleged that a psychiatric technician had engaged in an overly familiar relationship with a patient during an unspecified period of time.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the

	probable cause determination only because the manner in which the criminal investigation was conducted precluded the potential discovery of information sufficient to justify a referral. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not appropriately conducted because the investigator was unable to locate a percipient witness because he did not utilize available law enforcement databases and refused to interview a former patient who was allegedly involved with the psychiatric technician.
Pre-Disciplinary Assessment	1. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution? No. OPS's determination of insufficient probable cause was appropriate only because the manner in which the criminal investigation was conducted precluded the potential discovery of information sufficient to justify a referral. 2. Was the investigation thorough and appropriately conducted? No. The investigator was unable to locate a percipient witness because he did not utilize available law enforcement databases and did not interview a former patient who allegedly had a prior relationship with the psychiatric technician.
Department Corrective Action Plan	To ensure OPS complies with the policies and procedures governing the investigative process, Investigators will be instructed to utilize, not just one database, but attempt to exhaust all law enforcement databases available when conducting an investigation, which may lead to discovering additional information that would substantially justify a criminal referral. The investigators will make an attempt to interview all parties involved when conducting an investigation, which may lead to additional information sufficient to justify a criminal referral.

Case Detail	Description
Incident Date	07/14/2020
OLES Case Number	2020-00721-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 14, 2020, two psychiatric technicians allegedly hit a patient in the ribs.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/13/2020
OLES Case Number	2020-00723-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 13, 2020, a psychiatric technician allegedly pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/25/2020
OLES Case Number	2020-00727-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	On June 25, 2020, a senior psychiatric technician and a psychiatric technician allegedly caused a patient to fall out of his wheelchair. While the patient was on the floor, another staff member allegedly placed a knee on the patient's neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. A responding officer did not provide a psychiatric technician with the required legal admonition before taking a statement from the psychiatric technician.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. A responding officer failed to provide a psychiatric technician with the required legal admonition before taking a statement from the psychiatric technician.
Department Corrective Action Plan	To ensure OPS does not fail to comply with policies and procedures governing the investigative process, OPS will review this case with the officer and sergeant involved and ensure they are properly trained in issuing admonishments.

Case Detail	Description
Incident Date	07/01/2020
OLES Case Number	2020-00766-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	In July 2020, an unidentified staff member allegedly inappropriately touched a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/29/2020
OLES Case Number	2020-00774-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 29, 2020, a registered nurse allegedly pushed a patient to the ground and placed his knee on the patient's neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/05/2020
OLES Case Number	2020-00803-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 5, 2020, a patient reported that a psychiatric technician was allegedly engaging in inappropriate telephone conversations and sexual contact with a second patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/31/2020
OLES Case Number	2020-00806-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 31, 2020, a psychiatric technician allegedly hit and bruised a patient while attempting to restrain the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/09/2020
OLES Case Number	2020-00815-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin) 2. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 9, 2020, a patient allegedly fell and sustained a head laceration and a fractured hip and elbow.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The hiring authority failed to comply with the department's policies and procedures governing the investigative process. The incident was discovered on August 9, 2020, at 0840 hours, however, the OLES was not notified until August 9, 2020, at 1223 hours, approximately 4 hours later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not timely notify the OLES of the

	incident.
Department Corrective Action Plan	OPS has provided refresher training to all the OPS supervisors and sworn personnel on the OLES reporting guidelines. The department will reinforce the importance to make sure if the fall was not witnessed by a staff member it is a priority one reporting requirement.

Case Detail	Description
Incident Date	08/05/2020
OLES Case Number	2020-00821-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 5, 2020, a psychiatric technician allegedly broke a patient's wrist.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/10/2020
OLES Case Number	2020-00825-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 10, 2020, a psychiatric technician allegedly broke a patient's wrist.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which OLES did not accept for monitoring because the alleged misconduct did meet OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/15/2020
OLES Case Number	2020-00826-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On or about July 15, 2020, a psychiatric technician assistant allegedly intentionally shut a door on a wheelchair-bound patient's leg.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/12/2020
OLES Case Number	2020-00832-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 12, 2020, a psychiatric technician allegedly grabbed and bruised a patient. The psychiatric technician and an unidentified staff member allegedly then forced the patient onto the floor, and kicked and choked the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/15/2020
OLES Case Number	2020-00842-1C
Case Type	08/15/2020
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 15, 2020, a 100 year old patient died while at an outside hospital. The cause of death was advanced age and COVID-19 complications.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. An administrative investigation was not opened because there was no evidence of any staff misconduct. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/18/2020
OLES Case Number	2020-00858-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 18, 2020, a psychiatric technician allegedly grabbed and injured a patient's wrist.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES did not accept for monitoring because the alleged misconduct did not meet OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/19/2020
OLES Case Number	2020-00860-1C
Case Type	Monitored
Incident Types	1. Death

Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 19, 2020, a 73 year old patient died while at an outside hospital due to respiratory arrest and COVID-19.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. An administrative investigation was not opened as there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/18/2020
OLES Case Number	2020-00868-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 18, 2020, a psychiatric technician allegedly made a sexually suggestive gesture behind a patient. A second patient allegedly witnessed the gesture, recalled that he and the psychiatric technician were allegedly enlisted in the military in 1991, and during that enlistment, the psychiatric technician allegedly sexually assaulted the second patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES did not accept for monitoring because the alleged misconduct did not meet OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/25/2020
OLES Case Number	2020-00903-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	On August 25, 2020, a psychiatric technician allegedly repeatedly spun a patient in his wheelchair.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The department failed to notify the OLES of the incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services learned of the incident on August 26, 2020, but did not notify the OLES.
Department Corrective Action Plan	To ensure OPS does not fail to comply with the policies and procedures and a thorough investigative process is conducted, the sergeants and officers were trained and tasked with looking further into any claims of solely psychological abuse that may contain some degree of either Neglect, or Physical Abuse. This will ensure all cases falling under the umbrella of Neglect due to the perceived potential for injury are properly investigated.

Case Detail	Description
Incident Date	09/06/2020
OLES Case Number	2020-00938-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Incident Summary	On September 6, 2020, a unit supervisor allegedly entered a patient's room by himself, then pushed the patient against a wall, causing injury to the patient's mouth and shoulders.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to

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

Case Detail	Description
Incident Date	09/13/2020
OLES Case Number	2020-00961-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 13, 2020, an unidentified staff member allegedly punched a patient on his chest as the patient walked down a hall. A program assistant allegedly directed the unidentified staff to batter the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/21/2020
OLES Case Number	2020-00984-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	On September 21, 2020, a patient allegedly used brainwaves to sexually assault a second patient. A psychiatric technician also allegedly sexually assaulted the second patient in a separate incident.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective

	Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/27/2020
OLES Case Number	2020-00989-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 27, 2020, a patient died at an outside hospital from acute gastroenteritis and pneumonia.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. An administrative investigation was not opened as there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Administrative-With Sustained Allegations

Case Detail	Description
Incident Date	01/01/2016
OLES Case Number	2019-01094-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	Between January 1, 2016 and January 31, 2018, a lieutenant allegedly had illegally sold high capacity rifle magazines and received unauthorized secondary employment compensation.
Disposition	The hiring authority sustained the allegations and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	01/01/2020
OLES Case Number	2020-00427-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between January1, 2020, and January 31, 2020, a psychologist allegedly purchased food items from the hospital grill, and provided the food items to two patients. The psychologist also allegedly massaged patients' shoulders. On April 27, 2020, the psychologist allegedly purchased food items from an outside restaurant, and provided them to a third patient.
Disposition	The hiring authority sustained allegations against the psychologist for unprofessional interactions and boundary issues with patients. The psychologist was a probationary employee; therefore, the hiring authority ended her employment with the department. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/16/2020
OLES Case Number	2020-00511-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained

	3. Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	On May 16, 2020, a psychiatric technician allegedly entered a unit he was not assigned to, allegedly failed to sign onto the unit, and allegedly met with a group of patients without authorization. Upon being questioned by unit staff and hospital police, the psychiatric technician allegedly responded in a discourteous manner.
Disposition	The hiring authority sustained the allegations and determined a 10 percent salary reduction for 12 months was the appropriate penalty. The OLES concurred. OLES will not monitor the disciplinary phase because the case no longer meets OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	08/04/2019
OLES Case Number	2019-00779-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 4, 2019, health care staff allegedly failed to monitor a patient who required enhanced observation during meals. The patient choked on his food and died. The immediate cause of death was asphyxia, food aspiration, and dysphasia.
Disposition	The hiring authority determined there was insufficient evidence of employee misconduct to sustain the allegations. However, the hiring authority determined that hospital policies and procedures were insufficient because they did not provide adequate guidance for the monitoring of at risk patients with eating challenges. The hiring authority referred the case to Standards and Compliance to conduct a review of the policy, orders and actual practice of monitoring patients with eating challenges during meals. The OLES concurred with the hiring authority's determination.

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

Case Detail	Description
Incident Date	10/27/2018
OLES Case Number	2019-01179-3A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 5, 2019, an officer allegedly was dishonest when he signed an affidavit under penalty of perjury without having any firsthand knowledge of the underlying complaint. The officer also allegedly failed to report patient abuse.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/25/2019
OLES Case Number	2019-01197-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 15, 2019, two registered nurses and one psychiatric technician allegedly choked and struck a patient multiple times.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient

	The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 158 days after the date the incident was discovered.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 28, 2019; however, the investigation was not completed until April 3, 2020, 158 days later. It is noted that the Office of Protective Services did not complete its initial investigation until January 2, 2020, 66 days from the date of discovery.
Department Corrective Action Plan	A reminder was sent out to all watch commanders and officers that OLES Monitored cases have priority. The initial investigative report will be investigated and process thoroughly and within a reasonable time. This will be accomplished during our daily briefing sessions. Additionally, the Watch Commanders were reminded to review and approve the case themselves and not have multiple hands reviewing the reports to provide a more streamlined process.

Case Detail	Description
Incident Date	11/07/2019
OLES Case Number	2019-01235-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 3, 2019, a staff member allegedly failed to report that a patient had allegedly been assaulted.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/10/2019
OLES Case Number	2019-01240-2A
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 10, 2019, a staff member allegedly sat on and injured a patient's arm, while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/26/2019
OLES Case Number	2019-01312-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 26, 2019, a unit supervisor, and a psychiatric technician allegedly grabbed a patient's arms while escorting him to a seclusion room. A second psychiatric technician allegedly refused to provide a urinal to the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the unit supervisor, and the first psychiatric technician. The hiring authority also determined that the investigation conclusively proved the alleged misconduct against the second psychiatric technician did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures

	governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/15/2020
OLES Case Number	2020-00062-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 15, 2020, a staff member allegedly broke a patient's wrist. Additionally, a registered nurse allegedly pulled the patient's hair while the patient was using the phone.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/21/2020
OLES Case Number	2020-00087-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 21, 2020, a psychiatric technician allegedly pushed a patient. Additionally, a unit supervisor allegedly

	forced the patient against a wall, then grabbed the patient's wrist, and twisted the patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/30/2020
OLES Case Number	2020-00110-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 30, 2020, a psychiatric technician allegedly struck and kicked a patient during a floor containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/10/2020
OLES Case Number	2020-00146-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 10, 2020, a psychiatric technician allegedly grabbed and bruised a patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	01/11/2020
OLES Case Number	2020-00147-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 11, 2020, a psychiatric technician allegedly pulled a patient's hair.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/13/2020
OLES Case Number	2020-00153-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 13, 2020, an unidentified person allegedly raped a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	02/08/2020
OLES Case Number	2020-00171-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 8, 2020, Federal Bureau of Investigation officials informed hospital staff that a California prison inmate, who had been a former hospital patient, alleged in a letter, that she had been raped on an unspecified date by an unidentified person while at the hospital.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/27/2019
OLES Case Number	2020-00232-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 27, 2019, two officers allegedly failed to report their knowledge of a law enforcement supervisor operating a state vehicle after consuming alcohol.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/18/2020
OLES Case Number	2020-00276-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 18, 2020, hospital staff discovered a patient unresponsive in his room and initiated emergency life-saving measures; however, the patient was pronounced dead. An autopsy determined the cause of death was due to end stage renal disease.
Disposition	The hiring authority determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/20/2020
OLES Case Number	2020-00292-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 20, 2020, a psychiatric technician allegedly choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/25/2020
OLES Case Number	2020-00307-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 25, 2020, a psychiatric technician allegedly pushed a patient onto the ground.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/26/2020
OLES Case Number	2020-00312-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 26, 2020, a psychiatric technician allegedly pushed a patient onto his bed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/01/2020
OLES Case Number	2020-00344-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty

	2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 1, 2020, a psychiatric technician allegedly grabbed and injured a patient while attempting to stabilize the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/01/2019
OLES Case Number	2020-00367-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	During November 2019, a staff member allegedly allowed three non-staff members into a facility where they sexually assaulted a patient.
Disposition	The hiring authority determined that the allegation was unfounded. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/28/2020
OLES Case Number	2020-00392-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 28, 2020, a psychiatric technician allegedly pulled a patient by his shoulder.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/04/2020
OLES Case Number	2020-00407-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 4, 2020, a psychiatric technician allegedly physically and sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/23/2020
OLES Case Number	2020-00420-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between April 23, 2020, and April 25, 2020, a psychiatric technician allegedly pushed a patient on two occasions.

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

Case Detail	Description
Incident Date	04/25/2020
OLES Case Number	2020-00422-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 25, 2020, an officer allegedly falsified a timesheet, claiming overtime hours that he did not work.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/27/2020
OLES Case Number	2020-00424-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 27, 2020, a psychiatric technician allegedly hit a patient in the face, and also habitually followed and stared at the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and

	procedures governing the pre-disciplinary process. The responding officer failed to record the statements of the victim and two percipient witnesses. The officer also failed to ask the witnesses whether in fact the psychiatric technician had slapped the victim.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The responding officer did not audio record the victim's statement or the statements of the two percipient witnesses. Additionally, the responding officer did not specifically ask the two percipient witnesses whether the psychiatric technician slapped the victim.
Department Corrective Action Plan	Officers were reminded it is important to call a peer or watch commander if they need necessary equipment delivered to them during the course of their investigation. It is acceptable to delay an interview for a few minutes to ensure they have all the resources to conduct an interview. Additionally, officers were also reminded it is important to document in their report if they are making a reference to statements from previous report as to not cause confusion to the reader.

Case Detail	Description
Incident Date	04/29/2020
OLES Case Number	2020-00429-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 29, 2020, a psychiatric technician allegedly used an unauthorized headlock on a patient and forced the patient's head against a wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/30/2020
OLES Case Number	2020-00436-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 30, 2020, a psychiatric technician allegedly hit a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/01/2020
OLES Case Number	2020-00441-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 1, 2020, a registered nurse and psychiatric technician allegedly struck, and bruised a patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/20/2020
OLES Case Number	2020-00447-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Head/Neck

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 20, 2020, a psychiatric technician allegedly forced a patient against a wall, thereby dislodging one of the patient's teeth.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/28/2020
OLES Case Number	2020-00452-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Unknown Origin) 3. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 28, 2020, a patient fell from her wheelchair. She received x-rays as a precautionary measure and on May 4, 2020, she was diagnosed with a fractured nose.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, no allegations were sustained. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/09/2020
OLES Case Number	2020-00482-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed

	Final: No Penalty Imposed
Incident Summary	On May 9, 2020, a psychiatric technician allegedly pulled a patient forcibly by the arm in order to escort the patient to the restroom.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/14/2020
OLES Case Number	2020-00488-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 14, 2020, a senior psychiatric technician allegedly hit and bruised a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/10/2020
OLES Case Number	2020-00494-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 10, 2020, a psychiatric technician and licensed vocational nurse allegedly kicked a patient in the head and body while she was on the floor.

Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to timely notify OLES of the allegation. The responding officer failed to provide a suspect psychiatric technician with the legally required admonition prior to taking the psychiatric technician's statement.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services was aware of the allegation on May 13, 2020, at 1114 hours; however, did not notify OLES until 1448 hours. 2. Did the department adequately respond to the incident? No. The responding officer failed to provide one of the suspect psychiatric technicians with the legally required admonition prior to taking the psychiatric technician's statement.
Department Corrective Action Plan	Staff has been reminded of the importance of the OLES reporting requirements. A reminder was communicated to personnel to provide the appropriate admonishments to the appropriate individuals prior to conducting an interview. This was accomplished during the briefing and with individual officers.

Case Detail	Description
Incident Date	05/17/2020
OLES Case Number	2020-00506-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 17, 2020, a psychiatric technician allegedly inappropriately touched a patient.

Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/15/2020
OLES Case Number	2020-00507-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 15, 2020, a patient alleged that another patient and a psychiatric technician had allegedly engaged in sexual activity at an indeterminate time during the past year.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	05/17/2020
OLES Case Number	2020-00508-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 17, 2020, a patient died at an outside hospital from sepsis, colitis, and acute renal failure.
Disposition	The hiring authority determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	05/17/2020
OLES Case Number	2020-00509-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 17, 2020, a senior psychiatric technician allegedly hit and choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/20/2020
OLES Case Number	2020-00521-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 20, 2020, a registered nurse allegedly scratched a patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/23/2020
OLES Case Number	2020-00549-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 23, 2020, a senior psychiatric technician, a psychiatric technician, and a registered nurse allegedly bruised a restrained patient while administering an injection.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officer failed to provide suspect staff with the legally required admonition prior to taking their statements.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The responding officer failed to provide the suspect staff with the legally required admonition prior to taking their statements.
Department Corrective Action Plan	A reminder will be communicated to personnel to provide the appropriate admonishments to the appropriate individuals prior to conducting an interview. This can be accomplished during a briefing or with the individual officer who failed to advise the subject of the required admonishment. Regarding this specific incident the officer was counseled and understands that all potential staff subjects will be given the proper admonishment regardless if patient/victim has made an identification. If it is the belief of the officer that a staff may have been involved, they shall be provided the proper admonishment prior to the interview.

Case Detail	Description
Incident Date	04/01/2020
OLES Case Number	2020-00562-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between April 1, 2020, and May 31, 2020, a senior psychiatric technician allegedly poured water on, and physically assaulted, a restrained patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The hiring authority failed to comply with the department's policies and procedures governing the pre-disciplinary process. The hiring authority did not timely notify the Office of Law Enforcement Support (OLES) of the incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not timely notify the Office of Law Enforcement Support of the incident.
Department Corrective Action Plan	OPS has provided refresher training to all the OPS supervisors and sworn personnel on the OLES reporting guidelines.

Case Detail	Description
Incident Date	06/03/2020
OLES Case Number	2020-00569-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 3, 2020, a health care staff member allegedly struck a patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely notify the OLES of the incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The hiring authority did not timely notify the OLES of the

	incident.
Department Corrective Action Plan	OPS has provided refresher training to all the OPS supervisors and sworn personnel on the OLES reporting guidelines and will continue to reinforce the importance of timely notifications to OLES.

Case Detail	Description
Incident Date	04/26/2020
OLES Case Number	2020-00570-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between April 26, 2020, and May 9, 2020, a registered nurse allegedly twisted a patient's arm behind his back on multiple occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/12/2020
OLES Case Number	2020-00607-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 12, 2020, a registered nurse allegedly choked a patient and forced the patient's face against the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/14/2020
OLES Case Number	2020-00615-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 14, 2020, a psychiatric technician allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/13/2020
OLES Case Number	2020-00620-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 13, 2020, a psychiatric technician allegedly inappropriately touched a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/17/2020
OLES Case Number	2020-00629-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 17, 2020, a psychiatric technician allegedly hit a patient in the face while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/18/2020
OLES Case Number	2020-00634-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 18, 2020, an unidentified staff member allegedly struck a patient's hand with a book.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/16/2020
OLES Case Number	2020-00652-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Sexual Assault

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 16, 2020, a psychiatric technician allegedly sexually assaulted a patient while the patient was asleep.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's recommendation.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/01/2020
OLES Case Number	2020-00705-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between June 1, 2020, and July 30, 2020, unidentified staff members allegedly entered a patient's room and injected the patient with anesthesia.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/25/2020
OLES Case Number	2020-00727-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 25, 2020, a senior psychiatric technician and a psychiatric technician allegedly caused a patient to fall out of his wheelchair. While the patient was on the floor, another staff member allegedly placed a knee on the patient's neck.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/19/2020
OLES Case Number	2020-00740-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On July 19, 2020, a psychiatric technician allegedly mistakenly gave one patient medication prescribed for a different patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/01/2020
OLES Case Number	2020-00755-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between May 1, 2020, and July 31, 2020, a psychiatric technician allegedly requested sexual favors from a patient

	on multiple occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/25/2020
OLES Case Number	2020-00760-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On July 25, 2020, a psychiatric technician assistant allegedly hit a patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/31/2020
OLES Case Number	2020-00778-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On July 31, 2020, a patient died at an outside hospital from hypoxemic respiratory failure, pneumonia, and complications from COVID-19.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	08/24/2020
OLES Case Number	2020-00886-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 24, 2020, a patient was found unresponsive on the shower floor. A psychiatric technician allegedly failed to initiate life-saving measures, prior to the determination that the patient had an advanced medical directive, declining all resuscitative care.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred. Additionally, the hiring authority determined there was insufficient evidence to sustain the alleged policy violation against the psychiatric technician. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/02/2020
OLES Case Number	2020-01011-1A
Case Type	Monitored
Incident Types	1. Head/Neck
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 2, 2020, a psychiatric technician assistant allegedly knocked a patient down, causing a laceration to the patient's head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

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

Appendix C: Discipline Phase Cases

When an administrative investigation, either by the department or by OLES, is completed, an investigation report with facts about the allegations is sent to the hiring authority. The discipline phase commences as the hiring authority decides whether to sustain any allegations against the employee. This decision is based upon the evidence presented. If there is a preponderance of evidence showing the allegations are factual, the hiring authority can sustain the allegations. If one or more allegations are sustained, the hiring authority must impose appropriate discipline.

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

- Procedural sufficiency includes, among other things, whether OLES was notified and consulted in a timely manner during the disciplinary process and whether the entire disciplinary process was conducted in a timely fashion. Both departments have implemented policies that incorporate OLES' recommendation to serve a disciplinary action within 60 days after a decision is made to impose discipline.

- Substantive sufficiency includes the quality, adequacy and thoroughness of the disciplinary process, including selection of appropriate charges and penalties, properly drafting disciplinary documents and adequately representing the interests of the department at State Personnel Board proceedings.

Procedurally and Substantively Sufficient Cases

Case Detail	Description
Incident Date	02/13/2019
OLES Case Number	2019-00163-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Not Sustained 4. Sustained 5. Sustained 6. Not Sustained

	7. Sustained 8. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On February 13, 2019, a nurse practitioner, a nurse, and a senior psychiatric technician allegedly neglected a patient suffering from polydipsia. Also, the nurse practitioner also allegedly failed to properly review the patient's medical chart during the admissions process, the senior psychiatric technician allegedly failed to document and review notes of the patient's behavior, and the nurse allegedly failed to document and properly assess the patient's medical needs.
Disposition	The hiring authority found insufficient evidence to sustain the patient neglect allegations, but sustained the remaining allegations against the nurse practitioner, nurse, and senior psychiatric technician. The nurse practitioner retired before the investigation was completed. Therefore, no disciplinary action could be taken, and a letter indicating he retired under adverse circumstances was placed in his official personnel file. The hiring authority imposed a 10 percent salary reduction for 18 months against the senior psychiatric technician, and a 10 percent salary reduction for 12 months against the nurse. The nurse and senior psychiatric technician filed appeals with the State Personnel Board. Prior to the evidentiary hearing, the hiring authority entered into settlement agreements with the employees wherein the penalties were reduced to a 10 percent salary reduction for four months for both the nurse and senior psychiatric technician. The nurse and senior psychiatric technician withdrew their appeals. The OLES concurred with the settlements because the penalties remained within the appropriate range for the misconduct.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	07/05/2019
OLES Case Number	2019-00657-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty
Findings	1. Sustained

	2. Sustained 3. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Disciplinary Phase Pending
Incident Summary	On July 5, 2019, a psychiatric technician allegedly pushed a patient to the floor, causing an injury to the patient's head. The psychiatric technician allegedly failed to document the incident or inform the shift leader about the incident. A registered nurse allegedly failed to initiate head injury protocol after becoming aware of the head injury.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation against the psychiatric technician for failure to document the incident and imposed a 10 percent salary reduction for 12 months. The hiring authority determined there was sufficient evidence to sustain the allegation against the registered nurse for failure to initiate head injury protocols and imposed a 10 percent salary reduction for 12 months. The psychiatric technician and registered nurse filed appeals with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into settlement agreements with both employees wherein the penalty for each was reduced to a 5 percent salary reduction for 12 months. Both employees agreed to withdraw their appeals. The OLES concurred because the settlements were reasonable.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	09/12/2019
OLES Case Number	2019-00985-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On September 12, 2019, two nurses and a senior psychiatric technician allegedly failed to provide medical attention to a patient who complained of pain.

Disposition	The hiring authority sustained the allegations against the first nurse and determined a salary reduction of 10 percent for 12 months was the appropriate penalty, but determined there was insufficient evidence to sustain the allegations against the senior psychiatric technician and the second nurse. The OLES concurred. Following a *Skelly* hearing, the department entered into a settlement agreement with the nurse whereby the department agreed to lower the salary reduction to 5 percent for 12 months and the nurse agreed to waive his right to appeal. The OLES concurred with the settlement based on the nurse's sincere expression of remorse and acceptance of responsibility at the *Skelly* hearing making the recurrence of the misconduct less likely.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	10/30/2019
OLES Case Number	2019-01220-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Suspension
Incident Summary	On October 30, 2019, an officer allegedly inappropriately touched an academy cadet while she was sleeping.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. At the pre-hearing settlement conference, the department entered into a settlement agreement whereby the penalty was reduced to a 100 working-day suspension plus a salary reduction thereafter of 5 percent for 12 months. The OLES concurred as key witnesses were uncooperative, the officer had expressed remorse and sought out counseling on his own, and the penalty was still very significant making the misconduct unlikely to recur.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	12/08/2019
OLES Case Number	2019-01349-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	On December 8, 2019, a psychiatrist allegedly failed to properly return a set of controlled keys prior to leaving a secured area of the hospital.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a letter of reprimand. The OLES concurred with the hiring authority's determination. The psychiatrist did not file an appeal with the State Personnel Board.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	12/11/2019
OLES Case Number	2019-01371-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Discourteous treatment 3. Dishonesty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Reprimand
Incident Summary	On December 11, 2019, a registered nurse allegedly failed to medically assess a patient complaining of stomach pain. On December 11, 2019, a second registered nurse was allegedly discourteous to the first registered nurse. On January 14, 2020, the second registered nurse was allegedly dishonest during her investigative interview.
Disposition	The hiring authority sustained the allegation against the first registered nurse and determined a salary reduction of 5 percent for six months was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the second registered nurse. The OLES concurred with the hiring authority's

	determinations. Following a *Skelly* hearing, the department entered into a settlement agreement with the nurse whereby the department agreed to lower the salary reduction to letter of reprimand and the nurse agreed to waive his right to appeal. The OLES concurred with the settlement based on the nurse's sincere expression of remorse and acceptance of responsibility at the *Skelly* hearing making the recurrence of the misconduct less likely.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	12/18/2019
OLES Case Number	2019-01392-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On December 18, 2019, an officer was allegedly asleep while assigned to monitor two patients at an outside hospital.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 10 percent for 24 months was the appropriate penalty. The OLES concurred with the hiring authority's determination. At the pre-hearing settlement conference, the department entered into a settlement agreement whereby the penalty was reduced to a salary reduction of 10 percent for 12 months.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	02/08/2020
OLES Case Number	2020-00250-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Discourteous treatment
Findings	1. Sustained 2. Sustained

Penalty	**Initial:** Dismissal **Final:** Disciplinary Phase Pending
Incident Summary	Between February 8, 2020, and March 10, 2020, an officer allegedly made threatening and racist remarks during the training academy. On March 25, 2020, the officer was allegedly dishonest during the investigative interview.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer did not file an appeal with the State Personnel Board.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Appendix D: Combined Pre-Disciplinary and Discipline Phase Cases

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

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

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

The disciplinary phase is rated for procedural and substantive sufficiency.

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

Procedurally or Substantively Insufficient in the Pre-Disciplinary Phase

Case Detail	Description
Incident Date	03/01/2020
OLES Case Number	2020-00321-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On or about March 1, 2020, a pre-licensed psychiatric technician allegedly became inappropriately involved with a patient and sent him sexually suggestive photographs.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred. The pre-licensed psychiatric technician assistant resigned before discipline could be imposed. A letter indicating the

	pre-licensed psychiatric technician assistant resigned under adverse circumstances was placed in her official personnel file.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigator failed to notify OLES of the scheduling of a subject interview, thereby preventing the monitor from attending the interview and providing real-time feedback.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to notify OLES of the scheduling of the subject interview, thereby preventing the monitor from attending the interview and providing real-time feedback.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	When a case is monitored, the Supervising Special Investigator will ensure Investigators meet and discuss with the AIM when a subject interview is scheduled; this will allow the AIM the opportunity to attend and provide real time feedback.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	10/27/2019
OLES Case Number	2019-01262-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On October 27, 2019, and October 29, 2019, an officer allegedly drove a state vehicle while intoxicated.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 5 percent for 12 months was the appropriate penalty. The OLES concurred with the hiring authority's determination. At the pre-hearing settlement conference, the department entered into a settlement agreement with the sergeant whereby the salary reduction

	was reduced to 5 percent for seven months. The OLES concurred with the settlement as the sergeant had expressed remorse during the *Skelly* hearing, the misconduct was not likely to recur and the reduction was not unreasonable.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	11/01/2018
OLES Case Number	2019-01335-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	Between November 1, 2018, and July 15, 2019, a psychiatric technician was allegedly engaged in an overly familiar relationship with a patient.
Disposition	The hiring authority sustained the allegation and determined the appropriate penalty was dismissal. Subsequently, the hiring authority decided to reject the psychiatric technician on probation. The OLES concurred. However, the psychiatric technician resigned before the rejection on probation took effect.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	01/01/2017
OLES Case Number	2019-01361-1A
Case Type	Confidential
Incident Types	1. Confidential
Allegations	1. Other failure of good behavior 2. Other failure of good behavior
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	Between July 2019, and October 2019, a manager allegedly solicited and obtained loans from two subordinate staff members and failed to fully repay the loans.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The manager filed an appeal with the State Personnel Board. Prior to an evidentiary hearing, the department entered into a settlement agreement wherein the manager agreed to resign in lieu of dismissal. The OLES concurred with the settlement.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	01/29/2020
OLES Case Number	2020-00118-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Dishonesty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On January 29, 2020, a psychiatric technician allegedly

	neglected to assess a patient's blood sugar level, and allegedly falsified documents indicating she had conducted the assessment.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred. The psychiatric technician retired before discipline could be imposed. A letter indicating the psychiatric technician assistant retired under adverse circumstances was placed in her official personnel file.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	04/01/2020
OLES Case Number	2020-00421-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On or about April 1, 2020, a nurse allegedly kissed a patient on two occasions, allowed the patient to rub her buttocks and breasts over her clothing, and sent pornographic photographs and letters to the patient.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. The nurse resigned before discipline could be imposed. A letter indicating the nurse resigned under adverse circumstances was placed in her official personnel file.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	05/07/2020
OLES Case Number	2020-00469-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Other failure of good behavior
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** No Change
Incident Summary	On May 7, 2020, an officer allegedly overdosed on a controlled substance in the presence of his minor child. The officer allegedly was dishonest to responding law enforcement.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Appendix E: Monitored Issues

Case Details	Description
Incident Date	08/25/2016
OLES Case Number	2016-01094-1MI
Case Type	Monitored Issue
Incident Summary	The OLES identified that the Department of State Hospitals (DSH) lacked a clear policy governing when and how to conduct extractions of patients from their rooms or other areas.
Disposition	The OLES recommended that the DSH develop and provide to the OLES for review a statewide policy governing both calculated and exigent room and area extractions. The OLES further recommended that exigent extractions should be defined as life or death events where a measured, calculated extraction would not be practical. DSH has implemented a new policy and completed the majority of training for all sworn staff, and is now committed to conduct annual refresher training on calculated intervention for patient extractions.

Case Details	Description
Incident Date	01/10/2017
OLES Case Number	2017-00446-2MI
Case Type	Monitored Issue
Incident Summary	On January 10, 2017, the OLES issued a memorandum to the Department of State Hospitals (DSH) recommending that hospital police record investigatory interviews. In response to the OLES memorandum, DSH implemented a recording system on March 1, 2018. On July 30, 2020, the OLES issued a memorandum to the Chief of the Office of Protective Services, recommending statewide re-training on interview recording policy, to implement the appropriate recording of interviews by DSH police officers. This memorandum was generated because the OLES found multiple examples where DSH police officers were not properly recording interviews.
Disposition	On October 1, 2020, the Chief of the Office of Protective Services instituted protocols and re-training policies for DSH officers to ensure the appropriate recording of interviews as recommended by the OLES. The OLES will continue to monitor the department's adherence to its recording policies.

Case Details	Description
Incident Date	2018-01052-1MI
OLES Case Number	Monitored Issue
Case Type	Monitored Issue
Incident Summary	Since March 2018, OLES reported that delays in completing investigations were the most prevalent procedural deficiency for pre-disciplinary phase cases at DSH facilities. Patton State Hospital (PSH) historically had a disproportionately high number of untimely monitored investigations.
Disposition	In response, PSH implemented several remedial measures, including but not limited to, a visual tracking system, additional supervisory review and assignment of a liaison for contact between the hospital police department and the Office of Protective Services. Since implementing these changes, PSH significantly reduced the number of untimely investigations. PSH had no untimely investigations in the last reporting period.

Appendix F: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

(a) The Office of Law Enforcement Support shall be responsible for contemporaneous oversight of investigations that (1) are conducted by

the State Department of State Hospitals and involve an incident that meets the criteria of Section 4023, and (2) are conducted by the State Department of Developmental Services and involve an incident that meets the criteria of Section 4427.5.

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

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

(4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise made available to the public upon their release to the Governor and the Legislature.

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

California Welfare and Institutions Code 4427.5

4427.5.

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

(A) A death.

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

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

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

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

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

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

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

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

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

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

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

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

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

California Welfare and Institutions Code 4023

4023

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

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

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

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

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

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

(a) Assault, as defined in Section 240 of the Penal Code.

(b) Battery, as defined in Section 242 of the Penal Code.

(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.

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

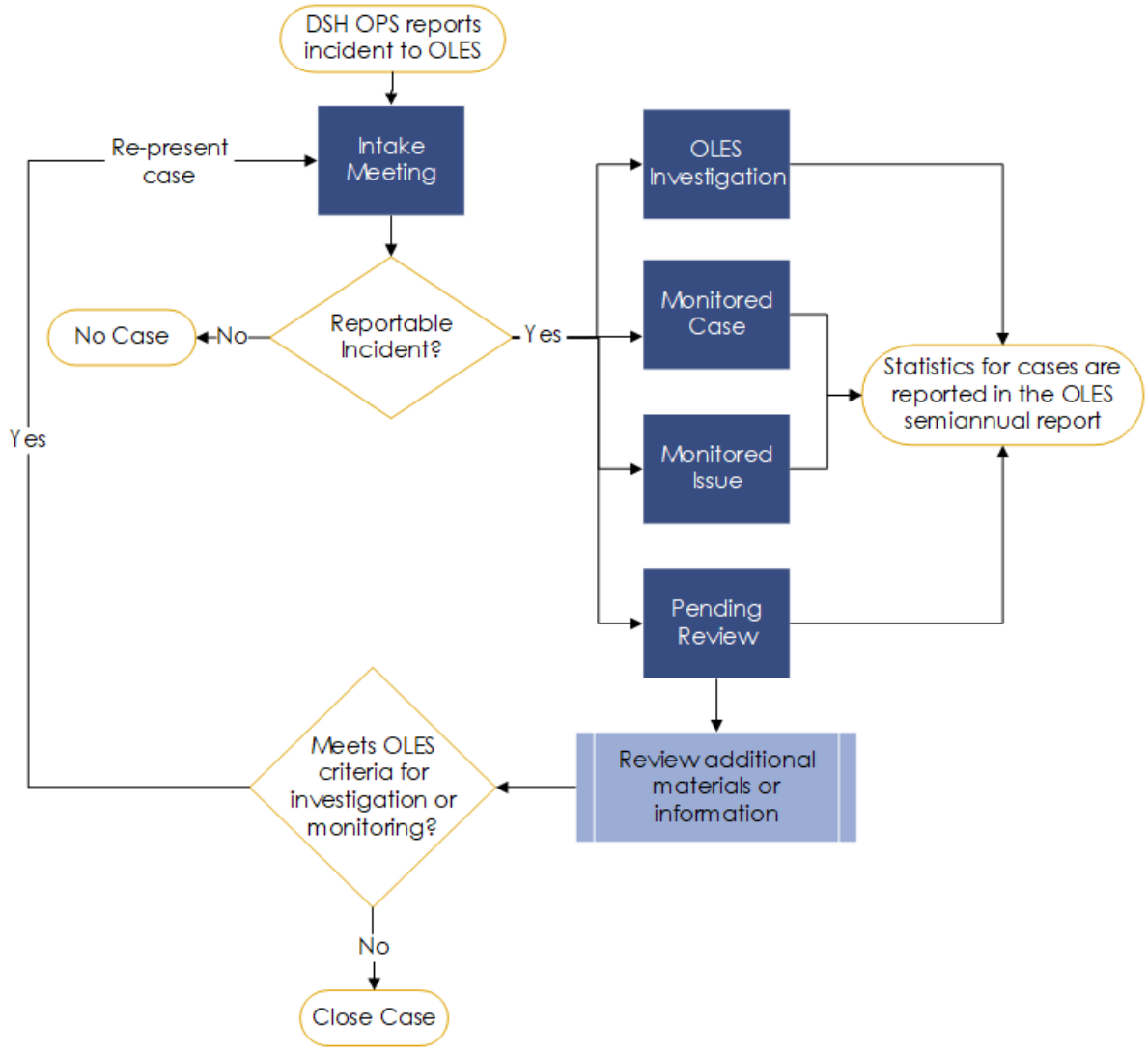
(e) Sexual assault, that means any of the following:

(1) Sexual battery, as defined in Section 243.4 of the Penal Code.

(2) Rape, as defined in Section 261 of the Penal Code.
(3) Rape in concert, as described in Section 264.1 of the Penal Code.
(4) Spousal rape, as defined in Section 262 of the Penal Code. (5) Incest, as defined in Section 285 of the Penal Code.
(6) Sodomy, as defined in Section 286 of the Penal Code.
(7) Oral copulation, as defined in Section 288a of the Penal Code.
(8) Sexual penetration, as defined in Section 289 of the Penal Code.
(9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.

(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
(1) For punishment.
(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
(3) For any purpose not authorized by the physician and surgeon.

Appendix 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. No Case
    b. Pending Review
        i. 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.
    c. OLES Investigation Case
    d. Monitored Case
    e. Monitored Issue

Appendix H: Guidelines for OLES Processes

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

If, instead, an incident is investigated by DSH but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH investigator and the department attorney, if one is designated[6], throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

1. Department notifies OLES of an incident that meets OLES reporting criteria.
2. The OLES reviews the incident and makes a case determination.
3. If the case is monitored by OLES, the OLES AIM meets with the OPS administrative investigator and identifies critical junctures.
4. DSH law enforcement completes investigation and submits final report.

Critical Junctures

- Site visit
- Initial case conference
    - Develop investigation plan
    - Determine statute of limitations
- Critical witness interviews
    - Primary subject(s) recorded
- Draft investigation report

It is recommended that within 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority must 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

[6] 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.

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 the AIM believes the hiring authority's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.

45 Days

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

Once a final determination is reached regarding the appropriate allegations and discipline in a case, it is recommended that a Notice of Adverse Action (NOAA) be finalized and served upon the employee within 60 days.

60 Days

1. The department's human resources unit completes the NOAA and provides it to AIM for review.
2. The approved NOAA is provided to the executive director for service to the 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, that is, whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee[7]. It is recommended that the *Skelly* due process meeting be completed within 30 days.

30 Days

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

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

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

Conclusion

1. The department attorney notifies AIM of any SPB hearing dates. The AIM monitors all hearings.
2. The department attorney notifies and consults with AIM prior to any settlements or changes to disciplinary action.
3. The AIM notes the quality of prosecution and final disposition.