Office of Law Enforcement Support

Semiannual Report

July 1, 2019–December 31, 2019

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

Promoting a safe, secure and therapeutic environment

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

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Introduction

I am pleased to present the eighth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency. This report details OLES' oversight and monitoring of the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS) from July 1 through December 31, 2019.

In this report, the OLES introduces a new, more accurate approach to classifying and identifying the allegations and occurrences within incidents reported to OLES. 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 now referred to as incident types. When examining the facts and circumstances of each incident, the OLES may identify one or more incident types. For example, a reported incident may include an allegation of physical abuse which resulted in a head or neck injury that required treatment beyond first aid. In this example, there is one incident with two incident types. The OLES began using this approach late into the reporting period and as such only a few incidents have been identified to have more than one incident type. In future reports, the new approach to classifying and identifying multiple incident types within an incident may result in a significant increase in numbers compared to those reported in the previous reports.

From July 1 through December 31, 2019, the OLES received a total of 608 incident reports from both DSH and DDS, 20 more incidents than in the prior reporting period. From the 608 incident reports, the OLES identified 612 incident types. The DSH reported 476 incidents, 28 more incidents compared to the prior reporting period. The DDS reported 132 incidents, eight less than in the prior reporting period.

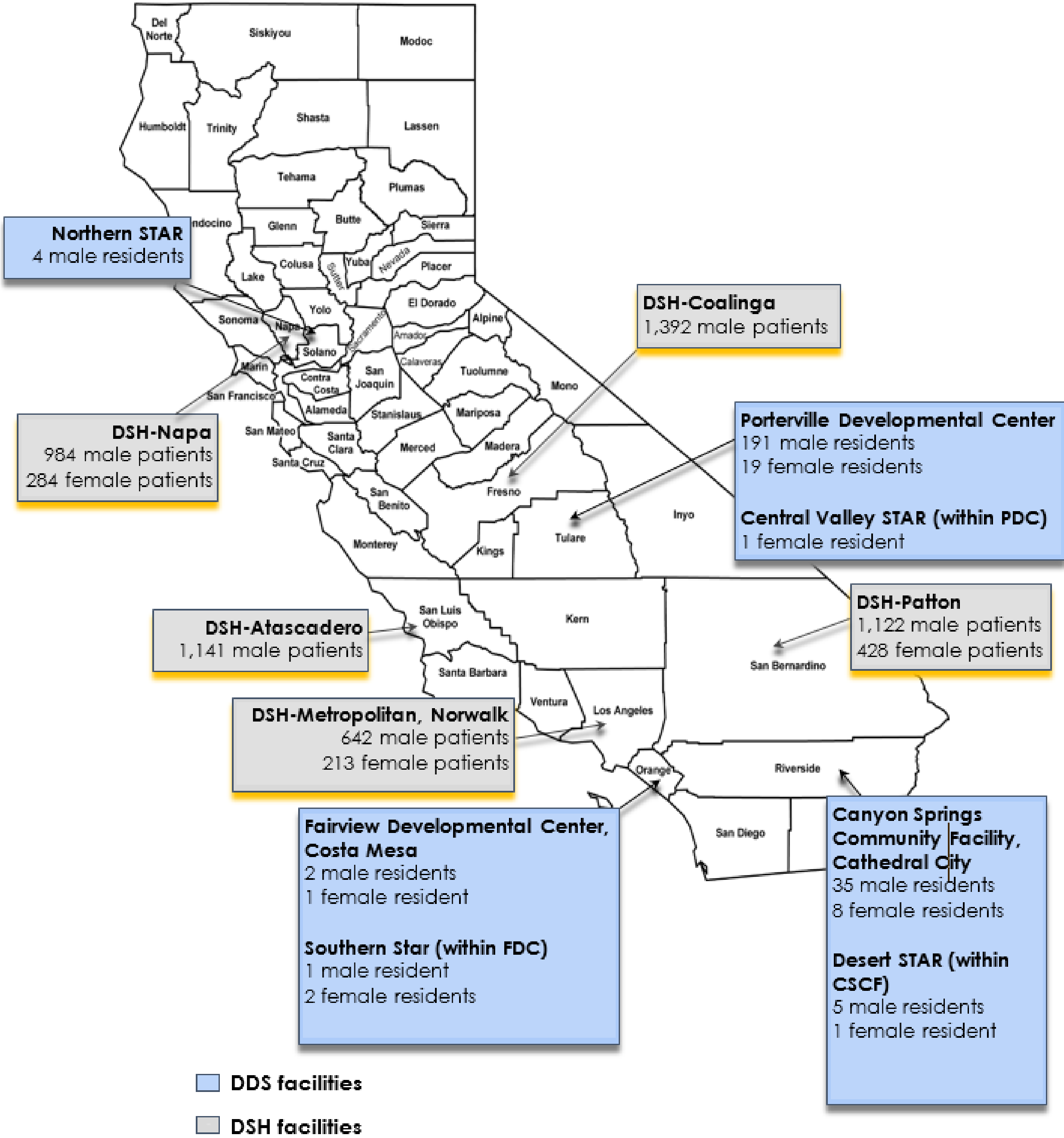
With this report, the OLES concludes its fourth year of oversight and monitoring. The OLES is grateful for the ongoing collaboration, dedication, and support of our stakeholders, as well as DSH and DDS management and personnel.

We welcome comments and questions. Please visit the OLES website at www.oles.ca.gov.

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the facilities below.



Note: Population numbers as of December 31, 2019, were provided by the departments. Residents in DDS receiving acute crisis services are listed in Stabilization, Training, Assistance, and Reintegration (STAR) homes.

DSH and DDS Facility Population Chart

Facility	Number of Male Residents/Patients	Number of Female Residents/Patients	Total
DSH-Atascadero	1,141	0	1,141
DSH-Coalinga	1,392	0	1,392
DSH-Metropolitan	642	213	855
DSH-Napa	984	284	1,268
DSH-Patton	1,122	428	1,550
Canyon Springs	35	8	43
Desert STAR	5	1	6
Southern STAR	1	2	3
Central Valley STAR	0	1	1
Fairview	2	1	3
Porterville	191	19	210
Northern STAR	4	0	4
Total	5,519	957	6,476

Executive Summary

During the reporting period of July 1, 2019 through December 31, 2019, the Office of Law Enforcement Support (OLES) received and processed 608 reportable incidents[1] at the California Department of State Hospitals (DSH) and the Department of Developmental Services (DDS). Reportable incidents include alleged misconduct by state employees, serious offenses between facility residents and patients, resident and patient deaths and other occurrences, per Welfare and Institutions Code, Sections 4023, 4023.6 and 4427.5. This is an increase of 20 incident reports compared to the prior reporting period which had 588 incident reports. The overall increase in reportable incidents statewide from 588 to 608 is a 3.4 percent increase from the prior reporting period. From the 608 incidents, four incidents featured two incident types[2] that were accounted for. There was a total of 612 incident types. Of these 612 incident types, there were 272 that met OLES criteria for investigation, monitoring or research into a systemic issue.

As shown in the following chart, of the total 608 reports, OLES received 476 incident reports from DSH and 132 from DDS. DSH's 476 reportable incidents reflect an increase of 28 incidents or 6.3 percent from the prior reporting period of January 1 through June 30, 2019. From the 476 DSH reportable incidents, there were a total of 479 incident types. Of the 479 incident types identified, 206 incident types met the criteria for OLES investigation, monitoring, and/or led to OLES research into a systemic departmental issue.

The DDS had 132 reportable incidents which reflect a decline of eight reportable incidents or 5.7 percent from the previous reporting period. Of these 132 reportable incidents, there were 133 incident types identified. From the 133 incident types, 66 incident types met the criteria for OLES investigation, monitoring, and/or led to OLES research into a systemic departmental issue[3].

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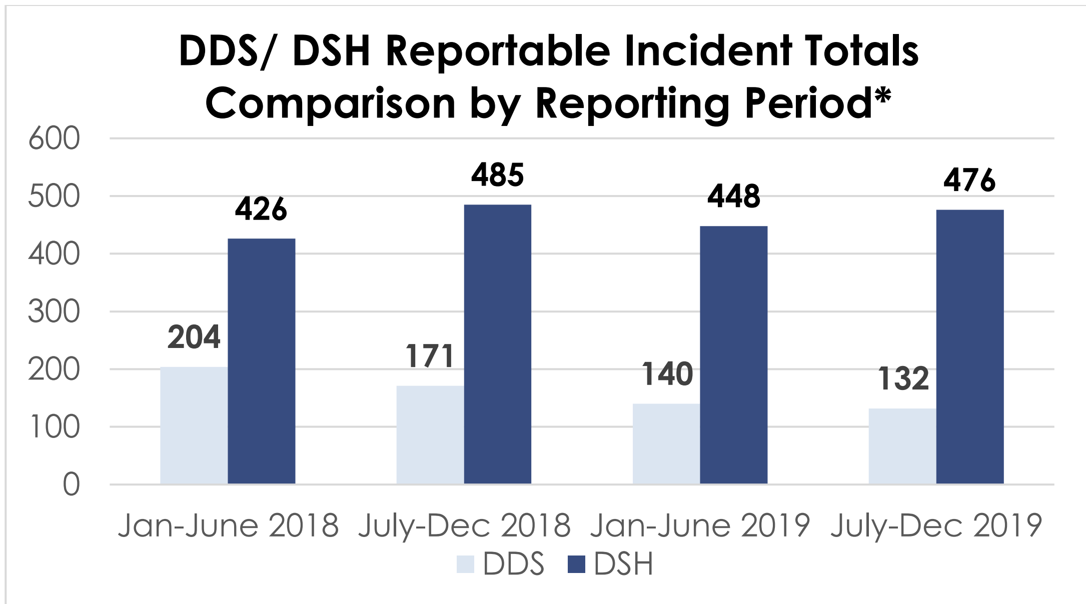
[1] Reportable incidents are pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix F).

[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 now referred to as incident types.

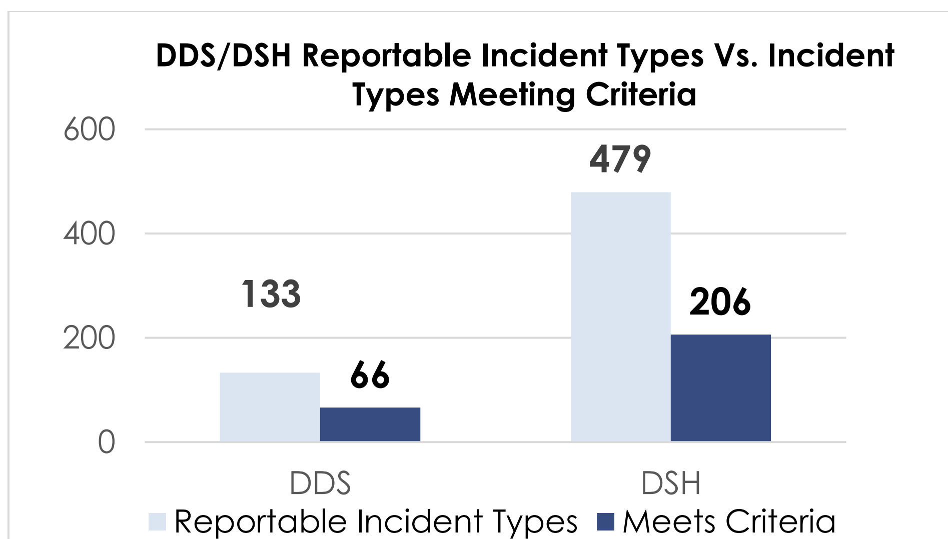
[3] The OLES chief determines whether an issue in DSH or DDS appears to be systemic and, if so, directs OLES staff to research the matter. The OLES labels such matters "monitored issues" and reports on their status in a separate section of each legislative report.



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

Incident Types - Reportable Incident Type vs. Incident Type Meeting Criteria

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



Patient and Resident Arrests

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

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

During this reporting period, DSH reported 27 patient arrests, three more arrests than reported in the prior reporting period. DDS did not report any resident arrests during the reporting period, which is one less report than in the prior reporting period.

DSH – Most Frequent Incident Types

Allegations of sexual assault represented the single largest number of alleged incidents reported by DSH during this reporting period. The OLES received 102 reports of alleged sexual assault, which accounted for 21.3 percent of all reported DSH incident types. There were a total of 79 reported incident types of patient abuse, making patient abuse the second largest category of incident types reported at DSH during this reporting period. The broken bone incident type is the third most frequently reported incident type, with 77 reports. Reports of peace officer misconduct was the fourth most frequent reported incident type with 41 reports. There were 23 reports of head/neck injuries at DSH, making it the fifth most frequently reported category in this reporting period. Sexual assault-Outside Jurisdiction (OJ) was the sixth most reported category with 35 reportable incident types. Neglect and Death was seventh most reported category, each with 19 incident type reports in this reporting period.

The sexual assault, broken bone, misconduct and sexual assault-OJ categories reflect an increase in reports compared to the number of incidents reported during the prior reporting period. The most notable change compared to the prior reporting period is the 95.2% increase in peace officer misconduct allegations and the 42.5% decrease in reports of head or neck injuries. The following table provides more comparisons to the prior reporting period.

DSH - Most Frequent Incident Types July 1 through December 31, 2019

Incident Type Categories	Prior Period Incidents January 1 through June 30, 2019	Current Period Incident Types July 1 through December 30, 2019	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Sexual Assault	96	102	6.3%	34
Abuse	80	79	-1.3%	75
Broken Bone	71	77	8.5%	26
Misconduct	21	41	95.2%	37
Sexual Assault-OJ*	32	35	9.4%	0
Head/Neck Injury	40	23	-42.5%	2
Death	27	19	-29.6%	5
Neglect	21	19	-9.5%	19

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

DDS - Most Frequent Incident Types

As shown in the chart on the following page, allegations of abuse at DDS comprised the top incident type category in this reporting period. There were 81 reports of alleged abuse. The second most reported incident type in this reporting period was in the category of sexual assault. There were 14 allegations of sexual assault. Reports of head/neck injuries, ranked as the third most frequently reported incident type, with 10 reported incident types. Broken bone was the fourth most frequent, with eight reports of broken bone. Allegations of neglect ranked as the fifth most frequent incident reported by DDS to OLES with five incident types reported. There were four reports of alleged peace officer misconduct, which was the same number as in the prior reporting period. Compared to the prior reporting period, there was a decrease in the number of abuse and neglect allegations. In contrast, the number of head/neck injury reports doubled from five reported incidents to 10 reported incident types. There was no change in the number of broken bone incidents or misconduct allegations when compared to the prior reporting period. The following table provides a list of the most frequent types reported during the reporting period along with the percent change from the prior reporting period.

DDS - Most Frequent Incident Types July 1 through December 31, 2019

Incident Type Categories	Prior Period Incidents January 1 through June 30, 2019	Current Period Incident Types July 1, 2019 through December 31, 2019	Percent Change from Previous Reporting Period	Current Period Number Meeting OLES Criteria
Abuse	94	81	-13.8%	51
Sexual Assault	11	14	27.3%	6
Head/Neck	5	10	100%	0
Broken Bone	8	9	12.5%	1
Neglect	6	5	-20%	5
Misconduct	4	3	-25%	2

Deaths at DSH and DDS

Deaths of DSH patients totaled to 19, a decrease of 29.6 percent from the prior reporting period. Five of the reported death incident types met the OLES criteria for investigation or monitoring. Twelve of the 19 patient deaths were expected due to existing medical conditions. Seven 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. Coalinga State Hospital (CSH) and Napa State Hospital (NSH), once again had the largest number of deaths reported with eight deaths reported at CSH and six deaths at NSH.

At CSH, four deaths were due to cardiac or respiratory issues, one to sepsis, one to cancer, one to suicide while at an outside facility and one death is still pending determination. At NSH, three deaths were due to cardiac/respiratory issues, one to cancer, one to renal/liver issues and one death to sepsis.

Two deaths of DDS residents were reported in this reporting period, both of which occurred at Porterville Developmental Center (PDC). One death was due to a cardiac or respiratory issue and the other due to cancer.

Results of OLES Investigations

Per statute[4], an OLES investigation is initiated after OLES is notified of an allegation that a DSH or DDS law enforcement officer of any rank committed

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

serious criminal misconduct or serious administrative misconduct during certain threshold incidents.

Appendix A of this report provides information on the 17 OLES investigations that were completed during this reporting period. Sixteen investigations involved an incident that occurred in 2019 and one in 2018. Four completed administrative investigations were submitted to the hiring authorities at the facilities for disposition, and OLES monitored the disposition process. The OLES conducted inquiries into 12 criminal allegations and determined there was insufficient evidence that a crime was committed. The cases were closed without referral to a district attorney's office. A summary of the review and decision was provided to the departments. In the remaining administrative investigation, the OLES determined that the allegation did not meet OLES criteria and the matter was closed. The OLES provided a summary of the review and decision to the department.

Results of OLES Monitored Cases

In Appendices B, C, and D of this report, OLES provides information on 167 monitored cases that, by December 31, 2019, had reached completion. Monitored cases include investigations conducted by the departments and the discipline process for employees involved in misconduct.

Eighty-four percent, or 141 of the 167 cases, were at DSH. Among the 141 DSH monitored cases, 25 cases were rated as procedurally insufficient. Seven DSH monitored cases were rated as substantively insufficient. Thirty-one monitored administrative cases had sustained allegations and 13 criminal investigations resulted in referrals to prosecuting agencies.

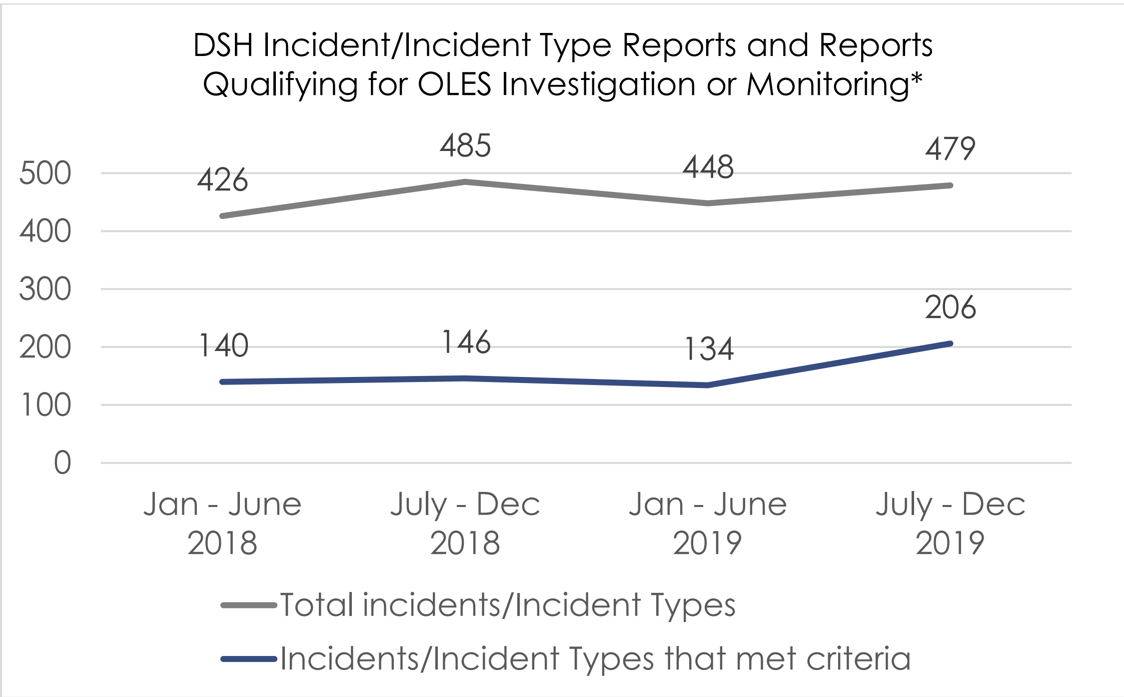
At DDS, 17 cases were rated as procedurally insufficient and four cases were rated as substantively insufficient. 10 DDS monitored administrative cases had sustained allegations and one criminal investigation resulted in a referral to the prosecuting agency.

DSH 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 Incidents during this Reporting Period

Overall, the number of DSH incidents reported to OLES from July 1 through December 31, 2019 increased 6.3 percent, from 448 during the prior reporting period to 476 in this reporting period. From the 476 reported incidents, the OLES identified 479 incident types, as three of the incidents featured two incident types.



* 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 reporting incidents to reporting incident types.

Most Frequent DSH Incident Types Reported this Period

During the reporting period, 206 of 479 reportable incidents types at DSH met criteria for OLES investigation or monitoring, or led to OLES research into a potential systemic issue.

The five most common categories under which incident types were reported accounted for 69.7 percent of all reportable incident types from DSH. These categories are sexual assault, abuse, broken bone, misconduct and sexual assault-OJ. There were 334 reportable incidents in these categories.

These same five categories accounted for 173 reportable incident types or 84% percent of all DSH reportable incidents that met the criteria for OLES to investigate or monitor.

Similar to the previous reporting period, allegations of sexual assault was the most frequently reported incident type. A total of 102 sexual assault allegations accounted for 21.3 percent of all incident types reported. This was an increase of one incident from the prior reporting period which had 96 allegations of sexual assault. Of the 102 allegations in this period, 34 qualified for investigation or monitoring, or consideration of a potential systemic issue. This is an increase of 25.9 percent from 27 qualifying reports in the prior reporting period.

Abuse allegations that did not involve sexual assault were the second most frequently reported incident type at DSH in this reporting period, totaling 79 and accounting for 16.5 percent of all incident types reported. This was a decrease of one reported incident type. The number of allegations of abuse that met criteria for investigation and/or monitoring, or consideration of a potential systemic issue in this period also increased by 13.6 percent, from 66 during the prior reporting period, to 75 in this reporting period.

While "abuse" was how certain incident types were described when reported to OLES, the determination of whether each incident met the threshold for OLES's purposes of investigation or monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code section 15610.63[5].

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

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

DSH Reportable Incidents/Incident Types by Reporting Period

Incident Categories	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Prior Period January 1- June 30, 2019 (Reported)*	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Current Period July 1- December 31, 2019 (Reported)	Current Period July 1 - December 31, 2019 (Meets Criteria)
Abuse	89	72	80	66	79	75
Broken Bone	76	7	71	6	77	26
Burn	3	0	3	0	3	0
Death	21	5	27	5	19	5
Genital Injury	1	0	1	0	2	0
Head/Neck Injury	50	0	40	0	23	2
Misconduct	23	20	21	12	41	38
Neglect	24	15	21	14	19	19
Non-patient assault/GBI on Patient	1	1	0	0	1	1
Patient on Patient Assault/GBI	5	0	9	0	15	0
Pregnancy	0	0	1	0	0	0
Sexual Assault	101	26	96	27	102	34
Sexual Assault-OJ**	35	0	32	0	35	0
Significant Interest-Attack on Staff***	2	0	2	0	10	0
Significant Interest-Attempted Suicide	4	0	4	0	1	0

Incident Categories	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Prior Period January 1- June 30, 2019 (Reported)*	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Current Period July 1- December 31, 2019 (Reported)	Current Period July 1 - December 31, 2019 (Meets Criteria)
Significant Interest-AWOL	14	0	8	1	9	2
Significant Interest-Child Pornography	13	0	2	0	3	0
Significant Interest-Other******	9	0	6	3	13	1
Significant Interest-Patient Arrest	14	0	24	0	27	0
Significant Interest-Riot	0	0	0	0	0	0
Totals	485	146	448	134	479	209

*Numbers in this column are unadjusted and provided as they were previously published.
**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 arrest for providing contraband to a patient; and the smuggling of drugs into a State hospital.

DSH Reportable Incident Types by Facility this Reporting Period

Incident Categories	Atascadero	Coalinga	Metropolitan	Napa	Patton	Totals
Abuse	5	16	21	11	26	79
Broken Bone	8	38	18	8	5	77
Burn	0	2	1	0	0	3
Death	1	8	3	6	1	19
Genital Injury	0	0	2	0	0	2

Incident Categories	Atascadero	Coalinga	Metropolitan	Napa	Patton	Totals
Head/Neck Injury	3	5	8	2	5	23
Misconduct	3	19	8	8	3	41
Neglect	4	4	5	0	6	19
Non-Patient on Patient Assault/GBI	1	0	0	0	0	1
Patient on Patient Assault/GBI	2	1	4	2	6	15
Pregnancy	0	0	0	0	0	0
Sexual Assault	17	23	29	14	19	102
Sexual Assault-OJ*	13	1	7	3	11	35
Significant Interest- Attack on Staff**	4	0	0	6	0	10
Significant Interest- Attempted Suicide	0	0	0	0	1	1
Significant Interest-AWOL	0	1	7	0	1	9
Significant Interest-Child Pornography	0	3	0	0	0	3
Significant Interest-Other***	1	7	2	2	1	13
Significant Interest-Patient Arrests	0	5	6	4	12	27
Significant Interest-Riot	0	0	0	0	0	0
Totals	62	133	121	66	97	479

*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 arrest for providing contraband to a patient; and the smuggling of drugs into a State hospital.

Distribution of DSH incident Types
DSH accounted for 479 or 78.3 percent of the total 612 reported incident types to OLES during this reporting period. With 6,206 patients department-wide, this equates to 0.077 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
Atascadero	1,141	62
Coalinga	1,392	133
Metropolitan	855	121
Napa	1,268	66
Patton	1,550	97
Totals	6,206	479

* The department provided population numbers as of December 31, 2019.

Coalinga State Hospital (CSH) had the highest number of reported incident types, with 133 incident types. Reports of broken bone and sexual assault were the most frequent. The Metropolitan State Hospital (MSH) had the second highest number of reportable incident types in this period with 121 incident types. Sexual assault and abuse allegations were the two most frequent incident types reported. Patton State Hospital (PSH) reported 97 incident types, abuse and sexual assault being the most frequent. NSH reported 66 incident types, sexual assault and abuse being the most frequent. Atascadero State Hospital (ASH) reported 62 incident types, sexual assault and sexual assault-OJ being the most frequent.

DSH Sexual Assault Allegations

Allegations of sexual assault continue to be the most frequently reported incident from DSH. The 102 alleged sexual assault incident types reported from July 1 through December 31, 2019, accounted for 21.3 percent of all reported incident types from DSH. Thirty-four of 102 reported incident types of alleged sexual assault, or 33.3 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 35 reported incident types under the sexual assault-OJ category.

MSH had the highest number of sexual assault reports with 29 or 28.4 percent of all alleged sexual assault incident types during this reporting period. ASH had 13

out of the 35 reported incidents of alleged sexual assault-OJ, which was once again the highest amongst the DSH facilities. This category included allegations that implicated family, friends, or others in incidents that occurred when patients were not in a DSH facility.

When excluding the sexual assault-OJ incident type, allegations of sexual assaults involving a patient assaulting other patient(s) were the most frequently reported, with a total of 71 incident types, or 69.6 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 26 incident types or 25.5 percent of the 102 sexual assault allegations. The third most frequent allegation involved an unknown assailant on a patient, with five incident types or 4.9 percent. Allegations involving an unknown assailant 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 reports of alleged sexual assaults received by OLES during the reporting period are shown in the chart on the following page.

DSH - Sexual Assault Allegations Reported July 1 through December 31, 2019

Facility	Patient on Patient	Non-Law Enforcement Staff on Patient	Law Enforcement on Patient	Unknown Person on Patient*	OJ **	Totals
Atascadero	9	6	0	2	13	30
Coalinga	21	2	0	0	1	24
Metropolitan	19	10	0	0	7	36
Napa	10	2	0	2	3	17
Patton	12	6	0	1	11	30
Totals	71	26	0	5	35	137

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

DSH Patient Deaths

There were 19 patient deaths reported to OLES from DSH facilities during this reporting period. This number decreased 29.6 percent from the 27 deaths reported in the prior reporting period, January 1 through June 30, 2019. Patient age at the time of death ranged from 53 years to 87 years old. Of the 19 deaths, 17 were male patients and two were female. As shown in the following chart, CSH and NSH had the highest number of deaths with eight reported deaths and six deaths respectively. One of the eight reported deaths from CSH occurred as

a result of a patient suicide while at an outside jurisdiction detention facility. This death incident is not included in the counts provided below.

DSH - Patient Deaths Reported July 1 through December 31, 2019

Facility	Cancer	Cardiac/ Respiratory	Renal/Liver	Sepsis	Other	Totals
Atascadero	0	1	0	0	0	1
Coalinga	1	4	0	1	1	7
Metropolitan	1	1	0	1	0	3
Napa	1	3	1	1	0	6
Patton	1	0	0	0	0	1
Totals	4	9	1	3	1	18

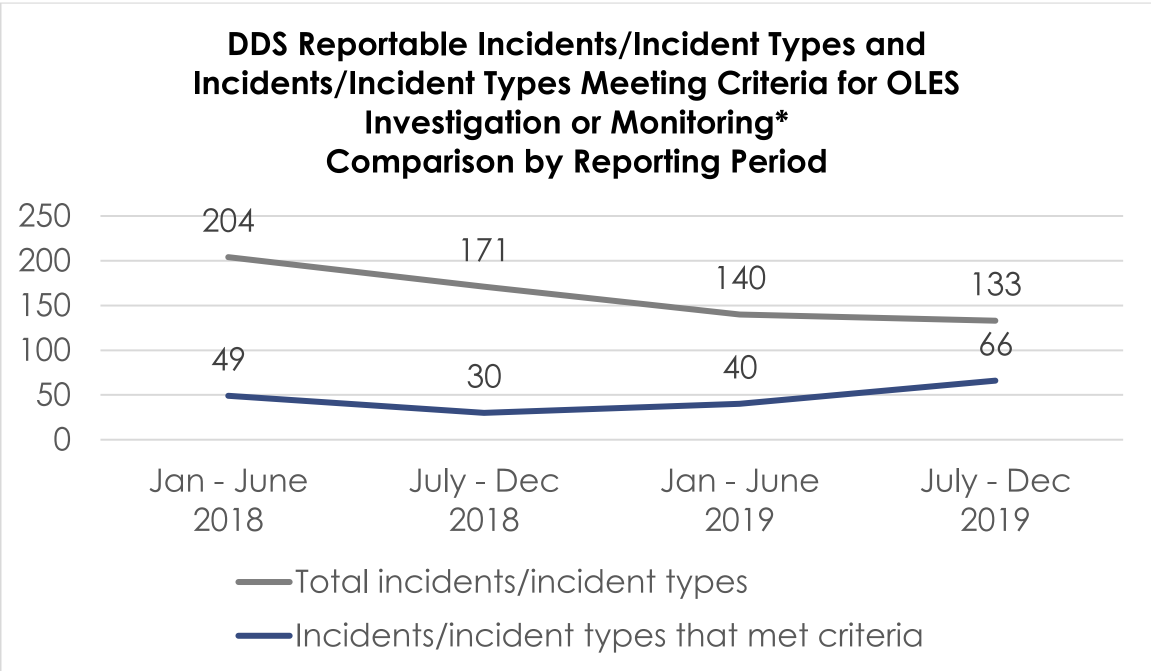
*Other deaths are those pending determination

Approximately 63.2 percent or 12 of the DSH patient deaths were classified as "expected" due to underlying health conditions, such as cancer and kidney disease. Seven deaths were classified as "unexpected and received two levels of review within DSH, per department policy. The OLES reviewed each unexpected death and monitored the cases that met OLES criteria. In five of the 19 patient deaths, the OLES monitored the departmental investigations. The final determination for the cause of death of "unexpected deaths" are included in the numbers for the chart above.

DDS Incidents and Incident Types

Decreased Incidents during this Reporting Period

Overall, the number of DDS incidents reported during this reporting period decreased by 5.7 percent, from 140 during the prior reporting period to 132 during this reporting period. One incident had two incident types, resulting in a total of 133 incident types reported by DDS. During this reporting period, the majority of incident reports came from the developmental centers.



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

Of the 133 reportable DDS incident types, 49.6 percent or 66 incident types, met the criteria for OLES investigation, monitoring or led to OLES research into a systemic departmental issue. As the graph shows, the percentage of incident types that met OLES criteria is significantly higher than that of the prior reporting period.

Most Frequent DDS Incident Types Reported this Period

Of the 133 reported incident types from DDS, 114 incident types or 85.7 percent of all reported incident types fell into the following four categories: abuse, sexual assault, head or neck injury and broken bone. The abuse, neglect and sexual assault categories accounted for 62 incident types or 93.9 percent of all DDS

reportable incident types that met the criteria for OLES to investigate, monitor or research for potential systemic departmental issues.

Alleged abuse was the most frequent DDS incident type reported in this reporting period. The 81 abuse allegations accounted for 60.9 percent of all DDS incident types reported. Fifty-one of the abuse allegations met OLES criteria for investigation or monitoring. Alleged sexual assault represented the second highest category for the number of incident types reported, with 14. Six of the alleged sexual assault incident types met criteria for investigation or monitoring. The determination of whether alleged abuse or alleged sexual assault incidents met the threshold for OLES's purposes of investigation or monitoring was based on the statutory definitions for physical abuse and sexual assault as defined in Welfare and Institutions Code Section 15610.63[6]. Head or neck injuries were the third most frequently reported incident type category, however none of the reports meet the OLES criteria for investigation or monitoring.

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

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

DDS Reportable Incidents/Incident Types by Reporting Period

Incident/Incident Type Categories	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Prior Period January 1- June 30, 2019 (Reported)*	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Current Period July 1- Dec 31, 2019 (Reported)	Current Period July 1- Dec 31, 2019 (Meets Criteria)
Abuse	91	24	94	33	81	51
Broken Bone	12	0	8	0	9	1
Burn	1	0	1	0	1	0
Death	3	1	2	0	2	0
Genital Injury	2	0	1	0	1	1
Head/Neck Injury	26	0	5	0	10	0
Misconduct	1	1	4	3	3	2
Neglect	2	1	6	4	5	5
Non-resident on Resident Assault/GBI	0	0	0	0	0	0
Pregnancy	0	0	0	0	0	0
Resident on Resident Assault/GBI	4	0	5	0	1	0
Sexual Assault	14	3	11	0	14	6
Sexual Assault-OJ**	0	0	0	0	0	0
Significant Interest-Attack on Staff***	0	0	0	0	3	0
Significant Interest-Attempted Suicide	1	0	0	0	0	0
Significant Interest-AWOL	7	0	1	0	3	0
Significant Interest-Child Pornography	0	0	0	0	0	0
Significant Interest-Other****	2	0	1	0	0	0

Incident/Incident Type Categories	Prior Period July 1- Dec 31, 2018 (Reported)*	Prior Period July 1- Dec 31, 2018 (Meets Criteria)*	Prior Period January 1- June 30, 2019 (Reported)*	Prior Period January 1 - June 30, 2019 (Meets Criteria)*	Current Period July 1- Dec 31, 2019 (Reported)	Current Period July 1- Dec 31, 2019 (Meets Criteria)
Significant Interest-Resident Arrest	5	0	1	0	0	0
Significant Interest-Riot	0	0	0	0	0	0
Totals	171	30	140	40	133	66

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

**These incidents occurred outside the jurisdiction of DDS.

***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 arrest for providing contraband to a resident; and the smuggling of drugs into a developmental center.

DDS Reportable Incident Types by Facility this Reporting Period

Incident Categories	Canyon Springs	Fairview	Porterville	Totals
Abuse	27	24	30	81
Broken Bone	2	0	7	9
Burn	0	0	1	1
Death	0	0	2	2
Genital Injury	0	1	0	1
Head/Neck Injury	1	2	7	10
Misconduct	1	0	2	3
Neglect	1	1	3	5
Non-resident on Resident Assault/GBI	0	0	0	0
Pregnancy	0	0	0	0
Resident on Resident Assault/GBI	0	0	1	1
Sexual Assault	5	0	9	14
Sexual Assault-OJ*	0	0	0	0
Significant Interest-Attack on Staff**	1	0	2	3
Significant Interest-Attempted	0	0	0	0

Incident Categories	Canyon Springs	Fairview	Porterville	Totals
Suicide				
Significant Interest-AWOL	1	1	1	3
Significant Interest-Child Pornography	0	0	0	0
Significant Interest-Other* **	0	0	0	0
Significant Interest- Resident Arrest	0	0	0	0
Significant Interest-Riot	0	0	0	0
Total	39	29	65	133

* Beginning with the prior reporting period covering January 1 through June 30, 2018, OLES added a category called "Sexual Assault-OJ". These incidents were previously included in the total count for these categories but are now identified into the category of outside jurisdiction. These incidents occurred outside the jurisdiction of DDS.
**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 incident of significant interest, e.g., serious crimes committed by a resident; unusual facility events that have the potential to involve residents; major resident-on-resident fights resulting in no broken bones and no head/neck injuries, but which require first aid treatment; inappropriate visitor-resident behavior that results in the discovery of contraband.

Distribution of DDS Incident Types
The 133 DDS incident types reported July 1 through December 31, 2019, accounted for 21.7 percent of all 612 reported incident types to OLES in this reporting period. As of December 31, 2019, the DDS population dropped from 333 to 270 since the prior reporting period. With 270 residents department-wide, this equates to 0.49 incident types per resident. Fourteen of the 270 residents reside at a STAR facility.

The highest population decrease is at Fairview Developmental Center (FDC), with a decrease of 40 residents. Three residents reside in FDC and three residents are at the Southern STAR, which is currently housed within FDC. On June 30, 2020 the Department of General Services will take over responsibility of the FDC facility. Only one resident remains at the Porterville Developmental Center (PDC) General Treatment Area.

DDS Population on December 31, 2019 and Total Incident Types

DDS Facility	Number of Residents*	Total Incident Types
Canyon Springs	43	39
Fairview	3	29
Porterville	210	65
STAR Homes	14	0
Totals	270	133

* The department provided population numbers as of December 31, 2019.

By the end of the reporting period, PDC had a population size of 210 residents, which is 77.8% of the reported DDS facility population. Of the three remaining DDS developmental centers, PDC also had the highest number of reported incident types with 65 reported incident types. Canyon Springs Community Facility (CSCF) had the second most reported number of incident types with 39 incident types and reported a population of 43 residents as of December 31, 2019. FDC reported 29 incident types and reported a population of three residents. At all three facilities, allegations of abuse were the most frequently reported incident type.

DDS Sexual Assault Allegations

The OLES received 14 incident type reports alleging sexual assault at DDS in this reporting period. Of these 14 incident types, nine were from PDC and five were from CSCF. Alleged sexual assault accounted for 10.5 percent of reported incident types from DDS.

Eleven of the reported sexual assault incidents, or 78.6 percent were alleged to be by non-law enforcement staff. Three of the 14 allegations of sexual assault reported to OLES, or 21.4 percent, were reports of resident on resident sexual assault.

DDS - Sexual Assault Incidents Reported July 1 through December 31, 2019

Facility	Resident on Resident	Non-Law Enforcement Staff on Resident	Law Enforcement on Resident	Unknown Person on Resident*	OJ **	Totals
Canyon Springs	1	4	0	0	0	5
Fairview	0	0	0	0	0	0
Porterville	2	7	0	0	0	9
Totals	3	11	0	0	0	14

*Sexual Assault by an unknown person on a resident is a resident allegation of sexual assault at DDS when the resident is unsure if another person is involved.
**Sexual Assault-OJ is a resident report of an alleged sexual assault that

occurred before the resident was in the care of the DDS or outside the jurisdiction of the developmental center.

DDS Resident Deaths

The DDS reported two deaths during this reporting period. Both resident deaths were reported by PDC. Of the two deaths reported, one was due to cardiac or respiratory issues, and one was due to cancer. The ages of the deceased residents were 55 and 49 years old and were both male. One death was classified as "expected" and the other as "unexpected". The OLES reviewed the unexpected resident death and determined the case did not meet OLES criteria for monitoring or investigation.

DDS - Resident Deaths Reported July 1 through December 31, 2019

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

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. (in Appendix F), 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 1" 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 no later than the close of the first business day following the discovery of the reportable incident. "Priority 2" threshold incidents require notification no later than one business day from the date of discovery. Priority 1 and 2 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 or resident by a non-patient or non-resident.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a patient.
Broken Bone	A broken bone of a patient or resident.
Deadly force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a patient or resident.
Genital Injury	An injury to the genitals of a patient or resident when the cause of injury is undetermined.
Physical Abuse	Any report of physical abuse of a patient or resident implicating staff.
Sexual Assault	Any allegation of sexual assault of a patient or resident.

Priority Two Notifications – One Day Notification

Incident	Description
Burns	Any burns of a patient or resident.
Head/Neck Injury	Any injury to the head or neck of a patient requiring treatment beyond first-aid. Any broken or chipped tooth 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.
Patient or Resident Arrest	Any arrest of a patient or resident.

Incident	Description
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 or resident pregnancy.
Significant Interest	Any incident of significant interest to the public, including, but not limited to: AWOL, suicide attempt (requiring treatment beyond first-aid), commission of serious crimes by patient(s) or staff, child pornography, riot (as defined for OLES reporting purposes), and any incident which may potentially draw media attention.

Timeliness of Notifications

In this reporting period, DSH and DDS timely reporting of incidents to OLES statewide was 93 percent. This is a decrease in timely reporting of incidents/incident types statewide from the prior reporting period where the timely reporting was 96.4 percent.

Four of the total 612 incident types were excluded from DSH's total incident type count when calculating timeliness due to the allegation being reported directly to OLES by a patient, or by a separate DSH facility. Of 608 reportable incident types from both DSH and DDS, 569 were reported timely, 39 reportable incident types were not. Eight of the 39 incident types were unreported and were discovered by OLES when reviewing the department's daily incident logs. All unreported incident types were from DSH.

DSH - Timely Notifications July 1 through December 31, 2019

The DSH had 475 reportable incident types department-wide that were considered for timeliness. Of these, 440 or 92.6 percent were reported timely, compared to 95.5 percent in the prior reporting period. Thirty-five incident types, or 7.4 percent were not reported timely. ASH had the highest percentage of timely notifications at 96.8 percent during this reporting period. PSH had the lowest percentage of timely notifications with 88.7 percent of all reportable incident types. When compared to the prior reporting period, all DSH facilities decreased in the percentage of timely reports.

Rank	DSH Facility	Number of Incident Types Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Atascadero	62	60	96.8%
2	Metropolitan	121	114	94.2%
3	Coalinga	129	121	93.8%

Rank	DSH Facility	Number of Incident Types Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
4	Napa	66	59	89.4%
5	Patton	97	86	88.7%
	Totals	475	440	92.6%

DDS - Timely Notifications July 1 through December 31, 2019

The DDS had 133 reportable incident types department-wide. Of these, 129 incidents or 97 percent were reported timely compared to 99.3 percent in the prior reporting period. Four allegations of abuse, three from PDC and one from FDC, were not reported timely. Similar to the prior reporting period, CSCF reported 100 percent of their 39 total reportable incident types timely.

Rank	DDS Facility	Number of Incident Types Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Canyon Springs	39	39	100%
2	Fairview	29	28	96.6%
3	Porterville	65	62	95.4%
	Totals	133	129	97.0%

Intake

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

The OLES categorizes the incident under a "Pending Review" category and conducts an extra step to ensure incidents that initially appear to not fit the criteria[7] for OLES involvement are being properly categorized. When allegations are unclear and additional information is needed to finalize an initial intake decision, OLES may review video files or digital recordings of a particular hallway, day room, or staff area where a patient or resident was located. Once OLES obtains and evaluates the additional materials or information, the decision to initially deem an incident as not meeting OLES criteria is reviewed again and may be reversed.

For the July 1 through December 31, 2019 reporting period, 340 of the total 608 or 55.9 percent of DSH and DDS incidents that OLES received were assigned a pending review. DSH reported 251 of the 340 incidents assigned with a pending review, or 73.8 percent. Ninety-eight monitored criminal cases and 54 monitored administrative cases were opened for DSH incidents.

DDS had 89 incidents, or 26.2 percent of all incidents assigned a pending review. Thirty-three monitored criminal cases and seven monitored administrative cases were opened for DDS incidents.

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

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

DSH Cases Opened in the Current and Prior Reporting Period

OLES Case Assignments	July 1 – December 30, 2019	Percentage of Reported Incidents
Pending Review	251	52.7%
Monitored, Criminal	98	20.6%
Monitored, Administrative	54	11.3%
Outside Jurisdiction*	35	7.4%
OLES Investigations, Criminal	22	4.6%
OLES Investigations, Administrative	16	3.4%
Totals	476	100%

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

DDS Cases Opened in the Current and Prior Reporting Period

OLES Case Assignments	January 1 – June 30, 2019	Percentage of Reported Incidents
Pending Review	89	67.4%
Monitored, Criminal	33	25%
Monitored, Administrative	7	5.3%
OLES Investigations, Administrative	2	1.5%
OLES Investigations, Criminal	1	0.8%
Outside Jurisdiction*	0	0%
Totals	132	100%

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

Investigations and Monitoring

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

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

OLES Investigations

During this reporting period, OLES completed 17 investigations. Twelve investigations were criminal cases and five were administrative.

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

DSH - Results of Completed OLES Investigations

Type of Investigation	Total completed June 30-December 31, 2019	Referred to prosecuting agency	Referred to facility management	Closed without referral*
Administrative	4	N/A	3	1
Criminal	11	0	N/A	11
Total	15	0	3	12

DDS - Results of Completed OLES Investigations

Type of Investigation	Total completed June 30-December 31, 2019	Referred to prosecuting agency	Referred to facility management	Closed without referral*
Administrative	1	N/A	1	0
Criminal	1	0	N/A	1
Total	2	0	1	1

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

OLES Monitored Cases

In this report, OLES provides information on 167 monitored cases at the two departments. By the end of the reporting period, 79 monitored criminal cases had either been referred or not referred to a prosecuting agency. Eighty-eight monitored administrative cases had allegations that were sustained or not sustained. Of these cases, 14 out of 79 criminal cases were referred to the prosecuting agency and 41 administrative cases out of 88 had sustained allegations. The results are summarized in the charts provided below, and synopses of the cases are provided in Appendices B, C, and D.

Results of Monitored Cases at DSH and DDS

Type of Case/Result	DSH	DDS	Totals
Criminal/Referred to Prosecuting Agency	13	1	14
Criminal/Not Referred	53	12	65
Total Criminal	66	13	79
Administrative/With Sustained Allegations	31	10	41
Administrative/Without Sustained Allegations	44	3	47

Total Administrative	75	13	88
Grand Totals	141	26	167

DSH Pre-Disciplinary Phase Cases

Of the 131 pre-disciplinary phase cases, the OLES rated 20 cases procedurally insufficient and seven cases substantively insufficient. The following tables provide the type of case, the corresponding number of insufficient cases and the frequency of the deficiencies.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	6	2
Criminal/Not Referred	1	0
Administrative/With Sustained Allegations	4	2
Administrative/Without Sustained Allegations	9	3
Total	20	7

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

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 provide sufficient information in incident notification	This may prevent OLES from properly reviewing an incident as OLES has to spend time seeking the information.
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 collect or preserve evidence	This may result in an inadequate investigation. This may prevent a district

Procedural Deficiency	Potential Consequence
	attorney's office or the department's legal department from taking criminal or administrative action against the employee.
Failure to consult with OLES regarding sufficiency of investigation and investigative findings in a timely manner	This consult should take place within 45 days. This may prevent the case from being processed in a timely manner.
Level of care staff did not report incident in a timely manner	This delays department's initial response and delays notification to OLES.
Failure to remove officer from post following incident	Some incidents are so serious that they require the immediate removal of the employee. This may increase the chances of the misconduct occurring again or put other patients and employees at risk.
Issued penalty prior to completion of investigation	This may preclude the taking of disciplinary action once the investigation is concluded.
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.

The DSH's failure to complete investigations within the 120-day required timeframe remains the most frequent procedural deficiency observed in pre-disciplinary phase cases. Eight out of the 126 DSH pre-disciplinary phase cases in which DSH conducted the investigation, or 6.3 percent were not completed within the required timeframe. The longest duration of an investigation was 484 days and the shortest duration was 149 days, both of which were conducted at PSH. The median duration for cases that did not meet the 120-day timeframe was 289 days.

Of the eight untimely cases, six cases were from PSH. Two PSH investigations took over 300 days to complete. More information on this can be found in the Monitored Issues section of this report.

Substantive Deficiencies found in Insufficient Cases

Substantive Deficiency	Potential Consequence
Failure to collect or preserve evidence	This may result in an inadequate investigation. This may prevent a district attorney's office or the department's legal department from taking criminal or administrative action against the employee.
Failure to provide required legal admonition prior to taking a statement	This may compromise the integrity of the statement and render a statement inadmissible in court. In some cases, it may violate union contracts or the Peace Office Bill of Rights.
Failure to interview suspect prior to drafting investigative report	This may result in an incomplete and inadequate investigation. The suspect may provide 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 complete investigation prior to deadline to file criminal charges	This prevents criminal action from being taken by the prosecuting agency.

DSH Disciplinary Phase Cases

The OLES rated five out of 17 DSH disciplinary phase cases as procedurally insufficient. In four out of the five of the DSH procedurally insufficient cases, disciplinary actions were served over 60 days after the hiring authority made a disciplinary determination. These four disciplinary actions were served between 79 and 196 days after a disciplinary determination was made. When compared to last year's average, the average length of time to serve an action in procedurally insufficient cases decreased from 157 days to 132.5 days. Other procedural insufficiencies include failing to adequately consult with OLES regarding the finalization of the disciplinary action, failing to provide the full set of supporting materials for OLES to review before the action was served and failing to notify OLES of the date of the Skelly hearing, which prevented OLES from attending.

Corrective action plans provided by DSH state that the department will continue to prioritize all OLES monitored cases to ensure the cases are meeting the designated timeframes and that DSH made changes to their process of scheduling Skelly hearings to ensure all parties, including the OLES monitors, are

notified prior to the hearing. More information on the cases that reached resolution during the current reporting period can be found in Appendices C and D.

DDS Pre-Disciplinary Phase Cases

Of the 25 DDS pre-disciplinary phase cases, the OLES rated 18 cases insufficient. Fifteen cases were procedurally insufficient and three cases were substantively insufficient. The following tables provide the type of case, the corresponding number of insufficient cases and the frequency of the deficiencies.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	0	0
Criminal/Not Referred	7	1
Administrative/With Sustained Allegations	6	1
Administrative/Without Sustained Allegations	2	1
Total	15	3

The OLES found a wide variety of procedural and substantive deficiencies in DDS pre-disciplinary phase cases. The tables below provide some, but not all of the deficiencies. There was one pre-disciplinary phase case in which the department did not provide a corrective action plan. More details of the scope of deficiencies and corrective action plans from the department are provided in Appendix B: Pre-Disciplinary Cases and Appendix D: Combined Pre-Disciplinary and Disciplinary Phase Cases.

Significant Procedural Deficiencies Found in Insufficient Cases

Procedural Deficiency	Potential Consequence
Failure to conduct appropriate and thorough witness interviews	This may result in an incomplete investigation. The investigator may have to re-interview witnesses. The hiring authority may have to send the investigation back for more interviews, further delaying the investigation.
Failure to complete investigations within 120 days	As investigations age, memories may fade, witnesses may become unavailable, patients may be discharged or transferred.

Procedural Deficiency	Potential Consequence
Failure to consult with OLES regarding sufficiency of investigation and investigative findings	This consult should take place within 45 days. This may prevent the case from being processed in a timely manner.
Failure to provide OLES with copies of draft or final reports	This prevents OLES from providing contemporaneous monitoring of the disciplinary and investigative process. This prevents OLES from identifying inadequacies and making suggestions to improve a report.
Failure to consult with OLES prior to issuing corrective action	This may preclude disciplinary action once the investigation is concluded. This prevents OLES from providing contemporaneous monitoring of the disciplinary process. This may also prevent OLES from seeking a higher level of review in cases where there is inappropriate disciplinary action.

Significant Substantive Deficiencies Found in Insufficient Cases

Substantive Deficiency	Potential Consequences
Failure to thoroughly and appropriately conduct the investigation	This may prevent criminal or disciplinary action from being taken. This may also result in additional time and resources required to conduct a subsequent investigation.
Failure to provide required legal admonition prior to taking a statement	This may compromise the integrity the statement and render a statement inadmissible in court. In some cases, it may violate union contracts or the Public Safety Officers Procedural Bill of Rights Act.
Failure to conduct appropriate and thorough witness interviews	This may result in an incomplete investigation. The investigator may have to re-interview witnesses. The hiring authority may have to send the investigation back for more interviews, further delaying the investigation.

DDS Disciplinary Phase Cases

The OLES rated the two DDS disciplinary phase cases as procedurally insufficient. In one case the department failed to provide OLES with written confirmation of the penalty discussions and failed to notify OLES of the Skelly hearing. The OLES rated the other case both procedurally and substantive insufficient due to the department reducing the penalty from a dismissal to a suspension without identifying any new evidence, flaws, or risk to justify the penalty reduction. The OLES believes the settlement was not reasonable given the seriousness of the misconduct.

Additional Mandated Data

The OLES is required by statute to publish data in its semiannual report about state employee misconduct, including discipline and criminal case prosecutions, as well as criminal cases where patients or residents are the perpetrators. All the mandated data for this reporting period came directly from DSH and DDS and are presented in the following tables.

DSH Mandated Data – Adverse Actions against Employees

DSH Facilities	Formal administrative investigations/actions completed*	Adverse action taken (Formal investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/ retired pending adverse action****
Atascadero	34	7	19	8	0
Coalinga	50	11	28	10	1
Metropolitan	54	2	49	3	0
Napa	34	6	21	5	2
Patton	62	10	43	7	2
Totals	234	36	160	33	5

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

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

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

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

DDS Mandated Data – Adverse Actions against Employees

DDS Facilities	Administrative investigations completed*	Adverse action taken**	No adverse action taken***	Resigned/retired pending adverse action****
Canyon Springs	2	1	1	0
Fairview	6	4	2	0
Porterville	5	3	2	0
Totals	13	8	5	0

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

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

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

**** Resigned or retired pending adverse action refers to employees who resigned or retired prior to being served with an adverse action. Note that DDS reports these as completed investigations.

DSH Mandated Data – Criminal Cases against Employees

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	1	1	0	0
Coalinga	0	0	0	0
Metropolitan	33	1	32	1
Napa	21	0	21	0
Patton	4	3	1	2
Totals	59	5	54	3

* Employee criminal cases include criminal investigations of any employee. Numbers are for investigations which were completed during the OLES reporting

period and do not necessarily reflect when the crimes occurred.

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

*** Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by a prosecuting agency.

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

DDS Mandated Data – Criminal Cases against Employees

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

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

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

*** Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by a prosecuting agency.

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

DSH Mandated Data – Patient Criminal Cases

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	228	176	52	156
Coalinga	329	95	234	34
Metropolitan	770	37	733	2
Napa	375	13	362	1
Patton	287	191	96	178
Totals	1989	512	1477	371

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

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

*** Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by prosecuting agencies.

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

DDS Mandated Data – Resident Criminal Cases

DDS Facilities	Total Cases*	Referred to prosecuting agencies**	Not Referred***	Rejected by prosecuting agencies****
Canyon Springs	0	0	0	0
Fairview	0	0	0	0
Porterville		39	0	20
Totals	0	39	0	20

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

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

*** Cases not referred to prosecuting agencies are criminal cases which, after the completion of the investigations, were determined to have insufficient evidence for criminal charges to be filed by prosecuting agencies.

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

DSH Mandated Data – Reports of Employee Misconduct to Licensing Boards

DSH Facilities	Registered Nursing	Vocational Nursing/Psych Tech	Medical Board	Public Health	CA Board of Psychologist
Atascadero	3	2	0	0	1
Coalinga	0	0	0	0	0
Metropolitan	0	1	0	0	0
Napa	0	1	0	0	0
Patton	1	1	0	0	0
Totals	4	5	0	0	1

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

DDS Mandated Data – Reports of Employee Misconduct to Licensing Boards

DDS Facilities	Registered Nursing	Vocational Nursing/Psych Tech	Medical Board	Pharmacy	Public Health
Canyon Springs	0	0	0	0	11
Fairview	0	0	0	0	9
Porterville	0	0	0	0	14
Totals	0	0	0	0	34

*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. Currently all monitored issues concern DSH. In this reporting period, there is one new monitored issue regarding the usage of Blue Team/IA Pro. Updates on long-running monitored issues are provided below.

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 and DDS 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 Complaint, 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 (Case 2017-00878-1-MI) 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

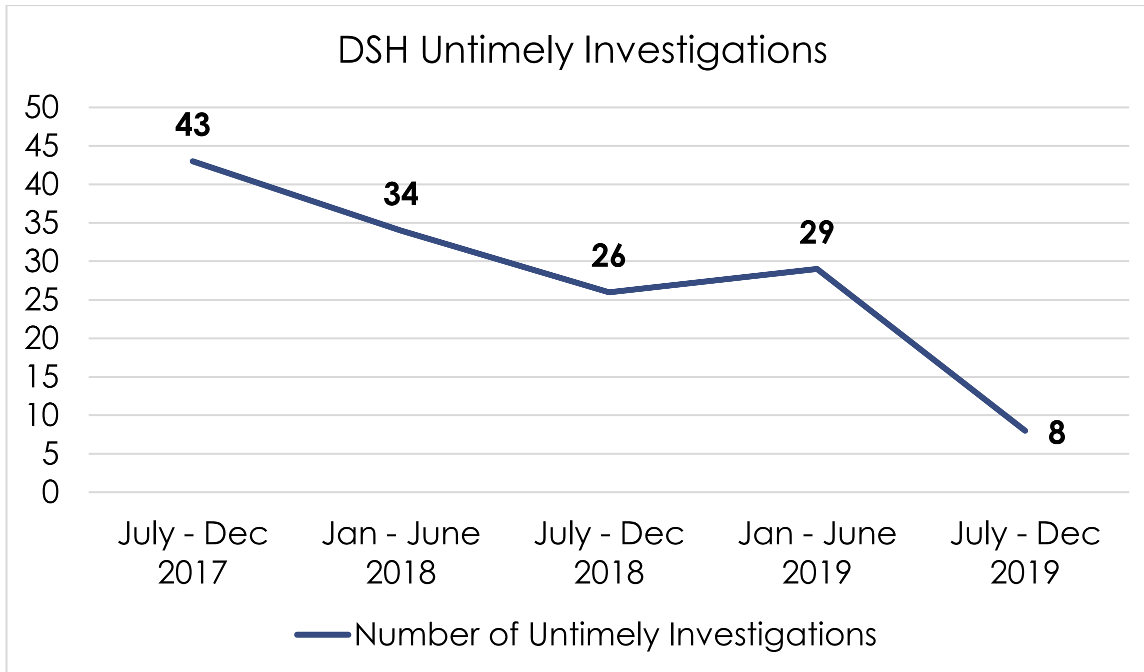
The OLES completed a comprehensive review of the data to determine whether the monthly reports submitted to the DSH Police Chiefs accurately reflected the number of reportable incidents, and to identify any potential systemic issues. The OLES determined IAPro did not accurately reflect the number of 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 appropriately did not occur. The DSH is re-evaluating their usage of IAPro/Blue team and will assess the effectiveness of the program. The OLES continues to monitor this issue and is working with DSH.

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 chart below shows the overall declining trend for untimely investigations for OLES monitored cases, including the significant drop in untimely investigations that were conducted during this reporting period.



OLES previously reported that PSH historically has had a disproportionately high number of untimely monitored investigations. In this reporting period, six of the eight DSH untimely monitored investigations were conducted at PSH.

Reporting Period	# of PSH Untimely Investigations	Total DSH Untimely Investigations	PSH Range for Untimely Investigations (days)
January-June 2018	19	34	134-588
July-December 2018	20	26	131-358
January-June 2019	17	29	132-674
July – December 2019	6	8	149-484

A criminal prosecution for misdemeanor criminal acts was time-barred as a direct result of PSH's delay in completing an investigation (OLES case # 2018-

00349-1-MONTR-C), which took the Office of Special Investigations 484 days to complete. The case involved allegations that a registered nurse was over-medicating patients and three psychiatric technicians were physically abusing restrained patients. The investigation revealed sufficient evidence for a probable cause referral to the district attorney's office. However, by the time the investigation was completed, the criminal statute of limitations, or the time in which the District Attorney’s Office must commence a criminal prosecution, had already expired.

Despite still having a disproportionately high number of untimely monitored investigations, PSH has taken several effective measures to track and hold officers and investigators accountable for timeliness and overall quality of investigations. The Supervising Special Investigator assigned to the Office of Special Investigations at PSH implemented a visual tracking system, as well as a spreadsheet, to track the progress of open investigations.

Each week, the Supervising Special Investigator monitors the status of hospital police reports to ensure their timely completion and approval. Furthermore, a lieutenant from the Office of Protective Services was assigned as a liaison between the Hospital Police Department and the Office of Protective Services to assist with preventing delays at the initial police investigative stage. In addition, investigators are now eligible for overtime pay if necessary and they are being held accountable should they fail to timely complete their assigned investigations. Overall, PSH has made tremendous progress in reducing the number of untimely investigations. The OLES continues to monitor this issue and will continue to work with DSH.

Duty to Cooperate at DSH

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

The department drafted a policy requiring the use of standardized interview notices in administrative investigations. The policy describes the service process of the interview notices to interviewees. DSH also drafted a set of standardized interview notices for use by OPS investigators during their investigations. DSH Legal and Labor Units reviewed the investigative interview notices and policy draft. DSH Labor sent the interview notices and policy out for Bargaining Unit

Notice. On August 30, 2019 the Duty to Cooperate at DSH - Administrative Investigations Policy 600 and updated interview forms were issued. More information on this resolved monitored issue can be found in Appendix E.

Lack of Patient Separation Policy at DSH

In the course of an investigation during the July 1, 2017 through December 31, 2017 reporting period, OLES discovered a lack of specific, written policy at MSH governing the relocation and separation of patients after they have been in a physical altercation. In the specific case, one patient committed a battery on another patient. Both resided in the same unit as roommates at the facility and continued to do so after the incident, which resulted in a second battery the next day. During the second battery, the aggressor patient choked the victim patient to the point of unconsciousness.

The DSH does not have a written department-wide policy to prevent these repeat incidents. The existing practice of giving the clinical treatment team the discretion to decide whether to move or separate patients involved in altercations puts patients at risk of harm and victimization. The OLES previously recommended DSH develop department-wide written policy and procedures regarding separation of patients who are involved in altercations. In response to the OLES recommendation, DSH drafted a policy directive which requires the review of a patient's housing to determine the most appropriate housing placement following an assaultive incident. PD 8008 Patient Transfer is pending additional updates and internal review.

Personal Electronic Devices at Work

In the semiannual report covering January 1 through June 30, 2017, OLES recommended that DSH draft and implement a department-wide policy prohibiting DSH staff from having and using personal electronic devices at their workstations and while screening staff and visitors. In response to the OLES recommendation, DSH developed a draft policy on the use of personal electronic devices at the facilities. PD 1102, Use of Personally Owned Electronic Devices at DSH Hospitals, is under Executive Team Review and an additional policy, OPS Policy 701 was submitted to Labor pending Union Notice.

DSH Patient Pregnancies

In the semiannual report covering January 1 through June 30, 2017, OLES made several recommendations to DSH with the goal of minimizing patient pregnancies. The OLES also made a recommendation on how to best manage patients who become pregnant while residing in a state hospital or if they are pregnant when they are admitted to a DSH facility. In response to the OLES recommendations, the DSH drafted two policies titled "Child Placement" and

“Patient Sexuality.”

The first policy titled “Child Placement” allows the pregnant patient to decide where and with whom her infant will be placed after birth. This policy was fully implemented. The second policy titled “Patient Sexuality” identifies what must be considered when determining patient placement in co-ed living quarters. DSH renamed “Patient Sexuality” to *PD 3106 – Patient Sexual Behavior and Health.* This Policy Directive is pending presentation to the DSH Medical Directors. PD 3108 is complete and posted. PD 3106 is currently being reviewed by the DSH legal division.

Appendix A: OLES Investigations

Appendix A1 OLES Investigations – DSH

Case Detail	Description
Incident Date	04/22/2019
OLES Case Number	2019-00401-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On April 22, 2019, an officer allegedly accidentally discharged his firearm.
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	04/19/2019
OLES Case Number	2019-00407-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On April 19, 2019, an officer allegedly pushed, choked, and threatened his girlfriend. The victim filed a restraining order against the officer on April 22, 2019.
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	06/13/2019
OLES Case Number	2019-00591-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On June 13, 2019, a sergeant allegedly negligently discharged his personal firearm in the hospital's parking lot. It was further alleged he failed to immediately report the incident.
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	07/31/2019
OLES Case Number	2019-00767-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On July 31, 2019, the OLES received a complaint alleging that a sergeant had compromising information on various police chiefs and was using the information as leverage to commit misconduct.
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	07/19/2019
OLES Case Number	2019-00828-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On July 19, 2019, three officers allegedly used excessive and unnecessary force while escorting a patient to a seclusion room.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that abuse occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	08/19/2019
OLES Case Number	2019-00853-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On August 19, 2019, a law enforcement supervisor allegedly made a comment which offended an officer.
Disposition	The Office of Law Enforcement Support conducted a full analysis of this matter and determined the allegation did not meet OLES criteria and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	09/03/2019
OLES Case Number	2019-00917-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On September 3, 2019, an officer allegedly used excessive force on a patient.
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	09/03/2019
OLES Case Number	2019-00925-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On September 3, 2019, officers and non-sworn staff members allegedly sexually assaulted a patient.
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	09/23/2019
OLES Case Number	2019-01037-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On September 23, 2019, non-sworn staff members and an officer were allegedly inappropriately touching patients during pat down searches.
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	08/26/2019
OLES Case Number	2019-01038-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On August 26, 2019, a hospital staff member allegedly told one patient he could assault another patient.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	09/30/2019
OLES Case Number	2019-01063-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On September 30, 2019, an officer allegedly falsified a report of a patient's complaint of abuse at a county jail.
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	06/06/2019
OLES Case Number	2019-01093-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On June 6, 2019, an officer allegedly used unnecessary force on a patient.
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	10/18/2019
OLES Case Number	2019-01186-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 18, 2019, an officer allegedly failed to appear for a court date for a domestic violence restraining order filed by his former spouse.
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	10/26/2019
OLES Case Number	2019-01188-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 26, 2019, level of care staff and officers allegedly struck a resistive patient.
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	11/30/2019
OLES Case Number	2019-01322-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On November 30, 2019, officers allegedly purposely unplugged a facility surveillance camera.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Appendix A2 OLES Investigations – DDS

Case Detail	Description
Incident Date	08/06/2018
OLES Case Number	2019-00450-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On August 6, 2018, an officer tested positive for marijuana.
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	10/17/2019
OLES Case Number	2019-01157-1FA
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 17, 2019, an officer allegedly assaulted a resident during an interview of the resident.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the review and decision was provided to the department.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

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

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

Appendix B1 Pre-Disciplinary Phase Cases – DSH

Criminal-Referred to Prosecuting Agency

Case Detail	Description
Incident Date	12/24/2017
OLES Case Number	2018-00349-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Referred 2. Referred 3. Referred
Incident Summary	Between December 24, 2017, and March 27, 2018, a registered nurse was allegedly over-medicating patients and three psychiatric technicians were allegedly physically abusing restrained 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:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The

	investigation was not completed until 484 days from the date of discovery. The deadline to file criminal charges expired before the investigation was completed.
Pre-Disciplinary Assessment	1. Did the deadline for taking disciplinary action or filing charges expire before the investigation was complete? Yes. The deadline for the district attorney to file misdemeanor charges expired because of investigative delays. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 28, 2018; however, the investigation was not completed until July 25, 2019, 484 days later.
Department Corrective Action Plan	OPS will ensure all investigative phases are conducted in a timely manner.

Case Detail	Description
Incident Date	08/15/2018
OLES Case Number	2018-00858-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On August 15, 2018, a nurse, and two psychiatric technicians allegedly intentionally administered a higher than prescribed dose of the patient's prescribed anti-psychotic medication.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 203 days from the

	date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on August 15, 2018; however, the investigation was not completed until March 5, 2019, 203 days later.
Department Corrective Action Plan	The Chief/OPS will ensure all investigative phases are conducted in a timely manner. Chief/OPS will meet on a weekly basis to discuss active cases.

Case Detail	Description
Incident Date	02/09/2019
OLES Case Number	2019-00167-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On February 9, 2019, three psychiatric technicians allegedly forced a patient's head against a wall, injuring the patient.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services did not open an administrative investigation after the district attorney's review. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. Although the department timely notified the OLES of the patient's injuries, the department failed to provide complete information regarding the incident and allegation of abuse.
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 alleged abuse on February 9, 2019, when an officer conducted a suspect interview of the involved patient;

	however, the Office of Protective Services did not notify the OLES until February 15, 2019, 6 days later. 2. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES? No. On February 9, 2019, the Office of Protective Services only notified the OLES that the patient sustained a head injury requiring stitches. No information was provided regarding allegations of abuse.
Department Corrective Action Plan	OPS will provide annual training regarding OLES reporting guidelines and expectations.

Case Detail	Description
Incident Date	03/12/2019
OLES Case Number	2019-00260-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On March 12, 2019, a physical therapist allegedly grazed his hands near a patient's genitals during a therapy session.
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 did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to notify OLES of the scheduling of a suspect interview.

Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services failed to notify OLES of the scheduling of a suspect interview.
Department Corrective Action Plan	For future suspect interviews, the Investigator was instructed to advise the OLES monitor when the interviews are to take place to ensure the monitor has the opportunity to attend the interview.

Case Detail	Description
Incident Date	04/05/2019
OLES Case Number	2019-00355-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On April 5, 2019, a psychiatric technician allegedly violently pushed a patient in a wheelchair.
Disposition	The Office of Special Investigations conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The district attorney's office declined to file charges. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/04/2019
OLES Case Number	2019-00360-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On April 4, 2019, a senior psychiatric technician allegedly slapped a patient's face, grabbed his legs,

	and stomped on the patient's head.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to notify the OLES monitor of the psychiatric technician's interview; therefore, the monitor could not attend the interview and provide input.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to adequately consult with the OLES monitor. The investigator did not notify the monitor about the senior psychiatric technician's interview, which prevented the monitor from attending the interview and providing real-time feedback.
Department Corrective Action Plan	For future interviews, It was discussed with the Investigator to contact the OLES monitor prior to setting up interviews and/or prior to speaking with them over the phone to allow the monitor the opportunity to attend or listen in and provide real time feedback.

Case Detail	Description
Incident Date	01/01/2013
OLES Case Number	2019-00373-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	During 2013, a psychiatric technician and nurse allegedly inappropriately touched a patient's genitals for sexual gratification.
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 did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/30/2019
OLES Case Number	2019-00531-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On May 30, 2019, a psychiatric technician allegedly grabbed a patient's genitals.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services also opened an administrative investigation, which the OLES did not accept 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	06/08/2019
OLES Case Number	2019-00566-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On June 8, 2019, a psychiatric technician allegedly struck a patient in the head with a coffee mug after the

	patient allegedly assaulted the psychiatric technician.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney for review. The OLES concurred with the determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process because unit staff and responding officers failed to preserve evidence from the crime scene.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The Office of Protective Services failed to take photographs of the coffee cup and failed to collect the coffee cup as evidence.
Department Corrective Action Plan	The Officer has been addressed and trained regarding all guidelines and established protocols to recognizing, photographing and collecting evidence in criminal cases.

Case Detail	Description
Incident Date	06/24/2019
OLES Case Number	2019-00618-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	On June 24, 2019, a physician allegedly inappropriately touched a patient's genitals during a medical examination.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings, and referred the case to the district attorney for review. The OLES concurred with the determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	06/26/2019
OLES Case Number	2019-00632-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On June 26, 2019, a food service technician allegedly kissed a 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.
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	07/22/2019
OLES Case Number	2019-00726-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On July 22, 2019, a unit supervisor allegedly spat on and struck a 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	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	08/04/2019
OLES Case Number	2019-00779-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Referred
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 investigation established sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with this determination. The Office of Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Criminal-Not Referred

Case Detail	Description
Incident Date	09/01/2018
OLES Case Number	2018-00836-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 1, 2018, a senior psychiatric technician and a psychiatric technician allegedly restrained a patient and twisted the patient's legs, with knowledge the patient had a previously injured leg.

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

Case Detail	Description
Incident Date	10/10/2018
OLES Case Number	2018-01103-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On October 10, 2018, staff members allegedly used excessive force while administering medication to a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/25/2018
OLES Case Number	2018-01378-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	On December 25, 2018, a psychiatric technician allegedly closed a wheelchair brake on a patient's thumb.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	02/13/2019
OLES Case Number	2019-00155-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 13, 2019, health care staff allegedly failed to administer adequate treatment to a patient who had fallen and was knocked unconscious. The patient subsequently died from natural causes due to complications from Crohn's Disease.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	02/23/2019
OLES Case Number	2019-00200-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 23, 2019, three psychiatric technicians allegedly forced a patient's head against a wall, thereby bruising the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/12/2019
OLES Case Number	2019-00261-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 12, 2019, a program director, a program assistant, and other staff members allegedly rushed towards a patient, forced the patient against a wall, and placed the patient into restraints without cause, thereby injuring the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient

	The department failed to comply with policies and procedures governing the investigative process. The department 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 Office of Protective Services learned of the incident on March 12, 2019, at 1221hrs, but did not notify the OLES until March 12, 2019, at 1620hrs, four hours later.
Department Corrective Action Plan	OPS has provided refresher training to all the OPS supervisors on the OLES reporting guidelines.

Case Detail	Description
Incident Date	03/01/2019
OLES Case Number	2019-00268-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 1, 2019, a psychiatric technician allegedly struck a patient with a clipboard and threw a soft helmet at the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation 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	03/16/2019
OLES Case Number	2019-00282-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 16, 2019, a psychiatric technician allegedly grabbed a patient's wrist, causing pain to the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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	03/19/2019
OLES Case Number	2019-00285-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 19, 2019, staff members allegedly used excessive force to place and hold a patient on a bed.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney’s office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/24/2019
OLES Case Number	2019-00312-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 24, 2019, several level of care staff allegedly assaulted a patient during an escort.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/26/2019
OLES Case Number	2019-00324-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 26, 2019, a psychiatric technician allegedly used derogatory and profane language towards a patient. The psychiatric technician also allegedly forced the patient against a wall and struck the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/27/2019
OLES Case Number	2019-00325-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 27, 2019, a staff member allegedly vigorously shook a patient's buttocks.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/01/2019
OLES Case Number	2019-00334-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 1, 2019, a psychiatric technician allegedly grabbed a patient by the throat and lifted him out of his chair.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative

	process.

Case Detail	Description
Incident Date	04/08/2019
OLES Case Number	2019-00356-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 8, 2019, a nurse allegedly struck a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/10/2019
OLES Case Number	2019-00359-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 10, 2019, two psychiatric technicians allegedly grabbed and pushed a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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	04/15/2019
OLES Case Number	2019-00409-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 15, 2019, a staff member and patient allegedly engaged in mutual sexual touching.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/29/2019
OLES Case Number	2019-00432-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 29, 2019, a staff member allegedly repeatedly struck a patient in the face while attempting to break up a fight.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney’s office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/02/2019
OLES Case Number	2019-00440-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 2, 2019, a psychiatric technician allegedly struck a patient.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/10/2019
OLES Case Number	2019-00475-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 10, 2019, a psychiatric technician allegedly sexually assaulted a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation 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	05/17/2019
OLES Case Number	2019-00493-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 17, 2019, a psychiatric technician allegedly scratched a patient's arm while restraining the patient against a wall.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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	05/10/2019
OLES Case Number	2019-00497-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 10, 2019, a psychiatric technician allegedly used excessive force to remove a patient from the shower.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative

	process.

Case Detail	Description
Incident Date	05/19/2019
OLES Case Number	2019-00502-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 19, 2019, a staff member allegedly repeatedly struck a patient's face.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation 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	05/21/2019
OLES Case Number	2019-00505-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 21, 2019, a psychiatric technician allegedly broke a patient's ribs.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/29/2019
OLES Case Number	2019-00522-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 29, 2019, a patient alleged she had been sexually assaulted in her sleep by an unidentified assailant.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/07/2019
OLES Case Number	2019-00550-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 7, 2019, two psychiatric technicians allegedly pushed a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and

	procedures governing the investigative process.

Case Detail	Description
Incident Date	06/02/2019
OLES Case Number	2019-00554-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 2, 2019, a psychiatric technician assistant allegedly inappropriately touched a patient.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/08/2019
OLES Case Number	2019-00555-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 8, 2019, a staff member allegedly raped a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complies with policies and

	procedures governing the investigative process.

Case Detail	Description
Incident Date	06/10/2019
OLES Case Number	2019-00563-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 10, 2019, a patient was found lying unresponsive in his bed. Life-saving measures were initiated; however, the patient had an advanced medical directive to refuse life-saving measures, and the resuscitative efforts ceased. The patient died from arteriosclerotic cardiovascular disease.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office, determining there was no evidence of a crime that contributed to the patient's death. The OLES concurred. 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	06/17/2019
OLES Case Number	2019-00596-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 17, 2019, two unit supervisors, three psychiatric technicians, and other staff members allegedly assaulted a patient in retaliation because the patient had made a staff complaint.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened

	an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/03/2019
OLES Case Number	2019-00648-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 3, 2019, a psychiatric technician allegedly kicked a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
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	06/28/2019
OLES Case Number	2019-00650-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 28, 2019, a registered nurse allegedly repeatedly touched a patient's genitals for sexual gratification during a medical procedure.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened

	an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/05/2019
OLES Case Number	2019-00658-1C
Case Type	Monitored
Incident Types	1. Broken Bone
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 5, 2019, health care staff allegedly forcefully placed a patient on the floor, causing the patient to suffer a nasal fracture and a fracture of the left orbital.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/14/2019
OLES Case Number	2019-00664-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 14, 2019, a unit supervisor allegedly grabbed and twisted a patient's arm.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause

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

Case Detail	Description
Incident Date	07/17/2019
OLES Case Number	2019-00707-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 17, 2019, a psychiatric technician allegedly pushed a patient's head.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
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	07/17/2019
OLES Case Number	2019-00708-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 17, 2019, a health care staff member allegedly rubbed harmful oil on a sleeping patient.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's

	office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/18/2019
OLES Case Number	2019-00715-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 18, 2019, a psychiatric technician assistant allegedly struck a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/07/2019
OLES Case Number	2019-00731-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 7, 2019, a psychiatric technician assistant allegedly pulled a patient by the arm, causing shoulder pain.
Disposition	An investigation failed to establish sufficient evidence

	for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/27/2019
OLES Case Number	2019-00742-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 27, 2019, a patient was found non-responsive in her bed. Responding staff initiated emergency life-saving measures; however, the patient was declared dead. The cause of death was cardiorespiratory arrest.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	07/28/2019
OLES Case Number	2019-00754-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	On July 28, 2019, a registered nurse allegedly sexually assaulted a patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation 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	07/26/2019
OLES Case Number	2019-00769-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 26, 2019, a staff member allegedly twisted a patient's arm while placing the patient in physical restraints.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/05/2019
OLES Case Number	2019-00789-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	On August 5, 2019, a psychiatric technician allegedly grabbed a patient's genitals while attempting to retrieve a urine receptacle from the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/07/2019
OLES Case Number	2019-00801-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 7, 2019, a patient who was on an enhanced level of observation fell and suffered a laceration.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/12/2019
OLES Case Number	2019-00825-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	On August 12, 2019, a psychiatric technician allegedly kicked a patient. A second psychiatric technician allegedly forcefully placed the patient on a bed, causing the patient to strike his head.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
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	08/15/2019
OLES Case Number	2019-00830-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 15, 2019, a rehabilitation therapist allegedly interrupted a patient during group treatment; asking about the patient's genitals. The rehabilitation therapist then allegedly placed a hand on the patient's thigh when the patient became upset.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/17/2019
OLES Case Number	2019-00839-1C

Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 17, 2019, a male staff allegedly stroked a patient's cheek and sexually assaulted the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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 pre-disciplinary process.

Case Detail	Description
Incident Date	08/25/2019
OLES Case Number	2019-00875-1C
Case Type	Monitored
Incident Types	1. Broken Bone
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 25, 2019, a patient was diagnosed with a minor fracture of his jaw.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/29/2019
OLES Case Number	2019-00898-1C
Case Type	Monitored

Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 29, 2019, a psychiatric technician allegedly forced a patient to the ground, and placed his knee on the patient's back, in order to restrain the patient.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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	08/28/2019
OLES Case Number	2019-00903-1C
Case Type	Monitored
Incident Types	1. Sexual Assault 2. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 28, 2019, a senior psychiatric technician allegedly forced a patient to engage in a sexual act with her, pulled another patient's hair, and put that patient in restraints.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description

Incident Date	09/03/2019
OLES Case Number	2019-00912-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 3, 2019, a patient died at an outside hospital due to complications from sepsis and diabetes.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, the case was not referred to the district attorney's office. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/15/2019
OLES Case Number	2019-00979-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 15, 2019, a registered nurse allegedly slammed a door on a patient's arm.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney’s office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/12/2019
OLES Case Number	2019-01027-1C

Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 12, 2019, a psychiatric technician allegedly slapped a patient's hand while the patient was drinking milk, causing milk to spill on the patient's clothing.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	10/03/2019
OLES Case Number	2019-01077-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On October 3, 2019, a patient began to choke on food in the patient dining room. Responding staff initiated emergency life-saving procedures. Despite staffs' efforts the patient was pronounced dead at the facility's urgent care room. The cause of death was asphyxia and the manner of death was determined to be accidental.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office, determining there was no evidence of a crime that contributed to the patient's death. The OLES concurred. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	10/01/2018
OLES Case Number	2019-01098-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	In October of 2018, a psychiatric technician allegedly grabbed and bruised a patient.
Disposition	An investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Administrative-With Sustained Allegations

Case Detail	Description
Incident Date	12/28/2016
OLES Case Number	2017-00009-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On December 28, 2016, a physician allegedly failed to provide adequate treatment to a patient who was attacked and injured by another patient. The patient died from his injuries on January 4, 2017.
Disposition	The hiring authority determined there was sufficient

	evidence to sustain the allegation and determined a letter of instruction was appropriate; however, a letter of instruction had been prematurely issued before the completion of the investigation. 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 consult with the OLES regarding the sufficiency of the investigation and the investigative findings. The hiring authority received the final investigation report on October 7, 2019; however, the hiring authority did not consult with the OLES regarding the investigation until November 25, 2019, 50 days later. Additionally, the hiring authority issued a letter of instruction on May 17, 2017, prior to the completion of the investigation. Even though the department completed the investigation, the department compromised its ability to take adverse action against the doctor by prematurely issuing the letter of instruction.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The hiring authority did not timely consult with the OLES regarding the sufficiency of the investigation and the investigative findings. The hiring authority received the final investigation report on October 7, 2019, however, the hiring authority did not consult with the OLES regarding the investigation until November 25, 2019, 50 days later. 2. Did the hiring authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority issued a letter of instruction on May 17, 2017, prior to the completion of the investigation, without consulting with the OLES.

Department Corrective Action Plan	A tracking system has been implemented to ensure continual and timely consultation with OLES.

Case Detail	Description
Incident Date	11/12/2017
OLES Case Number	2018-00591-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained 7. Sustained 8. Sustained
Penalty	**Initial:** Dismissal **Final:** Disciplinary phase pending
Incident Summary	On November 12, 2017, a senior psychiatric technician allegedly struck a patient several times. A nurse and a psychiatric technician allegedly witnessed the incident, failed to report the abuse, and were dishonest during the investigation. The senior psychiatric technician then allegedly deleted an electronic record of the incident completed by the nurse. The senior psychiatric technician also allegedly forwarded a patient's medical records to the senior psychiatric technician's personal email address.
Disposition	The hiring authority sustained allegations against the senior psychiatric technician, the nurse, and the pre-licensed psychiatric technician, and determined dismissal was the appropriate penalty for all three employees. 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	12/05/2017
OLES Case Number	2018-00736-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	On December 5, 2017, a senior psychiatric technician allegedly twisted a patient's arm, placed his knee on the patient's back, and twisted the patient's neck while restraining the patient. A psychiatric technician also allegedly twisted the patient's neck during the same incident.
Disposition	The hiring authority sustained an allegation against the psychiatric technician for a violation of therapeutic strategies and intervention policies and training, but did not sustain an allegation of abuse. The hiring authority determined re-training was appropriate. The OLES concurred. No allegations were sustained against the senior psychiatric technician. 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	09/11/2017
OLES Case Number	2018-01171-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction

Incident Summary	On September 11, 2017, a psychiatric technician allegedly failed to conduct the required 30 minute welfare check on a patient who was subsequently discovered to be deceased.
Disposition	The hiring authority sustained the allegation and provided verbal counseling to the psychiatric technician. 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 287 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on October 11, 2018; however, the investigation was not completed until July 25, 2019, 287 days later.
Department Corrective Action Plan	The Chief/OPS discussed with the entire investigative staff the importance of meeting the OLES notification time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame.

Case Detail	Description
Incident Date	01/14/2019
OLES Case Number	2019-00128-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained

	5. Not Sustained 6. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Disciplinary phase pending
Incident Summary	On January 14, 2019, a pharmacist allegedly mislabeled a patient's prescribed medicated cream. From January 14, 2019, until January 21, 2019, five psychiatric technicians then allegedly provided the mislabeled cream to the patient, failing to identify it was the wrong cream. On January 20, 2019, a nurse, and a unit supervisor allegedly failed to comply with medication variance policy after they were notified of the mislabeled cream.
Disposition	The hiring authority sustained allegations against the pharmacist, and imposed a 5 percent salary reduction for six months. The hiring authority also sustained an allegation against the unit supervisor and one of the psychiatric technicians for failing to comply with medication variance policy, and also sustained an allegation against that same psychiatric technician for failing to properly complete the controlled medication log. The hiring authority issued letters of expectation to the unit supervisor and the psychiatric technician. The OLES concurred with the hiring authority's findings, and penalty determinations. The hiring authority did not sustain any allegations against the nurse, and the remaining four psychiatric technicians. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/07/2019
OLES Case Number	2019-00139-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Inexcusable neglect of duty
Findings	1. Sustained

	2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Resignation before discipline could be imposed
Incident Summary	On February 7, 2019, it was discovered that a psychiatric technician assistant was involved in an overly familiar relationship with a patient. The psychiatric technician assistant allegedly provided the patient with money, greeting cards, shoes, and a stereo system, and spent an inordinate amount of time with the patient while at work. It is also alleged the psychiatric technician assistant was involved in a relationship with the patient after he was discharged from the hospital to a community facility. The psychiatric technician assistant allegedly assisted the patient in unlawfully leaving the community facility and provided the patient with food and shelter while he was absent without leave. The patient was without required supervision and prescribed medication for approximately four months, before turning himself in to law enforcement.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The psychiatric technician assistant resigned before discipline could be imposed. A letter indicating the psychiatric technician assistant 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.

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:** Disciplinary phase pending
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.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigator failed to notify the OLES of a psychiatric technician's interview. Also, the investigation was not

	completed until 219 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report included findings that a senior psychiatric technician had not violated hospital policy, when the investigation revealed that she violated hospital policy by not reviewing the notes made by a psychiatric technician trainee. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not contact the OLES prior to conducting a psychiatric technician's interview, thereby preventing the OLES from providing real-time monitoring. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 13, 2019; however, the investigation was not completed until September 20, 2019, 219 days later.
Department Corrective Action Plan	Training has been provided to the investigator to ensure all the appropriate and pertinent information is included in the report. The Supervising Investigator shall review expectations of monitored investigations as it pertains to OLES notifications of involved staff interviews to ensure OLES has an opportunity to monitor the case in real time. OPS will ensure all investigative phases are conducted in a timely manner. Chief/OPS will meet on weekly basis to discuss active cases.

Case Detail	Description
Incident Date	03/13/2019
OLES Case Number	2019-00271-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 3. Other failure of good behavior 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 9. Inexcusable neglect of duty 10. Inexcusable neglect of duty 11. Inexcusable neglect of duty 12. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained 7. Sustained 8. Sustained 9. Sustained 10. Sustained 11. Sustained 12. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	On March 13, 2019, four psychiatric technicians allegedly failed to appropriately respond to a patient having a seizure. One of the psychiatric technicians also allegedly used discourteous language towards the patient. A unit supervisor allegedly instructed staff to not provide hands-on assistance to the patient. A nurse allegedly failed to properly respond to that same patient when the patient complained of chest pains.
Disposition	The hiring authority sustained allegations against the nurse, and the unit supervisor, and ordered formal training. The OLES concurred with the hiring authority's findings, and penalty determinations. No allegations were sustained against the four psychiatric technicians. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description

Incident Date	04/05/2019
OLES Case Number	2019-00355-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On April 5, 2019, a psychiatric technician allegedly violently pushed a patient in a wheelchair.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a letter of correction. 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	04/01/2019
OLES Case Number	2019-00395-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On April 1, 2019, a psychiatric technician allegedly gave a patient, with a known tendency to injure himself, three sharpened pencils. The supervising registered nurse allegedly approved the psychiatric technician's decision. The patient stabbed himself shortly thereafter and subsequently died due to sepsis from complications of bowel resection surgery due to the self-inflicted wound.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty for both employees. The OLES concurred 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	04/22/2019
OLES Case Number	2019-00401-2A
Case Type	Monitored
Incident Types	1. Misconduct
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
Findings	1. Sustained 2. Sustained 3. Not Sustained 4. Sustained 5. Not Sustained 6. Not Sustained 7. Sustained
Penalty	**Initial:** Dismissal **Final:** Disciplinary phase pending
Incident Summary	On April 22, 2019, an officer allegedly brought a firearm onto hospital grounds and negligently discharged the firearm, causing damage to state property. A lieutenant and two sergeants allegedly failed to collect evidence, properly document the incident, and ensure the officer properly documented the incident.
Disposition	The hiring authority dismissed the officer, a retired annuitant, immediately following the incident. The hiring authority sustained the allegations against the lieutenant and the first sergeant, except that they allegedly failed to document criminal activity, and imposed salary reductions of 5 percent for four months and 5 percent for three months, respectively. The hiring authority sustained the allegation against the second

	sergeant that he failed to document the incident, but found insufficient evidence to sustain the remaining allegations, and issued a letter of instruction. The OLES concurred with the determinations.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with the policies and procedures governing the pre-disciplinary process. The hiring authority failed to remove the officer from his post following the negligent discharge of the firearm, and the Office of Protective Services failed to ensure the incident was properly documented and that evidence was collected and preserved.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The hiring authority failed to remove the officer from his post following the negligent discharge of his firearm. 2. Did the OPS adequately respond to the incident? No. The Office of Protective Services failed to properly document the incident and collect and preserve evidence at the scene. 3. Was the incident properly documented? No. The officer, two sergeants, and a lieutenant failed to properly document the incident and the damage to state property.
Department Corrective Action Plan	Due to the lack of training for accidental discharges, training has been provided to supervisors as well as all officers. The initial training will enhance the supervisors and officers knowledge and confidence in properly handling of these types of incidents.

Case Detail	Description
Incident Date	06/26/2019
OLES Case Number	2019-00632-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Dishonesty

	2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On June 26, 2019, a food service technician allegedly kissed a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/17/2019
OLES Case Number	2019-00760-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On June 17, 2019, a psychiatric technician allegedly placed the arms of a wheelchair bound patient behind the patient's back in order to restrain the patient. A second psychiatric technician allegedly saw the alleged incident and failed to intervene and failed to report and document the incident. A third psychiatric technician allegedly witnessed the incident and failed to intervene.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation against the first psychiatric technician; however, sustained the allegations against the two other psychiatric technicians. The two psychiatric technicians each received a letter of instruction. The OLES concurred with the hiring authority's determinations.

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

Case Detail	Description
Incident Date	08/01/2019
OLES Case Number	2019-00773-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Disciplinary phase pending
Incident Summary	On August 1, 2019, a unit supervisor allegedly pushed and yelled at a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations of physical and psychological abuse; however, the hiring authority sustained an allegation of verbal abuse and imposed a 5 percent salary reduction for three months. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	06/22/2017
OLES Case Number	2017-00734-1A
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 June 22, 2017, health care staff members allegedly

	failed to supervise and treat a patient with known violent tendencies, which resulted in the patient attacking and severely injuring another patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/29/2018
OLES Case Number	2018-00779-1A
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 29, 2018, staff members allegedly used unnecessary force while administering medication to a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officers failed to obtain the names of the staff involved in the incident. When subsequently directed to provide the names of the witnesses, the officers failed to provide the requested information. The investigation was not completed until 333 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. Responding officers failed to obtain the names of the staff who were present and/or involved in the incident. Further, when asked to provide additional

	information about the incident, including the names of witnesses, the officers failed to provide the requested information. 2. Was the incident properly documented? No. The responding officers failed to document the names of the staff present and/or involved in the incident. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 29, 2018; however, the investigation was not completed until June 27, 2019, 333 days later.
Department Corrective Action Plan	Per the Operations Lieutenant: the officers shall be instructed to obtain names of staff members present or involved in incidents being investigated by OPS. A briefing reminder will be given to all officers regarding the importance of obtaining relevant information during investigations. The OPS chief discussed with the entire investigative staff the importance of meeting the OLES completion/time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame.

Case Detail	Description
Incident Date	07/29/2018
OLES Case Number	2018-00788-1A
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 29, 2018, a senior psychiatric technician allegedly grabbed a patient by the back of the shirt and pulled the patient to her feet, and forcefully placed her in a seclusion room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred

	with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. Level of care staff did not report the incident in a timely manner. The investigator conducted the interview of the senior psychiatric technician without notice to OLES. The investigation was not completed until 303 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. The incident occurred on July 29, 2018; however, level of care staff did not report the incident until August 1, 2018, three days later. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services investigator did not notify OLES prior to interviewing the senior psychiatric technician. 3. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on July 29, 2019; however, the investigation was not completed until May 28, 2019, 303 days later.
Department Corrective Action Plan	Per the Nursing Coordinator, staff members were reminded of the reporting guidelines regarding any patient injuries or abuse. The investigator was directed that all communication with the OLES monitor be chronicled via email or WatchDox format for historical preservation to avoid any miscommunications. The OPS chief discussed with the entire investigative staff the importance of meeting the OLES completion/time frame criteria. In addition, it was explained the use of the extension memo and notifying the OLES monitor if the investigation report is going to go beyond the 120-day time frame.

Case Detail	Description
Incident Date	04/02/2018
OLES Case Number	2018-01082-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other failure of good behavior
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 2, 2018, a patient was found unresponsive in his bed. Unit staff responded and initiated life-saving measures. The patient was transported to the urgent care room, where he was later pronounced dead. An autopsy determined the patient died as a result of injuries sustained when he ingested a toxic amount of methamphetamine.
Disposition	The hiring authority determined that the investigation conclusively proved 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	11/16/2018
OLES Case Number	2018-01244-1A
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 November 16, 2018, multiple unidentified staff members allegedly forcefully restrained a patient on a bed and a senior psychiatric technician allegedly choked 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:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. A responding officer did not provide one of the suspect psychiatric technicians with the required legal admonition before taking a statement from the psychiatric technician. The investigation was not completed until 290 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. One of the responding officers failed to provide one of the suspect psychiatric technicians with the required legal admonition before taking the psychiatric technician's statement. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on November 16, 2018; however, the investigation was not completed until September 2, 2019, 290 days later.
Department Corrective Action Plan	Per the Operations Lieutenant: the officers shall be reminded to properly advise all interviewees of the proper admonishments/warnings prior to questioning. OPS will ensure all investigative phases are conducted in a timely manner.

Case Detail	Description
Incident Date	11/19/2018
OLES Case Number	2018-01255-1A
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 November 19, 2018, a patient was discovered unresponsive. Emergency life-saving measures were initiated by responding staff; however, the patient was declared dead. An autopsy determined the patient

	died from pulmonary thromboembolism.
Disposition	The hiring authority determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/11/2018
OLES Case Number	2019-00094-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Other failure of good behavior 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. Unfounded 3. Not Sustained 4. Unfounded 5. Not Sustained 6. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 11, 2018, three psychiatric technicians allegedly injured a patient while attempting to restrain the patient after the patient allegedly struck one of the psychiatric technicians.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the first two psychiatric technicians, and determined the allegations were unfounded against the third 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	01/30/2019
OLES Case Number	2019-00121-1A
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, 2019, a psychiatric technician allegedly repeatedly struck and threatened to kill 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	02/14/2019
OLES Case Number	2019-00168-1A
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 February 14, 2019, a psychiatric technician allegedly held a patient's wrist and forced the patient's face onto a bed.
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	02/19/2019
OLES Case Number	2019-00184-1A
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 February 19, 2019, a senior psychiatric technician allegedly used excessive force when he assisted a patient from 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	09/01/2018
OLES Case Number	2019-00191-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 1, 2018, a senior psychiatric technician and a psychiatric technician allegedly restrained a patient and twisted the patient's legs, with knowledge the patient had a previously injured leg.
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	02/22/2019
OLES Case Number	2019-00193-1A
Case Type	Monitored
Incident Types	1. Broken Bone
Allegations	1. Other
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 22, 2019, a patient was diagnosed at an outside hospital with a fractured hip.
Disposition	The hiring authority determined there was no evidence of staff misconduct and 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	02/23/2019
OLES Case Number	2019-00202-1A
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 February 23, 2019, a registered nurse allegedly grabbed a patient after the patient struck the nurse.
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	02/21/2019
OLES Case Number	2019-00203-1A

Case Type	Monitored
Incident Types	1. Broken Bone
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 21, 2019, staff members allegedly broke a patient's finger during a floor containment procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. Level of care staff did not timely report the incident as required by policy.
Pre-Disciplinary Assessment	1. Did the hiring authority respond timely to the incident? No. The patient's injury was confirmed on February 22, 2019; however, level of care staff did not report the incident until February 25, 2019, three days later.
Department Corrective Action Plan	Per the Nursing Coordinator, staff was educated on the risk factors of the patient, and reporting/documenting incidents that could result in injuries in a timely fashion.

Case Detail	Description
Incident Date	04/01/2018
OLES Case Number	2019-00214-1A
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	During April 2018, a psychiatric technician allegedly inappropriately touched a patient. During February 2019, the psychiatric technician also allegedly placed his chest against the same patient's chest.
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	03/05/2019
OLES Case Number	2019-00231-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Incident Summary	On March 5, 2019, a psychiatric technician allegedly kicked 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	03/05/2019
OLES Case Number	2019-00237-1A
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 5, 2019, a psychiatric technician assistant allegedly struck a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	03/06/2019
OLES Case Number	2019-00238-1A
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 6, 2019, several psychiatric technicians allegedly assaulted a patient while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The initial investigation was cursory and incomplete and the responding officer's report was insufficient and lacked detail. The initial investigation took 57 days to complete. The investigation was not completed until 149 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The responding officer did not conduct an appropriate initial investigation. The officer conducted cursory interviews with the subjects, did not ask for details about the incident, and did not try to find potential witnesses. 2. Did the OPS adequately respond to the incident? No. The responding officer asked only one question of the involved staff, did not ask follow up questions and sought no details.

	3. Was the incident properly documented? No. The officer's report was insufficient as it contained incomplete information. 4. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 6, 2019; however, the investigation was not completed until August 2, 2019, 149 days later. It is noted that the OPS did not complete the initial investigation until May 1, 2019; 57 days after the date of discovery.
Department Corrective Action Plan	Officers shall be reminded that the thoroughness of questioning is critical to any investigation. Any follow up questions are proper in order to provide depth to the answers given. Sergeants will be informed to have a more critical eye when reviewing reports to ensure a more thorough interview instead of a cursory interview is completed. Additionally, the Sergeants will be instructed to pay closer attention to the time frame from submission of a report by an officer to the approval of the report by the Sergeant. OPS will ensure all investigative phases are conducted in a timely manner.

Case Detail	Description
Incident Date	12/01/2018
OLES Case Number	2019-00269-1A
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	Between December 1, 2018 and February 1, 2019, several patients and an unidentified staff member allegedly raped a patient every night while she slept.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	12/25/2018
OLES Case Number	2019-00280-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Other failure of good behavior
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 25, 2018, a psychiatric technician allegedly closed a wheelchair brake on a patient's thumb.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/21/2019
OLES Case Number	2019-00299-1A
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 21, 2019, a registered nurse and two psychiatric technicians allegedly called a patient derogatory names and struck the patient with a food tray and set of keys.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred

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

Case Detail	Description
Incident Date	03/24/2019
OLES Case Number	2019-00306-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 24, 2019, three psychiatric technicians allegedly failed to appropriately respond to a choking 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 hiring authority failed to timely consult with the OLES regarding the sufficiency of the investigation, and the investigative findings.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The investigation was completed on June 6, 2019; however, the hiring authority did not consult with the OLES regarding the sufficiency of the investigation, and the investigative findings until August 27, 2019, 83 days

	later.
Department Corrective Action Plan	The Hiring authority conducted refresher training for all the staff who act on their behalf in their absence to ensure continual consultation with OLES is completed within the investigation process guidelines.

Case Detail	Description
Incident Date	03/26/2019
OLES Case Number	2019-00324-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 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. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 26, 2019, a psychiatric technician allegedly used derogatory and profane language towards a patient. The psychiatric technician also allegedly forced the patient against a wall and struck 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	03/19/2019
OLES Case Number	2019-00326-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 19, 2019, a program assistant, a unit supervisor, and a psychiatric technician allegedly placed a bleeding patient into five-point restraints. A physician allegedly participated in making the decision to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/14/2019
OLES Case Number	2019-00357-1A
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 February 14, 2019, a 73 year-old patient was discovered non-responsive in his room. Emergency life-saving measures were initiated; however, the patient was declared dead. The cause of death was cardiopulmonary arrest. A medical doctor allegedly may have been negligent in his duties and may have falsified documents relative to the incident.
Disposition	The hiring authority determined there was no evidence of staff misconduct and no allegations were sustained. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/10/2019
OLES Case Number	2019-00359-2A
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 10, 2019, two psychiatric technicians allegedly grabbed and pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/15/2019
OLES Case Number	2019-00381-1A
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 April 15, 2019, four psychiatric technicians allegedly 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:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officer failed to inform the subject employees of their legal rights before obtaining the

	employees' statement.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The responding officer failed to inform the subject employees of their legal rights before interviewing the employees.
Department Corrective Action Plan	Per the Operations Lieutenant, the officers shall be reminded to properly advise all interviewees of the proper admonishments/warnings prior to questioning.

Case Detail	Description
Incident Date	04/19/2019
OLES Case Number	2019-00397-1A
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 19, 2019, a staff member allegedly unnecessarily restrained 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	08/09/2018
OLES Case Number	2019-00467-1A
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	Between August 9, 2018, and August 10, 2018, a sergeant allegedly released confidential information to an officer about the anticipated arrest of another officer.

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	02/04/2019
OLES Case Number	2019-00485-1A
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 February 4, 2019, a staff member allegedly locked a patient in a seclusion room.
Disposition	The hiring authority determined there was no evidence of staff misconduct and did not sustain any 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	05/23/2019
OLES Case Number	2019-00510-1A
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, 2019, an unknown staff allegedly tightly grabbed 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	06/12/2019
OLES Case Number	2019-00584-1A
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 June 12, 2019, a psychiatric technician allegedly inappropriately rubbed 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	05/21/2019
OLES Case Number	2019-00593-1A
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 21, 2019, a food service worker allegedly slapped 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	**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	06/18/2019
OLES Case Number	2019-00598-1A
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, 2019, a psychiatric technician allegedly forced open a bathroom stall door, striking and injuring a patient's hand.
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	06/24/2019
OLES Case Number	2019-00618-2A
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 June 24, 2019, a physician allegedly inappropriately touched a patient's genitals during a medical examination.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	04/04/2019
OLES Case Number	2019-00620-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 4, 2019, a senior psychiatric technician allegedly slapped a patient's face, grabbed his legs, and stomped on 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:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to interview the senior psychiatric technician prior to drafting the investigative report.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report was not thorough because the investigator did not interview the senior psychiatric technician until after the draft report was submitted to OLES for review.
Department Corrective Action Plan	To avoid deficiencies, the Supervising Special Investigator shall ensure final drafts included all investigative interviews that have been conducted and reported are included in the final draft of the report before being sent to the AIM for review.

Case Detail	Description
Incident Date	06/28/2019
OLES Case Number	2019-00650-2A

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 June 28, 2019, a registered nurse allegedly repeatedly touched a patient's genitals for sexual gratification during a medical procedure.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/12/2019
OLES Case Number	2019-00682-1A
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 July 12, 2019, a psychiatric technician allegedly twisted a patient's wrist while escorting the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officer initially failed to record witness, reporting party, and complainant interviews, requiring the officer to subsequently re-interview critical

	witnesses.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The responding officer did not initially record the interviews of the reporting party and complaining patient, requiring the officer to conduct subsequent interviews. Witness interviews were not recorded as well.
Department Corrective Action Plan	Officers shall be reminded to use the department issued recorders to record interviews. If the officer is without a recorder (he can if time permits) request an officer to bring a recorder to his location.

Case Detail	Description
Incident Date	07/16/2019
OLES Case Number	2019-00702-1A
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 16, 2019, a registered nurse allegedly pushed and choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on July 16, 2019 at 1640 hours; however, OLES was not notified until July 17, 2019, at 0854 hours.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The incident was discovered on July 16, 2019, at 1640 hours; however it was not reported to OLES until July 17, 2019, at 0854 hours.
Department Corrective Action Plan	Per the Operations Lieutenant, the officers will be reminded of the importance of timeliness reporting regarding Priority 1 and Priority 2 incidents to their

	Watch Commanders so the information can be reported timely to OLES.

Case Detail	Description
Incident Date	07/17/2019
OLES Case Number	2019-00723-2A
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 17, 2019, a psychiatric technician assigned to monitor a patient, allegedly left the patient, who soiled himself, in a wet bed for three hours.
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	07/28/2019
OLES Case Number	2019-00750-1A
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 28, 2019, a psychiatric technician allegedly struck 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	08/09/2019
OLES Case Number	2019-00812-1A
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 August 9, 2019, a unit supervisor allegedly pushed and squeezed a patient's neck during the application of restraints. Another staff member allegedly placed a towel over the patient's face and struck 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 sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/05/2019
OLES Case Number	2019-00930-1A
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 September 5, 2019, a physician allegedly tapped a patient on the forehead.
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	09/17/2019
OLES Case Number	2019-01002-1A
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 September 17, 2019, a psychiatric technician allegedly grabbed and twisted a patient's wrist.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Appendix B2 Pre-Disciplinary Phase Cases - DDS

Criminal-Referred to Prosecuting Agency

Case Detail	Description
Incident Date	02/11/2019
OLES Case Number	2019-00145-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Referred 2. Referred 3. Referred 4. Referred
Incident Summary	On February 11, 2019, a senior psychiatric technician, a psychiatric technician, and two psychiatric technician assistants allegedly slapped, punched and pulled a

	resident's hair while restraining him against a wall and placing him in physical restraints.
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 did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Criminal-Not Referred

Case Detail	Description
Incident Date	02/25/2019
OLES Case Number	2019-00199-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On February 25, 2019, a psychiatric technician allegedly failed to report that he witnessed a resident violently strike a second resident with an electrical cord.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES did not accept 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	03/24/2019
OLES Case Number	2019-00304-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 24, 2019, a psychiatric technician allegedly struck and choked a resident, and twisted the resident's arm.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to provide continued real-time consultation with OLES by failing to provide OLES with copies of the draft or final reports.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The investigator failed to provide OLES a copy of the draft report. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to provide OLES with a copy of the draft and final report.
Department Corrective Action Plan	The commander has addressed the investigator's failure to provide OLES with both a draft and final copy of the investigative report and for not engaging in real-time case consultation with OLES.

Case Detail	Description

Incident Date	03/28/2019
OLES Case Number	2019-00323-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 28, 2019, a psychiatric technician assistant allegedly pulled a phone headset out of a resident's hands, grabbed the resident by the shirt, and pulled the resident from the facility phone booth.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to provide real time consultation with OLES by not notifying OLES that the draft or final reports were ready for review.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The investigator did not inform OLES that the draft report was ready for review prior to the report being finalized. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator failed to consult with OLES regarding the final investigative report.
Department Corrective Action Plan	The commander has addressed the investigator's failure to provide OLES with both a draft and final copy of the investigative report and for not engaging in real-time case consultation with OLES.

Case Detail	Description
Incident Date	03/30/2019
OLES Case Number	2019-00327-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 30, 2019, two psychiatric technicians allegedly restrained a resident in violation of department policy.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The hiring authority failed to timely notify OLES of the incident. Responding officers failed to interview witnesses and properly document the incident. The investigation was not thorough because a percipient witness was not initially interviewed, witness interviews were not thorough and several lacked significant clarifying detail. The draft report was incomplete in that it did not include an interview with a percipient witness and likewise failed to include necessary details in several witness statements. While some of these insufficiencies were corrected in the final report, the final report did not clarify whether the statement of a particular witness was based on direct knowledge or speculation. The investigation was not completed until 142 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 incident occurred on March 30, 2019, at 1805 hours; however, OLES was not notified until March 31, 2019, at 1415 hours, approximately 7 hours later.

	2. Did the OPS adequately respond to the incident? No. Responding officers did not open an investigation, interview witnesses, or properly document the incident. 3. Was the incident properly documented? No. Responding officers did not prepare an incident report. 4. Were all of the interviews thorough and appropriately conducted? No. One witness interview lacked necessary detail and as a result, a second interview with the witness was required. In another witness interview, the investigation failed to sufficiently establish whether the witness was a percipient witness or whether the witness was speculating about what had occurred. Further, the investigator failed to conduct an interview with a percipient witness. The investigator often asked leading questions, talked over witnesses and rushed through the interviews. 5. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report failed to include a complete quote from the police report naming a percipient witness. The draft report did not include an interview with a percipient witness and did not contain sufficient and important details from the incident. 6. Was the final investigative report thorough and appropriately drafted? No. The final investigative report did not clarify whether the statements of a purported percipient witness were based on direct knowledge. 7. Was the investigation thorough and appropriately conducted?

	No. The investigation was neither thorough nor appropriately conducted. The investigation lacked significant detail and clarity. 8. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on March 30, 2019; however, the investigation was not completed until August 19, 2019, 142 days later.
Department Corrective Action Plan	The first three issues occurred because the two responding officers believed the type of restraint used was proper, so only a Daily Log entry was made. The following day, the commander read the Daily Log, determined the incident was possibly abuse, and a police report was created. The type of restraint use was discussed with OPS officers, to prevent future misinterpretations.

Case Detail	Description
Incident Date	05/06/2019
OLES Case Number	2019-00452-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 6, 2019, a psychiatric technician allegedly choked a resident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The initial responding officer failed to provide the psychiatric technician with the legally required admonition before taking the psychiatric technician's statement. The OLES was not informed the draft investigative report was

	ready for review, prior to the report being finalized. The final report was inadequate and did not contain sufficient detail regarding the victim's statement.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The responding officer failed to provide the psychiatric technician with the legally required admonition prior to taking the psychiatric technician's statement. 2. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The OLES was not informed that the draft investigative report was ready for review. 3. Was the final investigative report thorough and appropriately drafted? No. The synopsis of the victim resident's statement was inadequate and did not contain sufficient details. 4. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The Office of Protective Services did not notify OLES that the draft report was ready for review prior to the report being finalized.
Department Corrective Action Plan	The commander provided training to OPS officers, regarding required admonishments. For the issues pertaining to the investigative process, the commander has addressed the investigators thoroughness when conducting interviews, their failure to provide OLES with both a quality draft and final copy of the investigative report and provide OLES with continued real-time consultation.

Case Detail	Description
Incident Date	06/07/2019
OLES Case Number	2019-00551-1C
Case Type	Monitored

Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 7, 2019, a psychiatric technician allegedly kicked a chair on which a resident was sitting, then kicked the resident.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services will open an administrative investigation, which the OLES will accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/16/2019
OLES Case Number	2019-00592-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 16, 2019, a senior psychiatric technician allegedly struck a resident, forced the resident against a wall, and restrained the resident in an unauthorized manner.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. 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	06/23/2019
OLES Case Number	2019-00612-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 23, 2019, three psychiatric technicians allegedly struck and slapped a resident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator failed to consult with OLES regarding the sufficiency of the investigative report.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The draft investigative report was not forwarded to OLES for review. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not consult with OLES regarding the investigative report.
Department Corrective Action Plan	The commander has addressed the investigators failure to provide OLES with both a draft copy of the investigative report and for not engaging in real-time case consultation with OLES.

Case Detail	Description
Incident Date	07/03/2019
OLES Case Number	2019-00647-1C

Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 3, 2019, a psychiatric technician allegedly pushed a resident off a bed causing significant bruising and swelling to the resident's face.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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 initial responding officer failed to provide the psychiatric technician with the legally required admonition before taking the psychiatric technician's statement. The same officer interviewed the victim/resident and percipient witness/resident while they were in the same room and could hear each other's statements.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The initial responding officer failed to provide the psychiatric technician with the legally required admonition prior to taking the psychiatric technician's statement. Further, the same officer interviewed the victim/resident and the percipient witness/resident while they were in the same room and could hear each other's statements.
Department Corrective Action Plan	The commander provided training to OPS officers, regarding required admonishments and to always interview witnesses, suspects, and victims separately.

Case Detail	Description
Incident Date	07/15/2019
OLES Case Number	2019-00694-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	On July 15, 2019, a psychiatric technician allegedly pulled a resident's hair and used profanity directed at the resident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation 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	08/20/2019
OLES Case Number	2019-00842-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 20, 2019, a psychiatric technician allegedly pushed a resident, causing the resident to fall.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The responding officer failed to fully question the witnesses about the facts of the allegation.
Pre-Disciplinary Assessment	1. Was the hiring authority's response to the incident appropriate? No. The responding officer did not ask the percipient witness any details about the incident.

	2. Was the incident properly documented? No. The interview summaries in the initial report were cursory and did not contain sufficient details.
Department Corrective Action Plan	Training was provided to all OPS officers on the need to be detailed. Additionally, training was provided to the OPS sergeant on the need to thoroughly review investigative reports and request additional investigation follow-up when needed.

Case Detail	Description
Incident Date	08/20/2019
OLES Case Number	2019-00843-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 20, 2019, a psychiatric technician allegedly kicked a resident.
Disposition	The investigation failed to establish sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Administrative-With Sustained Allegations

Case Detail	Description
Incident Date	09/03/2017
OLES Case Number	2018-00144-1A
Case Type	Monitored
Incident Types	1. Neglect 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Insubordination
Findings	1. Sustained

	2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On September 3, 2017, a pre-licensed psychiatric technician allegedly failed to timely report suspected abuse of a resident, did not maintain enhanced supervision over another resident as required, and was uncooperative during the investigation.
Disposition	The hiring authority sustained allegations against the pre-licensed psychiatric technician for leaving a resident unattended, delayed reporting of alleged abuse, and failing to cooperate during an investigation. The allegation of incompetency was not sustained. The hiring authority issued a letter of expectation, and ordered re-training. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not completed until 279 days after the initiation of the administrative investigation. The original facility delayed 71 days before forwarding the investigation to the proper hiring authority for review.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The administrative investigation was opened on February 3, 2018. Although most investigative work was completed in a timely manner, the investigative report was not completed until November 14, 2018. The investigation took 279 days to complete. Additionally, the completed investigative report was not timely forwarded to the proper hiring authority. The original facility, where the incident took place, delayed 71 days before forwarding the matter on March 15, 2018, to the facility where the psychiatric technician had transferred. Once the proper hiring authority received the matter, the consultation for investigative findings was timely conducted.
Department Corrective Action Plan	In an effort to ensure investigations are completed with due diligence and in a timely fashion, the PDC OPS Commander directed any temporary reassignments of

	an investigator will require that investigator's case load to be reassigned to another investigator.

Case Detail	Description
Incident Date	12/06/2018
OLES Case Number	2018-01320-1A
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 7. Dishonesty 8. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Not Sustained 7. Sustained 8. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On December 6, 2018, a psychiatric technician allegedly struck and pushed a resident, causing the resident to fall. A second psychiatric technician and a psychiatric technician assistant allegedly failed to report the incident and provide medical assistance to the resident. A food service worker also allegedly witnessed the incident and failed to report the misconduct. On March 14, 2019, and March 18, 2019, respectively, the psychiatric technician assistant and the psychiatric technician were allegedly dishonest during their investigative interviews.
Disposition	The hiring authority found sufficient evidence to sustain the allegations against both psychiatric technicians and the psychiatric technician assistant. The first psychiatric technician 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 determined dismissal was the appropriate penalty for the second psychiatric technician and the psychiatric technician assistant. The hiring authority found insufficient evidence to sustain the allegation against the food service worker, but did impose corrective action regarding the importance of reporting incidents of abuse or neglect of residents. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not consult with the OLES on the decision to issue corrective action to the food service worker.
Pre-Disciplinary Assessment	1. Did the hiring authority cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The hiring authority did not consult with the OLES regarding her decision to issue a letter of instruction to the food service worker.
Department Corrective Action Plan	The department did not provide a corrective action plan.

Case Detail	Description
Incident Date	04/25/2019
OLES Case Number	2019-00412-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On April 25, 2019, a psychiatric technician allegedly pushed a resident's face after the resident attempted to bite the psychiatric technician.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined

	dismissal was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/04/2019
OLES Case Number	2019-00449-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Willful disobedience
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Disciplinary Phase Pending
Incident Summary	On May 4, 2019, a psychiatric technician allegedly left a resident in a secured outdoor courtyard unattended overnight, falsified legal documents and was dishonest during his investigative interview. A second psychiatric technician allegedly falsified a legal document indicating the resident was inside his bedroom during the entire night and was intentionally misleading during her investigative interview. A third psychiatric technician allegedly was dishonest during his investigative interview. A fourth psychiatric technician allegedly falsified legal documents. A fifth psychiatric technician allegedly was negligent in his duties as shift lead, falsified legal documents, interfered in the investigation by contacting other staff and telling them what to say, and was dishonest on numerous occasions during his investigative interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain all of the allegations against each psychiatric technician. The first psychiatric technician received a salary reduction of 5 percent for three months. The hiring authority determined dismissal was the appropriate penalty for the second psychiatric

	technician. The third psychiatric technician received a salary reduction of 5 percent for three months. The fourth psychiatric technician received a salary reduction of 5 percent for three months. The hiring authority determined dismissal was the appropriate penalty for the fifth psychiatric technician.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to sufficiently comply with policies and procedures governing the pre-disciplinary process. The investigator failed to obtain and fully review all relevant documents, policies, and records prior to initiating interviews. The investigator failed to prepare written questions for the interviews and failed to listen to audio recordings of previous interviews before interviewing a witness a subsequent time. Due to the lack of preparation, the interviews were for the most part insufficient. The draft investigative report was improperly formatted, contained redundant and irrelevant information, along with grammatical errors throughout. The investigator failed to list all relevant documents in the attachments list. The final report failed to include relevant information and did not contain any of the attachments. The investigation was not completed until 152 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator failed to obtain and review all relevant policies, documents, and records prior to conducting some crucial interviews. The investigator did not prepare written interview questions. The investigator did not listen to previous interviews before interviewing a witness a second or third time. Due to the failure to adequately prepare, the interviews of the psychiatric technicians were neither thorough nor complete. 2. Were all of the interviews thorough and appropriately conducted? No. The investigator did not obtain and review all relevant documents prior to interviewing the psychiatric

	technicians and witnesses. The investigator did not prepare written questions for the interviews and as a result failed to cover all relevant issues. The investigator did not have relevant documents ready during interviews and did not have a plan when to use the documents when questioning the psychiatric technicians. 3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report was insufficient. The format was difficult to follow. The interview summaries contained redundancies and irrelevant information. The list of attachments was incomplete. The draft contained numerous grammatical errors and unsupported conclusions. 4. Was the final investigative report thorough and appropriately drafted? No. The final investigative report was not thorough nor did it contain any attachments. 5. Was the investigation thorough and appropriately conducted? No. The investigation was neither thorough nor appropriately conducted because the investigator failed to adequately review and assimilate the relevant documents, failed to adequately prepare for interviews, did not understand how to incorporate the relevant documents into the interviews, did not review prior interviews before interviewing a witness for a second time. 6. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on May 5, 2019; however, the investigation was not completed until October 3, 2019, 152 days later.
Department	For the issues pertaining to the investigative process, the

Corrective Action Plan	commander has addressed the investigator's thoroughness when conducting interviews, their failure to provide OLES with both a quality draft and final copy of the investigative report and for not completing the investigation with due diligence.

Case Detail	Description
Incident Date	08/06/2018
OLES Case Number	2019-00450-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 6, 2018, an officer tested positive for marijuana.
Disposition	The hiring authority determined the misconduct occurred but was beyond the statute of limitations for imposing discipline. Therefore, no discipline could be imposed. The OLES concurred with the 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	05/28/2019
OLES Case Number	2019-00525-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	On May 28, 2019, a psychiatric technician assistant allegedly used an unauthorized control hold on a resident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined the appropriate penalty was a letter of reprimand. The OLES

	concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The investigation was completed by the Office of Protective Services on August 12, 2019; however, the final disposition and penalty was not determined until December 11, 2019, 121 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The investigation was completed by the Office of Protective Services on August 12, 2019; however, the final disposition and penalty was not determined until December 11, 2019, 121 days later.
Department Corrective Action Plan	The facility director will provide training, to ensure timely OLES and department attorney (if applicable) consultations are conducted in the future.

Case Detail	Description
Incident Date	06/04/2019
OLES Case Number	2019-00543-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On June 4, 2019, a psychiatric technician allegedly failed to properly supervise a resident who required constant monitoring.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation of abuse; however, the hiring authority sustained an allegation for neglect of duty and issued the employee a letter of instruction. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Insufficient

Assessment	**Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on July 19, 2019; however, the final penalty was not determined until September 11, 2019; 54 days later.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The investigation was completed on July 19, 2019; however, the final penalty was not determined by the hiring authority until September 11, 2019; 54 days later.
Department Corrective Action Plan	The facility director will provide training, to ensure timely OLES and department attorney (if applicable) consultations are conducted in the future.

Case Detail	Description
Incident Date	08/28/2019
OLES Case Number	2019-00883-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On August 28, 2019, a psychiatric technician allegedly struck and cursed at a resident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the physical abuse allegation; however, found sufficient evidence to sustain the verbal abuse allegation and served the employee with a letter of instruction. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	06/11/2018
OLES Case Number	2018-01316-1A
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 11, 2018, a psychiatric technician allegedly slapped, scratched, and choked a resident. A pre-licensed psychiatric technician, and a second psychiatric technician allegedly failed to intervene, and failed to report the alleged 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:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process because the hiring authority did not timely consult with the OLES regarding the sufficiency of the investigation and the investigative findings.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The hiring authority did not consult with OLES regarding the sufficiency of the investigation and the investigative findings until 107 days after the investigation was completed.
Department	The facility has since implemented corrective measures

Corrective Action Plan	to ensure future disposition meeting compliance time.

Case Detail	Description
Incident Date	07/03/2019
OLES Case Number	2019-00647-2A
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 July 3, 2019, a psychiatric technician allegedly failed to assist a resident who had fallen to the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The responding officer interviewed the psychiatric technician without providing the psychiatric technician with the required legal admonition, thereby foreclosing the use of the statement to the detriment of the investigation. The responding officer interviewed two witnesses while they were in the same room and could hear each other's statements, negatively affecting the credibility of the statements.
Pre-Disciplinary Assessment	1. Did the OPS adequately respond to the incident? No. The initial responding officer failed to provide the psychiatric technician with the legally required admonition prior to taking the psychiatric technician's statement. Further, the same officer interviewed the victim/resident and the percipient witness/resident while they were in the same room and could hear each other's statements.
Department Corrective Action Plan	The commander provided training to OPS officers, regarding required admonishments and to always interview witnesses, suspects, and victims separately.

Case Detail	Description
Incident Date	09/23/2019
OLES Case Number	2019-01073-1A
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. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 23, 2019, four staff members allegedly improperly restrained a resident by holding his hands and sitting on him.
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.

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.

Appendix C1 Discipline Phase Cases – DSH

Procedurally Insufficient Cases

Case Detail	Description
Incident Date	11/01/2015
OLES Case Number	2017-00471-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained

Penalty	**Initial:** Dismissal **Final:** Resignation In Lieu of Dismissal
Incident Summary	Between November 2015 and April 19, 2017, a psychiatric technician allegedly was involved in an ongoing overly familiar relationship with a patient. Specifically, it is alleged the psychiatric technician placed money in the patient's trust account, exchanged correspondence and gifts with the patient, provided the patient with a mobile phone, and was in contact with the patient's family.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the finding and penalty determination. The psychiatric technician filed an appeal with the State Personnel Board. Prior to hearing, the psychiatric technician resigned in lieu of termination. The OLES concurred with the settlement agreement.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was not served until 79 days after the decision to take disciplinary action was made.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority made its decision to take disciplinary action on February 6, 2019; however, the adverse action was not served until April 26, 2019, 79 days later.
Department Corrective Action Plan	The department will continue to prioritize all OLES monitored cases to ensure the cases are meeting the designated timeframes.

Case Detail	Description
Incident Date	03/01/2016
OLES Case Number	2017-01447-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty

	3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	From March 2016 to February 2018, a psychiatric technician allegedly engaged in non-therapeutic behavior when she played basketball with patients on multiple occasions. From April 2017 to February 2018, the same psychiatric technician allegedly engaged in an overly-familiar relationship with a patient.
Disposition	The hiring authority sustained allegations against the psychiatric technician for overfamiliarity, but did not sustain any abuse allegations. The hiring authority imposed a 10 percent salary reduction for 13 months. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board hearing, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a 10 percent salary reduction for eight months. The psychiatric technician agreed to withdraw her appeal. The OLES concurred.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The department attorney failed to adequately consult with the OLES regarding finalization of the disciplinary action, and service on the psychiatric technician. The department attorney also failed to provide a full set of the supporting materials to the OLES for review before the action was served. The department did not diligently complete the disciplinary action, serving the action 196 days after the hiring authority made penalty determinations. The department failed to include all necessary supporting materials as part of the disciplinary action served on the psychiatric technician, causing the department to withdraw the action which was already pending a pre-hearing settlement conference before the State Personnel Board, and re-

	serve the psychiatric technician with the complete disciplinary action.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? No. The second department attorney failed to adequately respond to OLES' inquiries regarding the final draft of the disciplinary action and the service of the action on the psychiatric technician. The second department attorney also failed to ensure that the OLES timely received a complete set of the supporting materials to the disciplinary action. 2. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority made penalty determinations on October 12, 2018; however, the draft disciplinary action was not submitted for OLES review until April 10, 2019. The department did not serve the disciplinary action on the psychiatric technician until April 25, 2019, 196 days after the hiring authority determined the penalty for the psychiatric technician.
Department Corrective Action Plan	The attorney assigned during that period is no longer employed by the department. All department attorneys receive training on prosecuting disciplinary actions, including those monitored by OLES. This deficiency resulted from attrition and caseload reassignments. Additional training has been provided to staff assigned to NOAA reviews to emphasize the importance of timeliness.

Case Detail	Description
Incident Date	07/23/2018
OLES Case Number	2018-00763-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained

	2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Instruction
Incident Summary	On July 23, 2018, a dentist allegedly failed to properly medicate a patient prior to a surgical procedure. The dentist was allegedly uncooperative during his administrative interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a 5 percent salary reduction for six months. The OLES concurred with the hiring authority's determination. The dentist filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the dentist wherein the penalty was reduced to a letter of instruction. The dentist agreed to withdraw his appeal. The OLES concurred because the settlement was reasonable.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The hiring authority failed to comply with policies and procedures governing the disciplinary process. Although a Skelly hearing was held, the OLES was not notified of the hearing. The findings and penalty conference occurred on February 19, 2019; however, the disciplinary action was not served on the employee until May 22, 2019, 92 days later.
Disciplinary Assessment Questions	1. If there was a Skelly hearing, was it conducted properly? No. OLES was not notified of the Skelly hearing. 2. Was the disciplinary phase conducted with due diligence by the department? No. The findings and penalty conference occurred on February 19, 2019; however, the disciplinary action was not served until May 22, 2019, 92 days later.
Department Corrective Action Plan	The department has made changes in the process of scheduling Skelly hearings to ensure all parties including the OLES monitor are notified prior to the hearing. Also, calendar invites will be sent out to all parties to track

	and document the notification. The Employee Relations Office has implemented a tracking system for all Office of Law Enforcement Support monitored cases to ensure all the timeframes and notifications are being met.

Case Detail	Description
Incident Date	10/13/2018
OLES Case Number	2019-00293-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Non-Punitive Termination **Final:** Dismissal
Incident Summary	On October 13, 2018, an officer allegedly threatened to commit suicide and the officer was held in a mental health facility for a 72-hour period, resulting in the officer's loss of ability to own or possess firearms.
Disposition	The hiring authority found sufficient evidence that the officer lost the ability to own and possess firearms, and determined that a non-punitive termination was appropriate. The OLES concurred. The officer filed an appeal with the State Personnel Board. After the pre-hearing settlement conference, the officer filed a motion to dismiss the notice of adverse action, asserting that her inability to own and possess firearms did not disqualify her as an officer for the department. The department withdrew the non-punitive notice of adverse action. The hiring authority found sufficient evidence that the officer was dishonest during her interview with the OLES and punitively dismissed the officer. The OLES concurred. The officer did not file an appeal to the State Personnel Board.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority did not notify the OLES of the date of the Skelly hearing, thereby preventing OLES from attending.
Disciplinary	1. Did the hiring authority cooperate with and provide

Assessment Questions	continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? No. The hiring authority did not notify the OLES of the date of the Skelly hearing, thereby preventing OLES from attending.
Department Corrective Action Plan	The department will continue to coordinate with the Legal Department when scheduling the Skelly Hearing. The Legal Department will confirm attendance with the OLES AIM and notify the department.

Procedurally and Substantively Sufficient Cases

Case Detail	Description
Incident Date	03/13/2018
OLES Case Number	2018-00712-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On March 13, 2018, an officer allegedly struck a hospital employee in the buttocks with a round object. The officer was allegedly dishonest during the investigative interview.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board upheld the dismissal against the officer.
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	08/30/2018
OLES Case Number	2018-00914-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Resignation In Lieu of Dismissal
Incident Summary	On August 30, 2018, a psychiatric technician assistant allegedly grabbed, struck, and pushed a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The psychiatric technician assistant filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician assistant wherein the employee agreed to resign in lieu of dismissal. The psychiatric technician assistant agreed to withdraw his appeal. The OLES concurred because the settlement was reasonable.
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	01/16/2019
OLES Case Number	2019-00059-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Willful disobedience 3. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained

Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	On January 16, 2019, a nurse allegedly refused to medically assess a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 5 percent salary reduction for 12 months. The OLES concurred. The nurse filed an appeal with the State Personnel Board. At the pre-hearing settlement conference, the department entered into a settlement, wherein the penalty was reduced to a 5 percent salary reduction for six months. The OLES concurred due to the nurse's remorse and her taking responsibility for her actions.
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	01/26/2019
OLES Case Number	2019-00090-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	On January 26, 2019, a senior psychiatric technician allegedly failed to document a patient's injury.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 5 percent salary reduction for three months. The OLES concurred. The senior psychiatric technician did not file an appeal with the State Personnel Board.
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	04/01/2007
OLES Case Number	2019-00267-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty 2. Dishonesty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Dismissal **Final:** Resignation In Lieu of Dismissal
Incident Summary	During April 2007, a psychiatric technician allegedly provided a patient with personal information, began a relationship with the patient, resided with the patient following his release, and failed to notify her supervisor of her relationship with the patient. On or about January 1, 2019, the psychiatric technician allegedly failed to notify her supervisor of her continuing relationship and residing with a former patient. On April 4, 2019, the psychiatric technician was allegedly dishonest during her interview with the Office of Special Investigations.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. The OLES concurred. However, the psychiatric technician resigned before disciplinary action could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file.
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	07/01/2018
OLES Case Number	2019-00333-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Insubordination 3. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	Between July 1, 2018, and October 11, 2018, a communications operator and an officer allegedly engaged in excessive public displays of affection while on duty. On October 11, 2018, they allegedly engaged in sexual relations while on duty. Between January 8, 2019, and January 10, 2019, they allegedly discussed the investigation with each other after being admonished not to. On January 10, 2019, they were allegedly dishonest during their interviews with the OLES.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty for both employees. The OLES concurred with the determinations. The OLES concurred with the determinations. Both employees filed appeals with the State Personnel Board. Prior to the evidentiary hearing, the department entered into a settlement agreement with the officer, wherein he agreed to resign in lieu of dismissal. The OLES concurred. The communications operator subsequently withdrew her appeal to the State Personnel Board.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix C2 DDS Discipline Phase Cases – DDS

Procedurally Insufficient Case

Case Detail	Description
Incident Date	09/25/2018
OLES Case Number	2018-01021-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On September 25, 2018, a psychiatric technician allegedly placed a resident in a chokehold and pushed the resident against a wall. It is further alleged the psychiatric technician was dishonest during her investigatory interview.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and dismissed the psychiatric technician. The OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board upheld the dismissal against the psychiatric technician.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. Neither the department attorney nor human resources personnel provided OLES with written confirmation of the penalty discussions. The hiring authority failed to notify both the department attorney and OLES of the Skelly hearing; thereby preventing their attendance at the Skelly hearing.
Disciplinary Assessment Questions	1. Did the department attorney or human resources personnel provide to the hiring authority and OLES written confirmation of penalty discussion? No. Neither the department attorney nor human resources personnel provided OLES with written

	confirmation of penalty. 2. If there was a Skelly hearing, was it conducted properly? No. Neither the department attorney nor the OLES was notified of the Skelly hearing. 3. Did a department attorney attend the Skelly hearing? No. The hiring authority failed to notify the department attorney of the Skelly hearing.
Department Corrective Action Plan	In the future, the facility will ensure the OLES monitor is notified of any pre-disciplinary hearings.

Appendix D: Combined Pre-Disciplinary and Discipline Phase Cases

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

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

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

The disciplinary phase is rated for procedural and substantive sufficiency.

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

Appendix D1 Combined Cases – DSH

Cases Rated Procedurally or Substantively Insufficient in the Pre-Disciplinary Phase or Disciplinary Phase

Case Detail	Description
Incident Date	11/18/2016
OLES Case Number	2016-01514-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior 2. Dishonesty
Findings	1. Sustained 2. Sustained

Penalty	**Initial:** Dismissal **Final:** Demotion
Incident Summary	On November 18, 2016, an officer was arrested for allegedly committing a battery on his wife. The officer allegedly was dishonest to a supervisor regarding the status of his criminal case and was dishonest during the investigative interview.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred. Following a Skelly hearing, the department entered into a settlement agreement wherein the officer agreed to a voluntary demotion to a food service technician and agreed that he would not seek employment in a sworn position in the future. The OLES concurred with the settlement as it ensured the officer would not return to work in a sworn position.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was not served until 163 days from the date the hiring authority made findings and penalty determinations.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The decision to take disciplinary action was made on January 30, 2019; however, the disciplinary action was not served until July 12, 2019, 163 days later.
Department Corrective Action Plan	The Employee Relations Office has implemented a tracking system for all Office of Law Enforcement Support monitored cases to ensure all the timeframes and notifications are being met.

Cases Rated Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	03/23/2017
OLES Case Number	2018-00085-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Inexcusable neglect of duty 3. Other failure of good behavior
Findings	1. Not Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On March 23, 2017, an officer allegedly used excessive force on a patient. Three other officers allegedly conducted an inadequate investigation into the incident and made inaccuracies in their reports. A fifth officer allegedly falsified an arrest warrant to arrest the patient.
Disposition	The hiring authority sustained the allegations and issued a salary reduction of 10 percent for 12 months on the first officer, letters of instruction to the second, third, and fourth officers and dismissed the fifth officer. The OLES concurred with the hiring authority's determination. The first and fifth officers filed appeals with the State Personnel Board. At a settlement conference, the department entered into a settlement agreement with the first officer wherein the penalty was reduced to 10 percent for ten months. The OLES concurred because the penalty reduction was not significant and still had a deterrent effect. The fifth officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board upheld the dismissal based on a separate, unrelated misconduct case.
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	09/19/2015
OLES Case Number	2018-00354-1A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Incompetency
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On September 19, 2015, an officer allegedly failed to properly process a crime scene. On December 8, 2017, the officer allegedly made false and misleading statements during a preliminary hearing regarding the processing of the crime scene.
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 filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board upheld the dismissal.
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	05/15/2018
OLES Case Number	2018-01161-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Other failure of good behavior

	2. Other failure of good behavior 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Dismissal **Final:** Resignation In Lieu of Dismissal
Incident Summary	On May 15, 2018, a psychiatric technician allegedly challenged a patient to strike him. The psychiatric technician then allegedly pushed and caused the patient to fall. The psychiatric technician also allegedly dragged the patient on the floor by the ankle. During August 2018, the same psychiatric technician allegedly made a shooting gesture towards a psychiatric technician who reported the alleged patient abuse. The first psychiatric technician then allegedly followed and glared at the other psychiatric technician in an intimidating manner.
Disposition	The hiring authority sustained allegations against the psychiatric technician, and determined dismissal was the appropriate penalty. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician whereby the psychiatric technician resigned in lieu of termination, and agreed to never apply for employment with the department. The psychiatric technician also agreed to withdraw his appeal. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	11/09/2018
OLES Case Number	2019-00458-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Other
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Sustained
Penalty	**Initial:** Suspension **Final:** Salary Reduction
Incident Summary	On November 9, 2018, a psychiatric technician allegedly doused a sleeping patient with baby powder. On May 15, 2019, the psychiatric technician was evasive during his interview with the Office of Special Investigations.
Disposition	The hiring authority sustained the allegation that the psychiatric technician was evasive during the investigation, but found insufficient evidence that he abused the patient, and imposed a 30 day suspension. The OLES concurred. The psychiatric technician subsequently submitted a letter to the hiring authority in lieu of requesting a Skelly hearing, expressing regret for his actions. The hiring authority entered into a settlement agreement modifying the penalty to an equivalent salary reduction of 10 percent for 15 months. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
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	06/13/2019
OLES Case Number	2019-00591-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	On June 13, 2019, a sergeant allegedly negligently discharged his personal firearm in the hospital parking lot. The sergeant also allegedly failed to timely report the incident.
Disposition	The hiring authority sustained the allegations and imposed a salary reduction of 5 percent for 12 months. The OLES concurred with the hiring authority's determination. Following a Skelly hearing, the department entered into a settlement agreement with the sergeant whereby the department agreed to lower the salary reduction to 5 percent for three months and the sergeant agreed to waive his right to appeal. The OLES concurred with the settlement based on the sergeant's sincere expression of remorse and acceptance of responsibility at the Skelly hearing making the recurrence of the misconduct less likely.
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 Overall, the department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	03/04/2019
OLES Case Number	2019-00619-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other

Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resignation In Lieu of Dismissal
Incident Summary	Between March 4, 2019, and April 4, 2019, a senior psychiatric technician allegedly asked a psychiatric technician trainee on multiple occasions to socialize outside of work after she rejected his advances. Between March 10, 2019, and April 10, 2019, the senior psychiatric technician allegedly sent multiple messages via social media to a dietetic technician, requesting to socialize outside of work. On April 2, 2019, the senior psychiatric technician grabbed and forcibly held a registered dietitian, forced his hand into her pants, attempted to touch her genitals, and forcibly placed her pants on his genitals.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined dismissal was the appropriate penalty. However, the senior psychiatric technician resigned before disciplinary action could be taken. A letter indicating the senior psychiatric technician resigned under adverse circumstances was placed in his official personnel file. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Appendix D2 Combined Case – DDS

Case Rated Procedurally or Substantively Insufficient in the Pre-Disciplinary Phase or Disciplinary Phase

Case Detail	Description
Incident Date	12/14/2018

OLES Case Number	2019-00287-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Dishonesty 5. Inexcusable neglect of duty 6. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained
Penalty	**Initial:** Dismissal **Final:** Suspension
Incident Summary	On December 14, 2018, a psychiatric technician allegedly failed to conduct twice hourly checks on a resident, who was later found deceased, made false notations on a nursing log, and did not lock the residents' room doors. On March 18, 2019, the psychiatric technician was not forthcoming during her interview with the Department of Protective Services.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. At the pre-hearing settlement conference, the department entered into a settlement agreement with the psychiatric technician, reducing the penalty from a dismissal to a nearly three month suspension. The OLES did not concur with the department's decision because there was ample and substantial evidence supporting the allegation that the psychiatric technician neglected her duty, falsified official documents, and was dishonest during her administrative interview.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the pre-disciplinary process. The

	draft report did not contain admissions by the psychiatric technician that she failed to lock the doors to client bedrooms and knew that such failures violated department policy.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report did not include the psychiatric technician's admissions that she failed to lock the residents' bedroom doors and that this failure violated department policy.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The department entered into an unreasonable settlement reducing the penalty from dismissal to suspension without sufficient justification.
Disciplinary Assessment Questions	1. If the penalty was modified by department action or a settlement agreement, did OLES concur with the modification? No. The department reduced the penalty from a dismissal to a suspension without identifying any new evidence, flaws, or risks to justify the reduction. The OLES believes the settlement was not reasonable given the seriousness of the misconduct.
Department Corrective Action Plan	The commander directed all investigators and the investigations lieutenant to closely review investigation documents, recordings, statements and other evidentiary information for possible criminal/administrative violations.

Appendix E: Monitored Issues

Case Details	Description
Incident Date	11/29/2017
OLES Case Number	2017-01244-1MI
Case Type	Monitored Issue
Incident Summary	On November 29, 2017, the OLES issued a memorandum to the Department of State Hospitals (DSH) recommending it develop standardized interview admonishment notices to be issued to all witnesses and subjects of misconduct investigations.
Disposition	In response to the OLES memorandum, DSH developed standardized interview notices on August 30, 2019. Internal policies and procedures were updated to incorporate the OLES recommendations requiring the issuance of the investigatory interview notices. The OLES will continue to monitor the department's adherence to its interview notice policy.

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:

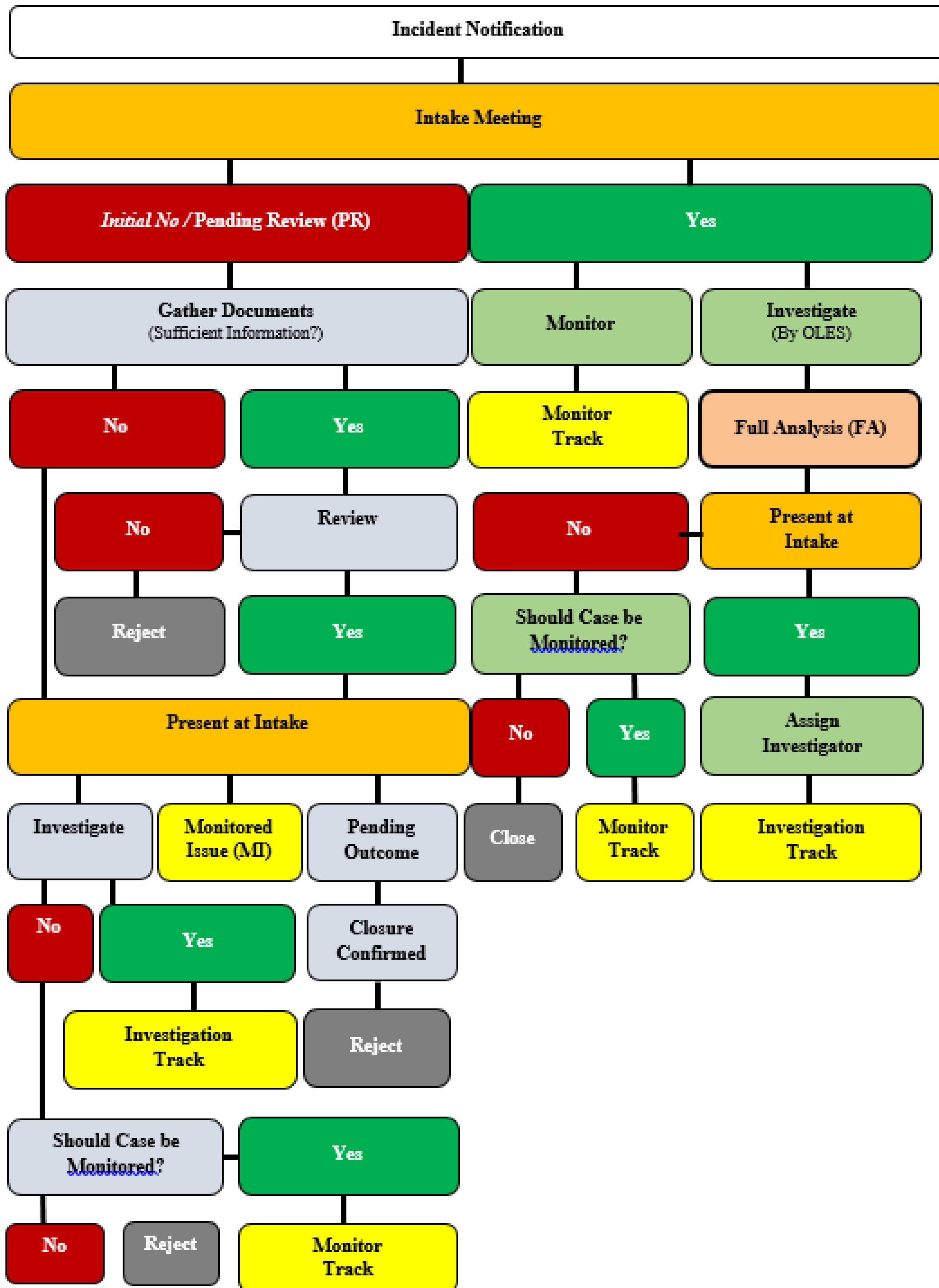
(a) Assault, as defined in Section 240 of the Penal Code.
(b) Battery, as defined in Section 242 of the Penal Code.
(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.
(d) Unreasonable physical constraint, or prolonged or continual 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. Initial No/Pending Review
    b. OLES Monitored Case
    c. OLES Investigation Case
3. If the disposition is "Initial No/Pending Review", the case is reviewed for sufficient information and is represented at an intake meeting. From there, the case may be investigated, become a monitored issue, be monitored, be investigated or be rejected.

Appendix H: Guidelines for OLES Processes

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

If, instead, an incident is investigated by DSH or DDS but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH or DDS investigator and the department attorney, if one is designated[8], throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

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

Critical Junctures

1. Site visit
2. Initial case conference

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

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

It is recommended that within 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority shall consult with the AIM attorney on the discipline decision, including 1) the allegations for which the employee should be exonerated, the allegations for which the evidence is insufficient and the allegations should not be sustained, or the allegations that should be sustained; and 2) the appropriate discipline for sustained allegations, if any. If 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. AIM attends disposition conference; discusses case and analyzes with the appropriate department representative
2. Additional investigation may be requested
3. AIM meets with executive director at the facility to finalize disciplinary determinations
4. Process for resolving disagreements may be enacted

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

60 Days

1. Human resources unit at the facility completes NOAA and forwards to AIM for review
2. Approved NOAA is provided to the executive director for service on the affected employee

State employees subject to discipline have a due process right to have the matter reviewed in a Skelly hearing by an uninvolved supervisor who, in turn, makes a recommendation to the hiring authority, i.e. whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee[9]. It is recommended that the Skelly due process meeting be completed within 30 days.

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

30 Days

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

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

Conclusion

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