Office of Law Enforcement Support

Semiannual Report

January 1, 2021–June 30, 2021

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

Promoting a safe, secure and therapeutic environment

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

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Introduction

I am pleased to present the eleventh semiannual report by the Office of Law Enforcement Support (OLES) in the California Health and Human Services Agency. This report details OLES's oversight and monitoring of the Department of State Hospitals (DSH) from January 1 through June 30, 2021.

In this report, the OLES provides details on 506 reported incidents and the results of completed investigations and monitored cases. In response to procedural and substantive insufficiencies OLES identified while monitoring cases, the DSH provided additional training on the OLES reporting guidelines, ensuring thorough written documentation and providing the appropriate admonishments to individuals prior to conducting interviews. The DSH also re-emphasized the importance of addressing inaccuracies in investigative reports and appropriately addressing investigative concerns to ensure all relevant facts are obtained from an investigation.

During this reporting period, the DSH resolved four monitored issues that were initiated by OLES. In response to OLES'S recommendations, DSH implemented two policies to minimize patient pregnancies and facilitate care for patients who become pregnant or are pregnant when they are admitted to a DSH facility. The DSH also prepared a statewide policy that requires clinical staff to consult with facility law enforcement when determining if an accused staff member can return to patient care. In addition, the DSH's legal division began providing ongoing statewide training on civil liability prevention and mitigation to assist the facility law enforcement in approaching critical incidents that may expose the department to liability.

The DSH continues to actively respond to the evolving pandemic to protect patients and staff. A comprehensive list of preparation and preventative activities, including updated protocols and guidance can be found on the DSH website.

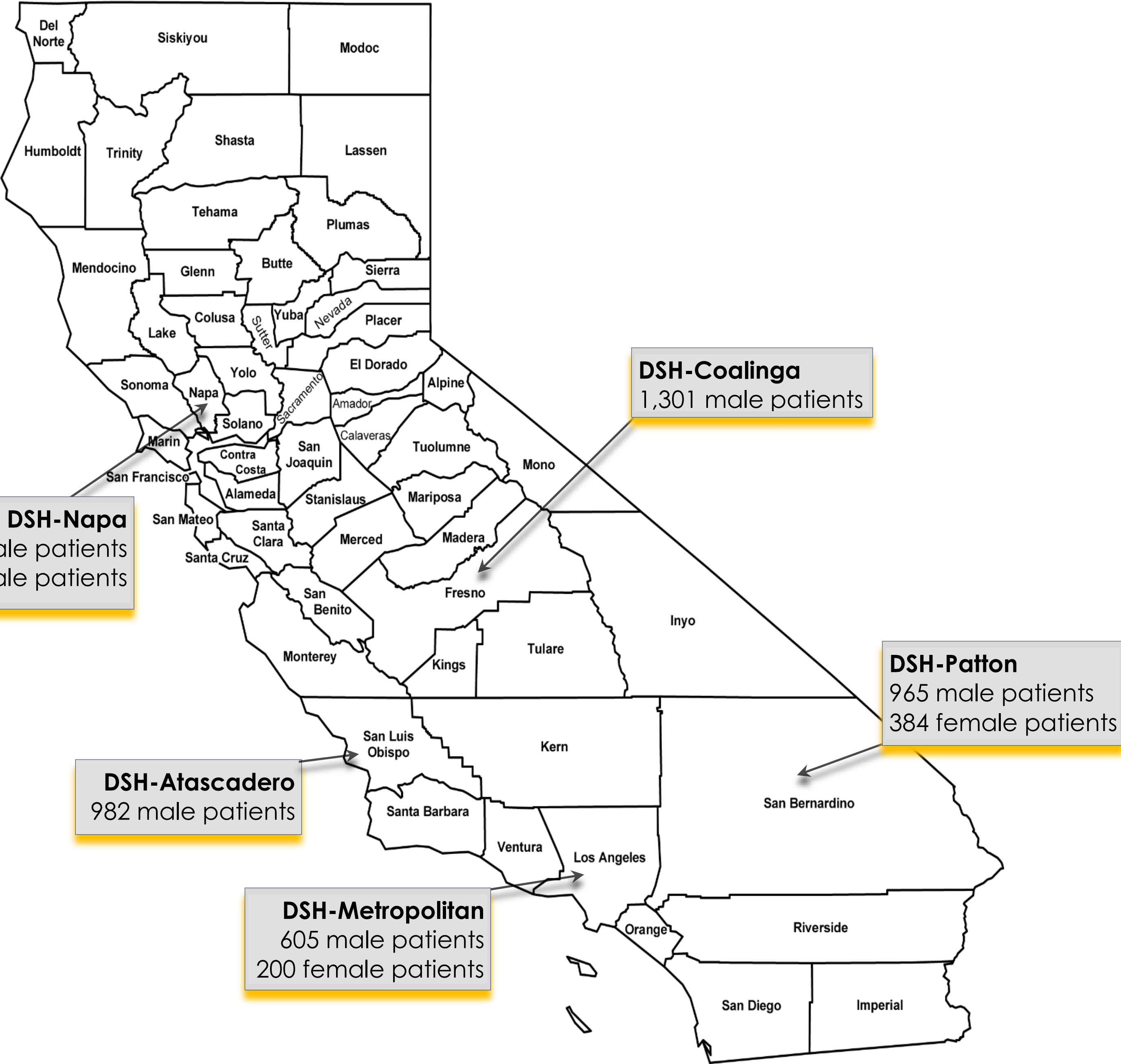
As OLES concludes its sixth year of oversight and monitoring, we remain committed to continuous quality improvement and instilling accountability at DSH.

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

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers as of June 30, 2021, were provided by the department.

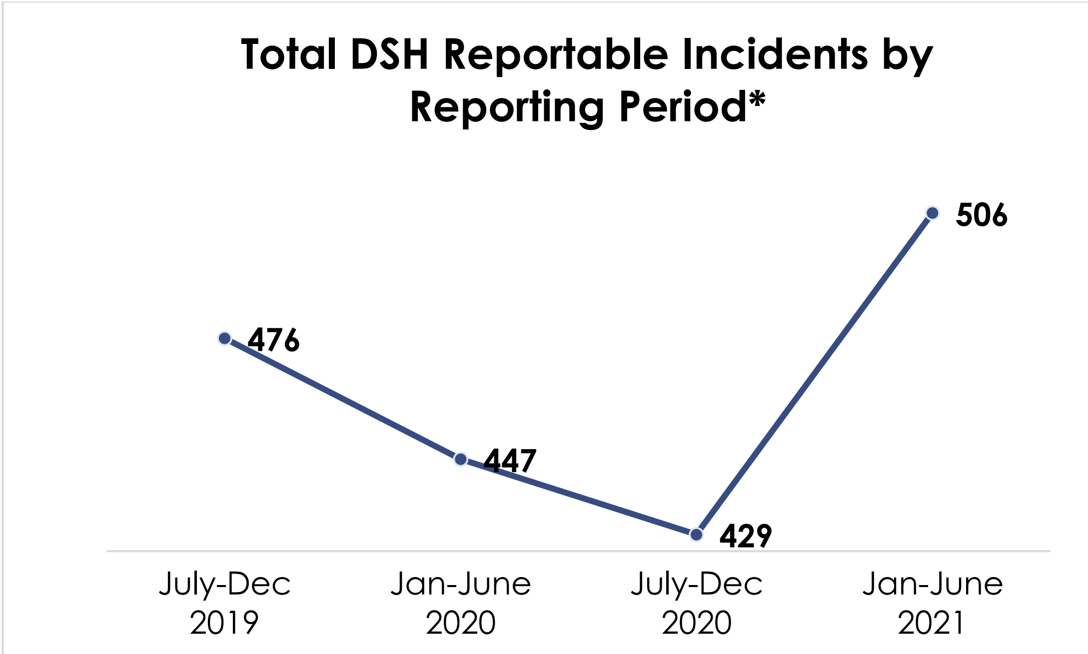


DSH Facility Population Table

Facility	Number of Male Patients	Number of Female Patients	Total
DSH-Atascadero	982	0	982
DSH-Coalinga	1,301	0	1,301
DSH-Metropolitan	605	200	805
DSH-Napa	893	227	1,120
DSH-Patton	965	384	1,349
Total	4,746	811	5,557

Executive Summary

During the reporting period of January 1, 2021, through June 30, 2021, the Office of Law Enforcement Support (OLES) received and processed 506 reportable incidents[1] from the California Department of State Hospitals (DSH). Reportable incidents include alleged misconduct by state employees, serious offenses between patients, patient deaths and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is an increase of 77 incident reports compared to the prior reporting period which had 429 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



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

Incident Types Meeting OLES Criteria

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

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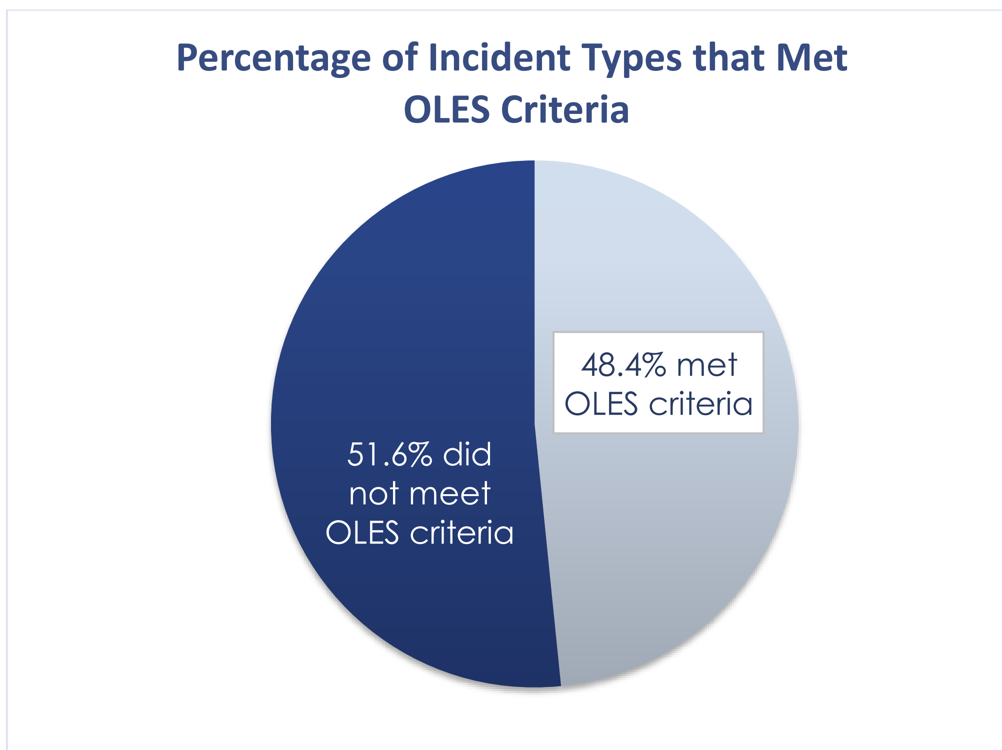
[1] Reportable incidents are pursuant to the California Welfare and Institutions Code Section 4023.6 et seq. (See Appendix F) and existing agreements between OLES and the department.

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

investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 506 reported incidents, the OLES identified 46 incidents with two or more incident types. The DSH reported a total of 568 incident types during this reporting period. Two hundred and seventy-five, or 48.4 percent of the 568 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported by DSH include: abuse, sexual assault, death, head or neck injury and broken bone of unknown origin. Allegations of abuse represented the single largest number of alleged incidents reported by DSH during this reporting period. The OLES received 103 reports of abuse, which accounted for 18.1 percent of all reported incident types by DSH. The DSH reported 101 incident types of sexual assault, making sexual assault the second most frequently reported incident type. Patient deaths were the third most reported incident type with 56 patient deaths reported, representing a 6.7 percent decrease when compared to the 60 patient deaths in the prior reporting period. The DSH reported 53 head or neck injury incident types. Reports of head or neck injuries increased by 76.7 percent when compared to the prior reporting period. The fifth most frequent incident type was broken bone of unknown origin; reports of broken bone increased by 23.1 percent to 48.

Patient Deaths

The number of patient deaths decreased by 6.7 percent, from 60 deaths to 56 deaths during this reporting period. Nine of the reported death incident types met the OLES criteria for investigation or monitoring. Twenty-nine of the 56 patient deaths were

expected due to existing medical conditions or COVID-19. Twenty-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. Seventeen of the 27 "unexpected" deaths were due to COVID-19, six were due to cardiac or respiratory issues and three are pending determination for the cause. The remaining unexpected patient death was due to numerous medical conditions.

Coalinga State Hospital (CSH) reported the largest number of patient deaths with 17 patient deaths. At CSH, the most frequent cause of death reported was COVID-19.

Patient Arrests

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

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

During this reporting period, DSH reported 13 patient arrests, two more arrests than in the prior reporting period. The patients were arrested for violations of the following statutes:

Statute	Description
Penal Code section 69	resisting an executive officer with threat or violence
Penal Code section 243(c)	battery on a peace officer
Penal Code section 243(d)	battery causing serious bodily injury
Penal Code section 245(a)(1)	assault with a deadly weapon
Penal Code section 245(a)(4)	assault with force likely to cause great bodily injury
Penal Code section 311.11(b)	possession of child pornography with priors
Penal Code section 664/187(a)	attempted murder

Results of Completed OLES Investigations on DSH Law Enforcement

Per statute[3], an OLES investigation is initiated after OLES is notified of an allegation that a DSH law enforcement officer of any rank committed serious criminal misconduct or serious administrative misconduct during certain threshold incidents. As of June 30,

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

2021, DSH had approximately 728 sworn staff members.

Appendix A provides information on the 12 OLES investigations that were completed during this reporting period. These investigations involved allegations against at least 14 sworn staff members, which is approximately 1.6 percent of DSH sworn staff. One investigation involved an alleged incident that occurred in 2021. Nine investigations involved alleged incidents that occurred in 2020. Two investigations involved alleged incidents that occurred in 2019.

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

Results of Completed OLES Monitored Cases

Monitored cases include investigations conducted by the department and the discipline process for employees involved in misconduct. In Appendices B, C and D of this report, OLES provides information on 75 monitored administrative cases and 86 monitored criminal cases that, by June 30, 2021, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These monitored cases included allegations against psychiatric technicians, psychiatric technician assistants, officers, registered nurses, unit supervisors and several other types of staff members.

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

The OLES monitored 159 pre-disciplinary phase cases; 154 of the pre-disciplinary phase cases are listed in Appendix B and five are in Appendix D. Twenty-six of the 159 pre-disciplinary phase cases were rated as procedurally insufficient only. Four cases were rated both procedurally and substantively insufficient. The DSH's failure to notify OLES of incidents in a timely manner was a frequent procedural deficiency.

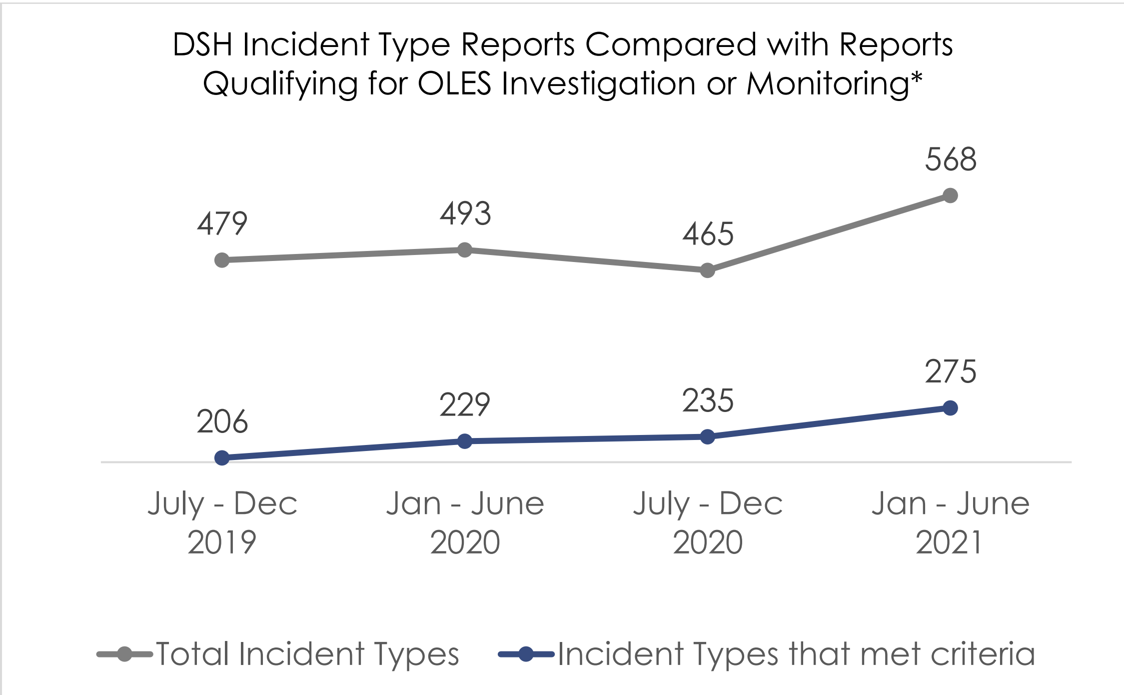
The OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in seven administrative cases; two are listed in Appendix C and five are in Appendix D. Three of the seven disciplinary phase cases were rated procedurally insufficient. All disciplinary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

Incidents and Incident Types

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

Increase in Reported Incident Types

The number of DSH incidents reported to OLES from January 1 through June 30, 2021, increased 17.9 percent, from 429 during the prior reporting period to 506 in this reporting period. From the 506 reported incidents, the OLES identified 568 incident types, as 46 of the incidents featured two or more incident types. Two hundred and seventy-five of the 568 reported incident types met OLES criteria for investigation, monitoring or research into a potential systemic issue.



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

Most Frequent Incident Types Reported

The most frequent incident types reported were abuse, sexual assault, death, head or neck injury and broken bone of unknown origin. These five incident type categories accounted for 361 or 63.6 percent of all incident types reported by DSH. Of the 361 incident types, 199 met criteria for OLES to investigate or monitor. This is 72.4 percent of the 275 incident types that met criteria.

Allegations of abuse were the most frequently reported incident type by DSH, with 103 incident types reported. Abuse allegations accounted for 18.1 percent of all incident types reported. Of the 103 abuse allegations reported in this period, 96 allegations qualified for investigation, monitoring or consideration of a potential systemic issue. This is an increase of 7.9 percent or seven qualifying reports from the prior reporting period, which had 89 incident types of abuse that met OLES criteria.

Sexual assaults accounted for 17.8 percent of all incident types reported. The number of sexual assault allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period increased by 32.4 percent, from 34 during the prior reporting period, to 45 in this reporting period.

Reports of patient death decreased by 6.7 percent when compared to the number reported in the prior reporting period. COVID-19 was the primary cause of death for 25 of the 56 reported patient deaths.

Reports for head or neck injuries or broken bones of unknown origin continue to be frequently reported. Reports of head or neck injuries increased 76.7 percent to 53 incident types. Twenty-six head or neck injuries resulted from a physical altercation between patients. Twenty-five head or neck injuries resulted from a self-injury by the patient, an unwitnessed or witnessed fall or the patient losing balance. One head or neck injury was caused during a containment by staff. The remaining head or neck injury was caused during a use of force incident by hospital police. Reports for broken bone of unknown origin increased 23.1 percent, from 39 incident types to 48 incident types. The following table provides the most frequently reported incident types reported by DSH and the percent change from the previous reporting period.

Most Frequent Incident Types January 1 through June 30, 2021

Incident Type Category	Prior Period Incident Type Total – July 1 through December 31, 2020	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Abuse	94	103	+9.6%	96
Sexual Assault	104	101	-2.9%	45
Death	60	56	-6.7%	9
Head/Neck Injury	30	53	+76.7%	4
Broken Bone (Unknown Origin)	39	48	+23.1%	45

Incident Types by Reporting Period

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

Incident Categories	Prior Period January 1 - June 30, 2020 (Reported)*	Prior Period January 1 - June 30, 2020 (Meets Criteria)*	Prior Period July 1 - December 31, 2020 (Reported)*	Prior Period July 1 - December 30, 2020 (Meets Criteria)*	Current Period January 1 - June 30, 2021 (Reported)	Current Period January 1 - June 30, 2021 (Meets Criteria)
Abuse	93	85	94	89	103	96
Broken Bone (Known Origin)	27	1	12	1	19	2
Broken Bone (Unknown Origin)	33	29	39	37	48	45
Burn	3	0	2	0	4	1
Death	38	20	60	20	56	9
Genital Injury (Known Origin)	3	1	1	0	5	1
Genital Injury (Unknown Origin)	2	1	8	3	11	8
Head/Neck Injury	44	8	30	5	53	4
Misconduct**	30	21	19	17	24	17
Neglect	18	11	19	16	26	25
Non-patient assault/GBI on Patient	0	0	0	0	0	0
Patient on Patient Assault/GBI	24	0	15	2	23	1
Pregnancy	0	0	1	1	0	0
Sexual Assault	86	43	104	34	101	45
Sexual Assault-OJ***	33	0	13	0	27	0
Significant Interest-Attack on Staff****	13	0	12	0	11	0
Significant Interest-Attempted Suicide	5	0	1	0	2	1

Incident Categories	Prior Period January 1 - June 30, 2020 (Reported)*	Prior Period January 1 - June 30, 2020 (Meets Criteria)*	Prior Period July 1 - December 31, 2020 (Reported)*	Prior Period July 1 - December 30, 2020 (Meets Criteria)*	Current Period January 1 - June 30, 2021 (Reported)	Current Period January 1 - June 30, 2021 (Meets Criteria)
Significant Interest-AWOL	6	0	6	0	6	2
Significant Interest-Child Pornography	1	0	1	0	3	0
Significant Interest-Other* ***	9	1	7	1	23	8
Significant Interest-Over-Familiarity	9	8	10	9	10	9
Significant Interest-Patient Arrest	16	0	11	0	13	1
Significant Interest-Riot	0	0	0	0	0	0
Total	493	229	465	235	568	275

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

Incident Types by Facility

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

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Abuse	10	19	38	16	20	103
Broken Bone (Known Origin)	3	7	4	2	3	19

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Broken Bone (Unknown Origin)	6	11	13	3	15	48
Burn	1	3	0	0	0	4
Death	2	17	11	13	13	56
Genital Injury (Known Origin)	0	0	5	0	0	5
Genital Injury (Unknown Origin)	0	0	11	0	0	11
Head/Neck Injury	8	6	20	8	11	53
Misconduct*	2	13	5	3	1	24
Neglect	4	3	6	2	11	26
Non-Patient on Patient Assault/GBI	0	0	0	0	0	0
Patient on Patient Assault/GBI	3	2	11	2	5	23
Pregnancy	0	0	0	0	0	0
Sexual Assault	11	17	46	10	17	101
Sexual Assault-OJ**	15	2	7	2	1	27
Significant Interest- Attack on Staff***	5	1	2	2	1	11
Significant Interest-Attempted Suicide	0	1	1	0	0	2
Significant Interest-AWOL	0	0	3	1	2	6
Significant Interest-Child Pornography	0	3	0	0	0	3
Significant Interest-Other****	2	8	3	3	7	23
Significant Interest-Over-Familiarity	0	4	2	0	4	10
Significant Interest-Patient Arrest	0	2	5	1	5	13

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Significant Interest-Riot	0	0	0	0	0	0
Total	72	119	193	68	116	568

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

Distribution of Incident Types

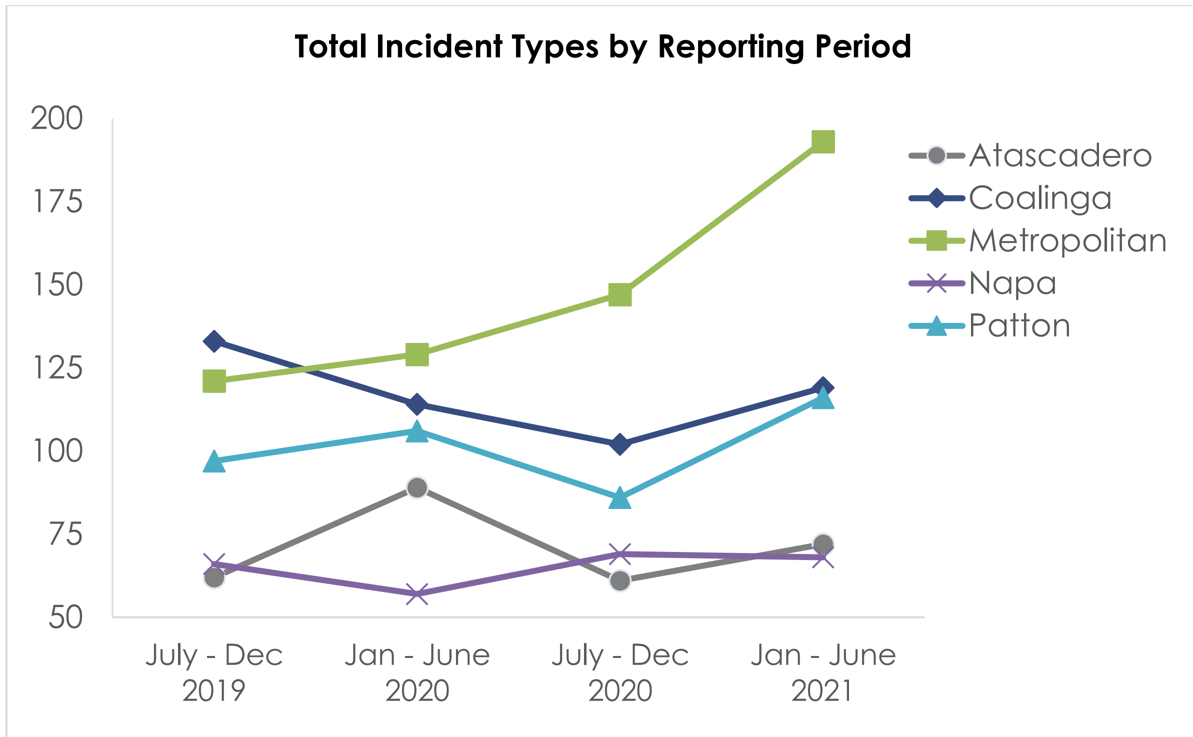
With 5,557 patients department-wide, this equates to 0.102 incident types per patient. The following table provides the population counts of DSH facilities for reference.

DSH Population and Total Incident Types

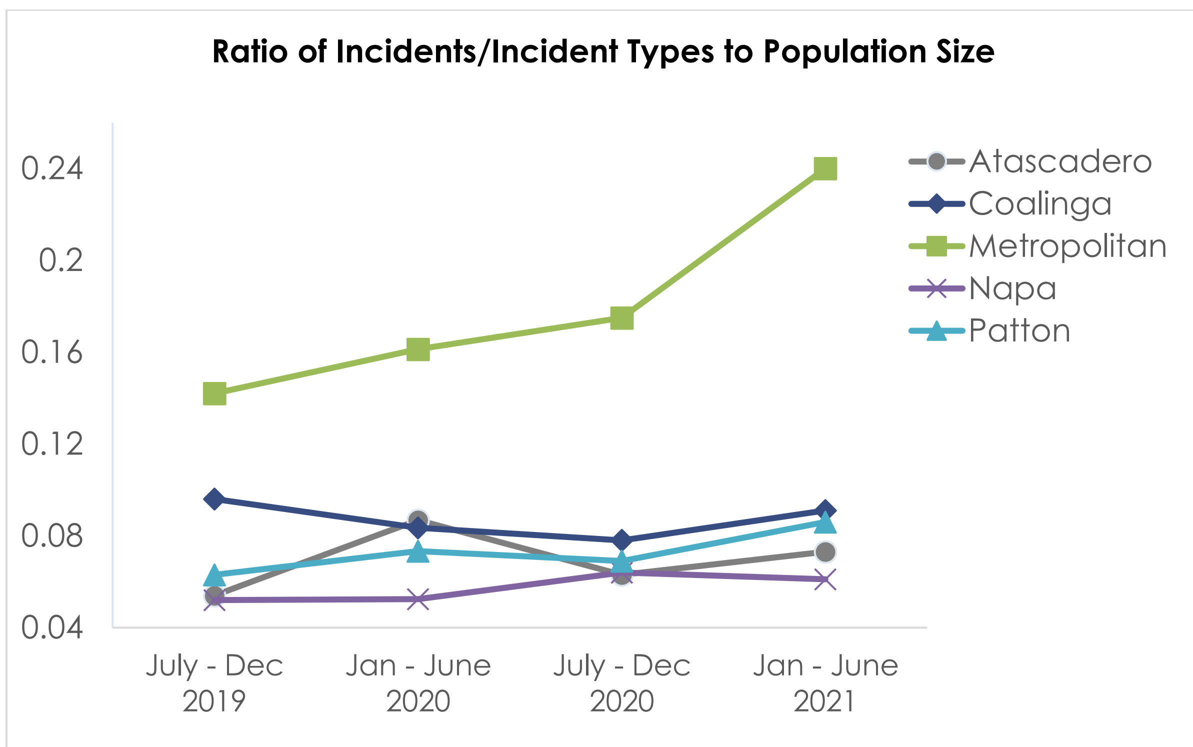
DSH Facility	Number of Patients*	Total Incident Types	Ratio of Incident Types to Population
Atascadero	982	72	0.073
Coalinga	1,301	119	0.091
Metropolitan	805	193	0.240
Napa	1,120	68	0.061
Patton	1,349	116	0.086
Total	5,557	568	0.102

* The department provided population numbers as of June 30, 2021.

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



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



Sexual Assault Allegations

Sexual assault was the second most frequently reported incident types from January 1 through June 30, 2021. The 101 alleged sexual assault incident types reported in this reporting period accounted for 17.8% percent of all reported incident types from DSH. Forty-five of the 101 reported incident types of alleged sexual assault, or 44.6 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 27 reported incident types under the sexual assault-OJ category, none of which met OLES criteria for investigation or monitoring.

MSH reported the highest number of incident types under the sexual assault incident type category. MSH reported 46 incident types, or 45.5 percent of all alleged sexual assault incident types reported during this reporting period. CSH and PSH both reported 17 incident types under the sexual assault category, the second highest number of sexual assault incident type reports.

ASH reported the highest number of alleged sexual assault-OJ incident types. In this reporting period, ASH reported 15 out of the 27 reported incident types under the alleged sexual assault-OJ. This category includes allegations that implicated family, friends, or others in incidents that occurred when patients were not in a DSH facility.

As shown in the following table, which delineates law enforcement staff from non-law enforcement staff, allegations of sexual assault involving a patient assaulting other patient(s) were the most frequently reported, with a total of 49 incident types, or 48.5 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 41 incident types or 40.6 percent of the 101 alleged sexual assault incident types. There were nine allegations pf sexual assault involving an unknown assailant on a patient. These include allegations made by patients that did not implicate DSH employees or contractors. DSH reported two allegations of sexual assault on a patient by law enforcement personnel during this reporting period. All DSH reports of alleged sexual assaults received by OLES during the reporting period are shown in the following table.

Sexual Assault Allegations Reported January 1 through June 30, 2021

Facility	Patient on Patient	Law Enforcement Staff on Patient	Non-Law Enforcement Staff on Patient	Unknown Person on Patient	OJ*	Totals
Atascadero	6	1	2	2	15	26
Coalinga	10	1	4	2	2	19
Metropolitan	23	0	21	2	7	53
Napa	3	0	6	1	2	12
Patton	7	0	8	2	1	18
Totals	49	2	41	9	27	128

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

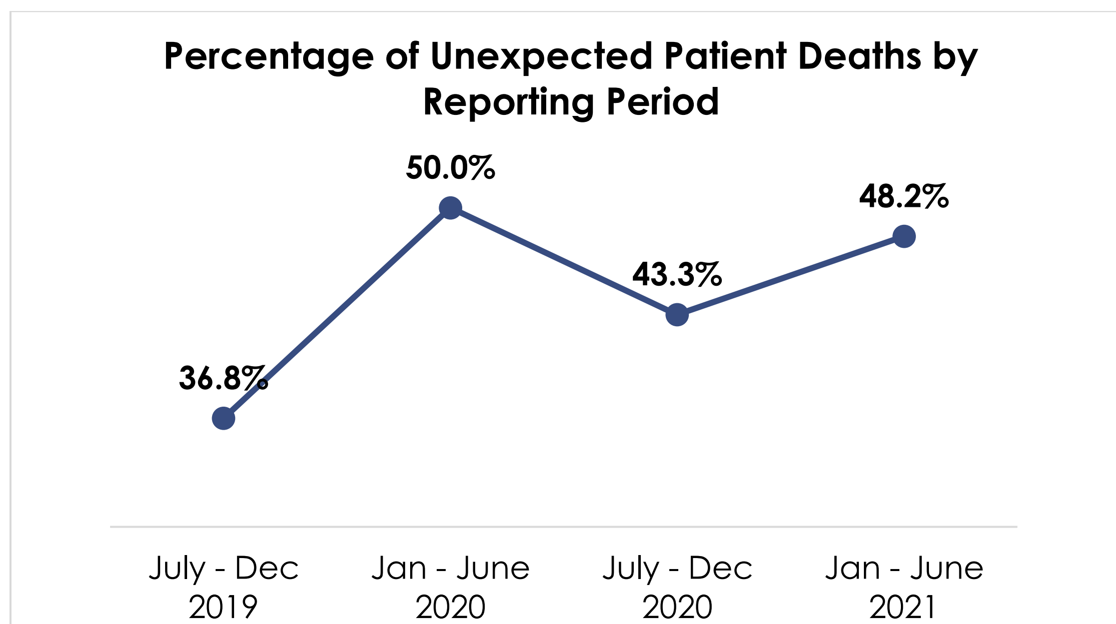
Patient Deaths

There were 56 patient deaths reported to OLES from DSH facilities during this reporting period. This number decreased 6.7 percent from the 60 patient deaths reported in the prior reporting period of July 1 through December 31, 2020. Of the 56 patient deaths, 53 were male patients and three were female. The patient age at the time of death ranged from 45 years to 83 years old. The following table provides the total number of patient deaths in each age group.

Patient Deaths by Age Group

Age Group (years)	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
45-54	0	1	2	2	1	6
55-64	1	5	4	3	4	17
65-74	1	6	3	6	5	21
75-84	0	5	2	2	3	12
Total	2	17	11	13	13	56

Twenty-nine of the patient deaths were classified as "expected" due to COVID-19 or underlying health conditions, such as cancer and kidney disease. Twenty-seven deaths were classified as "unexpected". The percentage of unexpected patient deaths increased compared to the percentage in the prior reporting period. The following chart depicts the percentage of unexpected patient deaths in this reporting period and the three prior reporting periods.



Each unexpected patient death receives two levels of review within DSH, per department policy. The OLES reviewed each unexpected death and monitored the cases that met OLES criteria. In nine of the 56 patient deaths, the OLES monitored the departmental investigations.

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

Cause of Patient Deaths

Facility	Cancer	Cardiac/ Respiratory	Renal/Liver	Cerebral Issue	COVID-19	Other	Totals
Atascadero	0	2	0	0	0	0	2
Coalinga	2	5	0	0	10	0	17
Metropolitan	0	3	1	0	5	2	11
Napa	3	7	0	0	2	1	13
Patton	2	1	0	1	8	1	13
Totals	7	18	1	1	25	4	56

COVID-19 was listed as the cause of death for 44.6 percent of the reported patient deaths. The second most frequently reported cause of death was cardiac or respiratory issues. Three patient deaths listed under the "Other" category are pending determination for the cause. One patient death from PSH was due to numerous medical conditions and was included under the "Other" category.

Reports of Patients Absent without Leave

In this reporting period, DSH reported six incident types under the significant interest-absent without leave (AWOL) category. Five of the incidents involved forensic patients, which are patients in custody due to a criminal matter. MSH reported three of the six incident types. At MSH, a forensic patient opened an east hallway door that was left ajar, which led to the patio. The patient then climbed over the patio fence and ran south towards the administration building. Officers detained the patient and transported the patient back to his unit. The patient did not sustain any injuries from the incident. Another forensic patient attempted to climb a patio fence, but was stopped by staff without incident. A non-forensic patient walked away from a medical appointment at an outside hospital. When officers located the patient, the patient ran. Officers apprehended the patient 28 minutes later. The patient sustained a small abrasion on his left arm from the incident.

At NSH, a forensic patient ran away from staff while being escorted to another unit inside the secure treatment area. Officers responded and took the patient into custody without incident. The patient never left the secure treatment area.

At PSH, a forensic patient exited through an unsecured exterior door on the unit and walked down the stairway to the unit courtyard. The patient climbed over the courtyard fence and walked to the west sally port, where he contacted the sally port officer and requested to be returned to the unit. The patient sustained superficial scratches to his hands and abdominal area from climbing the fence. Another forensic patient climbed over a courtyard fence and then climbed over a barbed wire fence. Officers responded and used force to detain the resisting patient and subsequently returned the patient to the building. The patient did not sustain injuries requiring treatment beyond first aid and did not leave the secure treatment area.

Notification of Incident Types

Different incident types require different kinds of notification to OLES. Based on legislative mandates in Welfare and Institutions Code sections 4023 and 4427.5 et seq., and agreements between OLES and the departments, certain serious incident types are required to be reported to OLES within two hours of discovery. Notification of these "Priority One" incident types was deemed to be satisfied by a telephone call to the OLES hotline in the two-hour period and the receipt of a detailed report within 24 hours of the time and date of discovery of the reportable incident. "Priority Two" threshold incidents require notification within 24 hours of the time and date of discovery. Priority One and Two threshold incident types are shown in the tables below.

Priority One Notifications – Two Hour Notification

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

Priority Two Notifications – 24 Hour Notification

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

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

Timeliness of Notifications

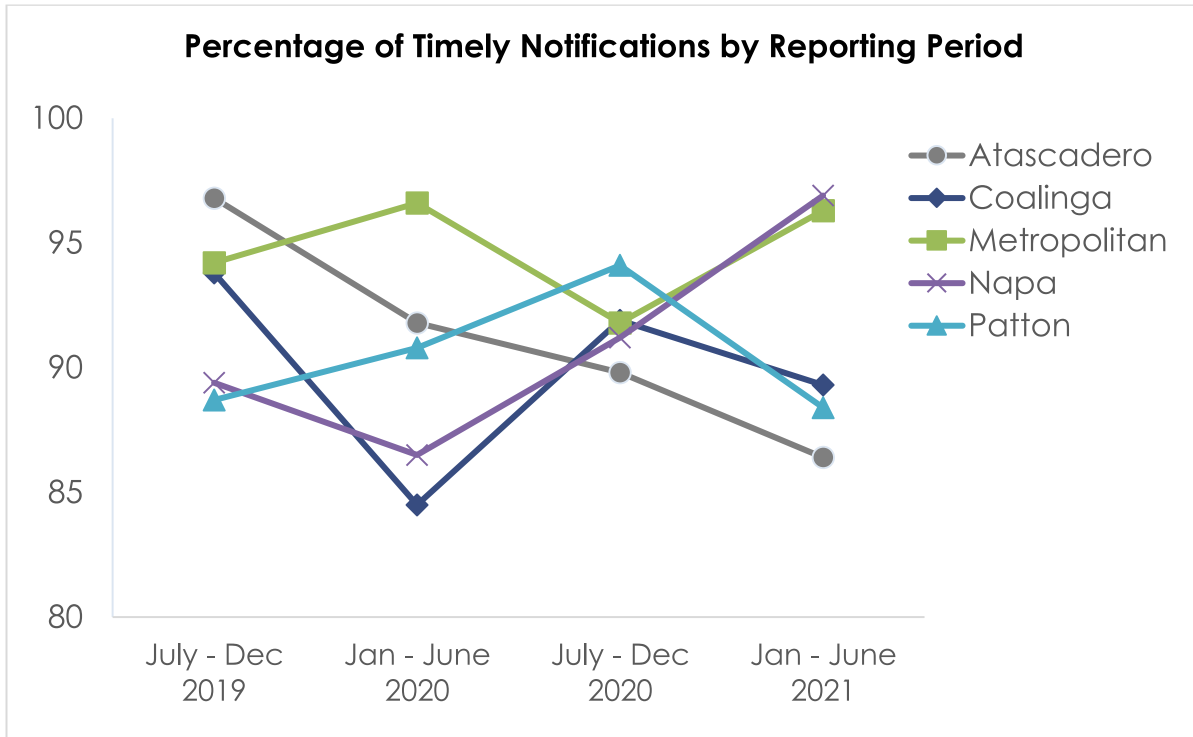
The DSH improved in the timely reporting of incident types with 92.1 percent timely reports when compared to the prior reporting period, which had 91.9 percent timely reports.

Thirty-three of the 568 reported incident types were excluded from DSH's total incident type count when calculating timeliness. These 33 incident types involved a patient attack on staff or were incidents reported directly to OLES by a patient, family member of a patient, facility staff member or by an outside law enforcement agency. Of the 535 incident types evaluated for timeliness, 493 were reported timely and 42 incident types were not timely. Six of the 42 untimely incident types were unreported and were discovered by OLES when reviewing the DSH facility daily incident logs or incident reports.

NSH had the highest percentage of timely notifications at 96.9 percent during this reporting period. ASH had the lowest percentage of timely notifications at 86.4 percent. The following table provides the percentage of timely notifications to OLES for each facility.

Rank	DSH Facility	Number of Incidents Types Reported	Number of Timely Notifications	Percentage of Notifications That Were Timely
1	Patton	112	99	88.4%
2	Coalinga	103	92	89.3%
3	Metropolitan	190	183	96.3%
4	Napa	64	62	96.9%
5	Atascadero	66	57	86.4%
	Total	**535**	**493**	**92.1%**

The following chart compares the percentage of timely notifications by reporting period. When compared to the prior reporting period, MSH and NSH increased in the percentage of timely reports. ASH, CSH and PSH had a lower percentage of timely notifications this reporting period compared to the prior reporting period.



Intake

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

For incidents that initially do not appear to fit the criteria[4] for OLES involvement, the OLES categorizes the incident under the "Pending Review" category and conducts an extra step to ensure the incident is properly categorized. When allegations are unclear and additional information is needed to finalize an initial intake decision, OLES may review video files or digital recordings of a particular hallway, day room, or staff area where a patient was located. Once OLES obtains and evaluates the additional materials or information, the decision to initially deem an incident as not meeting OLES criteria is reviewed again and may be reversed.

For the January 1 through June 30, 2021, reporting period, 229 of the total 553 cases opened for DSH incidents that occurred within DSH's jurisdiction or 41.4 percent were assigned a pending review. The OLES opened cases for 27 incidents that may have occurred while the patient was not housed within a DSH facility and assigned those cases a pending review. The OLES opened 11 administrative investigations and eight criminal investigations. The OLES opened 192 monitored criminal cases and 86 monitored administrative cases.

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

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

Cases Opened in the Current Reporting Period

OLES Case Assignments	January 1 – June 30, 2021	Percentage of Opened Cases
Pending Review	229	41.4%
Monitored, Criminal	192	34.7%
Monitored, Administrative	86	15.6%
Outside Jurisdiction*	27	4.9%
OLES Investigations, Criminal	11	2.0%
OLES Investigations, Administrative	8	1.4%
Totals	553	100%

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

Completed Investigations and Monitored Cases

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

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

OLES Investigations

During this reporting period, OLES completed 12 investigations. Four investigations were criminal cases and eight were administrative.

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

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

Results of Completed OLES Investigations

Type of Investigation	Total completed January- June 30, 2021	Referred to prosecuting agency	Referred to facility management*	Closed without referral
Administrative	8	N/A	6	2
Criminal	4	0	N/A	4
Total	12	0	6	6

OLES Monitored Cases

In this report, OLES provides information on 161 completed monitored cases. By the end of the reporting period, 86 monitored criminal cases had either been referred or not referred to a prosecuting agency. Four out of 86 criminal cases were referred to a prosecuting agency.

There were 75 completed monitored pre-disciplinary administrative cases with allegations that were sustained or not sustained during this reporting period. Eleven of the 75 cases had sustained allegations. Sixty-two cases had no sustained allegations. Two of the monitored administrative cases had sustained allegations that OLES reported on in a prior reporting period. Results of OLES monitored cases are provided in the table below.

Type of Case/Result	DSH
Criminal-Referred to Prosecuting Agency	4
Criminal-Not Referred	82
Total Criminal	86
Administrative-With Sustained Allegations	11
Administrative-With Sustained Allegations Reported in the Prior Reporting Period	2
Administrative-Without Sustained Allegations	62
Total Administrative	75
Grand Total	161

Pre-Disciplinary Phase Cases

Of the 159 pre-disciplinary phase cases provided in Appendix B and D, the OLES rated 22 cases procedurally insufficient only and four cases both procedurally and substantively insufficient. The following table provides the type of case and the corresponding number of cases rated procedurally or substantively insufficient.

Outcomes of Procedural and Substantive Insufficient Cases

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Criminal/Referred to Prosecuting Agency	0	0
Criminal/Not Referred	13	3
Administrative/With Sustained Allegations	0	0
Administrative/Without Sustained Allegations	13	1
Total	26	4

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

Procedural Deficiencies found in Insufficient Cases

Procedural Deficiency	Potential Consequence
Failure to complete investigations within 120 days or delays in making findings and penalty determinations	As investigations age, memories may fade, witnesses may become unavailable, patients may be discharged or transferred.
Failure to notify OLES of suspect or witness 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 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 Public Safety Officer Procedural Bill of Rights Act.

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

Substantive Deficiencies found in Insufficient Cases

Substantive Deficiency	Potential Consequence
Failure to appropriately determine probable cause existed	The case in which there was probable cause to believe a crime was committed was not referred to the prosecuting agency, thereby precluding a criminal prosecution.

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

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

DSH Tracking of Law Enforcement Compliance with Training Requirements

The DSH primarily uses a training database to track training completed by law enforcement staff. The software tracks courses required in the 2020 DSH OPS Training Plan as well as any additional courses required by the legislature. Each facility has a designated training coordinator or manager that is responsible for using the compliance monitor within the database to track law enforcement personnel who have expired certifications or have trainings that are approaching expiration.

The training database tracking system sends law enforcement personnel a email reminder of any upcoming assigned trainings due. Upon completion, training coordinators receive an email notification of the completed training. There is currently no specific requirement for how often training coordinators must check the training records to ensure compliance records are up to date.

Due to COVID-19, many courses were cancelled or delayed. Each facility is responsible for ensuring law enforcement personnel who have been out of compliance the longest are scheduled for training at the earliest opportunity. The DSH also shifted training operations to have smaller class sizes with social distancing and began offering more classes, as well as online training.

The DSH reported the following percentages for law enforcement compliance with training requirements:

DSH Facility	Percentage of Compliance
Atascadero	50%
Coalinga	75%
Metropolitan	87.7%
Napa	89.9%
Patton	95%

Certification Tracking in DSH's Training Database

As of June 30, 2021, the DSH certification records in DSH's training database show 64.5 percent compliance, or 3349 active certifications out of 5195. Four of these certifications had a status of "Not Yet Issued,' one was revoked, and two were listed as suspended. The certifications that had the highest total of expired certifications include:

- area extraction,
- arrest methods and defensive tactics,
- chemical agents,
- California Law Enforcement Telecommunications System (CLETS) full access operator,

- Cardiopulmonary Resuscitation – American Heart Association Basic Life Support for the Health Care Provider (CPR – AHA BLS for HCP),
- domestic violence,
- first aid,
- gang awareness,
- Rapid Containment Baton (RCB) Baton certification,
- Tactical communications,
- Title 22 First Aid and
- Use of Force.

However, the certification records in the training database do not accurately reflect compliance with training requirements. Each facility manually enters training records in the database. Some completed trainings were not recorded as certifications, and therefore, the certification status remains listed as "expired" within the database. In addition, expiration dates for certification entries are manually entered by designated personnel at each facility. The OLES found errors in some records that did not adhere to the listed expiration rule for renewal. For example, a certification for area extraction was issued on May 8, 2019, but the expiration date was listed as April 19, 2023. Despite the expiration rule for renewal being listed as one year, the certification for that record was listed as active.

The certification records for each position also varied significantly across facilities and individuals. The certification compliance report in the database accounts for certifications that are inputted into an individual's training history record. For example, if area extraction was not entered into a person's training history, the compliance report would not indicate that the individual was deficient or compliant in that required training. Despite being subject to the same training requirements, an officer may show five total certifications in the training history record and be listed as 100 percent compliant, whereas another officer may have ten certifications listed and have 50 percent compliance despite having completed the same trainings.

The following table provides the specific number of active and expired certifications as extracted from the database. Blank areas indicate there were zero certifications. Of the 82 certification categories, the DSH reported 10 categories are inactive. The inactive categories were not specified to OLES, and remain listed in the table.

Certification	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
1st Aid	10	6				16
Academy Instructor Certification Course	15					15
Active Shooter Instructor	6					6

Certification	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
Advanced Instructor Certification Course	8					8
AHA BLS for HCP (CPR)		1				1
AHA Heartsaver (1st Aid)		1				1
AICC - Level II-B Technology Course	3					3
Area Extraction	184	265				449
Area Extraction Instructor	26					26
Armorer Certification - Sig Sauer P-320 Armorer	3					3
Arrest and Control Instructor	2					2
Arrest and Control/ Defensive Tactics Instructor	19					19
Arrest Methods & Defensive Tactics	225	125	1			351
ASP Baton Tactical Weapon Instructor	2					2
Basic Law Enforcement Academy	2					2
Baton	55					55
Bicycle Patrol Instructor	1					1
Blue Team NexGen Train the Trainer	49					49
Chemical Agent Instructor	11					11
Chemical Agents	153	153				306

Certification	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
CLETS - Full Access Trainer	1	1				2
CLETS full access operator	88	86				174
Communication Keeping Your Edge	1					1
Communications Training Officer (CTO)	1					1
Continuing Professional Training (CPT)	63	26				89
CPR - AHA BLS 2020 Instructor Update	1					1
CPR - AHA BLS for HCP	162	174				336
CPR - BLS for HCP	16	1				17
CPR Instructor - AHA /BLS	3	1				4
CPR Instructor - AHA BLS for HCP	5	3				8
Crisis Intervention and Behavioral Health Instructor	6					6
Domestic Violence	115	168				283
Domestic Violence Instructor	2					2
Drill and Ceremony Instructor	3					3
Driver Awareness Update	21					21
Emergency Vehicle Operations Course (EVOC)	223					223

Certification	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
Evidence Specialist	2					2
Field Training Officer	60	53		1	2	116
Field Training Officer Update	1	9				10
Field Training Program - Supervisor/ Administrator/ Coordinator	15					15
Firearms (All Firearm Types) Instructor Course	16					16
Firearms (All Firearms Types) Instructor Update Course	1					1
First Aid	7	85				92
First Aid Instructor	6	5				11
Gang Awareness	113	169				282
Hazardous Materials Instructor	2					2
Hazmat Awareness Instructor	1					1
IDI Level II Core Course	2					2
LD 03 Tactical Communications	1					1
Level II Modular Academy		3				3
Level III Modular Academy		3				3
LGBT AWARENESS LE T4T	2					2
Lifetime Fitness Instructor	4					4

Certification	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
P.C. 832 Certificate	16					16
PC 832 Firearms Course	244					244
Pepper Ball Launcher Instructor	13					13
PepperBall Launcher	54		3			57
PepperBall Launcher Course	51					51
Pistol Mounted Optics Instructor	1					1
POST Management Class	2					2
POST Prop 115	215					215
POST Supervisory Course	11					11
PRINCIPLED POLICING FOR BASIC COURSES T4T	2					2
Prop 115 (Hearsay Testimony)	9					9
Psychological Screening Program Proctor	1					1
Public Safety Dispatcher Instructor	3					3
Racial Profiling	292					292
Racial Profiling Instructor	13					13
RCB Baton Certification	162	119				281
RCB Baton Instructor	35	3				38
Recruit Training Officer (RTO)	4					4

Certification	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
Report Writing for Instructors	4					4
Scenario Management (Evaluator) Training	1					1
Tactical Communications	121	127				248
Tactical Communications Instructor	8					8
Tactical Social Interaction, Train the Trainer	5					5
Title 22 (1st Aid and CPR)	21	11				32
Title 22 First Aid	147	126				273
Traffic Collision Investigator	1					1
Training Manager Course	1					1
Use of Force	193	115				308
Weapons Impact Instructor	1					1
Total	**3349**	**1839**	**4**	**1**	**2**	**5195**

The following table provides the certification data by facility. Five law enforcement personnel were not assigned a facility within the training database.

Facility	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
Atascadero	1443	533	4		1	1981
Coalinga	552	498		1	1	1052
Metropolitan	793	374				1167
Napa	191	169				360
Patton	354	252				606
Sacramento/ Headquarters	7					7
Facility Left Blank	9	13				22

Facility	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
Total	**3349**	**1839**	**4**	**1**	**2**	**5195**

Additional Mandated Data

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

Adverse Actions against Employees

DSH Facilities	Formal administrative investigations/actions completed*	Adverse action taken (Formal investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/ retired pending adverse action****
Atascadero	44	7	23	9	5
Coalinga	39	2	21	16	0
Metropolitan	44	1	34	7	2
Napa	51	1	45	4	1
Patton	29	3	22	3	1
Totals	207	14	145	39	9

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

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

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

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

Criminal Cases against Employees

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	0	0	0	0
Coalinga	0	0	0	0
Metropolitan	39	1	38	0
Napa	44	1	43	0
Patton	4	4	0	3
Totals	87	6	81	3

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

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

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

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

Reports of Employee Misconduct to Licensing Boards

DSH Facilities	CA Board of Behavioral Science	Registered Nursing	Vocational Nursing/ Psych Tech	CA Medical Board
Atascadero	1	3	6	0
Coalinga	0	0	0	0
Metropolitan	0	1	2	1
Napa	0	0	0	0
Patton	0	0	0	0
Totals	1	4	8	1

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

Patient Criminal Cases

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	579	50	529	42
Coalinga	348	80	268	47
Metropolitan	258	12	246	1
Napa	230	5	225	0
Patton	195	106	89	98
Totals	1610	253	1357	188

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

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

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

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

Monitored Issues

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

Area Extraction and Use of Force at ASH

In April 2021, the OLES issued a monitored issue memorandum to DSH after investigating an incident involving allegations of peace officer misconduct that was reported to OLES as a significant-interest- attack on staff incident. From the investigation, OLES determined OPS HPOs, supervisors and managers failed to follow DSH OPS Policy 300 Use of Force - Patients and Policy 338 Area Extraction. The involved HPOs failed to follow Policy 338, when they forcibly removed a patient from a common area for placement into seclusion and restraint. Furthermore, OPS supervisors and managers failed to conduct the review of the event or force used as required by Policy 300.

The monitored issue memorandum highlighted the need for implementation and training of OPS personnel for Policy 338 and determined OPS supervisors and managers may not have a clear understanding of what constitutes use of force or the use of force review requirements as defined in Policy 300. The OLES will work collaboratively with the department and continue to monitor the department's progress on this issue.

DSH Patient Pregnancies

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

The OLES' recommendations included the following:

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

aggression and sexually harmful behavior are not in DSH coed units.

In response to OLES recommendations, DSH drafted two policies titled "PD 3108 Child Placement" and "PD 3106 Patient Sexual Behavior and Health." The first policy allows a pregnant patient to decide where and with whom her infant will be placed after birth. The second policy identifies what must be considered when determining patient placement in co-ed living quarters. The DSH fully implemented both policies. The OLES will continue to monitor the department's adherence to these policies.

Enforcement of Employee Return to Patient Care Policy

As previously published in the semiannual report covering the period of January 1, 2018, through June 30, 2018, the OLES identified a systemic issue involving DSH employees who were accused of physical or sexual abuse of patients. Department policy allowed clinical staff to decide whether an employee who was accused of patient abuse could be reinstated to a patient-care position without consultation with facility law enforcement and before facility law enforcement completed an investigation of the abuse allegation.

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

In April 2021, DSH implemented PD 9500 Incident Management System, which established an incident management system within DSH to identify, classify, document, report, track and trend events that have or may have an adverse effect on the safety, care, treatment, and rehabilitation of patients at each DSH facility. The system includes a multi-level review process to ensure that incidents are documented, assessed, and corrective actions are appropriate and effective to prevent recurrence. PD 9500 also established requirements for investigations of incidents that involve allegations of abuse, neglect, or exploitation, and requirements for protecting patients while the investigation is conducted.

With PD 9500, DSH fully implemented a statewide policy standardizing the recommendations made by OLES. Clinical staff now consult with facility law enforcement when determining if an accused staff member can be returned to patient care, even if the law enforcement investigation has not yet concluded.

Escape Prevention and Key Control at CSH

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

The OLES recommended CSH implement the following 14 recommendations:

Receiving and Release Area

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

Key Control

- Repair or replace the key boxes in such a manner their security features function appropriately (this includes regular software updates).
- Assign a HPO or supervisor to monitor key activity at the beginning, during and end of each shift to ensure keys are turned to the lock position and the key boxes are properly secured.
- Allow OPS access to the key computer system so an inventory of each box can be completed on each shift. Have policy in place to address next steps when a key is missing. (Lockdown, secure a given area etc.).
- Provide ongoing training to all staff regarding key control.
- All key box areas must be under DVR-video surveillance.
- Develop policy where officers are responsible for key inventory and security. The locksmiths should only be responsible for functioning keys and ensuring the lock box operates properly.

Per a memorandum from DSH in April 2020, DSH accomplished six out of the eight recommendations for the receiving and release area. Since the previous SAR, DSH completed all but two recommendations. The remaining two recommendations are for footage from video cameras at CSH should be DVR-recorded and for key box areas to be under DVR-video surveillance. The DSH obtained the cameras and DVR system. The DSH anticipates work on camera installation in large hallways will begin in November

2021. The OLES will continue to monitor the department's progress.

Special Review of NSH Policy and Procedures

In the semiannual report covering the period of July 1, 2018, through December 31, 2018, OLES published the results of a special review on policy and procedures relating to use of force, patient arrests, training, and emergency responses as a result of an incident at NSH. The review determined there needed to be a higher level of awareness and involvement by supervision and management in incidents that potentially expose the department to liability.

More specifically, the OLES recommended DSH document action conducted by supervision and management to gather information that would protect the department. This would allow DSH to proactively prepare for potential litigation and ensure management has all the necessary information to improve or create policies that support patient and staff safety. The OLES recommended OPS managers and supervisors at NSH receive additional training on civil liability prevention and mitigation to assist them in approaching critical incidents that may expose the department to liability.

In response to the OLES's recommendations, the DSH legal division is providing ongoing statewide training to staff.

Underutilization of Blue Team/IAPro

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

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

Advance Denial. The DSH-HQ would generate monthly reports to send to the DSH Police Chief at each facility for review.

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

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

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

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

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

On December 22, 2020, OLES received notification from the DSH OPS Chief, that Blue Team training had been completed, with an overall completion rate of 93.67 percent. Individually, the completion rates reflected

- ASH-88.00%
- CSH-90.00%
- MSH-84.00%

- NSH-100.00%
- PSH-100.00%, and
- DSH-Headquarters-100.00%.

The DSH OPS Chief advised a yearly refresher will be conducted to ensure staff remain current in their knowledge and understanding.

On August 16, 2021, and August 31, 2021, OLES reviewed the incidents DSH entered into Blue Team/IA Pro between January 1, 2021, through June 30, 2021. The number of incidents inputted by the facilities are provided below.

Category	Total Incidents on August 16, 2021	Total Incidents on August 31, 2021
Use of Force	47	78
Citizen's Complaint	1	1
Citizen's Complaint Other-O	1	1
Patient Complaint	0	0
Administrative Investigation	2	2
MSA Denial	0	1
Vehicle Accident	0	0
Censurable Incident	3	8
Total	54	91

From this review, OLES discovered DSH was not promptly inputting reportable incidents. For example, an incident involving use of force occurred on May 11, 2021, but was not listed in Blue Team/IA Pro when OLES first reviewed the total incidents entered on August 16, 2021. The incident was subsequently discovered in the system on the August 31, 2021. Similarly, two censurable incidents that occurred on April 12, 2021, were not listed on August 16, 2021, but were listed in the system on August 31, 2021.

The OLES reviewed the 2017 DSH Early Intervention System Procedure manual, which provides guidelines for the usage and data input in the Blue Team and IAPro software. The procedure manual does not include specific timeframes for supervisors and managers to input incidents. However, DSH advised OLES of a planned update to the procedure manual. The OLES recommends DSH input each reportable incident into Blue Team within 72 hours of discovery of the incident.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2021.

Case Detail	Description
Incident Date	03/21/2020
OLES Case Number	2020-00295-1A
Case Type	Investigative
Incident Type	1. Head/Neck 2. Misconduct
Incident Summary	On March 21, 2020, officers allegedly refused to assist outside hospital medical personnel with a patient who had fallen and failed to report the incident.
Disposition	The Office of Law Enforcement Support conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the findings was provided to the department.

Case Detail	Description
Incident Date	08/01/2019
OLES Case Number	2020-00455-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between August 2019 and May 11, 2020, a lieutenant allegedly engaged in inappropriate financial transactions with subordinate employees. In December 2019, the lieutenant allegedly brought alcohol onto hospital grounds.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES will monitor the disposition process.

Case Detail	Description
Incident Date	08/11/2020
OLES Case Number	2020-00837-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On August 11, 2020, an officer was allegedly dishonest regarding the loss or theft of his state-issued vest.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES will monitor the disposition process.

Case Detail	Description
Incident Date	08/01/2020
OLES Case Number	2020-00898-1-A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between August 1, 2020, and August 31, 2020, a hospital police officer allegedly sent harassing text messages and made unsolicited phone calls to a hospital employee.
Disposition	The OLES conducted an inquiry into this matter and determined there was insufficient evidence that misconduct occurred and the matter was closed. A summary of the review and decision was provided to the department.

Case Detail	Description
Incident Date	07/01/2020
OLES Case Number	2020-01018-1A
Case Type	Investigative
Incident Type	1. Misconduct 2. Misconduct
Incident Summary	Between July 1, 2020, and September 7, 2020, an officer made threatening, discriminatory and discourteous statements, and engaged in threatening conduct toward co-workers.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES will monitor the disposition process.

Case Detail	Description
Incident Date	09/27/2020
OLES Case Number	2020-01048-1CON
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between September 27, 2020, and September 30, 2020, an officer allegedly gave a felon a state police radio and sold two boxes of ammunition to, and agreed to purchase a firearm for the felon. On October 19, 2020, the officer allegedly possessed illegal narcotics and was dishonest during a law enforcement interview. On February 12, 2021, the officer was allegedly dishonest during an administrative interview. Between January 1, 2019, and October 31, 2020, the officer allegedly associated with a felon and known gang member who was involved in continuing illegal activity.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	11/16/2020
OLES Case Number	2020-01189-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	On November 16, 2020, two officers allegedly twisted a patient's arm behind his head.
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	11/18/2020
OLES Case Number	2020-01208-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On November 18, 2020, a sergeant allegedly returned to work after a possible coronavirus exposure and made false statements to a supervisor. On January 14, 2021, the sergeant allegedly was dishonest during an investigative interview.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	06/01/2019
OLES Case Number	2020-01275-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Between June 1, 2019, and September 28, 2020, an officer allegedly engaged in sexual misconduct while on duty.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES will monitor the disposition process.

Case Detail	Description
Incident Date	12/30/2020
OLES Case Number	2021-00070-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	On December 30, 2020, an officer and staff members allegedly used excessive force to restrain a patient.
Disposition	The OLES conducted an investigation into this matter. The

	case was not referred to the district attorney’s office due to a lack of probable cause. A summary was provided to the department.

Case Detail	Description
Incident Date	01/27/2020
OLES Case Number	2021-00106-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On January 27, 2020, an officer allegedly improperly investigated allegations of patient abuse.
Disposition	The Office of Law Enforcement Support conducted an investigation into this matter. The case was not referred to the district attorney’s office due to a lack of probable cause. A summary was provided to the department.

Case Detail	Description
Incident Date	02/01/2021
OLES Case Number	2021-00332-1C
Case Type	Investigative
Incident Type	1. Sexual Assault
Incident Summary	Between February 1, 2021, and March 31, 2021, an officer allegedly sexually assaulted a patient.
Disposition	The OLES conducted an inquiry into this matter and determined there was insufficient evidence that a crime was committed and the matter was closed without referral to the district attorney's office. A summary of the findings was provided to the department.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2021, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. The OLES monitored each departmental investigation for both procedural and substantive sufficiency.

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

Criminal-Referred to Prosecuting Agency

Case Detail	Description
Incident Date	08/19/2020
OLES Case Number	2020-00904-1C
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 August 19, 2020, a senior psychiatric technician and three other staff members allegedly grabbed and forced a patient into a seclusion room. The patient reportedly sustained a cut lip, a bump on his head, and a dislocated shoulder.
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:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/16/2020
OLES Case Number	2020-01219-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	Between November 16, 2020, and November 17, 2020, a psychiatric technician allegedly pinched a patient's arms and persisted in pretending to put lotion on the patient's arms even though the patient told the psychiatric technician to stop. The psychiatric technician allegedly pulled on the patient's sleeve and made statements ridiculing the patient's intelligence and weight.
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 did not object to 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	02/25/2021
OLES Case Number	2021-00253-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On February 25, 2021, a psychiatric technician gave a patient the wrong medication, after which the patient suffered adverse side effects.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	02/25/2021
OLES Case Number	2021-00264-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On February 25, 2021, an information technology specialist allegedly downloaded patients' protected health information to his personal laptop.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Criminal-Not Referred

Case Detail	Description
Incident Date	05/08/2020
OLES Case Number	2020-00493-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 8, 2020, several level of care staff allegedly forced a disruptive patient onto the floor, jumped on the patient, and grabbed the patient's head and hair. The patient was then placed in restraints. X-rays later confirmed the patient sustained five fractured ribs.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.

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

Case Detail	Description
Incident Date	08/23/2020
OLES Case Number	2020-00887-2C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 23, 2020, a patient alleged that staff members may have been providing drugs to patients.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/29/2020
OLES Case Number	2020-00897-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Referred
Incident Summary	On August 29, 2020, a patient was found unresponsive in her bed and was pronounced deceased. An autopsy revealed the cause of death was acute Clozapine toxicity.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the hiring authority's determination. The department opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/25/2020
OLES Case Number	2020-00891-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 25, 2020, a nurse allegedly slammed a refrigerator door on a patient's hand.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/05/2020
OLES Case Number	2020-00923-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On September 5, 2020, a nurse allegedly failed to continuously monitor a patient who required enhanced observation for possible water intoxication.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES did not concur with the probable cause determination because the investigation established that the nurse intentionally did not provide continuous enhanced observation of the patient. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. A responding officer did not provide the nurse with the required Beheler admonition before taking his statement, the draft investigative report contained references to

	inapplicable statutes, the Office of Protective Services did not consult with the OLES regarding whether to refer the case to the district attorney's office for prosecution, the Office of Protective Services did not appropriately determine whether probable cause existed for a referral to the district attorney's office, and the investigation was not completed until 157 days from the date of discovery.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not provide the nurse with the Beheler admonishment prior to taking his statement. 2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report contained a reference to an incorrect statute. 3. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution? No. The department did not appropriately determine that probable cause existed, even though the investigation established that the nurse intentionally did not provide continuous enhanced observation of the patient. 4. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The department did not consult with the OLES regarding the decision to not refer the case to the district attorney's office for prosecution. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident occurred on September 5, 2020; however, the investigative report was not completed until February 9, 2021, 157 days later.
Department Corrective Action Plan	The involved sergeants have been reminded of the importance of providing the appropriate admonishments prior to taking a statement. In addition, admonishment protocol will be discussed at each watch briefing to ensure future compliance. The responding officer was counseled on proper statute considerations and the correct statute was

	entered in the final draft of the report. The Investigator has been reminded it is imperative they collaborate with the assigned AIM to explain his position regarding the staff member's lack of willful intent. The Investigator has been reminded it is imperative they confer with the assigned AIM when he elects not to submit a case that may have established probable cause. The Investigator will be reminded and retrained on how to prioritize their cases to ensure deadlines are met. To prevent further delays, an electronic tracking system has been implemented to ensure timeliness of investigations.

Case Detail	Description
Incident Date	09/08/2020
OLES Case Number	2020-00934-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 8, 2020, a registered nurse allegedly taunted and induced a patient to pull out his feeding tube, resulting in bleeding.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/07/2020
OLES Case Number	2020-00935-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 7, 2020, a registered nurse allegedly grabbed a patient by the shirt collar, pushed the patient against a wall, causing the patient to fall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for

	monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The incident was discovered on September 9, 2020; however, the investigation was not completed until January 14, 2021, 127 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on September 9, 2020; however, the investigation was not completed until January 14, 2021, 127 days later.
Department Corrective Action Plan	The Supervising Special Investigator I discussed with the investigative staff the importance of communicating with the AIM prior to the due date of the report.

Case Detail	Description
Incident Date	09/09/2020
OLES Case Number	2020-00941-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 9, 2020, a psychiatric technician allegedly fell asleep while providing an enhanced level of supervision of a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The incident was discovered on September 9, 2020; however, the investigation was not completed until February 4, 2021, 148 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on September 9, 2020; however, the investigation was not completed until February

	4, 2021, 148 days later.
Department Corrective Action Plan	A spreadsheet that has been created to ensure that all investigations are completed within the required timeframes will be checked against the face sheet that is attached to each report at the monthly investigators monthly meeting.

Case Detail	Description
Incident Date	09/16/2020
OLES Case Number	2020-00955-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 16, 2020, a psychiatric technician allegedly used a racial slur and forced a patient against a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services did not open an administrative investigation. The OLES concurred with the determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/16/2020
OLES Case Number	2020-00959-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 16, 2020, an unidentified staff member allegedly raped a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/18/2020
OLES Case Number	2020-00962-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Incident Summary	On September 18, 2020, a psychiatric technician assigned to conduct enhanced observation of a patient allegedly choked the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred. 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	09/27/2020
OLES Case Number	2020-00988-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 27, 2020, a registered nurse and a psychiatric technician allegedly hit a patient in the arm while placing the patient in restraints.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES did not accept for monitoring because the alleged misconduct did not fall within the OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/29/2020
OLES Case Number	2020-01003-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 29, 2020, a patient alleged she was sexually assaulted by another patient while she was on an enhanced level of observation.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. Responding officers did not attempt to locate and collect physical evidence and did not interview staff members assigned to continuously monitor the patient. Also, medical staff did not immediately medically assess the patient.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. Staff did not immediately medically assess the patient after she alleged she was sexually assaulted by another patient. The responding officer did not attempt to locate and collect physical evidence, and did not interview staff members assigned to continuously monitor the patient.
Department Corrective Action Plan	Supervisors and Officers have received training on following procedural guidelines for the collection of evidence. Additionally, a review of procedures for interviewing all potential witnesses has been reiterated to include reporting all pertinent reasons why a witness wasn't available for interview. OPS shall maintain continuous monitoring to ensure proper evidence collection, identification and interviewing of all potential witnesses occurs.

Case Detail	Description
Incident Date	10/09/2020
OLES Case Number	2020-01038-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act

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

Case Detail	Description
Incident Date	10/12/2020
OLES Case Number	2020-01045-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On October 12, 2020, a psychiatric technician allegedly kicked a patient and held his knee on the patient's neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/14/2020
OLES Case Number	2020-01053-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between September 14, 2020, and October 14, 2020, a psychiatric technician allegedly harassed and physically abused a patient. Level of care staff also allegedly allowed other patients to threaten and assault that patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective

	Services did not open an administrative investigation. 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	10/16/2020
OLES Case Number	2020-01070-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On October 16, 2020, a psychiatric technician assistant allegedly asked a patient for oral sex in exchange for diapers.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	10/26/2020
OLES Case Number	2020-01092-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	On October 26, 2020, a nurse and two psychiatric technicians allegedly grabbed and forced a patient to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective

	Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The patrol report did not indicate whether the responding officer provided the suspects with the required Beheler admonition before taking their statements.
Pre-Disciplinary Assessment	1. Was the incident properly documented? No. The patrol report did not state whether the responding officer provided the suspects with the required Beheler admonition before taking their statements, and did not include a summary of all relevant information obtained during those interviews regarding the allegations of patient abuse.
Department Corrective Action Plan	Supervisors and Officers have received training on required legal admonitions before taking statements from suspects. OPS shall maintain continuous monitoring to ensure legal admonitions are provided when legally required. OPS will also ensure officers provide a complete summary of interviews for the allegation.

Case Detail	Description
Incident Date	10/20/2020
OLES Case Number	2020-01097-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On October 20, 2020, a patient left a voice message on the OLES's hotline alleging that a psychiatric technician provided narcotics to a patient which contributed to a second patient's death on February 20, 2015.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. 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	10/27/2020
OLES Case Number	2020-01100-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other 2. Criminal Act
Findings	1. Unfounded 2. Not Referred
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	On October 27, 2020, a patient was discovered choking. Responding staff initiated emergency life-saving measures; however, the patient was declared dead at an outside hospital. An autopsy determined the primary cause of death was choking as a consequence of consumption of food outside of a liquid diet.
Investigative Assessment	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.

Case Detail	Description
Incident Date	10/31/2020
OLES Case Number	2020-01108-1C
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 31, 2020, a psychiatric technician allegedly hit and slapped a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/03/2020
OLES Case Number	2020-01127-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 3, 2020, a patient unexpectedly died. The cause of death was cardiopulmonary arrest complicated by other medical conditions.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/01/2020
OLES Case Number	2020-01128-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between September 1, 2020, and October 31, 2020, a psychiatric technician allegedly grabbed, pulled, and threatened a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. 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	11/02/2020
OLES Case Number	2020-01129-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 2, 2020, six staff members allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation which the OLES did not accept for monitoring because the incident did not meet the OLES's monitoring criteria.
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	11/05/2020
OLES Case Number	2020-01134-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 5, 2020, a social worker allegedly dragged and forced a patient onto his bed.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services opened an administrative case which the OLES did not accept for monitoring because there was no evidence of staff misconduct.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/06/2020
OLES Case Number	2020-01148-1C
Case Type	Monitored
Incident Types	1. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 6, 2020, a nurse allegedly failed to continuously monitor a patient and intervene before the patient intentionally fell and sustained a head injury.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/08/2020
OLES Case Number	2020-01152-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 8, 2020, a psychiatric technician allegedly fell asleep while assigned to monitor a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES did not concur with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services repeatedly did not adequately consult with the OLES during the investigation regarding the investigative plan, the scheduling of witness interviews, and whether probable cause existed for a referral to the district attorney's office. The draft and final investigative reports contained inappropriate findings, and changes to the reports were made without consultation with the OLES. Also,

	the Office of Protective Services did not adequately investigate the possible criminal liability for assigning the psychiatric technician to monitor patients when he had a demonstrated history of falling asleep while conducting continuous observations.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The investigator completed an initial investigative plan that consisted solely of a statement stating that because the patient did not want to pursue criminal charges against the psychiatric technician, the criminal case would be closed. 2. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator did not initially determine that any investigation was needed of the psychiatric technician's claims he allegedly had a medical condition that caused him to fall asleep and that he allegedly provided information about this medical condition to the department. 3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The first draft investigative report contained inappropriate findings that the psychiatric technician did not willfully fall asleep and therefore was not criminally liable. The initial draft investigative report also inappropriately concluded that the psychiatric technician was solely responsible for his actions, and did not examine the circumstances under which the psychiatric technician was assigned to conduct continuous monitoring of patients when he had a demonstrated history of falling asleep. In addition, the draft investigative report dated January 25, 2021, indicated the case would not be forwarded to the district attorney's office; however, later that afternoon, the draft investigative report was changed stating that the case would be forwarded to the district attorney's office. The draft investigative report was changed a third time on January 27, 2021, stating that the case was closed. These changes were not made in consultation with the OLES. 4. Was the final investigative report thorough and appropriately drafted? No. The final investigative report included findings that the

contained inappropriate findings that the psychiatric technician did not willfully fall asleep and therefore was not criminally liable. The final investigative report also inappropriately concluded that the psychiatric technician was solely responsible for his actions, and did not examine the circumstances under which the psychiatric technician was assigned to conduct continuous monitoring of patients when he had a demonstrated history of falling asleep.

5. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution?

No. The department did not appropriately determine that probable cause existed, even though the investigation established that the psychiatric technician had a history of falling asleep and failing to provide continuous enhanced observation of the patient.

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

No. The investigator did not notify the OLES of the scheduling of the two witness interviews, thereby preventing the monitor from attending the interviews and providing real-time feedback. Also, the department did not consult with the OLES regarding the decision to not refer the case to the district attorney's office for prosecution.

7. Was the investigation thorough and appropriately conducted?

No. The investigator initially decided to immediately close the case solely because the patient stated that he did not wish to pursue criminal charges against the psychiatric technician. Also, the department did not examine the circumstances under which the psychiatric technician was assigned to conduct continuous monitoring of patients when he had a demonstrated history of falling asleep.

8. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase?

No. The investigator did not cooperate with the OLES regarding the investigative plan and the scheduling of

	witness interviews. Also, the department did not cooperate with the OLES regarding the probable cause determination.
Department Corrective Action Plan	During daily investigative meetings, Investigators were reminded of the importance of contacting the AIM when they develop a case plan and when there are discrepancies identified by the AIM to advise the Supervising Special Investigator before proceeding. It was determined through the course of the investigation that a Reasonable Accommodation was not in place. The staff member claimed it was well-known by several of his peers that he had a condition; however, there was no formal medical accommodation in place. Investigators have been reminded to collaborate with the AIM during the investigation to ensure all questions are answered throughout the investigation particularly. The Investigators have also been instructed to re-interview when discrepancies are noted in statements as needed for both draft and final reports. Investigators have been reminded of the importance of conferring with the assigned AIM during the initial and on-going investigative efforts to provide continued real-time consultation with OLES. Investigators have been reminded of the importance of conferring with the assigned AIM when they elect not to submit a case that may have established probable cause. If an agreement cannot be reached and/or the Investigator elects not to use a recommendation from the assigned AIM, they must advise the Supervising Special Investigator and conduct a case brief to justify their position. Investigators have been reminded of the importance of conferring with the assigned AIM during the initial and on-going investigative efforts to provide continued real-time consultation with OLES.

Case Detail	Description
Incident Date	11/05/2020
OLES Case Number	2020-01171-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 5, 2020, a senior psychiatric technician allegedly poked a transgender patient's chest, grabbed at the patient's hormone patch, and twisted the patient's arm. The patient sustained bruises, and complained of pain.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the

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

Case Detail	Description
Incident Date	07/01/2020
OLES Case Number	2020-01175-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	During July 2020, a senior psychiatric technician and a psychiatric technician allegedly forced a patient against a wall. The senior psychiatric technician and the psychiatric technician then allegedly dragged and forced the patient onto her bed.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/22/2020
OLES Case Number	2020-01176-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 22, 2020, a registered nurse and a psychiatric technician allegedly forced a patient onto her bed. The psychiatric technician then allegedly pushed his forearm into the patient's neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services 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	11/14/2020
OLES Case Number	2020-01192-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 14, 2020, a registered nurse allegedly inappropriately touched a patient over the patient's clothes.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/18/2020
OLES Case Number	2020-01205-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 18, 2020, an unidentified person allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/19/2020
OLES Case Number	2020-01226-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 19, 2020, a psychiatric technician allegedly kicked a patient's wheelchair, causing the patient's knee to strike a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation. The OLES did not monitor the administrative investigation as it no longer meets monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/01/2020
OLES Case Number	2020-01230-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between May 1, 2020 and November 27, 2020, a psychiatric technician allegedly touched a patient's breasts.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/26/2020
OLES Case Number	2020-01231-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 26, 2020, two staff members allegedly grabbed and bruised a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/22/2020
OLES Case Number	2020-01232-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 22, 2020, staff found a 72 year-old patient unresponsive and initiated emergency life-saving measures. The patient was sent to an outside hospital where he died five days later. An autopsy determined the cause of death was cardiopulmonary arrest, myocardial infarction, and atherosclerotic heart disease.
Disposition	The case was not referred to the district attorney’s office due to a lack of probable cause. The OLES concurred with the probable cause determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/30/2020
OLES Case Number	2020-01240-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On November 30, 2020, two psychiatric technicians allegedly hit and kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	08/01/2020
OLES Case Number	2020-01242-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Between August 1, 2020, and November 30, 2020, a registered nurse, psychiatric technician and a student intern allegedly gave a patient injections and left the needles in the patient's arm.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	12/03/2020
OLES Case Number	2020-01248-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 3, 2020, a psychiatric technician allegedly hit a patient multiple times.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES will not monitor the administrative case because there is no evidence of staff misconduct.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/09/2020
OLES Case Number	2020-01273-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 9, 2020, two psychiatric technicians allegedly pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/09/2020
OLES Case Number	2020-01274-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	On December 9, 2020, a psychiatric technician allegedly hit a patient in the back.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Special Investigations opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/12/2020
OLES Case Number	2020-01279-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 12, 2020, a staff member allegedly twisted a patient's knee while administering medication.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/13/2020
OLES Case Number	2020-01280-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 13, 2020, a psychiatric technician allegedly exposed himself to a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	12/13/2020
OLES Case Number	2020-01295-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 13, 2020, a doctor allegedly facilitated a sexual assault of a patient by three other patients.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	11/29/2020
OLES Case Number	2020-01313-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between November 29, 2020, and December 16, 2020, two staff members allegedly grabbed and pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/20/2020
OLES Case Number	2020-01325-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 20, 2020, a psychiatric technician assistant allegedly grabbed a patient's hands and twisted the patient's finger, causing bruising and swelling.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. 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	10/01/2020
OLES Case Number	2020-01333-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between October 1, 2020, and October 31, 2020, a psychiatric technician allegedly sexually assaulted a restrained patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/23/2020
OLES Case Number	2020-01339-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 23, 2020, a psychiatric technician assistant allegedly entered a patient's room and repeatedly hit the patient while the patient was sleeping. The patient claimed to have sustained injuries to his head and face area; however, no injuries were visible.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation. The OLES did not monitor the administrative investigation as it no longer meets monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/01/2020
OLES Case Number	2020-01357-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between December 1, 2020, and December 31, 2020, a staff member allegedly attempted to hit a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/25/2020
OLES Case Number	2020-01358-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 25, 2020, and December 26, 2020, a nurse allegedly improperly administered injections to a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
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	12/29/2020
OLES Case Number	2020-01360-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 29, 2020, a psychiatric technician allegedly failed to maintain constant observation of a patient who was a danger to himself and others.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES did not concur with the probable cause determination because the investigation established that the psychiatric technician repeatedly and willfully failed to continuously monitor a patient who was in restraints. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The draft and final investigative reports contained inappropriate comments regarding the applicability of a penal code section, the Office of Protective Services did not consult with the OLES regarding whether to refer the case to the district attorney's office for prosecution, and the Office of Protective

	Services did not appropriately determine whether probable cause existed for a referral to the district attorney's office.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report contained inappropriate opinion regarding the applicability of a penal code section. 2. Was the final investigative report thorough and appropriately drafted? No. The final investigative report contained inappropriate opinion regarding the applicability of a penal code section. 3. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution? No. The department inappropriately determined probable cause did not exist and did not make a referral to the district attorney's office for prosecution. The investigation established that the psychiatric technician repeatedly and willfully failed to maintain constant observation of a patient in restraints. 4. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The department did not consult with the OLES regarding the decision to not forward the case to the district attorney's office for prosecution.
Department Corrective Action Plan	Investigators have been reminded of the importance to collaborate with the AIM during the investigation to ensure all questions are answered throughout the investigation particularly. The Investigators have also been instructed to re-interview when discrepancies are noted in statements as needed. The Investigator has been reminded of the importance to collaborate with the assigned AIM to explain his position regarding the staff member's lack of willful intent. The Investigator has been reminded to confer with the assigned AIM when he elects not to submit a case that may have established probable cause.

Case Detail	Description
Incident Date	12/24/2020
OLES Case Number	2020-01364-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between December 24, 2020, and December 25, 2020, a staff member allegedly grabbed, dragged and then forced a patient onto a chair.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation. The OLES is not monitoring the resulting administrative investigation as it does not meet monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/27/2020
OLES Case Number	2020-01366-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 27, 2020, a staff member allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES did not accept for monitoring because the alleged incident did not meet the OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	12/31/2020
OLES Case Number	2021-00018-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 31, 2020, a patient collapsed and emergency life saving measures were initiated; however, the patient was declared dead. An autopsy determined the cause of death to be a posterior wall myocardial infarction.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred. The department opened an administrative investigation which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/05/2021
OLES Case Number	2021-00035-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 5, 2021, a registered nurse allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation which the OLES did not accept for monitoring because the incident did not meet the OLES's monitoring criteria.
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	12/22/2020
OLES Case Number	2021-00058-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 22, 2020, a registered nurse allegedly pushed a patient while taking the patient's blood pressure.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/27/2020
OLES Case Number	2021-00075-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 27, 2020, a senior psychiatric technician allegedly grabbed and bent a patient's hand backwards when the patient attempted to grab food from a cart. The senior psychiatric technician also allegedly denied the patient extra snacks based on the patient's race.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation. The OLES is not monitoring the resulting administrative investigation as it does not meet monitoring criteria.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The responding officer did not provide the senior psychiatric technician with the required Beheler legal admonition before taking his statement.
Pre-Disciplinary	1. Did the department adequately respond to the incident?

Assessment	No. The responding officer did not provide the senior psychiatric technician with the required Beheler legal admonition before taking his statement.
Department Corrective Action Plan	Training has been provided to all OPS sworn staff regarding providing the Beheler legal admonishments when interviewing all suspects of a possible crime. This training will be ongoing to ensure the legal requirement is being met when interviewing suspects.

Case Detail	Description
Incident Date	01/05/2021
OLES Case Number	2021-00079-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Between January 5, 2021, and January 6, 2021, a staff member allegedly inappropriately touched a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/14/2021
OLES Case Number	2021-00086-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 14, 2021, a registered nurse allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES did not accept for monitoring.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	01/22/2021
OLES Case Number	2021-00111-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Behavior that results in death
Findings	1. Not Referred
Incident Summary	On January 22, 2021, a patient was found unresponsive on the floor of his bedroom. Multiple staff members responded and initiated life-saving measures; however, the patient was pronounced dead. The treating physician determined cardiac arrest as the cause of death.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/21/2021
OLES Case Number	2021-00112-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 21, 2021, a psychiatric technician allegedly inappropriately touched himself while looking directly at a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and

	procedures governing the investigative process.

Case Detail	Description
Incident Date	01/27/2021
OLES Case Number	2021-00130-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 27, 2021, a nurse allegedly hit a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
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	01/26/2021
OLES Case Number	2021-00131-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 26, 2021, a patient was diagnosed with a fractured foot after falling. There were no allegations of abuse or neglect.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	02/02/2021
OLES Case Number	2021-00154-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 2, 2021, a psychiatric technician allegedly pushed a patient onto his bed.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation which the OLES did not accept for monitoring because the incident did not meet the OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. A responding officer did not provide a psychiatric technician with the required Beheler legal admonition before taking a statement from the psychiatric technician.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. A responding officer failed to provide a psychiatric technician with the required Beheler legal admonition before taking a statement from the psychiatric technician.
Department Corrective Action Plan	Training has been provided to all OPS sworn staff regarding providing the Beheler legal admonishments when interviewing all suspects of a possible crime. This training will be ongoing to ensure the legal requirement is being met when interviewing suspects.

Case Detail	Description
Incident Date	02/05/2021
OLES Case Number	2021-00163-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 5, 2021, a psychiatric technician allegedly hit a patient in the face.
Disposition	The Office of Protective Services conducted an investigation and found there was insufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The

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

Case Detail	Description
Incident Date	02/08/2021
OLES Case Number	2021-00167-1C
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 8, 2021, a custodian allegedly bumped a trash can into a patient's leg.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation because the custodian resigned prior to the completion of criminal investigation. The OLES concurred.
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	02/09/2021
OLES Case Number	2021-00171-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 9, 2021, several health care staff members allegedly suffocated a restrained patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	02/13/2021
OLES Case Number	2021-00192-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 13, 2021, a registered nurse allegedly placed his foot on a patient's arm while restraining the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services 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	01/01/2009
OLES Case Number	2021-00197-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Beginning in 2009, staff members and patients allegedly have been sexually assaulting a patient in his room every night.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services did not timely notify the OLES of the alleged incident.

Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the alleged abuse on February 15, 2021, at 2032 hours; however, the OLES was not notified until 2241 hours, over two hours later.
Department Corrective Action Plan	The Sergeants involved in the alleged abuse case have been reminded of the importance to review the criteria established for notification purposes for Priority One Reporting and Priority Two Reporting to ensure untimely notifications are avoided in the future.

Case Detail	Description
Incident Date	02/16/2021
OLES Case Number	2021-00203-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 16, 2021, a registered nurse allegedly slapped a patient on the face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/27/2021
OLES Case Number	2021-00209-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other 2. Use of Force Review
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 27, 2021, a psychiatric technician allegedly brought illegal drugs onto facility grounds and confronted a patient regarding the allegation.
Disposition	The Office of Protective Services conducted an investigation and found there was insufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services 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	02/22/2021
OLES Case Number	2021-00235-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 22, 2021, a senior psychiatric technician allegedly masturbated in a patient's room.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which the OLES did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	02/23/2021
OLES Case Number	2021-00241-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 23, 2021, a patient fell and sustained a nasal fracture.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services 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 February 23, 2021, at 1913 hours; however, the OLES was not notified until 2300 hours, almost four hours later.
Department Corrective Action Plan	OPS has provided refresher training to all the OPS supervisors and sworn personnel on the OLES reporting guidelines.

Case Detail	Description
Incident Date	02/24/2021
OLES Case Number	2021-00276-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 24, 2021 and March 3, 2021, a custodian allegedly pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	03/05/2021
OLES Case Number	2021-00294-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 5, 2021, level of care staff observed bruising to a patient's buttocks and inner arm. The patient advised he sustained the bruises when he fell.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. 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	03/05/2021
OLES Case Number	2021-00296-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On March 5, 2021, a psychiatric technician and a nurse allegedly pushed a patient into a wall, causing an injury to the patient's head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation which the OLES did not accept for monitoring because the incident did not meet the OLES's monitoring criteria.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. A responding officer did not provide a psychiatric technician and nurse with the required Beheler legal admonition before taking their statements.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. A responding officer failed to provide a psychiatric technician and nurse with the required Beheler legal admonition before taking their statements.
Department Corrective Action Plan	Training has been provided to all OPS sworn staff regarding providing the Beheler legal admonishments when interviewing all suspects of a possible crime. This training will be ongoing to ensure the legal requirement is being met when interviewing suspects.

Case Detail	Description
Incident Date	03/01/2021
OLES Case Number	2021-00297-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 27, 2021, a psychiatric technician allegedly placed a patient in an unauthorized chokehold.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The responding officer did not attempt to identify the suspect, other involved parties, or witnesses.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The initial report did not document whether the responding officer made any efforts to identify the staff suspect, involved parties or witnesses.
Department Corrective Action Plan	OPS will provide refresher training in the monthly squad training to all OPS supervisors and sworn personnel on the OLES reporting guidelines. We will also provide on–going squad trainings for the involved officer, as we as all the other officers to ensure that they are familiar with other policies and procedures pertaining to investigation and report writing.

Case Detail	Description
Incident Date	03/10/2021
OLES Case Number	2021-00319-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On March 10, 2021, a psychiatric technician allegedly placed a patient in an unauthorized control hold and kneed the patient in the face.
Disposition	The case was not referred to the district attorney's office due

	to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services 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	03/07/2021
OLES Case Number	2021-00345-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 7, 2021, a patient was transported to an outside hospital due to anemia, low heart rate, and hypothermia. The patient's condition declined, and he remained at the outside hospital. On March 17, 2021, the patient became unresponsive, and life-saving measures were attempted; however, the patient was later pronounced dead.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/01/2021
OLES Case Number	2021-00411-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between January 1, 2020, and January 1, 2021, a psychologist allegedly engaged in a sexual relationship with a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.

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

Case Detail	Description
Incident Date	04/06/2021
OLES Case Number	2021-00413-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On April 6, 2021, staff members allegedly restrained and choked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/21/2021
OLES Case Number	2021-00486-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 21, 2021, a psychiatric technician allegedly threw a food tray at a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/29/2021
OLES Case Number	2021-00526-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 29, 2021, a patient was allegedly sexually assaulted.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open and 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	04/09/2018
OLES Case Number	2020-00023-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Incident Summary	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Disposition	Between April 9, 2018, and May 1, 2020, an officer allegedly failed to follow department policy regarding outside employment.
Investigative Assessment	The hiring authority sustained the allegation and determined a letter of instruction and training was appropriate. The OLES concurred.

Case Detail	Description
Incident Date	11/01/2019
OLES Case Number	2020-00719-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty

Findings	1. Not Sustained 2. Not Sustained 3. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On or about November 1, 2019, a psychiatric technician allegedly engaged in a sexual relationship with a patient. On or about July 1, 2020, a second psychiatric technician allegedly told friends that his girlfriend, the first psychiatric technician, was pregnant with the patient's child. On July 28, 2020, and September 4, 2020, a third psychiatric technician was allegedly less than truthful during her interview with the Office of Protective Services.
Disposition	The hiring authority sustained the allegation against the third psychiatric technician and determined a formal counseling memorandum was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the first and second psychiatric technicians. 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	08/05/2020
OLES Case Number	2020-00803-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 5, 2020, a patient reported that a psychiatric technician was allegedly engaging in inappropriate telephone conversations and sexual contact with a second patient.
Disposition	The hiring authority sustained the allegation against the psychiatric technician; however, no disciplinary action could be taken because the psychiatric technician resigned before completion of the investigation. A letter indicating the

	psychiatric technician resigned under adverse circumstances was placed in her official personnel file. 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	09/05/2020
OLES Case Number	2020-00923-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Other failure of good behavior
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On September 5, 2020, a nurse allegedly failed to monitor a patient who required enhanced observation for possible water intoxication.
Disposition	The hiring authority sustained the allegation that the nurse failed to consistently monitor a patient, but found insufficient evidence that the nurse neglected the patient, and determined a letter of instruction 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	10/30/2020
OLES Case Number	2020-01122-1A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On October 30, 2020, a registered nurse and a psychiatric technician allegedly failed to timely report a patient's sexual assault allegation.
Disposition	The hiring authority determined there was sufficient evidence

	to sustain the allegations against the registered nurse and psychiatric technician and issued a letter of instruction to both staff members. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/08/2020
OLES Case Number	2020-01152-2A
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
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On November 8, 2020, a psychiatric technician allegedly fell asleep while assigned to monitor a patient.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred. The psychiatric technician resigned before discipline could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in his official personnel file.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	09/01/2019
OLES Case Number	2020-00409-2A
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	Between September 2019, and April 2020, a psychiatric technician allegedly engaged in a sexual relationship with a patient.
Investigative Assessment	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.

Case Detail	Description
Incident Date	05/04/2020
OLES Case Number	2020-00454-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	On May 4, 2020, a psychiatric technician allegedly failed to stop a patient, who was on an enhanced level of observation, from pulling out his own toenail.
Investigative Assessment	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

Case Detail	Description
Incident Date	04/24/2020
OLES Case Number	2020-00462-2A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Incident Summary	**Initial:** No Penalty Imposed

	Final: No Penalty Imposed
Disposition	On April 24, 2020, a patient complained of leg pain. She was sent to an outside hospital where she was diagnosed with a fractured femur.
Investigative Assessment	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The investigation was completed on March 17, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 63 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The administrative investigation was assigned on September 3, 2020; however, the investigation was not completed until March 17, 2021, 195 days later.
Department Corrective Action Plan	Will assign a second investigator to complex cases with multiple subjects.

Case Detail	Description
Incident Date	06/02/2020
OLES Case Number	2020-00571-2A
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 June 2, 2020, a psychiatric technician allegedly grabbed and pulled a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/29/2020
OLES Case Number	2020-00574-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 29, 2020, a nurse allegedly shaved a patient's head without authorization.
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	06/05/2020
OLES Case Number	2020-00581-2A
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 5, 2020, a staff member allegedly choked, sexually assaulted, and raped a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/06/2020
OLES Case Number	2020-00582-1A
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 6, 2020, a registered nurse and a psychiatric technician allegedly hit and kneed 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	06/04/2020
OLES Case Number	2020-00587-1A
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 4, 2020, a psychiatric technician allegedly grabbed and bruised a patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/18/2020
OLES Case Number	2020-00638-2A
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 June 18, 2020, three psychiatric technicians allegedly pushed and choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/28/2020
OLES Case Number	2020-00663-1A
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 28, 2020, a psychiatric technician allegedly choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficient complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/24/2020
OLES Case Number	2020-00681-1A
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 24, 2020, a psychiatric technician allegedly pushed a wheelchair bound patient by placing his fists into the upper back of the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The responding officer did not provide two psychiatric technicians with the legally required Beheler admonition prior to taking their statements.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not provide two psychiatric technicians with the legally required Beheler admonition prior to taking their statements.
Department Corrective Action Plan	A reminder has been communicated to personnel to ensure that all the appropriate admonishments are being provided to the appropriate individuals prior to conducting an interview. This is and will continue to be accomplished during briefing or if need be with the individual officer/officers who failed to advise the subject/subjects with the required admonishment. Further training will be provided to the both the officers and sergeants, who approve the reports, to ensure all criteria is met before approving reports.

Case Detail	Description
Incident Date	06/01/2020
OLES Case Number	2020-00706-3A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between June 1, 2020, and June 30, 2020, a psychiatric

	technician allegedly grabbed and forced a patient to 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:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on March 4, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 75 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 March 4, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 75 days later.
Department Corrective Action Plan	The department has reviewed the factors contributing to delays in completing penalty conferences and those have been corrected. The department will schedule additional conferences when necessary to ensure timely review.

Case Detail	Description
Incident Date	07/10/2020
OLES Case Number	2020-00710-1A
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 10, 2020, a psychiatric technician allegedly pushed a patient in the chest.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's recommendation.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/14/2020
OLES Case Number	2020-00721-2A
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 14, 2020, two psychiatric technicians allegedly hit a patient in the ribs.
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 did not comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on March 5, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 74 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 March 5, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 74 days later.
Department Corrective Action Plan	The department has reviewed the factors contributing to delays in completing penalty conferences and those have been corrected. The department will schedule additional conferences when necessary to ensure timely review.

Case Detail	Description
Incident Date	07/13/2020
OLES Case Number	2020-00723-2A
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 13, 2020, a psychiatric technician allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with

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

Case Detail	Description
Incident Date	07/14/2020
OLES Case Number	2020-00748-1A
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 14, 2020, a psychiatric technician allegedly hit a patient in the mouth while placing the patient in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/10/2020
OLES Case Number	2020-00766-2A
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 10, 2020, a psychiatric technician allegedly inappropriately slapped a patient on the buttocks.
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 disciplinary process.

Case Detail	Description
Incident Date	05/05/2020
OLES Case Number	2020-00779-1A
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 May 5, 2020, and May 9, 2020, a registered nurse allegedly sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed did not comply with policies and procedures governing the investigative process. The department did not timely notify the OLES of the allegation.
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 July 31, 2020, at 0517 hours, but did not notify the OLES until July 31, 2020, at 1258 hours, over seven hours later.
Department Corrective Action Plan	The sergeants involved have been reminded of the importance of reviewing the criteria established for notification purposes for Priority One Reporting and Priority Two Reporting to ensure untimely notifications are avoided in the future. During watch briefings, supervisors will provide training on the importance of advising supervisors of OLES cases that require notification to avoid untimely notifications.

Case Detail	Description
Incident Date	08/06/2020
OLES Case Number	2020-00807-1A
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 August 6, 2020, three psychiatric technicians, a senior psychiatric technician, and a licensed vocational nurse allegedly assaulted and bruised a patient.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The responding officer did not provide each of the identified subject staff with the legally required Beheler admonition before taking their statements.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not provide each of the subject staff members with the legally required Beheler admonition before taking their statements.
Department Corrective Action Plan	A reminder has been communicated to personnel to ensure that all the appropriate admonishments are being provided to the appropriate individuals prior to conducting an interview. This is and will continue to be accomplished during briefing or if need be with the individual officer/officers who failed to advise the subject/subjects with the required admonishment. Further training will be provided to the both the officers and sergeants, who approve the reports, to ensure all criteria is met before approving reports.

Case Detail	Description
Incident Date	08/06/2020
OLES Case Number	2020-00808-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 6, 2020, an anonymous form was received which alleged that a psychiatric technician was involved in an overly familiar relationship with 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	08/05/2020
OLES Case Number	2020-00821-2A
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 August 5, 2020, a psychiatric technician allegedly broke 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:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on March 30, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 49 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 March 30, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 49 days later.
Department Corrective Action Plan	The department has reviewed the factors contributing to delays in completing penalty conferences and those have been corrected. The department will schedule additional conferences when necessary to ensure timely review.

Case Detail	Description
Incident Date	08/12/2020
OLES Case Number	2020-00832-2A
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 August 12, 2020, a psychiatric technician allegedly grabbed and bruised a patient. The psychiatric technician and an unidentified staff member allegedly then forced the patient onto the floor, and kicked and choked the patient.

Disposition	The 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	08/13/2020
OLES Case Number	2020-00834-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 13, 2020, a psychiatric technician allegedly engaged in an inappropriate relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	08/17/2020
OLES Case Number	2020-00854-1A
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 August 17, 2020, a psychiatric technician allegedly sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and

	procedures governing the pre-disciplinary process. The investigation was completed on March 24, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 55 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 March 24, 2021; however, the findings and penalty conference was not completed until May 18, 2021, 55 days later.
Department Corrective Action Plan	The department has reviewed the factors contributing to delays in completing penalty conferences and those have been corrected. The department will schedule additional conferences when necessary to ensure timely review.

Case Detail	Description
Incident Date	08/19/2020
OLES Case Number	2020-00861-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 19, 2020, a patient died while receiving treatment at an outside hospital. An autopsy determined the immediate cause of death was due to COVID-19.
Disposition	The hiring authority determined there was no evidence of staff misconduct. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	08/19/2020
OLES Case Number	2020-00873-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 19, 2020, a patient alleged that a psychiatrist had

	blamed the patient for incidents the patient was involved in, medicated the patient in retaliation, and ordered enhanced observation of the patient.
Disposition	The hiring authority determined that the investigation conclusively proved that the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	08/19/2020
OLES Case Number	2020-00874-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 19, 2020, a psychiatric technician allegedly choked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/02/2020
OLES Case Number	2020-00893-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On July 2, 2020, a psychiatric technician allegedly inappropriately kissed 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	08/25/2020
OLES Case Number	2020-00903-2A
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 August 25, 2020, a psychiatric technician allegedly repeatedly spun a patient in his wheelchair.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/06/2020
OLES Case Number	2020-00920-1A
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 September 6, 2020, a registered nurse allegedly inappropriately touched a patient while searching the patient for contraband.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. 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	09/04/2020
OLES Case Number	2020-00932-1A
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 September 4, 2020, a psychiatric technician allegedly did not continuously monitor a patient who required an enhanced level of supervision.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/14/2020
OLES Case Number	2020-00944-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 14, 2020, a patient received a letter purportedly written by a social worker wherein she allegedly admitted to retaliating against the patient and referred to the patient using derogatory language.
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 did not comply with policies and

	procedures governing the pre-disciplinary process. The Office of Protective Services did not report the alleged incident to the OLES.
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 did not notify the OLES of the alleged incident.
Department Corrective Action Plan	The department will train staff on the reporting guidelines surrounding over-familiarity and timely reporting to OLES.

Case Detail	Description
Incident Date	09/19/2020
OLES Case Number	2020-00950-1A
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 September 19, 2020, staff members allegedly sexually assaulted and harassed 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	09/17/2020
OLES Case Number	2020-00957-1A
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, 2020, a psychiatric technician allegedly pinched a patient's nose.
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 did not comply with policies and procedures governing the investigative process. The Office of Protective Services did not timely notify the OLES of the alleged incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the alleged abuse on September 17, 2020, at 2206 hours; however, the OLES was not notified until September 18, 2020, at 0400 hours, nearly six hours later.
Department Corrective Action Plan	The sergeants involved in the alleged physical abuse case have been reminded of the importance of reviewing the criteria established for notification purposes for Priority One and Priority Two Reporting to ensure untimely notifications are avoided in the future.

Case Detail	Description
Incident Date	09/18/2020
OLES Case Number	2020-00962-2A
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 September 18, 2020, a psychiatric technician assigned to conduct enhanced observation of a patient 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:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/01/2020
OLES Case Number	2020-00963-1A
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 June 1, 2020, and June 30, 2020, a psychiatric technician allegedly inappropriately touched a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's recommendation.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/21/2020
OLES Case Number	2020-00973-1A
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 21, 2020, a social worker allegedly hit 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	09/10/2020
OLES Case Number	2020-01005-1A
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 September 10 and 11, 2020, a psychiatric technician allegedly refused to give a patient his prescribed medication and falsely documented that the patient had refused the medication.
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	10/13/2020
OLES Case Number	2020-01046-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 13, 2020, two psychiatric technicians allegedly hit a patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/14/2020
OLES Case Number	2020-01078-1A
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	Between October 14, 2020 and October 29, 2020, a unit supervisor allegedly subjected a patient to living conditions that did not comply with infectious illness policies and procedures.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures

	governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/19/2020
OLES Case Number	2020-01123-1A
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 October 19, 2020, a staff member allegedly inappropriately touched a patient during a medical procedure.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/02/2020
OLES Case Number	2020-01124-1A
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 2, 2020, two psychiatric technicians allegedly hit a patient in the face, resulting in a laceration to the patient's 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	11/11/2020
OLES Case Number	2020-01182-1A
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 11, 2020, a licensed vocational nurse allegedly kicked 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	11/13/2020
OLES Case Number	2020-01184-1A
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 13, 2020, a registered nurse allegedly hit a patient during a medical assessment.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/01/2020
OLES Case Number	2020-01215-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between March 1, 2020, and March 31, 2020, a psychiatric technician allegedly grabbed a patient by the 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 complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	11/30/2020
OLES Case Number	2020-01240-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 30, 2020, two psychiatric technicians allegedly hit and kicked a patient. The two psychiatric technicians and a senior psychiatric technician allegedly failed report the patient's claim of abuse.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination. The hiring authority provided additional training on reporting requirements to unit staff.
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	11/08/2020
OLES Case Number	2020-01249-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Behavior that results in death
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 8, 2020, a patient tested positive for COVID-19. On November 11, 2020, the patient was transported to an outside hospital. On December 4, 2020, he was pronounced dead. The cause of death was cardiac arrest and acute respiratory failure related to COVID-19.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death; therefore, no allegations were sustained. 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	12/07/2020
OLES Case Number	2020-01263-1A
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 December 7, 2020, a psychiatric technician allegedly slapped a patient on the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	12/11/2020
OLES Case Number	2020-01291-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 11, 2020, a patient alleged that a psychologist had previously showed him her clothed buttocks.
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	12/20/2020
OLES Case Number	2020-01325-2A
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 December 20, 2020, a psychiatric technician assistant allegedly sat on a patient's lap, grabbed the patient's hands and twisted the patient's finger.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** 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 OLES regarding the sufficiency of the investigation and investigative findings until 75 days after the investigative report was completed.
Pre-Disciplinary	1. Did the hiring authority timely consult with OLES and the

Assessment	department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? No. The investigation was completed on March 26, 2021; however, the hiring authority did not consult with OLES regarding the sufficiency of the investigation and investigative findings until June 9, 2021, 75 days later.
Department Corrective Action Plan	The Office of Special Investigations will review controls in place and work with the Executive Director to ensure timely receipt of files for the review and disposition conference phase.

Case Detail	Description
Incident Date	12/29/2020
OLES Case Number	2020-01360-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	On December 29, 2020, a psychiatric technician allegedly failed to maintain constant observation of a patient who was a danger to himself and others.
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 did not comply with policies and procedures governing the pre-disciplinary process. The investigator did not notify OLES of the scheduling of the second interview of the subject matter expert, thereby preventing the monitor from attending the interview and providing real-time feedback. The investigator conducted an unnecessary second interview of the subject matter expert that yielded an inconsistent and contradictory second opinion. The investigator did not attempt to reconcile the expert's opinions. The draft and final investigative reports were not thorough nor appropriately drafted because they contained summaries of the expert's contradictory opinions without explanation. The hiring authority was unable to sustain the allegations because of the insufficient investigation.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted?

No. The investigator conducted an unnecessary second interview of the expert wherein he did not accurately present the facts discovered during the investigation, thereby resulting in obtaining an inconsistent opinion. Prior to conducting the second interview of the subject matter expert the investigator made inaccurate representations regarding the documentation collected during the investigation. The investigator did not attempt to reconcile the differing opinions.

2. Was the draft investigative report provided to OLES for review thorough and appropriately drafted?

No. The draft report contained a summary of the expert's contradictory opinions that were based on inaccurate information.

3. Was the final investigative report thorough and appropriately drafted?

No. The final report contained a summary of the expert's contradictory opinions that were based on the inaccurate information.

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

No. The investigator did not notify OLES of the scheduling of the second interview of the subject matter expert, thereby preventing the monitor from attending the interview and providing real-time feedback. The final investigative report was forwarded to the executive director without having addressed the monitor's concerns regarding the second interview of the subject matter expert.

5. Was the investigation thorough and appropriately conducted?

No. The investigator conducted an unnecessary second interview of the subject matter expert, and allowed the subject matter expert to render an opinion based on information that was contrary to the facts developed during the investigation. By having obtained this contrary second opinion, the investigator impacted the executive director's ability to impose any discipline against the psychiatric technician.

	6. If the hiring authority determined that any of the allegations could not be sustained or that an accurate finding could not be made regarding any allegation was that determination the result of an insufficient or untimely investigation? Yes. The executive director was unable to sustain any allegations because of insufficiencies in the investigation regarding the expert's contradictory opinions.
Department Corrective Action Plan	Moving forward, the investigator will ensure any changes in an expert's opinion as it pertains to neglect and/or abuse, will be properly documented in the administrative report. Moving forward, Investigators have been advised to address any inaccuracies in what was reported or how investigative interviews were conducted during the monitoring process. Moving forward, Investigators have been asked to increase their communication with assigned AIMs to ensure they have an opportunity to contribute to the interview or make investigative recommendations. Moving forward, the Supervising Special Investigator (SSI) will ensure, thorough written documentation. Along with the documentation, the SSI follow up with the hiring authority to clarify any questions, address investigative concerns, or complete additional investigation if necessary. This will ensure the Hiring Authority is receiving all the relevant facts based on the administrative investigation.

Case Detail	Description
Incident Date	01/01/2021
OLES Case Number	2021-00007-1A
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 1, 2021, a social worker allegedly hit a patient's hands while opening a door.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	12/31/2020
OLES Case Number	2021-00018-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 31, 2020, a patient collapsed and emergency life saving measures were initiated; however, the patient was declared dead. An autopsy determined the cause of death to be a posterior wall myocardial infarction.
Disposition	The hiring authority determined there was no evidence of staff misconduct; therefore, no allegations were sustained. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/05/2021
OLES Case Number	2021-00037-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 5, 2021, a psychiatric technician allegedly knowingly exposed staff and patients to the coronavirus.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	12/16/2020
OLES Case Number	2021-00041-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On December 16, 2020, a psychiatric technician was allegedly sleeping while assigned to work in the medication room. The psychiatric technician then allegedly became irate when a patient woke the psychiatric technician to request pain medication.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/07/2021
OLES Case Number	2021-00126-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 7, 2021, a patient was observed limping and he stated he had fallen. He was subsequently diagnosed with a fractured foot.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority’s determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	02/07/2021
OLES Case Number	2021-00169-1A
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 7, 2021, a registered nurse allegedly fell asleep while providing enhanced observation of a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/31/2021
OLES Case Number	2021-00179-1A
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 31, 2021, a senior psychiatric technician allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/28/2021
OLES Case Number	2021-00210-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between January 28, 2021, and February 18, 2021, a psychiatrist allegedly prescribed poisonous medication to a patient, hoping the patient would go blind. The medication allegedly caused the patient to experience blurred vision.
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 did not comply with policies and procedures governing the pre-disciplinary process. The Office of Protective Services discovered the alleged abuse on February 18, 2021, at 0800 hours; however, the notification was not sent to the OLES until February 19, 2021, at 0837 hours.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the alleged abuse on February 18, 2021, at 0800 hours; however, the notification template was not sent to the OLES until February 19, 2021, at 0837 hours.
Department Corrective Action Plan	To ensure OPS complies with policies and procedures governing the investigative process, OPS has instructed the office professional staff to check their email promptly and ensure there are no pending OLES templates needing to be sent. Additionally, the sergeants were instructed to notify the lieutenants when there are difficulties completing OLES templates so the lieutenants can ensure the OLES notification process is completed on time.

Case Detail	Description
Incident Date	03/05/2021
OLES Case Number	2021-00293-1A
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, 2021, a senior psychiatric technician allegedly grabbed a patient by the arm and forced him to the medication room window.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/10/2021
OLES Case Number	2021-00319-2A
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 March 10, 2021, a psychiatric technician allegedly placed a patient in an unauthorized control hold and kneed the patient in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Appendix C: Discipline Phase Cases

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

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

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

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

Procedurally Insufficient Cases

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:** Letter of Reprimand
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 letter of reprimand. The OLES concurred. The unit supervisor filed an appeal with the State Personnel Board. The State Personnel

	Board upheld the penalty.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the disciplinary process. The department did not provide OLES with written confirmation of penalty discussions. The disciplinary phase took 353 days to complete.
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. The department did not provide OLES written confirmation of penalty discussions. 2. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority made the decision on findings on November 8, 2019, and the final penalty determination on April 28, 2020; 172 days later. The Notice of Adverse Action was served on October 26, 2020; 181 days later. It took 353 days to serve the disciplinary action from the date allegations were sustained.
Department Corrective Action Plan	The department will place a greater focus on issuing discipline in a more timely manner and will train staff on the importance and priority discipline matters should be given.

Case Detail	Description
Incident Date	01/01/2019
OLES Case Number	2019-01175-1A
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. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Suspension **Final:** Suspension
Incident Summary	In 2019, a senior psychologist supervisor and four psychiatric technicians were allegedly aware of an overly familiar relationship between a former psychiatric technician

	assistant and a patient and failed to report the misconduct. The senior psychologist supervisor allegedly was overly familiar with the same patient when she provided clothing and other items to the patient without the approval of the hiring authority and failed to wait a year from the patient's discharge before involving herself with the patient in any personal capacity. It was also alleged that the senior psychologist supervisor was less than truthful during her investigative interview.
Disposition	The hiring authority determined the senior psychologist supervisor violated policy when she purchased clothing and other items for the patient and gave the patient those items on the day of his discharge without obtaining permission from the hiring authority. The hiring authority determined the senior psychologist supervisor likewise violated policy when she failed, in spite of significant evidence, to report the former psychiatric technician assistant for being overly familiar with the patient. Further, it was determined the senior psychologist supervisor was less than truthful during her investigative interview. The hiring authority determined a 14 day suspension was the appropriate penalty. The hiring authority determined there was insufficient evidence to sustain the allegations against the four psychiatric technicians. The OLES concurred with the hiring authority's determinations. Pursuant to a settlement agreement, the senior psychologist supervisor agreed to waive her appeal rights and the department agreed to remove a technical deficiency contained in the disciplinary action; there was no change to the penalty. The OLES concurred with the settlement.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the disciplinary process. The findings and penalty determinations were made on May 21, 2020; however, the disciplinary action was not served until January 29, 2021, 254 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The findings and penalty determinations were made on May 21, 2020; however, the disciplinary action was not served until January 29, 2021, 254 days later.
Department Corrective Action Plan	The department will continue to prioritize all Office of Law Enforcement Support cases to ensure they are meeting the designated timeframes. Due to the declared state of

	emergency by Governor Newsom on March 4, 2020, for novel coronavirus (COVID-19), this caused a huge impact on Human Resources. The impact caused an increase in workload along with a shortage of staff, this resulted in a delay of issuing the adverse action.

Appendix D: Combined Pre-Disciplinary and Discipline Phase Cases

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

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

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

The disciplinary phase is rated for procedural and substantive sufficiency.

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

Procedurally Insufficient in the Disciplinary Phase

Case Detail	Description
Incident Date	01/28/2020
OLES Case Number	2020-00095-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Suspension **Final:** Suspension
Incident Summary	On January 28, 2020, a psychiatric technician grabbed and forced a patient to the floor.
Disposition	The hiring authority sustained the allegation and determined a 30-day suspension was the appropriate penalty. The employee did not appeal the suspension. 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.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the disciplinary process. The penalty conference was held on January 19, 2021; however, the disciplinary action was not served until March 23, 2021, 63 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The penalty conference was held on January 19, 2021; however, the disciplinary action was not served until March 23, 2021, 63 days later.
Department Corrective Action Plan	Monitor timelines. Communicate and monitor timeliness with both Executive Director and Legal during all communication. LR Manager will also monitor the timeliness upon assignment of OLES cases. Continuous monitoring of case from assignment until service on a weekly basis.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	02/21/2020
OLES Case Number	2020-00182-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On February 21, 2020, a doctor allegedly had been negligent in providing appropriate medical care to patients.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the doctor and determined dismissal was the appropriate penalty. The OLES concurred. The doctor resigned prior to service of the disciplinary action. A letter stating he resigned under unfavorable circumstances was placed in his official personnel file.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disciplinary	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	03/21/2020
OLES Case Number	2020-00289-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	On March 21, 2020, a psychiatric technician allegedly did not properly monitor a patient who was on an enhanced level of supervision for self-injurious behavior.
Disposition	The hiring authority sustained the allegation and determined a 10 percent salary reduction for 24 months was the appropriate penalty. The psychiatric technician filed an appeal with the State Personnel Board. At the prehearing settlement conference, the department entered into a settlement agreement with the psychiatric technician, reducing the penalty from a 10 percent salary reduction for 24 months to a 10 percent salary reduction for four months. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	07/01/2020
OLES Case Number	2020-01018-2A
Case Type	Monitored
Incident Types	1. Misconduct 2. Misconduct
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	Between July 1, 2020, and September 7, 2020, an officer allegedly made threatening and derogatory comments to two co-workers. On September 7, 2020, the officer allegedly kicked a file cabinet drawer closed on a co-worker's hand and kicked a chair towards another co-worker.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 5 percent for 12 months was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
Incident Date	06/01/2019
OLES Case Number	2020-01275-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	Between June 1, 2019, and September 28, 2020, an officer allegedly engaged in sexual misconduct while on duty.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. The officer resigned before the effective date of the dismissal.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Appendix E: Monitored Issues

Case Details	Description
Incident Date	01/01/2017
OLES Case Number	2016-00846-1MI
Case Type	Monitored Issue
Incident Types	1. Significant Interest - Other
Incident Summary	In the semiannual report covering January 1 through June 30, 2017, the OLES made several recommendations to the DSH to minimize patient pregnancies. The OLES also made a recommendation on how to best manage patients who become pregnant while residing in a state hospital or if they are pregnant when they are admitted to a DSH facility.
Disposition	The DSH implemented two policies in response to the OLES's recommendations. The first policy titled Child Placement allows the pregnant patient to decide where and with whom her infant will be placed after birth. The second policy titled Patient Sexual Behavior and Health identifies what must be considered when determining patient placement in co-ed living quarters. The OLES will continue to monitor the department's adherence to these policies.

Case Details	Description
Incident Date	03/17/2017
OLES Case Number	2017-00644-2MI
Case Type	Monitored Issue
Incident Types	1. Sexual Assault
Incident Summary	During an investigation involving a patient allegation of sexual abuse against staff, the OLES identified a systemic issue involving Department of State Hospital employees who are accused of physical or sexual abuse of patients. Department policy allowed clinical staff to decide whether an employee who was accused of patient abuse could be reinstated to a patient-care position without consultation with facility law enforcement and before facility law enforcement completed an investigation of the abuse allegation.
Disposition	The department appropriately responded to the concerns raised by the OLES. The department prepared a statewide policy standardizing the recommendations made by OLES. Clinical staff now consult with facility law enforcement when

	determining if an accused staff member can be returned to patient care, even if the law enforcement investigation has not yet concluded.

Case Details	Description
Incident Date	08/03/2017
OLES Case Number	2017-00928-1MI
Case Type	Monitored Issue
Incident Types	1. Significant Interest - Child Porn
Incident Summary	The Office of Law Enforcement Support opened a Monitored Issue into possession of Child Pornography by patients in the Department of State Hospitals - Coalinga State Hospital. The OLES identified several policy and procedural issues and began to work with the DSH to eradicate, investigate and prevent possession of electronic contraband of all types at the hospital.
Disposition	The OLES entered into an agreement with CSH that monthly reports would be provided to the OLES on the progress of processing and adjudicating all illegal and contraband materials seized during the January 2018 implementation of a three phase eradication plan. Materials discovered from processing this seized material were reported to the OLES on a monthly basis to reflect the progress being made. As of December 2020, the processing is now complete, and CSH will no longer report on a monthly basis. DSH continues to report newly discovered contraband to the OLES, which is then documented in the appropriate SAR, according to the reported timeframe. The OLES continues to monitor and work collaboratively with DSH to increase compliance with the DSH regulations on contraband to improve the safety and security for all patients.

Case Details	Description
Incident Date	11/01/2018
OLES Case Number	2018-00328-1MI
Case Type	Monitored Issue
Incident Summary	In November 2018, the OLES conducted a review of policies and procedures relating to the use of force, patient arrests, training, and emergency responses. Specifically, the OLES had questions regarding the supervisory response to emergency incidents, supervisory review of reports, and the level of authority required to arrest a patient. The OLES recommended that Office of Protective Services' managers and supervisors

	receive additional training on civil liability prevention and mitigation to assist them in approaching critical incidents that may expose the department to liability.
Disposition	In response to the OLES's recommendations, the department's legal division is providing ongoing statewide training.

Appendix F: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

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

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

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

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

and the Legislature.

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

California Welfare and Institutions Code 4427.5

4427.5.

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

(A) A death.

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

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

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

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

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

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

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

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

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

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

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

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

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

California Welfare and Institutions Code 4023

4023

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

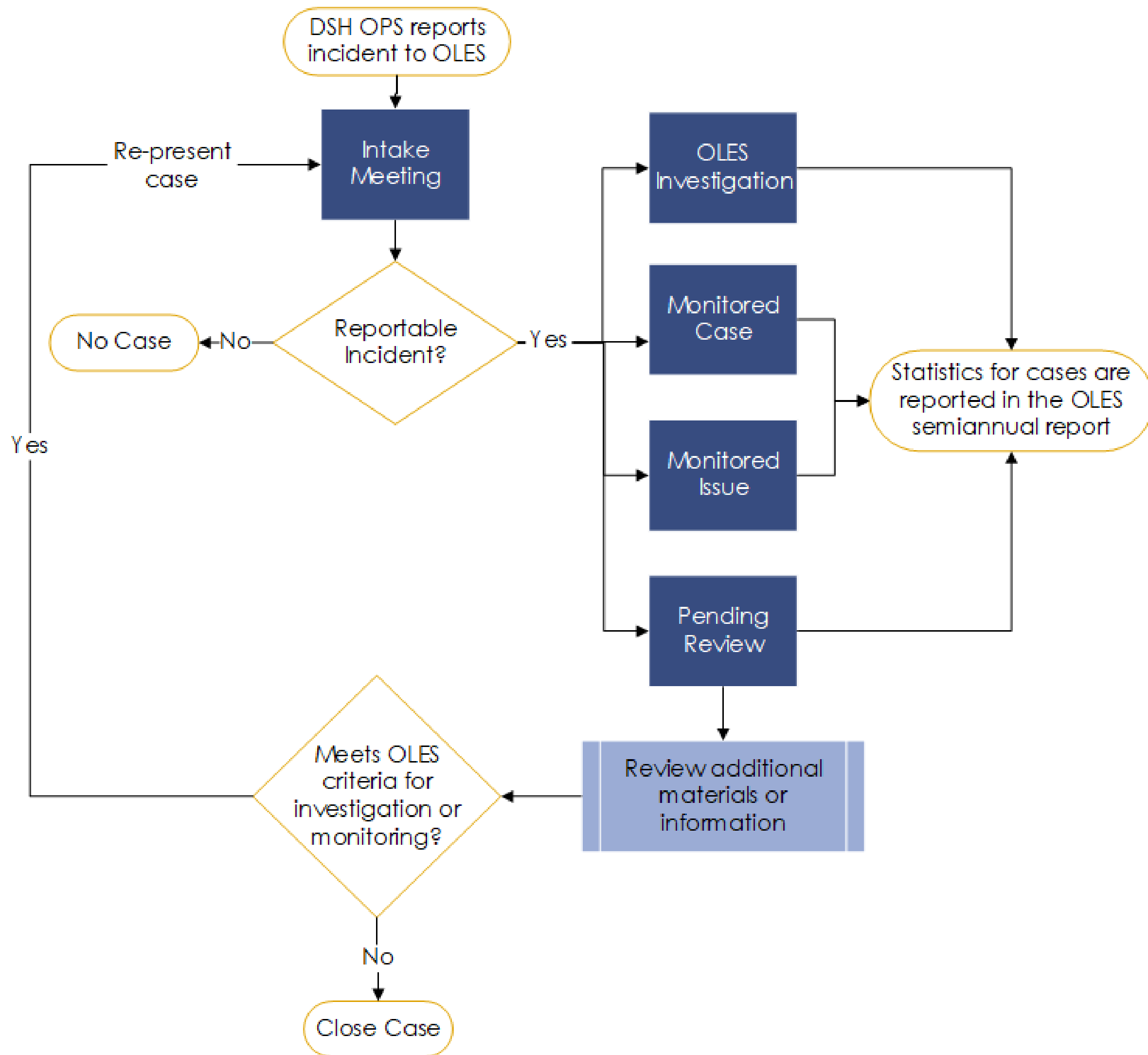
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

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

Appendix G: OLES Intake Flow Chart



Outline Description

1. OLES receives a notification of an incident and discusses the incident during an intake meeting
2. The disposition of the incident case may be assigned to any of the following:
    a. No Case
    b. Pending Review
        i. If the disposition is "Pending Review", the case is reviewed for sufficient information and is represented at an intake meeting. From there, the case may be investigated, become a monitored issue, be monitored, be investigated or be rejected.
    c. OLES Investigation Case
    d. Monitored Case
    e. Monitored Issue

Appendix H: Guidelines for OLES Processes

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

If, instead, an incident is investigated by DSH but is accepted for OLES monitoring, an OLES AIM is assigned and then consults with the DSH investigator and the department attorney, if one is designated[5], throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

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

Critical Junctures

- Site visit
- Initial case conference
    - Develop investigation plan
    - Determine statute of limitations
- Critical witness interviews
- Draft investigation report

It is recommended that within 45 days of the completion of an investigation, the hiring authority (facility management) thoroughly review the investigative report and all supporting documentation. Per the California Welfare and Institutions Code, the hiring authority must consult with the AIM attorney on the discipline decision, including 1) the allegations for which the employee should be exonerated, the allegations for which the evidence is insufficient and the allegations should not be sustained, or the allegations

[5] 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.

that should be sustained; and 2) the appropriate discipline for sustained allegations, if any. If the AIM believes the hiring authority's decision is unreasonable, the matter may be elevated to the next higher supervisory level through a process called executive review.

45 Days

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

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

60 Days

1. The department's human resources unit completes the NOAA and provides it to AIM for review.
2. The approved NOAA is provided to the executive director for service to the employee.

State employees subject to discipline have a due process right to have the matter reviewed in a *Skelly* hearing by an uninvolved supervisor who, in turn, makes a recommendation to the hiring authority, that is, whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee[6]. It is recommended that the *Skelly* due process meeting be completed within 30 days.

30 Days

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

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

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

Conclusion

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