Office of Law Enforcement Support

Semiannual Report

July 1, 2021–December 31, 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.

Contents

Introduction **5**

Facilities **6**

Executive Summary **8**

Incident Types Meeting OLES Criteria *8*

Most Frequent Incident Types *9*

Patient Deaths *10*

Patient Arrests *10*

Results of Completed OLES Investigations on DSH Law Enforcement *12*

Results of Completed OLES Monitored Cases *12*

Incidents and Incident Types **14**

Increase in Reported Incident Types *14*

Most Frequent Incident Types Reported *14*

Incident Types by Reporting Period *15*

Incident Types by Facility *18*

Sexual Assault Allegations *21*

Patient Deaths *22*

Reports of Patients Absent without Leave *23*

Notification of Incident Types **25**

Priority One Notifications – Two Hour Notification *25*

Priority Two Notifications – 24 Hour Notification *25*

Timeliness of Notifications *26*

Intake **28**

Cases Opened in the Current Reporting Period *29*

Completed Investigations and Monitored Cases **30**

OLES Investigations *30*

OLES Monitored Cases *31*

DSH Tracking of Law Enforcement Compliance with Training Requirements **34**

Training Database Limitations *34*

DSH Law Enforcement Training Advisory Committee *35*

Self-Reported Compliance Rates for Mandated Training...36
Certification Tracking in DSH's Training Database...36
Additional Mandated Data...38
Adverse Actions against Employees...38
Criminal Cases against Employees...39
Reports of Employee Misconduct to Licensing Boards...39
Patient Criminal Cases...40
Monitored Issues...41
Area Extraction and Use of Force at ASH...41
Escape Prevention and Key Control at CSH...41
Underutilization of Blue Team/IAPro...42
Use of Force Reports, Reviews and Tracking at DSH...45
Delayed Reporting by Mandated Reporters...47
Appendix A: Completed OLES Investigations...49
Appendix B: Pre-Disciplinary Cases Monitored by the OLES...53
Appendix C: Combined Pre-Disciplinary and Discipline Phase Cases...123
Appendix D: Statutes...132
California Welfare and Institutions Code 4023.6 et seq....132
California Welfare and Institutions Code 4427.5...134
California Welfare and Institutions Code 4023...135
California Welfare and Institutions Code 15610.63 (Physical Abuse)...135
Appendix E: OLES Intake Flow Chart...136
Appendix F: Guidelines for OLES Processes...137
Administrative Investigation Process...137

Introduction

I am pleased to present the twelfth semiannual report by the Office of Law Enforcement Support (OLES) in the California Health & Human Services Agency. This report details OLES's oversight and monitoring of the Department of State Hospitals (DSH) from July 1 through December 31, 2021.

In this report, OLES provides details on 562 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, required legal admonitions before taking statements and the importance of appropriate follow up and clarifying questions for initial investigative reports. To better track OLES monitored investigations, DSH developed a comprehensive spreadsheet documenting the investigative stages from initial OLES notification to final disposition. The DSH reviewed and corrected factors contributing to delays in completing disposition conferences.

During this reporting period, OLES expanded our reporting guidelines to include the intake of use of force (UOF) by law enforcement and further delineated drug-related incidents previously reported under the significant interest-other incident type category. The OLES also opened two new monitored issues to address concerns regarding use of force reports, supervisory reviews and tracking at DSH and delayed reporting to the Office of Protective Services (OPS) by mandated reporters at DSH.

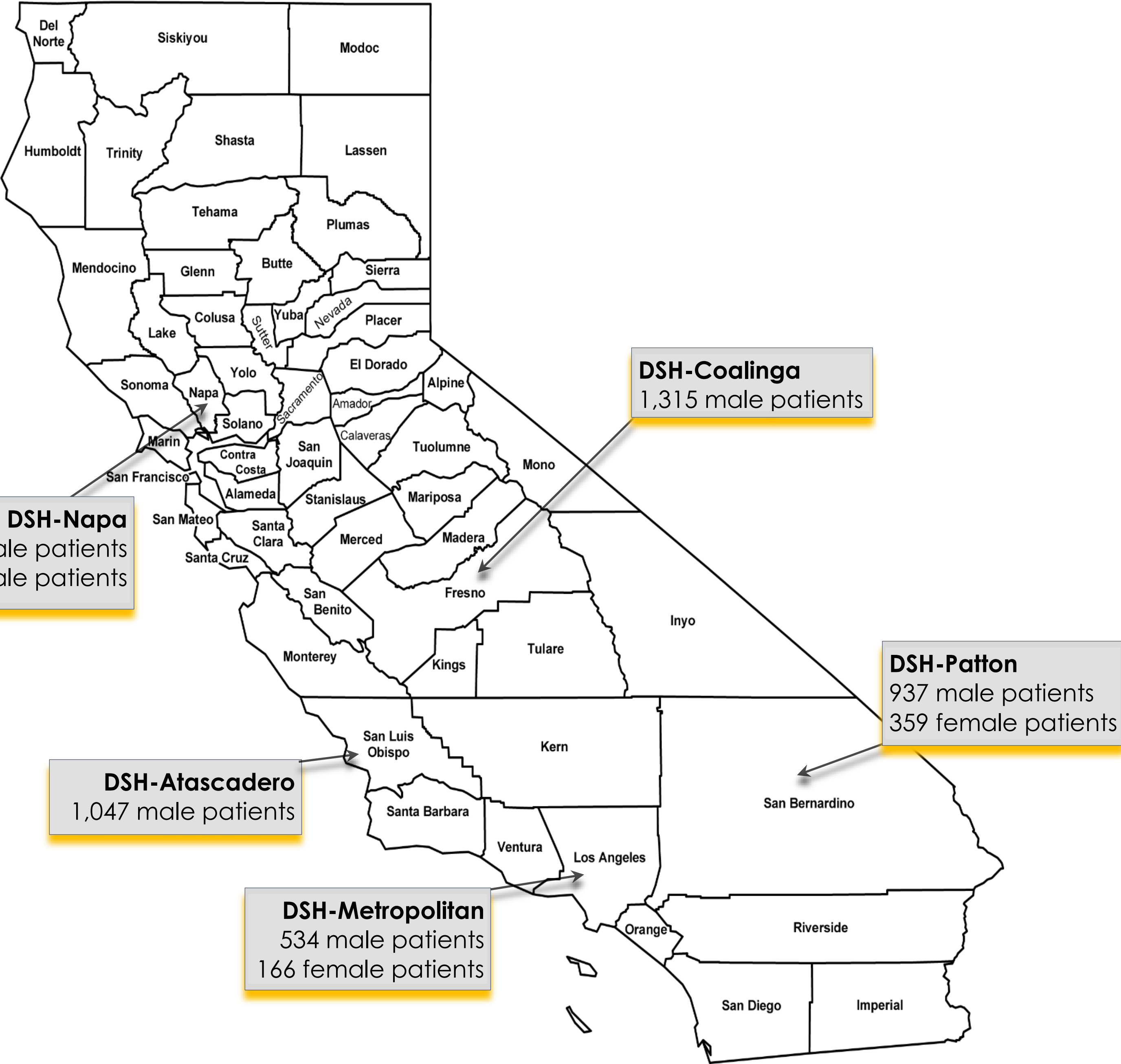
As OLES begins its seventh year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DSH.

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

Geoff Britton
Chief
Office of Law Enforcement Support

Facilities

The OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers as of December 31, 2021, were provided by the department.

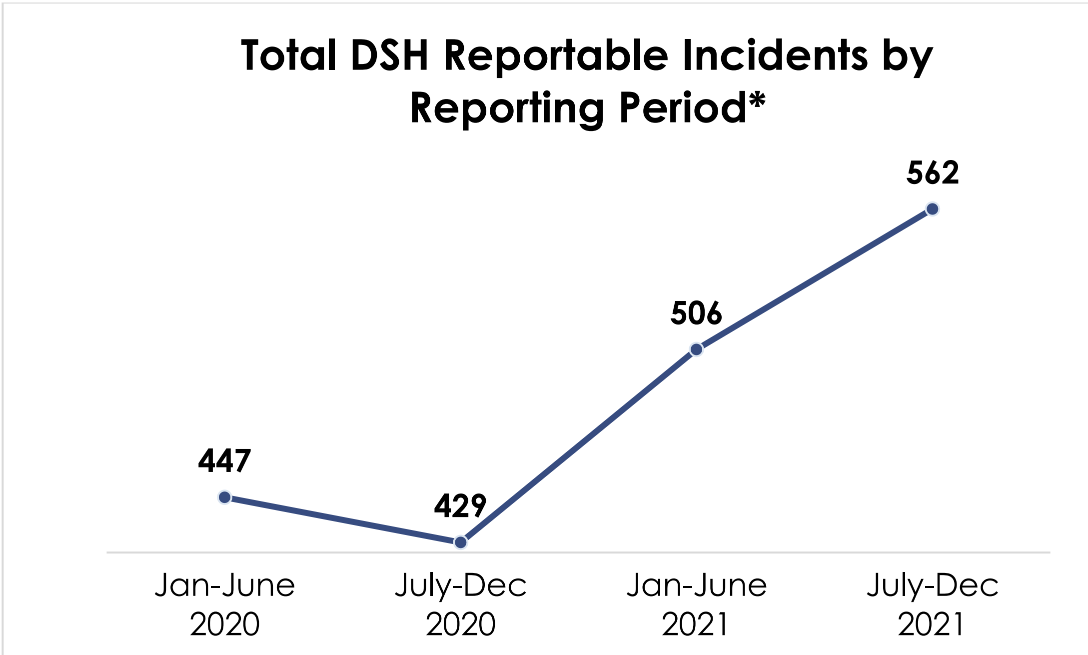


DSH Facility Population Table

Facility	Number of Male Patients	Number of Female Patients	Total
DSH-Atascadero	1,047	-	1,047
DSH-Coalinga	1,315	-	1,315
DSH-Metropolitan	534	166	700
DSH-Napa	820	241	1,061
DSH-Patton	937	359	1,296
Total	4,653	766	5,419

Executive Summary

During the reporting period of July 1 through December 31, 2021, the Office of Law Enforcement Support (OLES) received and processed 562 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 56 incident reports compared to the prior reporting period which had 506 incident reports. The increase in reported incidents is attributed to OLES's expansion of the reporting guidelines to include the intake of use of force incidents by law enforcement. 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.

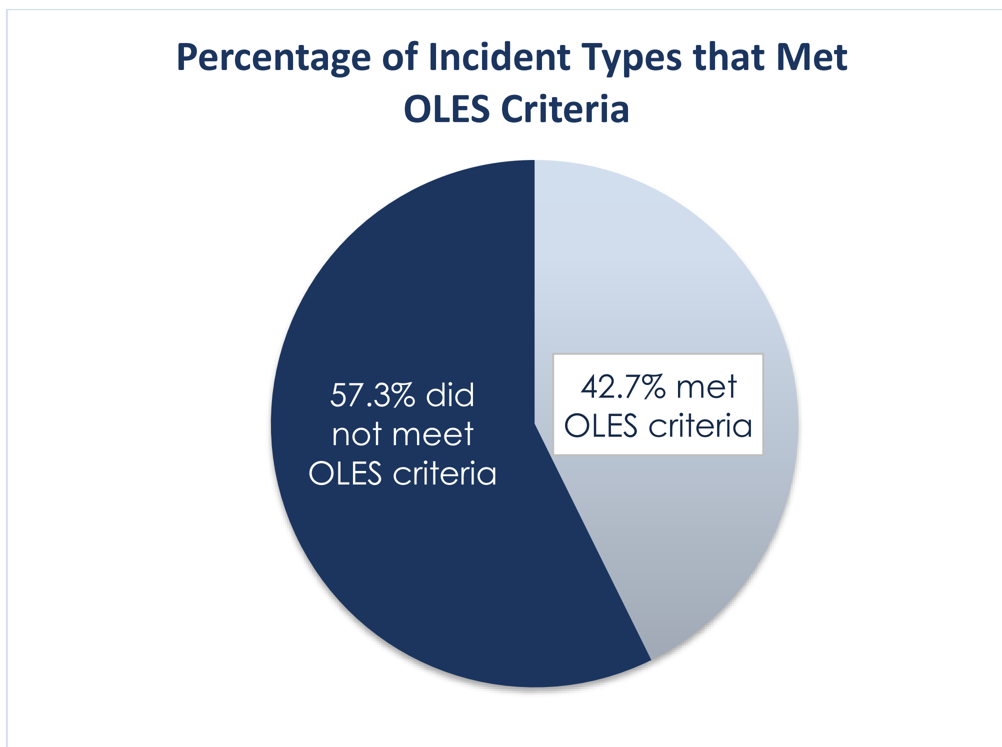
Incident Types Meeting OLES Criteria

The DSH reports to OLES any incidents and associated reportable incident types[2] listed

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

in the Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. An incident type "meeting criteria" is an occurrence that the OLES determined to meet OLES criteria for investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 562 reported incidents, the OLES identified 55 incidents with two or more incident types. The DSH reported a total of 634 incident types during this reporting period. Two hundred and seventy-one, or 42.7 percent of the 634 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported by DSH include: use of force by law enforcement, sexual assault, abuse, head or neck injury and patient death. Use of force by law enforcement represented the single largest number of incidents reported by DSH during this reporting period. A use of force report documents an operational incident and does not necessarily indicate misconduct or excessive force by an officer. For reporting purposes, the OLES reporting guidelines lists the following definition for use of force by staff from the Office of Protective Services (OPS):

Any OPS staff member within DSH that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject shall be considered a reportable use of force incident regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by subject to the officer or officers.

The OLES received 130 reports of use of force, which accounted for 20.5 percent of all

reported incident types by DSH. Six of the 130 use of force reports included an allegation of patient abuse against law enforcement.

The DSH reported 103 incident types of sexual assault, making sexual assault the second most frequently reported incident type. Allegations of patient abuse was the third most reported incident type, with 85 allegations reported, representing a 17.5 percent decrease when compared to the 103 reported allegations in the prior reporting period. The DSH reported 47 head or neck injury incident types. Reports of head or neck injuries decreased by 11.3 percent when compared to the prior reporting period. The fifth most frequent incident type was patient death, which decreased compared to the prior reporting period.

Patient Deaths

The number of patient deaths decreased by 39.3 percent, from 56 deaths to 34 deaths during this reporting period. Eleven of the reported death incident types met the OLES criteria for investigation or monitoring. Twenty-three of the 34 patient deaths were expected due to existing medical conditions or COVID-19. Eleven 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. Two of the 11 "unexpected" deaths were due to cardiac or respiratory issues, one was due to COVID-19, one due to inflammation of the colon and seven deaths are pending determination for the cause.

Metropolitan State Hospital (MSH) reported the largest number of patient deaths with 12 patient deaths. At MSH, the most frequent cause of death reported was cardiac or respiratory issues.

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 12 patient arrests, one less arrest compared to the prior reporting period. The patients were arrested for violations of the statutes listed in the table below.

Statute	Description
Penal Code section 69	resisting an executive officer with threat or violence

Statute	Description
Penal Code section 148.4(a)(1)	making a false fire alarm
Penal Code section 236	false imprisonment with violence
Penal Code section 242	battery
Penal Code section 243(c)(1)	battery with injury on medical personnel
Penal Code section 243(c)(2)	battery on a peace officer
Penal Code section 243(d)	battery causing serious bodily injury
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 4502(a)	possession of a weapon by a prisoner

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 administrative or criminal misconduct.

Appendix A provides information on the 12 OLES investigations that were completed during this reporting period. These investigations involved allegations against at least 12 sworn staff members, which is approximately 1.7 percent of the 721 DSH sworn staff as of December 31, 2021. Nine investigations involved alleged incidents that occurred in 2021. Three investigations involved alleged incidents that occurred in 2020.

The OLES submitted eight completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process. Administrative investigations were initiated in response to alleged policy violations such as committing an act of domestic violence, dishonesty, discourteous treatment, sleeping on duty and negligently discharging a firearm at a personal residence or during weapons training. The OLES completed four criminal investigations. The criminal cases were closed without referral to a district attorney's office due to a lack of probable cause. A summary of the review and decision for each case was provided to the department.

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 and C of this report, OLES provides information on 69 monitored administrative cases and 66 monitored criminal cases that, by December 31, 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.

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

The OLES monitored 135 pre-disciplinary phase cases; 126 of the pre-disciplinary phase cases are listed in Appendix B and nine are in Appendix C. Twenty-three of the 135 pre-disciplinary phase cases were rated as procedurally insufficient only. One case was rated both procedurally and substantively insufficient. Frequent procedural deficiencies include late notifications to OLES, delayed investigations and delays in conducting the findings and penalty conference.

The OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in nine administrative cases listed in Appendix C. Three of

---

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

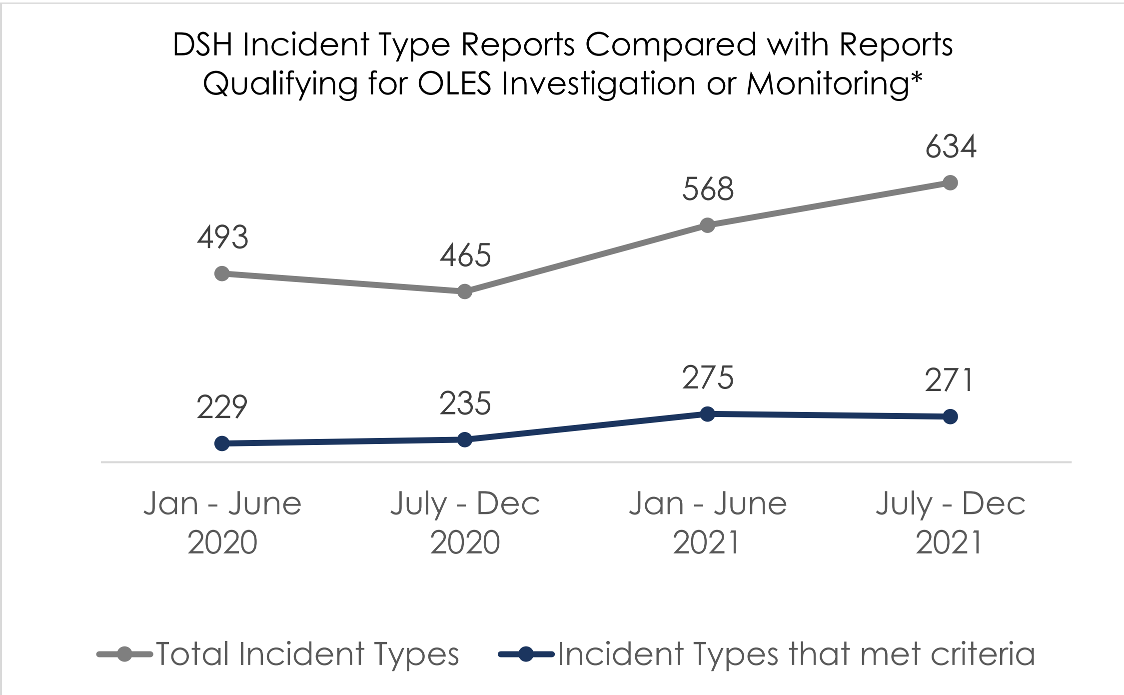
the nine disciplinary phase cases were rated procedurally insufficient due to delays in serving a disciplinary action or not providing OLES with the draft of the disciplinary action prior to serving it. All disciplinary cases were rated substantively sufficient.

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 July 1 through December 31, 2021, increased 11.1 percent, from 506 during the prior reporting period to 562 in this reporting period. From the 562 reported incidents, the OLES identified 634 incident types, as 55 of the incidents featured two or more incident types. Two hundred and seventy-one of the 634 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.

Most Frequent Incident Types Reported

The most frequent incident types reported were use of force, sexual assault, abuse, head or neck injury and death. These five incident type categories accounted for 399 or 62.9 percent of all incident types reported by DSH. Of the 399 incident types, 157 met criteria for OLES to investigate or monitor. This is 57.9 percent of the 271 incident types that met criteria.

The DSH's most frequent report to OLES was use of force by law enforcement. The 130 reports of use of force accounted for 20.5 percent of the reported incident types.

Sexual assaults accounted for 16.2 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 4.4 percent, from 45 during the prior reporting period, to 47 in this reporting period.

Allegations of abuse were the third most frequently reported incident type by DSH, with 85 incident types reported. Abuse allegations accounted for 13.4 percent of all incident types reported. Of the 85 abuse allegations reported in this period, 84 allegations qualified for investigation, monitoring or consideration of a potential systemic issue. This is a decrease of 12.5 percent or 12 qualifying reports from the prior reporting period, which had 96 incident types of abuse that met OLES criteria.

Reports for head or neck injuries continue to be frequently reported. Reports of head or neck injuries decreased 11.3 percent to 47 incident types. Sixteen head or neck injuries resulted from a physical altercation between patients. The remaining head or neck injuries resulted from a self-injury by the patient or an unwitnessed or witnessed fall.

Reports of patient deaths decreased by 39.3 percent when compared to the number reported in the prior reporting period. This decrease is associated with a reduction in reported patient deaths due to COVID-19, which decreased by 92 percent.

The following table provides the most frequently reported incident types reported by DSH and the percent change from the previous reporting period.

Most Frequent Incident Types July 1 through December 31, 2021

Incident Type Category	Prior Period Incident Type Total – January 1 through June 30, 2021	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Use of Force	-	130*	-	6
Sexual Assault	101	103	+2.0%	47
Abuse	103	85	-17.5%	84
Head/Neck Injury	53	47	-11.3%	9
Death	56	34	-39.3%	11

*Six use of force reports included allegations of excessive force by law enforcement and are also included in the total count for the abuse incident type category.

Incident Types by Reporting Period

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

Incident Categories	Prior Period July 1 - December 31, 2020 (Reported)*	Prior Period July 1 - December 30, 2020 (Meets Criteria)*	Prior Period January 1 - June 30, 2021 (Reported)*	Prior Period January 1 - June 30, 2021 (Meets Criteria)*	Current Period July 1 - December 31, 2021 (Reported)	Current Period July 1 - December 31, 2021 (Meets Criteria)
Abuse	94	89	103	96	85	84
Broken Bone (Known Origin)	12	1	19	2	12	2
Broken Bone (Unknown Origin)	39	37	48	45	32	31
Burn	2	0	4	1	7	0
Death	60	20	56	9	34	11
Genital Injury (Known Origin)	1	0	5	1	11	1
Genital Injury (Unknown Origin)	8	3	11	8	10	7
Head/Neck Injury	30	5	53	4	47	9
Misconduct	19	17	24	17	25	23
Neglect	19	16	26	25	25	21
Non-patient assault/GBI on Patient	0	0	0	0	1	1
OPS Use of Force	-	-	-	-	130**	6
Patient on Patient Assault/GBI	15	2	23	1	18	2
Pregnancy	1	1	0	0	0	0
Sexual Assault	104	34	101	45	103	47
Sexual Assault-OJ***	13	0	27	0	28	0
Significant Interest-Attack on Staff*****	12	0	11	0	12	1

Incident Categories	Prior Period July 1 - December 31, 2020 (Reported)*	Prior Period July 1 - December 30, 2020 (Meets Criteria)*	Prior Period January 1 - June 30, 2021 (Reported)*	Prior Period January 1 - June 30, 2021 (Meets Criteria)*	Current Period July 1 - December 31, 2021 (Reported)	Current Period July 1 - December 31, 2021 (Meets Criteria)
Significant Interest-Attempted Suicide	1	0	2	1	1	1
Significant Interest-AWOL	6	0	6	2	4	2
Significant Interest-Child Pornography	1	0	3	0	1	0
Significant Interest-Drugs* **	-	-	-	-	10	5
Significant Interest-Other* ***	7	1	23	8	11	2
Significant Interest-Over-Familiarity	10	9	10	9	15	15
Significant Interest-Patient Arrest	11	0	13	1	12	0
Significant Interest-Riot	0	0	0	0	0	0
Total	465	235	568	275	634	271

*Numbers in this column are unadjusted and provided as they were previously published.
**Six use of force reports included allegations of excessive force by law enforcement and are also included in the total count for the abuse incident type category.
***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.
*****Beginning in the July 1, 2021, through December 31, 2021, reporting period, the OLES distinguished drug-related allegations and crimes by patients or staff as a separate incident type. These incidents include verified drug offenses by patients and allegations of drug trafficking or smuggling against patients or staff.
******Any other incident of significant interest, e.g., drone found on facility grounds, bomb threats from unidentified callers, or a staff arrest by an outside law enforcement agency for possession of child pornography.

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	8	35	11	21	85
Broken Bone (Known Origin)	5	4	2	0	1	12
Broken Bone (Unknown Origin)	4	8	5	10	5	32
Burn	0	6	1	0	0	7
Death	4	6	12	8	4	34
Genital Injury (Known Origin)	0	0	11	0	0	11
Genital Injury (Unknown Origin)	1	0	8	0	1	10
Head/Neck Injury	9	12	15	3	8	47
Misconduct	1	13	4	3	4	25
Neglect	12	2	7	1	3	25
Non-Patient on Patient Assault/GBI	0	0	0	1	0	1
OPS Use of Force	77	10	10	22	11	130*
Patient on Patient Assault/GBI	4	4	3	1	6	18
Pregnancy	0	0	0	0	0	0
Sexual Assault	13	19	27	24	20	103
Sexual Assault-OJ**	14	1	2	8	3	28
Significant Interest- Attack on Staff***	2	1	1	6	2	12
Significant Interest- Attempted Suicide	0	0	1	0	0	1
Significant Interest-AWOL	0	0	3	1	0	4

Incident Type	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Significant Interest-Child Pornography	0	1	0	0	0	1
Significant Interest-Drugs******	0	8	0	0	2	10
Significant Interest-Other*********	1	1	1	2	6	11
Significant Interest-Over-Familiarity	3	2	2	3	5	15
Significant Interest-Patient Arrest	3	6	0	0	3	12
Significant Interest-Riot	0	0	0	0	0	0
Total	163	112	150	104	105	634

*Six use of force reports included allegations of excessive force by law enforcement and are also included in the total count for the abuse incident type category.
**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.
****Beginning in the July 1, 2021, through December 31, 2021, reporting period, the OLES distinguished drug-related allegations and crimes by patients or staff as a separate incident type. These incidents include verified drug offenses by patients and allegations of drug trafficking or smuggling against patients or staff.
*****Any other incident of significant interest, e.g., drone found on facility grounds, bomb threats from unidentified callers, or a staff arrest by an outside law enforcement agency for possession of child pornography.

Distribution of Incident Types

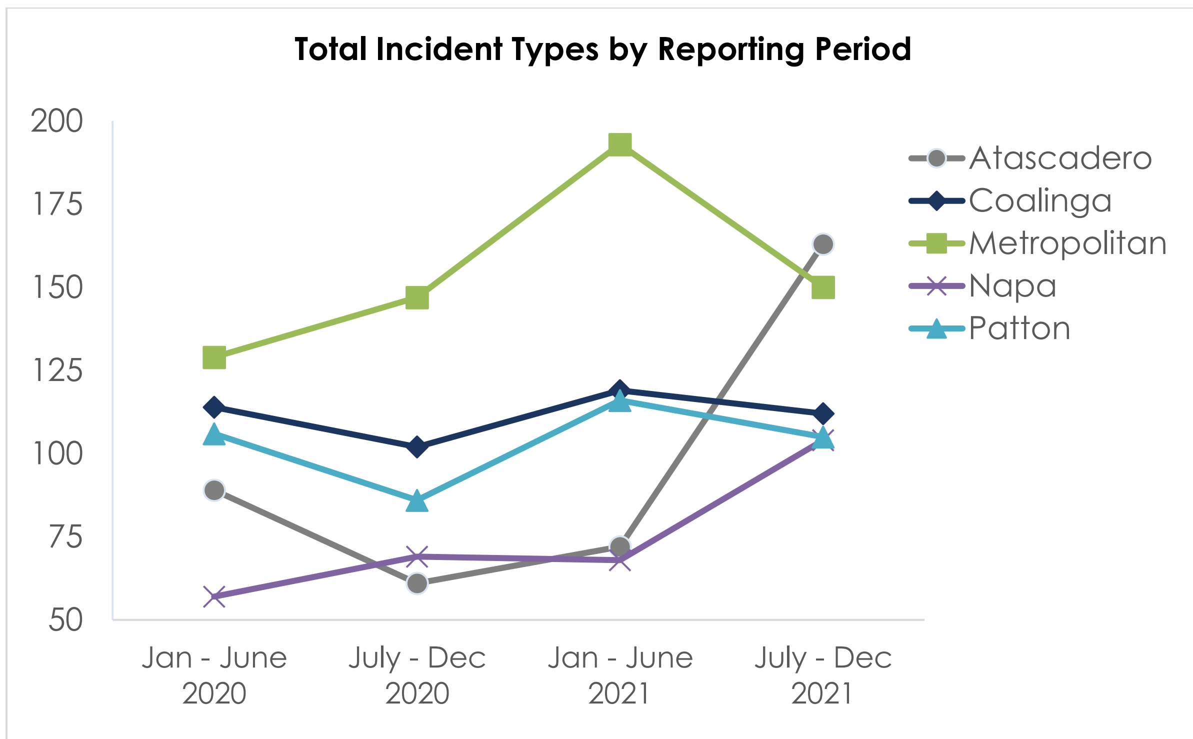
With 5,419 patients department-wide, this equates to 0.117 incident types per patient. The following table provides the population counts of DSH facilities for reference.

DSH Population and Total Incident Types

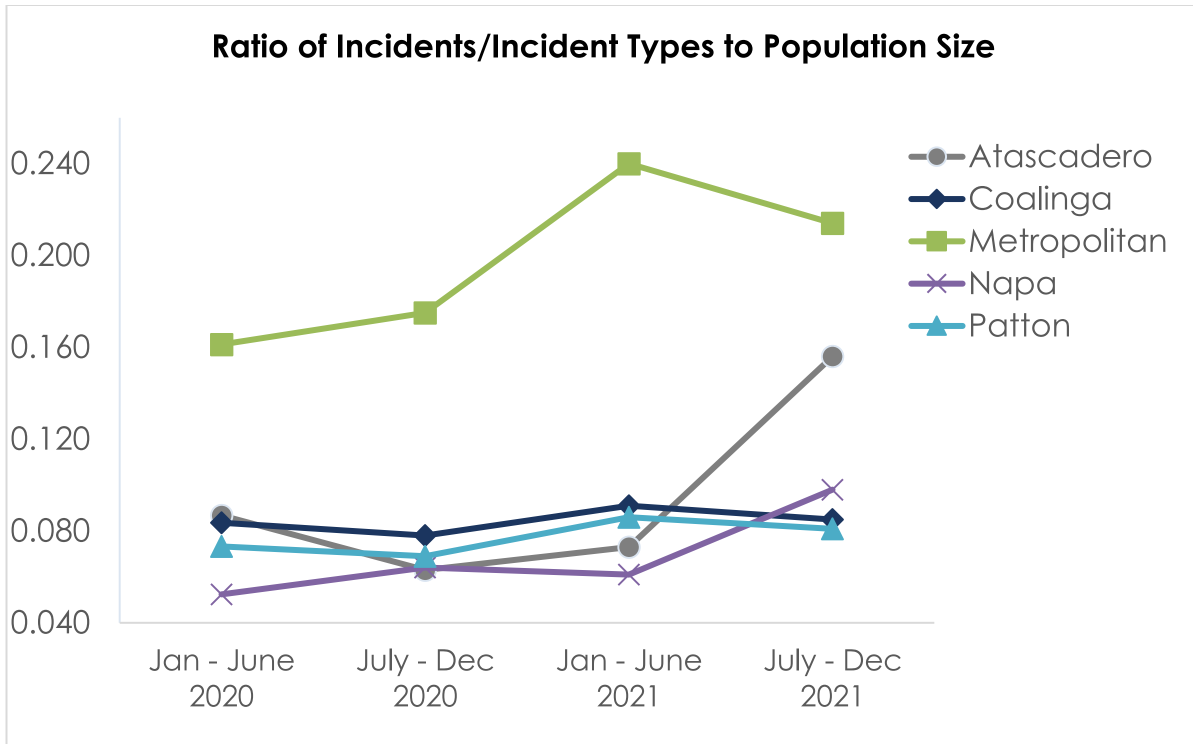
DSH Facility	Number of Patients*	Total Incident Types	Ratio of Incident Types to Population
Atascadero	1,047	163	0.156
Coalinga	1,315	112	0.085
Metropolitan	700	150	0.214
Napa	1,061	104	0.098
Patton	1,296	105	0.081
Total	5,419	634	0.117

*The department provided population numbers as of December 31, 2021.

With the inclusion of use of force incidents, Atascadero State Hospital (ASH) reported significantly more incident types compared to the prior reporting period and reported the highest number of incident types in this reporting period. The Napa State Hospital (NSH) also reported more incident types compared to the prior reporting period. The MSH, Coalinga State Hospital (CSH) and Patton State Hospital (PSH) reported fewer 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 following chart.



Sexual Assault Allegations

Sexual assault was the second most frequently reported incident type from July 1 through December 31, 2021. The 103 alleged sexual assault incident types reported in this reporting period accounted for 16.2% percent of all reported incident types from DSH. Forty-seven of the 103 reported incident types of alleged sexual assault, or 45.6 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 28 reported incident types under the sexual assault-OJ category, none of which met OLES criteria for investigation or monitoring.

The MSH reported the highest number of incident types under the sexual assault incident type category. The MSH reported 27 incident types, or 26.2 percent of all alleged sexual assault incident types reported during this reporting period. The NSH reported the second highest number of sexual assault allegations, with 24 reports.

The ASH reported the highest number of alleged sexual assault-OJ incident types. In this reporting period, ASH reported 14 out of the 28 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 57 incident types, or 55.3 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 29 incident types or 28.2 percent of the 103 alleged sexual assault incident types. There

were 16 allegations of sexual assault involving an unknown assailant on a patient. These include allegations made by patients that did not implicate DSH employees or contractors. The DSH reported one allegation of sexual assault on a patient by law enforcement personnel during this reporting period. All DSH reports of alleged sexual assaults received by OLES during the reporting period are shown in the following table.

Sexual Assault Allegations Reported July 1 through December 31, 2021

Facility	Patient on Patient	Law Enforcement Staff on Patient	Non-Law Enforcement Staff on Patient	Unknown Person on Patient	OJ*	Totals
Atascadero	9	0	0	4	14	27
Coalinga	11	0	6	2	1	20
Metropolitan	15	0	7	5	2	29
Napa	14	1	6	3	8	32
Patton	8	0	10	2	3	23
Totals	57	1	29	16	28	131

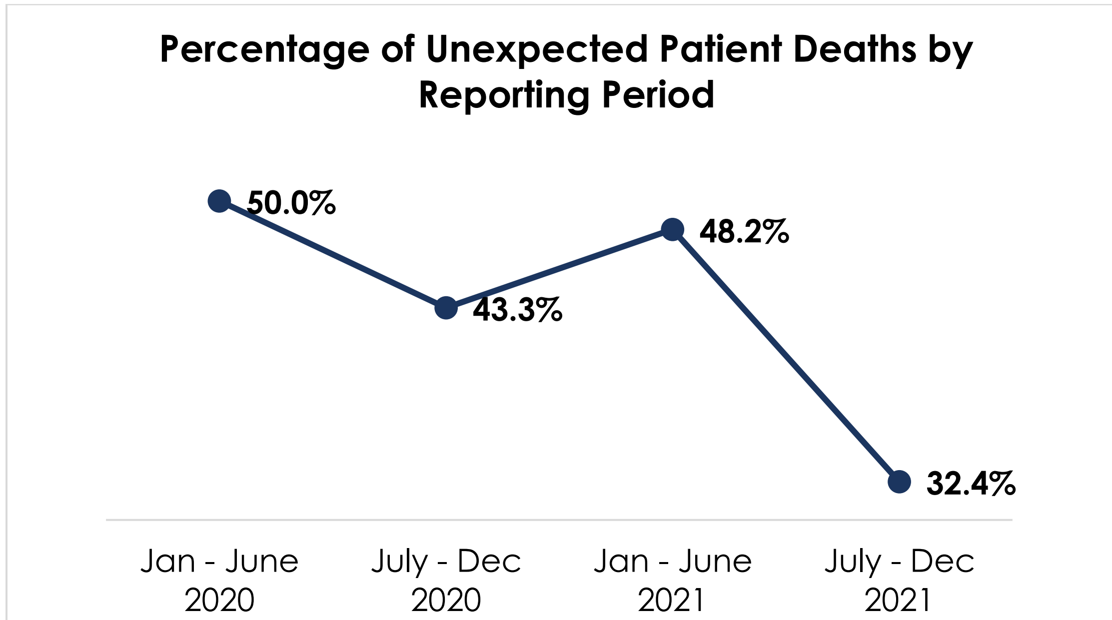
*Sexual Assault-OJ is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH or outside the jurisdiction of the state hospital.

Patient Deaths

There were 34 patient deaths reported to OLES from DSH facilities during this reporting period. This number decreased 39.3 percent from the 56 patient deaths reported in the prior reporting period of January 1 through June 30, 2021. Of the 34 patient deaths, 32 were male patients and two were female.

Twenty-three of the patient deaths were classified as “expected” due to COVID-19 or underlying health conditions, such as cancer, cardiac or respiratory issues, cerebral issues, renal or liver issues or sepsis. Eleven deaths were classified as “unexpected”. The percentage of unexpected patient deaths decreased compared to the percentage in the prior reporting period. 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 eight of the 34 patient deaths, the OLES monitored the departmental investigations.

The following chart depicts the percentage of unexpected patient deaths in this reporting period and the three prior reporting periods.



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	Cerebral Issue	COVID-19	Renal/ Liver	Sepsis	Other	Total
Atascadero	0	1	0	0	2	0	1	4
Coalinga	1	2	0	2	1	0	0	6
Metropolitan	1	6	0	0	1	1	3	12
Napa	0	2	1	0	0	1	4	8
Patton	2	1	0	0	0	0	1	4
Totals	4	12	1	2	4	2	9	34

Cardiac or respiratory issues was listed as the cause of death for 35.3 percent of the reported patient deaths. The second most frequently reported cause of death was cancer or renal or liver issues. Eight patient deaths listed under the "Other" category are pending determination for the cause. One patient death from PSH was due to inflammation of the colon and was included under the "Other" category.

Reports of Patients Absent without Leave

In this reporting period, DSH reported four incident types under the significant interest-absent without leave (AWOL) category. All four incidents involved non-forensic patients. The MSH reported three of the four incident types. While under the care of staff from an outside hospital, a MSH patient exited the outside community hospital and was

redirected back inside by the hospital staff. Another MSH patient stole a staff member's key and exited her living unit. She was contained without injury or incident and did not leave departmental grounds. Another MSH patient was found near the intersection of Magnolia and South Circle on MSH grounds by an officer. The officer transported the patient back to his unit without further incident.

At NSH, a patient went out of the building through an emergency door. An officer found the patient and escorted the patient to his unit without further incident.

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 and was not witnessed by staff.
Deadly force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a patient, including a patient that is officially declared brain dead by a physician or other authorized medical professional noting the date and time, or a death that occurs up to 30 days from patient discharge from the facility.
Genital Injury (U)	An injury to the genitals of a patient when the cause of injury is undetermined and was not witnessed by staff.
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 or witnessed 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 or witnessed 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

Incident	Description
	from a forceful impact, regardless of treatment. Injuries that are beyond treatment beyond first aid include physical trauma resulting in an altered level of consciousness or loss of consciousness or the use of skin adhesive, staples or sutures.
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.
OPS Use of Force	Any Office of Protective Services staff member within DSH that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject, regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by the subject to the officer or officers.
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. Allegations against a peace officer that include a priority one incident type must be reported in accordance with the priority one reporting requirements.
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, drug trafficking or smuggling, 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

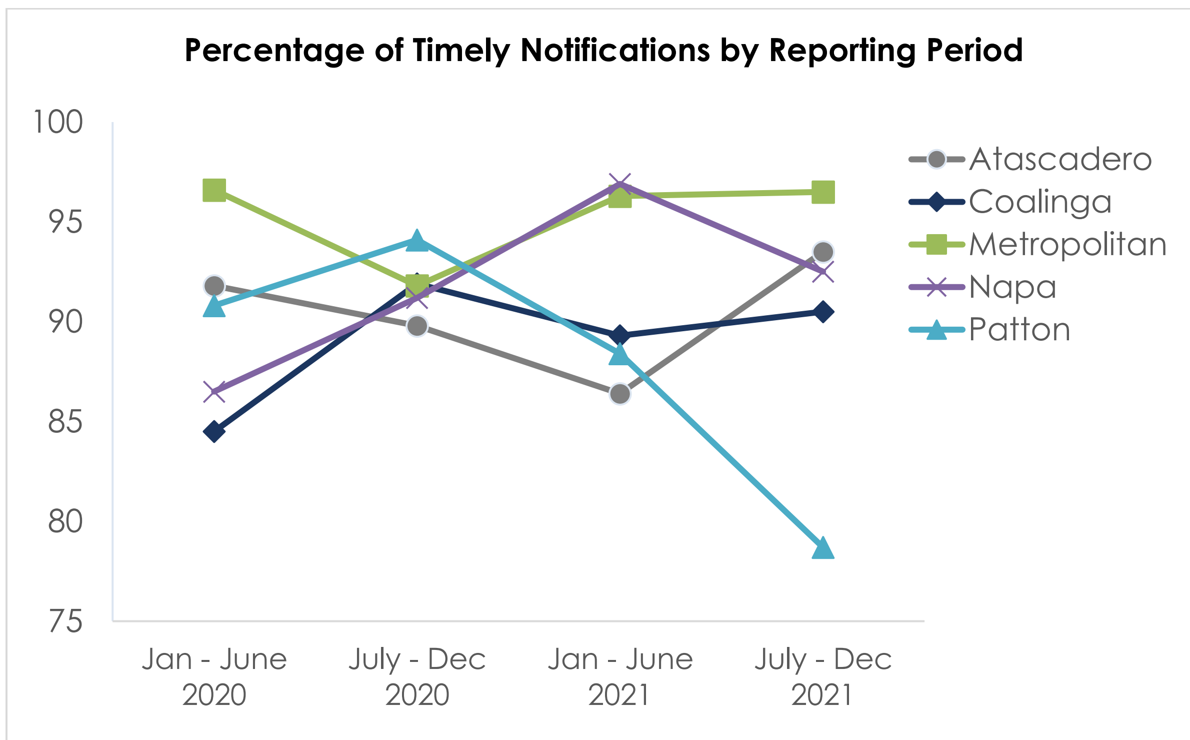
The DSH decreased in the timely reporting of incident types with 91.1 percent timely reports when compared to the prior reporting period, which had 92.1 percent timely reports.

Sixty of the 634 reported incident types were excluded from DSH's total incident type count when calculating timeliness. These incident types include use of force incidents reported prior to the inclusion of the use of force incident type in the OLES reporting guidelines, 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 574 incident types evaluated for timeliness, 523 were reported timely and 51 incident types were not timely. Five of the 51 untimely incident types were unreported and were discovered by OLES when reviewing the DSH facility daily incident logs or incident reports.

The MSH had the highest percentage of timely notifications at 96.5 percent during this reporting period. The PSH had the lowest percentage of timely notifications at 78.7 percent. The following table provides the percentage of timely notifications to OLES for each facility.

Rank	DSH Facility	Number of Timely Notifications	Number of Untimely Notifications	Number of Excluded Incident Types from Timeliness calculation	Total Reported Incident Types	Percentage of Timely Notifications
1	Metropolitan	139	5	6	150	96.5%
2	Atascadero	129	9	25	163	93.5%
3	Napa	86	7	11	104	92.5%
4	Coalinga	95	10	7	112	90.5%
5	Patton	74	20	11	105	78.7%
	Total	**523**	**51**	**60**	**634**	91.1%

The following chart compares the percentage of timely notifications by reporting period. When compared to the prior reporting period, ASH, CSH and MSH increased in the percentage of timely reports. The NSH 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 E. 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 July 1 through December 31, 2021, reporting period, 324 of the total 614 cases opened for DSH incidents that occurred within DSH's jurisdiction or 52.8 percent were assigned a pending review. The OLES opened cases for 28 incidents that may have occurred while the patient was not housed within a DSH facility and assigned those cases a pending review. The OLES opened 12 administrative investigations and 12 criminal investigations. The OLES opened 179 monitored criminal cases and 59 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 the outside jurisdiction cases from the Pending Review cases.

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

Cases Opened in the Current Reporting Period

OLES Case Assignments	July 1 – December 31, 2021	Percentage of Opened Cases
Pending Review	324	52.8%
Monitored, Criminal	179	29.2%
Monitored, Administrative	59	9.6%
Outside Jurisdiction*	28	4.6%
OLES Investigations, Criminal	12	2.0%
OLES Investigations, Administrative	12	2.0%
Totals	614	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 D). 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, eight 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 criminal investigations in which the OLES determined there was a lack of probable cause.

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

Results of Completed OLES Investigations

Type of Investigation	Total completed July - December 31, 2021	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	8	N/A	8	N/A
Criminal	4	0	N/A	4
Total	12	0	8	4

OLES Monitored Cases

In this report, OLES provides information on 135 completed monitored cases. By the end of the reporting period, 66 monitored criminal cases had either been referred or not referred to a prosecuting agency. Two out of 66 criminal cases were referred to a prosecuting agency.

There were 69 completed monitored pre-disciplinary administrative cases with allegations that were sustained or not sustained during this reporting period. Nineteen of the 69 cases had sustained allegations. Fifty cases did not have sustained allegations. Results of OLES monitored cases are provided in the table below.

Type of Case/Result	DSH
Criminal-Referred to Prosecuting Agency	2
Criminal-Not Referred	64
Total Criminal	66
Administrative-With Sustained Allegations	19
Administrative-Without Sustained Allegations	50
Total Administrative	69
Grand Total	135

Pre-Disciplinary Phase Cases

Of the 135 pre-disciplinary phase cases provided in Appendix B and C, the OLES rated 23 cases procedurally insufficient only and one case 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	1	1
Criminal/Not Referred	10	0
Administrative/With Sustained Allegations	3	0
Administrative/Without Sustained Allegations	10	0

Type of Case/Result	Cases Rated Procedurally Insufficient	Cases Rated Substantively Insufficient
Total	24	1

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. Poor performing employees may continue to perform poorly throughout the delay.
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 six investigations that were not completed within the 120 day timeframe. Another frequent deficiency is delays in completing findings and penalty conferences for completed investigations.

Substantive Deficiencies found in Insufficient Cases

Substantive Deficiency	Potential Consequence
Failure to treat witnesses as possible suspects for failure to report abuse	Failure to treat witnesses as potential suspects could have compromised the criminal prosecution

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

Disciplinary Phase Cases

The OLES monitored the disciplinary action, *Skelly* hearings, settlements and State Personnel Board proceedings in seven administrative cases. Three cases were procedurally insufficient due to delays in serving the disciplinary action or not providing

OLES the opportunity to review the draft disciplinary action prior to serving the action. Details regarding the monitoring of these cases are in Appendix C of this report.

DSH Tracking of Law Enforcement Compliance with Training Requirements

The DSH OPS Training Plan, approved by the DSH chief of law enforcement and executive staff in 2020, identifies and prioritizes the training requirements for law enforcement personnel. The training plan categorizes courses for each rank or position into the following categories:

- **Mandated/Job-Required**: Training in this category is required by federal law, state law or OPS policy. Unless otherwise noted, this training should be completed within one year of appointment to the position.
- **Essential/Job-Related**: This training has been designated by OPS as necessary for the professional development of an employee in his or her specified rank or task assignment
- **Desirable/Career-Related**: Upon completion of the mandatory and essential courses, an employee may pursue additional interests in their law enforcement training.
- **Necessary**: Training needed for assignments requiring specialized skills or knowledge.

The DSH primarily uses a training database to track training completed by law enforcement staff. The software tracks courses required in the 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 an 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. 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.

Training Database Limitations

Standardized Data Entry and Data Review

The training coordinator at each facility or the designated staff manually enters training courses or completed certifications and courses for each staff member in the training database. These trainings are reflected in a training history report that can be generated for each staff member listed in the database. There does not appear to be an option to automatically assign trainings based on a staff member's rank or position. For example, the training plan lists 17 mandated trainings for the hospital police officer position. In order for these trainings to appear on a staff member's training history

report, each training must be manually entered or assigned to the staff member. This results in inconsistent and potentially inaccurate records for staff in the database. Examples of inconsistencies and inaccuracies include:

- Staff in the same rank or position have varying certification counts and there is no option to view compliance for all mandated training without reviewing each staff's training history report individually. 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.
- Some completed trainings were not recorded as certifications which results in a higher number of "expired" certifications, despite staff having already completed the training.
- Expiration dates for certifications are manually entered and sometimes do not match the expiration rule.

Due to the lack of standardization and manual data entry, the trainings documented in the database require regular review for accuracy and completeness.

Compliance Reports

The compliance monitor feature in the database is the primary method to track training compliance within the database.

Despite being able to categorize training courses or certifications into the four categories specified in the training plan, e.g. mandated, essential, desirable and necessary, the training database does not provide a convenient, user-friendly method to extract an aggregated report showing compliance rates for the four categories or each individual certification. Instead, the compliance report lists each individual certification that has been entered for each staff member in the system.

When searching for training compliance using person criteria information, the compliance monitor lists only certifications, which must be entered in a specific manner, instead of all training courses entered. This restricts the ability to easily view completion and compliance rates for all training data entered into the system. In addition, reports extracted from the compliance monitor using the person criteria search are limited. One report lists all certifications entered for staff, including certifications that have been deactivated and are no longer in use. The second report lists certifications that are expiring and has the option to include certifications that expired in the last 30 days.

Due to these limitations, some training coordinators use a separate tracking spreadsheet to supplement or supplant the training database tracking features.

DSH Law Enforcement Training Advisory Committee

In order to coordinate training efforts across the facilities, the DSH established the Law Enforcement Training Advisory Committee. Training lieutenants, training sergeants and training officers from each facility, as well as, academy and staff from DSH OPS

headquarters attend the bimonthly meeting to discuss training topics and changes to training. The committee recently discussed training database limitations and is working with the database vendor to more efficiently generate user-friendly compliance reports that address the tracking needs of the department.

Self-Reported Compliance Rates for Mandated Training

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

DSH Facility	Percentage of Compliance
Atascadero	92.6%
Coalinga*	67.6%
Metropolitan	73.0%
Napa	98.9%
Patton	77.9%

*Average of compliance rate across mandated trainings reported

Certification Tracking in DSH's Training Database

As of December 31, 2021, certification records in DSH's training database show 70.8 percent compliance, or 3,978 active certifications out of 5,617. Certifications that were reported to be no longer in use were excluded. Four of these certifications had a status of "Not Yet Issued," "Revoked" or "Suspended". The certifications with the highest total of expired certifications are listed below.

Certification	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Total
Area Extraction	391	165	0	556
Arrest Methods & Defensive Tactics	334	165	1	430
Chemical Agents	297	103	0	400
CLETS full access operator	43	123	0	169
CPR - AHA BLS for HCP	253	172	0	425
Domestic Violence	154	192	0	346
Gang Awareness	122	196	0	318
Title 22 First Aid	248	139	0	387
Use of Force	191	139	0	330

The following table provides the certification data by facility.

Facility	Active (Active)	Expired (Inactive)	Not Yet Issued (Inactive)	Revoked (Inactive)	Suspended (Inactive)	Total
Atascadero	1,387	421	1	0	1	1,810
Coalinga	726	426	0	1	1	1,154
Metropolitan	753	376	0	0	0	1,129
Napa	563	182	0	0	0	745
Patton	541	230	0	0	0	771
Sacramento/ Headquarters	8	0	0	0	0	8
Total	**3978**	**1635**	**1**	**1**	**2**	**5,617**

Since the last reporting period, facilities reported increased use of the database. However, similar to the prior reporting period, DSH's overall self-reported compliance does not align with the certification data from the database. The OLES will continue to work collaboratively with DSH to address these concerns and monitor the department's progress.

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	19	4	5	10	0
Coalinga	53	8	33	11	1
Metropolitan	62	3	56	2	1
Napa	53	4	27	10	0
Patton	42	4	29	8	1
Totals	229	23	150	41	3

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

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

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

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

Criminal Cases against Employees

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	1	1	0	0
Coalinga	0	0	0	0
Metropolitan	44	0	44	0
Napa	9	1	8	0
Patton	3	1	1	1
Totals	57	3	53	1

* 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	0	2	7	0
Coalinga	0	0	0	0
Metropolitan	0	0	0	0
Napa	0	1	0	0
Patton	0	0	3	0
Totals	0	3	10	0

*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	702	76	626	145
Coalinga	339	25	314	55
Metropolitan	462	3	459	10
Napa	314	3	311	1
Patton	231	121	110	57
Totals	2048	228	1820	235

* 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. This column includes rejected cases that were referred from prior reporting periods.

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 two new monitored issue on the review and tracking of use of force reports and delayed reporting by mandated reporters. 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.

In response, ASH command staff developed a sergeant information guide to aid sergeants with all use of force incidents. This guide was sent to all sergeants on May 13, 2021. The DSH reported ASH sergeants now brief officers at each watch to ensure all processes of OPS Policy 300 are met and when Policy 338 should be considered. Additional training was sent out to OPS staff on September 2, 2021.

The OLES will work collaboratively with the department and continue to monitor the department’s progress on this issue.

Escape Prevention and Key Control at CSH

On April 7, 2020, the OLES initiated a monitored issue in response to a patient escape attempt 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 and is working with a vendor for installation. The OLES will continue to monitor the department's progress.

Underutilization of Blue Team/IAPro

In March 2015, the OLES provided the Legislature with a report that described the

challenges faced by law enforcement at DSH along with recommendations to address these challenges. One of the recommendations was for the department 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 department 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. As of December 31, 2021, DSH has not updated implemented this recommendation. The OLES will continue to monitor the department's progress.

Use of Force Reports, Reviews and Tracking at DSH

On July 15, 2021, OLES issued a monitored issue memorandum documenting concerns and recommendations regarding use of force on patients at DSH facilities after reviewing 42 use of force packages submitted to OLES from August 3, 2020, to July 15, 2021. For reporting purposes, the OLES reporting guidelines lists the following definition for use of force by staff from the Office of Protective Services (OPS):

Any OPS staff member within DSH that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject shall be considered a reportable use of force incident regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by subject to the officer or officers.

A use of force report documents an operational incident and does not necessarily indicate misconduct or excessive force by an officer.

OPS Therapeutic Strategies and Interventions vs. Use of Force

The OLES conducted a review and discovered five use of force incidents were not reported to OLES from August 3, 2020 to July 15, 2021. The DSH determined several of these incidents involved Therapeutic Strategies and Interventions (TSI) techniques, rather than use of force by law enforcement.

The DSH has no requirement to write a report following the use of TSI techniques on a patient. HPOs often deemed the force they used to be TSI and therefore their use of force was not documented and reviewed by supervision. Pursuant to Policy 300, sworn staff are required to write use of force reports after they go hands on with a patient regardless if their actions are referred to as TSI. Reports describing sworn staff using force must articulate the imminent threat to the safety of staff, patients, or facility that precipitated the use of force. The OLES reviewed some reports that simply stated TSI was used without providing any details of what transpired.

Supervision's Review of UOF Reports

The OLES determined that supervision of use of force incidents was not adequate. While

the Chief of Police at each facility is ultimately responsible for the review and determinations on use of force incidents, the OLES recommends each facility have an assigned UOF coordinator, who has access to all UOF incidents and would be responsible for promptly moving the reports through all levels of review. The coordinator should also ensure that the final facility package is sent to OLES and the Chief of Law Enforcement.

One of the issues identified pertains to the supervisor's role as defined under DSH Policy 300.6.2. While most of the UOF incidents reported to OLES are immediate and not calculated, this portion of the policy addresses both. It requires the supervisor to perform specific actions, regardless if the supervisor responds to the scene. The OLES recommends that the supervisor complete a supplemental report regarding their actions in compliance with the policy. Many supervisors' use of force reports did not add anything of substance and did not address some of the requirements under this policy.

The supervisors who review use of force reports must ensure that all necessary information was obtained and all discrepancies were resolved before approving the report. In fact, DSH policy 322.4 states, "Supervisors shall review reports for content and accuracy." However, OLES discovered that supervisors approved reports which contained discrepancies and needed further clarification. The DSH policy requires that "all reports shall accurately reflect the identity of the persons involved, all pertinent information seen, heard, or assimilated by any other sense, and any actions taken."

Use of Force Documentation
The DSH Policy 300.5 requires sworn staff to document the use of force "promptly, completely and accurately" in their report along with the requirement to "…articulate the factors perceived and why he/she believed the use of force was reasonable under the circumstances." However, sworn staff did not always meet these requirements as many reports did not provide sufficient details regarding the factors which resulted in the use of force against the patient.

Instead, reports which contained general statements which did not provide the specific order the patient refused, the reasonableness of the decision to use force, the identity of the HPOs and staff who were involved or witnessed the use of force, and the precise actions the HPOs and staff took when used force on the patient. Incidents involving the use of force against a patient are more likely to result in allegations of excessive force; therefore it is essential the reports contain sufficient information which details the actions and observations of all involved parties.

Tracking UOF Incidents
Of the 42 use of force packages the OLES received, only 17 of those cases were entered into Blue Team/IA Pro. The DSH was also not consistently categorizes use of force incidents in its records management system (RMS). The RMS contains a UOF check box within the "Additional Information" section. The DSH explained the purpose of the check box is to designate the case as an UOF incident, and acknowledged the check box was not being used consistently by all facilities.

Recommendations

1. The OLES recommends that DSH incorporate a standard code for UOF in RMS so all UOF incidents can be quickly identified in RMS. In RMS, there is a filter that lists all the unique values in the columns that allow a user to search for uses of force but these columns are underutilized. There is no category for use of force but there are categories for assault and resisting arrest. There are at least three different categories for resisting arrest. OLES identified that some assault sections are used for assault on peace officer but there is no consistency. This system is capable of retrieving all UOF incidents if there were better categories within these three columns of data. With the addition of some categories, such as "Officer Use of Force," and subcategories such as attack on peace officer and physical resistance, OLES and the DSH would have the ability to obtain a list of all UOF incidents for a desired timeframe, instantly.
2. OPS supervisors need to improve their communication with officers when reviewing use of force packets. Sworn staff assigned to conduct follow-up investigations should receive training, as well as, clear and specific direction regarding the additional information they need to obtain to properly complete a UOF packet.
3. The OLES also recommends the UOF policy be changed to require written reports by all personnel (sworn and non-sworn) present during a UOF incident. The practice of allowing staff members to interview other staff who witnessed force being used or who used force and write reports for them should be prohibited. Written reports by witnesses should be included with every use of force packet. Prompt, thorough and impartial documentation of an UOF incident is critical. This documentation supports future process improvements, changes to policy, promotes safety and public trust and aids in Department risk mitigation if incidents or staff actions are questioned.
4. TSI Techniques that also involve physical force by law enforcement personnel to overcome resistance or gain control of a patient should be considered a use of force requiring compliance with all use of force policies including the writing of reports and completion of a UOF packet.
5. In order to allow OPS to track uses of force, Blue Team/IA Pro and RMS should be used regularly.
6. A copy of all UOF packets should be submitted to OLES within 30 days and UOF packets should have a new section added that includes a signature line acknowledging the UOF packet has been received and reviewed by OLES and with an indicator box to request additional information or investigation if warranted.

On December 28, 2021, DSH acknowledged there are opportunities for improvement in its UOF review and reporting process and the OLES will work collaboratively with the department and monitor the department's progress.

Delayed Reporting by Mandated Reporters

In December 2021, the OLES issued a monitored issue memorandum to DSH after discovering significant delays in required reporting by mandated reporters at DSH. The OLES reviewed several incidents where OPS made timely notification to OLES;

however, level of care staff who are mandated reporters, did not report the incident to OPS or delayed their notification to OPS. The delays ranged from several hours to several days after initial discovery by the mandated reporters.

These delays may have a negative impact on the investigations of the incidents. Timely notification to appropriate law enforcement is critical, especially for alleged sexual assaults or other potential crimes of violence. When an allegation is made of a recent sexual assault, time is of the essence. Valuable forensic evidence could be lost if a victim or suspect changes clothes, showers, brushes their teeth or uses the restroom. Additionally, for sexual assaults and other allegations of abuse, delays could undermine investigations in other ways. For example, delays give opportunity for collusion amongst involved parties or may cause a patient or victim to fear going forward with abuse allegations. Finally, the victims involved in these alleged incidents are a unique population with various mental, emotional and developmental conditions that may affect the accurate recall of events. As such, investigative efforts must commence immediately whenever possible.

There was no information indicating DSH mandated reporters make appropriate notifications to outside law enforcement when required. Timely notification to all appropriate law enforcement entities is crucial to preserving the integrity of diligent, thorough and fair investigations.

To address this issue and ensure accurate, thorough investigations are completed without delay or compromise, OLES recommended:

1. DSH implement a statewide policy requiring mandated reporters to make timely notifications to OPS as required by Welfare and Institutions Code (WIC), sections 15630(b)(1)(E)(i-iii).
    a. As some incidents that are reportable pursuant to the OLES Facility Reporting Guidelines may not specifically be listed in the WIC, the policy must also require staff make timely notifications to OPS for all incidents listed in the OLES Facility Reporting Guidelines.

2. DSH implement a statewide policy requiring all DSH mandated reporters to make timely notification of reportable incidents to outside law enforcement agencies as required by law.

The OLES will work collaboratively with the department and monitor the department's progress on this issue.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of July 1 through December 31, 2021.

Case Detail	Description
Incident Date	11/11/2020
OLES Case Number	2020-01185-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On November 11, 2020, an officer allegedly committed an act of domestic violence and was arrested.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Case Detail	Description
Incident Date	01/18/2021
OLES Case Number	2021-00160-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	Between January 18, 2021, and January 31, 2021, an officer allegedly hit a restrained 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 of the investigation was provided to the department.

Case Detail	Description
Incident Date	11/13/2020
OLES Case Number	2021-00200-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On November 13, 2020, a lieutenant was allegedly disrespectful and discourteous toward an officer in the presence of other personnel.
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	02/23/2021
OLES Case Number	2021-00308-1C

Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On February 23, 2021, an officer allegedly verbally threatened department staff.
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 of the investigation was provided to the department.

Case Detail	Description
Incident Date	03/22/2021
OLES Case Number	2021-00356-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On March 22, 2021, an off-duty officer allegedly negligently discharged a firearm at his residence.
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	02/02/2021
OLES Case Number	2021-00370-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On February 3, 2021, and March 25, 2021, an officer allegedly was asleep while on-duty and assigned to patient observation.
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	03/27/2021
OLES Case Number	2021-00464-1C
Case Type	Investigative
Incident Type	1. Abuse 2. Head/Neck 3. Significant Interest - Attack on Staff 4. Use of Force Review
Incident Summary	On March 27, 2021, an officer allegedly assaulted 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 of the investigation was provided to the department.

Case Detail	Description
Incident Date	10/09/2020
OLES Case Number	2021-00476-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On October 9, 2020, an officer allegedly stole department police equipment.
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 of the investigation was provided to the department.

Case Detail	Description
Incident Date	05/13/2021
OLES Case Number	2021-00593-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On May 13, 2021, an officer allegedly was asleep while on-duty.
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	07/23/2021
OLES Case Number	2021-00964-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On July 23, 2021, an officer allegedly provided false information to his supervisors in order to obtain time off.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition of the case.

Case Detail	Description
Incident Date	08/06/2021
OLES Case Number	2021-00970-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On August 6, 2021, an officer allegedly provided false information during a COVID screening process.
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	09/14/2021
OLES Case Number	2021-01083-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	On September 14, 2021, an investigator allegedly negligently discharged his firearm during weapons training.
Disposition	The investigation was completed by the Office of Law Enforcement Support and submitted to the hiring authority for disposition. The OLES monitored the disposition of the case.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by December 31, 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.

The Office of Protective Services referenced in this section may include the Department of Police Services or the Office of Special Investigations.

Criminal-Referred to Prosecuting Agency

Case Detail	Description
Incident Date	05/01/2020
OLES Case Number	2021-00360-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	Between May 1, 2020, and May 31, 2020, a psychiatric technician allegedly kissed a patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. 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	05/15/2021
OLES Case Number	2021-00605-1C
Case Type	Monitored
Incident Types	1. Abuse

Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On May 15, 2021, a psychiatric technician allegedly grabbed a restrained patient by the neck for approximately 15 seconds.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigator delayed sending a video recording of the incident to the OLES monitor for 24 days, and the department did not, despite OLES's recommendation, investigate witnesses to the incident as possible suspects for their alleged failure to report the abuse.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The investigator did not send the video of the incident to the monitor until 24 days after the incident. 2. Was the investigation thorough and appropriately conducted? No. The department did not interview witnesses to the incident as possible suspects for failing to report physical abuse, and did not provide them the required Beheler legal admonition.
Department Corrective Action Plan	In order to address this deficiency, Investigators have been advised to notify the AIM when circumstances are technological in nature and cannot be made readily available upon request. The Investigators have been given direction to advise the AIM when they do not plan to use the recommendations given. A consult with the AIM needs to occur to provide an explanation and/or reasoning for the decision.

Criminal-Not Referred

Case Detail	Description
Incident Date	06/14/2020

OLES Case Number	2020-00624-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On June 14, 2020, two staff members allegedly tackled, choked, injured, and pepper sprayed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department 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 incident on June 16, 2020, at 1916 hours.; however, they did not notify OLES until 2131 hours, approximately two and a half hours later.
Department Corrective Action Plan	The Chief/OPS conducted training with the Sergeants/Command staff on the OLES's reporting guidelines.

Case Detail	Description
Incident Date	11/10/2020
OLES Case Number	2020-01166-1C
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 November 10, 2020, a unit supervisor allegedly twisted and injured a patient's arm while stabilizing the patient. A psychiatric technician also allegedly forced the patient onto a bed. Then a nurse allegedly forced the patient up against

	a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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 Beheler legal admonishment before interviewing the unit supervisor.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? No. The responding officer did not provide the Beheler legal admonishment before interviewing the unit supervisor, even though the patient had clearly accused the unit supervisor of 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	12/11/2020
OLES Case Number	2020-01277-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On December 11, 2020, two staff members allegedly pushed a patient from behind after the patient threw coffee at a second patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation. The OLES is not monitoring the resulting administrative investigation as it does not meet monitoring criteria.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	12/31/2020
OLES Case Number	2021-00010-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 31, 2020, a 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. 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	12/31/2020
OLES Case Number	2021-00070-2C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On December 31, 2020, a senior psychiatric technician allegedly used excessive force to restrain 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	01/15/2021
OLES Case Number	2021-00091-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 15, 2021, 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 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	01/21/2021
OLES Case Number	2021-00113-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 21, 2021, a senior psychiatric technician allegedly pushed a patient against a wall. In addition, the senior psychiatric technician and a psychiatric technician allegedly pulled down the patient's pants while he was restrained.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to timely notify the OLES of the alleged incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the alleged

	abuse on January 21, 2021, at 2330 hours; however, the OLES was not notified until January 22, 2021, at 0952 hours, over ten hours later.
Department Corrective Action Plan	The Chief/OPS conducted training with the sergeants/ command staff on the OLES's reporting guidelines. The Office of Protective Services will be sure to report any disputed untimely entry notifications to OLES within OLES time frames.

Case Detail	Description
Incident Date	01/07/2021
OLES Case Number	2021-00117-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between January 7, 2021, and January 21, 2021, staff members allegedly poured chemicals on toilet seats, sink counters and blankets.
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	01/18/2021
OLES Case Number	2021-00160-2C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between January 18, 2021, and January 22, 2021, two psychiatric technicians allegedly hit and kicked 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 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	02/13/2021
OLES Case Number	2021-00187-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 13, 2021, a psychiatric technician assistant allegedly hit a patient in the face with a towel and elbowed the patient in the mouth.
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	02/14/2021
OLES Case Number	2021-00191-1C
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 February 14, 2021, a registered nurse and two psychiatric technicians allegedly grabbed and dragged a patient into a bathroom.
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 did not accept as it no longer met 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	02/12/2021
OLES Case Number	2021-00196-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 12, 2021, a social media user alleged a manager was engaging in sexual activity with minors and 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 department did not open an administrative investigation.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	02/24/2021
OLES Case Number	2021-00256-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 24, 2021, a psychiatric technician allegedly hit a patient with a restroom door while attempting to prevent the patient from entering a restricted area.
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 Office of Protective Services failed to 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 discovered the alleged incident on February 24, 2021, at 1035 hour; however, the OLES was not notified until February 25, 2021, at 1118 hours, over one day later.
Department Corrective Action Plan	Upon discovery of the late notification, the sergeant was given direction on the necessity for reporting to OLES as required by policy. DPS management has directed all supervision to follow the necessary protocols in reporting to OLES under the guidelines set forth by OLES.

Case Detail	Description
Incident Date	02/26/2021
OLES Case Number	2021-00262-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 26, 2021, a psychiatric technician allegedly grabbed a patient by the neck and forced the patient onto a 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 did not accept for monitoring as it no longer met 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	02/17/2021
OLES Case Number	2021-00266-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On February 17, 2021, a 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 did not open an administrative investigation due to lack of evidence. The OLES concurred.
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	03/09/2021
OLES Case Number	2021-00307-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 9, 2021, a patient became unresponsive during a medical assessment. Responding staff initiated emergency life-saving measures and transferred the patient to an outside hospital for further treatment, where he was declared dead. The cause of death was atherosclerotic heart disease.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause, nor was an administrative investigation opened. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	01/01/2021
OLES Case Number	2021-00324-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On or about January 1, 2021, a psychiatric technician allegedly provided contraband 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	01/29/2021
OLES Case Number	2021-00361-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 29, 2021, a psychiatric technician allegedly attempted to escort a patient who was in a wheelchair into the patient's room even though the patient did not want to go inside. The psychiatric technician allegedly closed the door on the patient's hand, causing a laceration.
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	02/26/2021
OLES Case Number	2021-00372-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On or about February 26, 2021, a psychiatric technician allegedly used excessive force to place a patient on the floor.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which the OLES did not accept for monitoring as it no longer met monitoring criteria.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	03/31/2021
OLES Case Number	2021-00386-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 31, 2021, a psychiatric technician allegedly repeatedly hit a 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 did not accept for monitoring.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The responding officer interviewed the suspect psychiatric technician without providing the legally required Beheler admonition. The incident was discovered on March 31, 2021; however, the investigation was not completed until August 17, 2021, 139 days later.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer interviewed the suspect psychiatric technician without providing the required Beheler legal admonition. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on March 31, 2021; however, the investigation was not completed until August 17, 2021, 139 days later.
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. The OPS will also ensure officers provide a complete summary of interviews for the allegation. The OPS hired new investigators to assist with cases and the transition from detective permanent investigators.

Case Detail	Description
Incident Date	12/01/2019
OLES Case Number	2021-00403-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	During December 2019, a nurse allegedly walked into a patient's room with a gun then allegedly slapped the patient's hand when the patient put her hands up to cover her 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 Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/03/2021
OLES Case Number	2021-00405-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 3, 2021, a registered nurse allegedly forced a patient into a room and hit 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 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	03/25/2021
OLES Case Number	2021-00409-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 25, 2021, March 29, 2021, and on April 2, 2021, a psychiatric technician allegedly grabbed a patient by the throat.
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	01/14/2021
OLES Case Number	2021-00410-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On January 14, 2021, two psychiatric technicians allegedly kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which the OLES did not accept for monitoring as it no longer met 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	01/01/2018
OLES Case Number	2021-00421-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On or about January 1, 2018, an unidentified person allegedly sexually assaulted a patient in her 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 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 pre-disciplinary process.

Case Detail	Description
Incident Date	04/10/2021
OLES Case Number	2021-00428-1C
Case Type	Monitored
Incident Types	1. Sexual Assault 2. Significant Interest – Patient Arrest
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 10, 2021, a patient called a psychiatric technician a "rapist" after stabbing the psychiatric technician in the eyelid with an eating utensil.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The investigator did not notify OLES of any of the interviews, thereby precluding contemporaneous monitoring.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES?

	No. The investigator did not notify OLES of any interviews, thereby precluding contemporaneous monitoring.
Department Corrective Action Plan	Moving forward in the interest of "Best Practice," OSI understands there may be instances, where an interview may need to be conducted immediately and OLES may not available. However, reasonable means should be made at the time of the interview to contact OLES. Should OLES not be available, the investigator will be reminded to provide an immediate email or telephone call with message of any immediate investigative interviews conducted.

Case Detail	Description
Incident Date	02/21/2021
OLES Case Number	2021-00477-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	On February 21, 2021, a staff member allegedly sexually assaulted a patient while a second staff member injected the patient with an illegal substance.
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	04/19/2021
OLES Case Number	2021-00482-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 19, 2021, and April 20, 2021, a psychiatric technician 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 Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 133 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on April 21, 2021; however, the investigation was not completed until September 1, 2021, 133 days later.
Department Corrective Action Plan	The OSI will assign investigator cases in a timely manner.

Case Detail	Description
Incident Date	04/24/2021
OLES Case Number	2021-00492-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 24, 2021, a psychiatric technician allegedly pushed a laundry cart 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 also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	04/01/2018
OLES Case Number	2021-00497-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	On or about April 1, 2018, a senior psychiatric technician allegedly grabbed and restrained a patient against a wall after the patient uttered a racial epithet.
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	04/08/2021
OLES Case Number	2021-00510-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Neglect
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 April 8, 2021, a psychiatric technician allegedly hit and threatened a patient. A nurse and a pre-licensed psychiatric technician also allegedly failed to change the patient's soiled briefs.
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	04/27/2021
OLES Case Number	2021-00519-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between April 27, 2021, and April 28, 2021, a psychiatrist and his brother 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 as it no longer met 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	04/30/2021
OLES Case Number	2021-00525-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 30, 2021, a psychiatric technician allegedly climbed on top of and squeezed a patient while she was receiving dialysis treatment.
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	05/07/2021
OLES Case Number	2021-00562-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 7, 2021, a psychiatric technician assistant and a registered nurse allegedly assaulted and attempted to choke a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/07/2021
OLES Case Number	2021-00568-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 7, 2021, a psychiatric technician assistant allegedly forced a patient to the floor, then repeatedly kicked the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation which the OLES did not accept for monitoring as it no longer met 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	05/08/2021
OLES Case Number	2021-00570-1C
Case Type	Monitored
Incident Types	1. Head/Neck 2. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 8, 2021, a psychiatric technician allegedly failed to prevent a patient from falling off his bed, which resulted in the patient suffering a lacerated chin, requiring sutures.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/12/2021
OLES Case Number	2021-00591-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin) 2. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 12, 2021, a patient sustained a fractured nose after falling in the unit hallway.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to timely notify the OLES of the alleged incident.
Pre-Disciplinary	1. Did the hiring authority timely notify the Office of Law

Assessment	Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the patient's injury on May 13, 2021, at 0054 hours; however, the OLES was not notified until 0839 hours, almost eight hours later.
Department Corrective Action Plan	The OPS Sergeants were educated and refreshed as to Priority One guideline surrounding a Broken Bone of Unknown Origin (cause undetermined). The Sergeants reviewed both the OLES Facility Reporting Guidelines as well as Penal Code Section 368.

Case Detail	Description
Incident Date	04/21/2021
OLES Case Number	2021-00628-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On April 21, 2021, a patient was in an altercation with another patient and sustained a fractured knee.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	05/23/2021
OLES Case Number	2021-00646-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 23, 2021, a patient cut herself with, and swallowed, the hinge from her eyeglasses.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	05/24/2021
OLES Case Number	2021-00655-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 24, 2021, a psychiatric technician allegedly choked a patient and forced the patient's head against the floor after the patient allegedly hit the psychiatric technician
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 investigation was not completed until 128 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The Office of Protective Services discovered the alleged incident on May 24, 2021; however, the investigation was not completed until September 29, 2021, 128 days later.
Department Corrective Action Plan	The OPS will strive to maintain time frames designated by OLES and keep the monitor apprised of delays. The OSI investigator and supervisor were advised of time frames to include submission and approval of investigations.

Case Detail	Description
Incident Date	05/27/2021
OLES Case Number	2021-00665-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 27, 2021, a senior psychiatric technician allegedly hit a patient on the mouth and administered the patient an injection.

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	05/25/2021
OLES Case Number	2021-00666-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin) 2. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 25, 2021, a patient slipped in the shower and sustained an orbital 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 due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/01/2021
OLES Case Number	2021-00698-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 1, 2021, two psychiatric technicians allegedly grabbed a food tray from a patient, forced the patient to the floor and dragged him to his 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 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	06/06/2021
OLES Case Number	2021-00713-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 6, 2021, a psychiatric technician and a psychiatric technician assistant allegedly forced a patient onto a bed while administering medication to the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation. 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	04/01/2021
OLES Case Number	2021-00733-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between April 1, 2021, and April 30, 2021, a psychiatric technician allegedly placed his hand around a patient's throat.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and

	procedures governing the investigative process.

Case Detail	Description
Incident Date	06/10/2021
OLES Case Number	2021-00737-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 10, 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 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	05/30/2021
OLES Case Number	2021-00749-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On May 30, 2021, a registered nurse allegedly forcefully grabbed a patient's arm.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	06/22/2021
OLES Case Number	2021-00767-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 22, 2021, an unidentified person allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. OPS did not consult with the OLES at any time during the investigation.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? No. The Office of Protective Services did not notify OLES that the report was complete. 2. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The Office of Protective Services failed to consult with OLES at any stage of the investigation.
Department Corrective Action Plan	Develop a spreadsheet for each report to OLES that will be comprehensive and cover the entire monitor process from initial notification to final disposition. This spreadsheet will improve upon an existing spreadsheet for this purpose by requiring more detailed information over each stage of the process. The spreadsheet will enable management to know exactly where an OLES monitored investigation is at any time of the monitoring process. This spreadsheet will ensure that nothing is overlooked. The spreadsheet will be the responsibility of all department members involved in the monitoring process and will be passed on from one

	department member to the next as the process continues. A written procedure will be developed documenting each stage of the monitoring process. This procedure will clearly identify the responsibility of each department member involved in the monitoring process. All department members involved in this process will be held accountable for their area of responsibility. In this incident the investigator who did not write a report in a timely manner was issued a written corrective action document. There will be redundancy built into this written procedure so that proper notifications to OLES and to department members will be made. This will ensure there is always someone available who will be able to continue the monitor/notification process. This entire corrective action plan will be monitored by the OLES liaisons and the chief of police. Corrections will be made in real time in necessary and the entire plan will be reviewed for effectiveness six months after the plan is initiated.

Case Detail	Description
Incident Date	06/30/2021
OLES Case Number	2021-00819-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On June 30, 2021, a psychiatric technician allegedly pushed a wheelchair bound patient into another wheelchair.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	06/01/2021
OLES Case Number	2021-00827-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between June 1, 2021, and June 30, 2021, two unidentified staff members allegedly forced a patient onto his bed and

	bruised his thigh.
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	07/05/2021
OLES Case Number	2021-00839-1C
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 July 1, 2019, and July 5, 2021, a pharmacy technician allegedly engaged in a sexual relationship and physically abused a patient. The patient also alleged that he had engaged in a sexual relationship with a nurse.
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	07/09/2021
OLES Case Number	2021-00846-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 9, 2021, an unidentified person allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due

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

Case Detail	Description
Incident Date	07/05/2021
OLES Case Number	2021-00875-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 5, 2021, a registered nurse allegedly firmly squeezed a patient's hand after the patient made an offensive gesture toward the registered nurse.
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 did not accept for monitoring as it did not meet OLES 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	06/01/2021
OLES Case Number	2021-00898-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Between June 1, 2021, and June 30, 2021, an unidentified person allegedly repeatedly 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	06/15/2021
OLES Case Number	2021-00920-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	On June 15, 2021, a nurse and psychiatric technician allegedly injured a patient when they dragged him by lifting under his armpits. Multiple staff allegedly heard the patient cry out in 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 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	08/02/2021
OLES Case Number	2021-00928-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 2, 2021, a patient, confined to a wheelchair, was diagnosed with a pressure wound to his genital area.
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	08/03/2021
OLES Case Number	2021-00942-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 3, 2021, a staff member allegedly forced a patient onto a bed, injuring the patient's chin.
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	08/15/2021
OLES Case Number	2021-00984-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 15, 2021, a psychiatric technician allegedly pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The 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	07/20/2021
OLES Case Number	2021-01064-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On July 20, 2021, a psychiatric technician allegedly hit a patient repeatedly in the 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 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	08/01/2021
OLES Case Number	2021-01071-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On August 1, 2021, a psychiatric technician allegedly pushed 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 The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	09/12/2021
OLES Case Number	2021-01072-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On September 12, 2021, a psychiatric technician allegedly pushed a patient into a wheelchair.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	10/13/2021
OLES Case Number	2021-01215-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On October 13, 2021, a staff member allegedly hit a patient on the back of the neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
Incident Date	10/15/2021
OLES Case Number	2021-01231-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On October 15, 2021, a patient was diagnosed with multiple dark discolorations on his body, upon his return from an outside hospital.
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	11/14/2021
OLES Case Number	2021-01358-1C
Case Type	Monitored
Incident Types	1. Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On November 14, 2021, an unidentified person allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
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	08/15/2020
OLES Case Number	2020-00883-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	On August 15, 2020, a psychiatric technician allegedly grabbed a patient by the neck and arm while pushing the patient in a wheelchair.
Investigative Assessment	The hiring authority sustained the allegations against the psychiatric technician; however, no disciplinary action could be taken because the psychiatric technician's licensure had previously been revoked due to an unrelated incident and the psychiatric technician had already been non-punitively terminated before the conclusion of the investigation. Record of the allegations sustained against the psychiatric technician will remain in the official personnel file. The OLES concurred.

Case Detail	Description
Incident Date	10/27/2020
OLES Case Number	2020-01101-2A
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 27, 2020, a licensed clinic social worker allegedly failed to timely notify the Office of Protective Services of a patient's allegation of being sexual assaulted.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a letter of instruction and directed additional training for the licensed clinic social worker. 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 administrative case was opened on March 4, 2021, however, the final investigative report was not completed until August 4, 2021, 154 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The administrative case was opened on March 4, 2021, however, the final investigative report was not completed until August 4, 2021, 154 days later.
Department Corrective Action Plan	In the future, the investigator will comply with all deadlines as outlined by OLES. Additionally, the investigator will confer with the supervisor well in advance to arrange coverage, review and a plan of action to maintain required timeframes.

Case Detail	Description
Incident Date	12/30/2020
OLES Case Number	2021-00023-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Other **Final:** Other
Incident Summary	On December 30, 2020, a psychiatric technician allegedly failed to adequately monitor a patient who required enhanced supervision for self-injurious behavior.
Disposition	The hiring authority sustained the allegation and determined a letter of warning was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary and disciplinary process.

Case Detail	Description
Incident Date	01/27/2021
OLES Case Number	2021-00159-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	Beginning January 27, 2021, a psychiatric technician allegedly was overly familiar with a recently discharged patient.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. However, the psychiatric technician resigned before disciplinary action could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in his official personnel file.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/25/2021
OLES Case Number	2021-00264-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On February 25, 2021, an information technology specialist allegedly downloaded patients' protected health information onto his personal laptop.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority’s determination. However, the employee resigned before the disciplinary action could be imposed.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	03/22/2021
OLES Case Number	2021-00356-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On March 22, 2021, an off-duty officer allegedly negligently discharged a firearm at his residence.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/07/2021
OLES Case Number	2021-00419-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	On April 7, 2021, a registered nurse and a psychiatric technician allegedly failed to properly monitor a patient who required an enhanced level of observation, thereby giving the patient an opportunity to insert a spoon into her genitals.
Disposition	The hiring authority determined there was insufficient evidence to sustain allegations of neglect; however, the hiring authority did sustain allegations of policy violations regarding documentation of their supervision of patients and ordered training. The OLES concurred with the hiring authority’s determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	05/10/2021
OLES Case Number	2021-00560-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	On May 9, 2021, two psychiatric technician allegedly failed to properly monitor a patient who was on an enhanced level of observation. The patient fell and was injured.
Disposition	The hiring authority sustained the allegations. However, the employees had prematurely received training and corrective action, thereby precluding disciplinary action.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The department prematurely issued corrective action prior to the completion of the disciplinary process; thereby precluding disciplinary action.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The employees received training and corrective action prior to the completion of the disciplinary process; thereby precluding disciplinary action.
Department Corrective Action Plan	The hospital is developing hospital-wide communication to all levels of leadership to inform supervisors, managers and above that that they should consult with HR prior to any measure of corrective action is taken when there is an open investigation. Similar training will be provided to all new supervisors moving forward.

Case Detail	Description
Incident Date	08/11/2021
OLES Case Number	2021-00972-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	On August 11, 2021, two psychiatric technicians allegedly left a patient unattended in a courtyard for approximately four minutes.
Disposition	The hiring authority sustained the allegations and determined a letter of instruction to both psychiatric technicians was appropriate. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
Incident Date	01/24/2020
OLES Case Number	2020-00086-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	On January 24, 2020, a psychiatric technician allegedly failed to immediately provide emergency life-saving measures to a patient in medical distress and instead allowed other patients to assist the patient while the psychiatric technician stood by and watched.
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	06/17/2020
OLES Case Number	2020-00630-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	On June 17, 2020, two senior psychiatric technicians allegedly forced a patient onto the floor, then hit and kneeled on the 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	08/25/2020
OLES Case Number	2020-00891-2A
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 nurse allegedly slammed a refrigerator door on a patient's hand.
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	08/19/2020
OLES Case Number	2020-00904-2A
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 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 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	09/08/2020
OLES Case Number	2020-00934-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Incident Summary	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Disposition	On September 8, 2020, a registered nurse allegedly taunted and induced a patient to pull out his feeding tube, resulting in bleeding.
Investigative Assessment	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority’s determination.

Pre-Disciplinary 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 May 27, 2021; however, the findings and penalty conference was not completed until July 27, 2021, 61 days later.
Department Corrective Action Plan	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 May 27, 2021; however, the findings and penalty conference was not completed until July 27, 2021, 61 days later.

Case Detail	Description
Incident Date	09/07/2020
OLES Case Number	2020-00935-2A
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 September 7, 2020, a registered nurse allegedly grabbed and pushed a patient against a wall, causing the patient to fall.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was completed on May 20, 2021; however, the findings and penalty conference was not completed until July 27, 2021, 68 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 May 20, 2021; however, the findings and penalty conference was not completed until July 27, 2021, 68 days later.
Department	The department has reviewed the factors contributing to

Corrective Action Plan	delays in completing penalty conferences and those have been corrected. The department will schedule additional conferences when necessary to ensure timely review and has implemented a bifurcation of OLES monitored cases to ensure the penalty conference is conducted as per guidelines.

Case Detail	Description
Incident Date	10/12/2020
OLES Case Number	2020-01045-2A
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 October 12, 2020, a psychiatric technician allegedly kicked a patient and held his knee on the patient's neck.
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	10/16/2020
OLES Case Number	2020-01070-2A
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 October 16, 2020, a psychiatric technician assistant allegedly asked a patient for oral sex in exchange for diapers.
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 May 19, 2021; however, the findings and penalty conference was not held until July 27, 2021, 70 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 May 19, 2021; however, the finds and penalty conference was not held until July 27, 2021, 70 days later.
Department Corrective Action Plan	The facility has implemented a bifurcation of OLES monitored cases to ensure the penalty conference is conducted as per guidelines. This will ensure that OLES cases take priority and will adhere to OLES time frames.

Case Detail	Description
Incident Date	10/26/2020
OLES Case Number	2020-01092-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On October 26, 2020, a nurse and two psychiatric technicians allegedly grabbed and forced a patient to the ground.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	10/31/2020
OLES Case Number	2020-01108-2A
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 October 31, 2020, a psychiatric technician allegedly hit and slapped 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	11/05/2020
OLES Case Number	2020-01171-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On November 5, 2020, a senior psychiatric technician allegedly poked a transgendered 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 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 phase.

Case Detail	Description
Incident Date	07/01/2020
OLES Case Number	2020-01175-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained

	2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	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 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	09/22/2020
OLES Case Number	2020-01176-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On 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 hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/01/2020
OLES Case Number	2020-01230-2A
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	Between May 1, 2020, and November 27, 2020, a psychiatric technician allegedly inappropriately touched a patient's chest.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	12/01/2020
OLES Case Number	2020-01239-1A
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 December 1, 2020, a patient died at an outside hospital. An autopsy determined the death to be from natural causes due to respiratory failure.
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	10/01/2020
OLES Case Number	2020-01333-2A
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	Between October 1, 2020, and October 31, 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:** 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	2021-00070-3A
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	On December 31, 2020, a senior psychiatric technician allegedly used excessive force to restrain a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority’s determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	01/19/2021
OLES Case Number	2021-00100-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On January 19, 2021, a patient was having difficulty breathing and was transferred to an outside hospital where the patient subsequently died of cardiac arrest.
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 investigative process.

Case Detail	Description
Incident Date	01/22/2021
OLES Case Number	2021-00111-2A
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 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 Office of Protective Services completed the required post-death investigation, determining there was no policy violation that caused or contributed to the patient's death. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigator did not consult with the OLES monitor before scheduling an interview with a subject matter expert.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not consult with the OLES when scheduling a subject matter expert interview.
Department Corrective Action Plan	The Supervising Investigator will confirm the case status before assigning monitored criminal cases administratively. This was a newly assigned Investigator who was working his first death investigation. At the time of the incident, the supervising investigator discussed the failure to notify the AIM and outlined supervisory expectations in dealing with monitored OLES cases. A written policy review was also given.

Case Detail	Description
Incident Date	01/22/2021
OLES Case Number	2021-00124-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
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 22, 2021, a patient alleged that a senior psychiatric technician had provided outside food and other contraband to patients. Additionally, a psychiatric technician allegedly provided toiletries, cosmetics and other contraband to patients.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/01/2021
OLES Case Number	2021-00156-1A
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 1, 2021, two psychiatric technicians allegedly failed to prevent a patient from injuring himself while on an enhanced level of observation.
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	02/13/2021
OLES Case Number	2021-00188-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On February 13, 2021, a psychiatric technician allegedly hit a patient on the back of the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/01/2020
OLES Case Number	2021-00202-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between September 1, 2020, and September 30, 2020, a psychiatric technician allegedly kicked a patient. A senior psychiatric technician allegedly grabbed a second patient by the shirt and called the patient derogatory names.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against both the psychiatric technician and senior psychiatric technician. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/17/2021
OLES Case Number	2021-00204-1A
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 February 17, 2021, a patient collapsed and staff initiated emergency life-saving measures; however, the patient died at an outside hospital. An autopsy revealed the immediate cause of death was idiopathic cardiomyopathy.
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	01/28/2021
OLES Case Number	2021-00230-1A
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 28, 2021, a psychiatric technician allegedly pushed a patient on the shoulder.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	02/21/2021
OLES Case Number	2021-00240-1A
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 21, 2021, and February 22, 2021, two registered nurses allegedly failed to properly conduct body checks of a patient known to engage in self-injurious behavior.
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 incident was discovered on February 23, 2021; however, the final investigative report was not completed until July 1, 2021, 128 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The incident was discovered on February 23, 2021, however, the final investigative report was not completed until July 1, 2021, 128 days later.
Department Corrective Action Plan	The importance of reviewing and approving the police officer's reports has been discussed with the Patrol Operations Lieutenant, which needs to be imparted upon the approving watch commanders. The investigators will be reminded of meeting the time frame of 120 days in which to complete an investigation and requesting an extension if the investigation will move beyond the 120 days. A request for extension will be discussed with the assigned OLES monitor, according to the parameters set out in the issued memorandum.

Case Detail	Description
Incident Date	03/03/2021
OLES Case Number	2021-00283-1A
Case Type	Monitored
Incident Types	1. Significant Interest - AWOL 2. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On March 3, 2021, a patient exited through an unlocked door and attempted to escape from the hospital.
Disposition	The hiring authority determined that the investigation conclusively proved staff misconduct did not occur. 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 June 8, 2021; however, the findings and penalty conference was not completed until July 27, 2021, 50 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 June 8, 2021; however, the findings and penalty conference was not completed until July 27, 2021, 50 days later.
Department Corrective Action Plan	The department plans to develop a course of action that will adhere to the current OLES timeframes. The department has implemented a bifurcation of OLES monitored cases to ensure the penalty conference is conducted as per guidelines.

Case Detail	Description
Incident Date	03/02/2021
OLES Case Number	2021-00288-1A
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 2, 2021, a psychiatric technician allegedly tapped a patient on the arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/01/2020
OLES Case Number	2021-00291-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Misuse of state property 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Between March 1, 2020, and March 1, 2021, a physician allegedly was not working his entire assigned shifts.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	03/12/2021
OLES Case Number	2021-00336-1A
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 March 12, 2021, a psychiatric technician allegedly engaged in sexual activity 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	03/24/2021
OLES Case Number	2021-00365-1A
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 24, 2021, an unidentified department employee allegedly grabbed and attempted to bite a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/02/2021
OLES Case Number	2021-00400-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 2, 2021, a psychiatric technician allegedly grabbed a patient by the neck and forced the patient's head onto a pool table.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to timely notify the OLES of the

	alleged incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services discovered the alleged abuse on April 3, 2021, at 1800 hours; however, the OLES was not notified until April 6, 2021, at 0834 hours, over two days later.
Department Corrective Action Plan	The sergeant was counseled regarding confirming OLES email address before emailing/sending notification templates.

Case Detail	Description
Incident Date	04/06/2021
OLES Case Number	2021-00412-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 6, 2021, a psychiatric technician allegedly hit a patient in the head and chest when the patient refused to get out of the shower.
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	04/06/2021
OLES Case Number	2021-00413-2A
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 April 6, 2021, staff members allegedly restrained and choked a patient.
Disposition	The hiring authority determined that the investigation conclusively proved the misconduct did not occur. The OLES concurred with the hiring authority’s determination.

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

Case Detail	Description
Incident Date	04/10/2021
OLES Case Number	2021-00430-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 10, 2021, a psychiatric technician allegedly pushed a patient to the ground and slapped her in the face. A second psychiatric technician allegedly failed to intervene on behalf of the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against both psychiatric technicians. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not follow policies and procedures governing the pre-disciplinary process. The responding officer's initial interview of the percipient witness was incomplete, necessitating two additional interviews.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer's initial interview of the percipient witness was incomplete, necessitating two additional interviews.
Department Corrective Action Plan	The officer will be counseled on the importance of appropriate follow up and clarifying questions to have a sufficient initial investigative report. The Watch Commander shall be counseled on the importance of having a more critical eye in the review and approval process of reports. The objective being if a report needs more information it is to be sent back to the initial investigative officer and not approved.

Case Detail	Description
Incident Date	04/15/2021
OLES Case Number	2021-00455-1A
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 April 15, 2021, a nurse allegedly failed to assist a patient who had fallen onto the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/21/2021
OLES Case Number	2021-00467-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 21, 2021, a rehabilitation therapist allegedly elbowed a patient in the chest as the patient was waiting in line at the nurses' station.
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	04/24/2021
OLES Case Number	2021-00494-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 24, 2021, a registered nurse allegedly improperly restrained a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	05/01/2021
OLES Case Number	2021-00534-1A
Case Type	Monitored
Incident Types	1. Neglect 2. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On May 1, 2021, a nurse allegedly inappropriately touched a patient's stomach area while taking the patient's monthly body measurements.
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	04/29/2021
OLES Case Number	2021-00535-1A
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 April 29, 2021, multiple staff members allegedly raped a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	04/30/2021
OLES Case Number	2021-00536-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On April 30, 2021, a psychiatric technician allegedly hit a patient and pulled the patient's hair, while attempting to restrain the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The incident was discovered on April 30, 2021; however, the final investigative report was not completed until September 9, 2021, 132 days later.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The incident was discovered on April 30, 2021; however, the final investigative report was not completed until September 9, 2021, 132 days later.
Department Corrective Action Plan	The importance of meeting the time frame of 120 days in which to complete an investigation has been discussed with all investigators. A request for extension will be requested if the investigation will move beyond the 120 days, which will be discussed with the assigned OLES monitor, according to the parameters set out in the issued memorandum.

Case Detail	Description
Incident Date	05/20/2021
OLES Case Number	2021-00637-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
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 May 20, 2021, a nurse, a senior psychiatric technician and two psychiatric technicians allegedly failed to observe a patient swallowing a pencil while the patient was on enhanced observation status.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	09/01/2019
OLES Case Number	2021-00734-1A
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 September 1, 2019, and September 30, 2019, a psychiatric technician allegedly sexually assaulted a heavily medicated 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	06/12/2021
OLES Case Number	2021-00740-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 12, 2021, a psychiatric technician allegedly grabbed, pushed and bruised a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	06/14/2021
OLES Case Number	2021-00744-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 14, 2021, a psychiatric technician allegedly hit a patient.
Disposition	The hiring authority determined there was insufficient

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

Case Detail	Description
Incident Date	06/24/2021
OLES Case Number	2021-00773-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 24, 2021, two unidentified persons allegedly raped 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	06/16/2021
OLES Case Number	2021-00776-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 16, 2021, two psychiatric technicians allegedly failed to provide medical treatment to a patient after witnessing the patient fall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	**Procedural Rating:** Sufficient

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

Case Detail	Description
Incident Date	06/29/2021
OLES Case Number	2021-00796-1A
Case Type	Monitored
Incident Types	1. Head/Neck 2. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 29, 2021, a psychiatric technician allegedly failed to prevent a patient from jumping off a chair and injuring himself.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
Incident Date	07/11/2021
OLES Case Number	2021-00849-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Sustained 4. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	On July 11, 2021, a nurse and a senior psychiatric technician allegedly failed to maintain constant observation of a patient.
Disposition	The hiring authority sustained the allegations that the nurse and the senior psychiatric technician failed to maintain

	constant observation of the patient, but found insufficient evidence they neglected the patient. The hiring authority determined that corrective action was appropriate. 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	07/22/2021
OLES Case Number	2021-00913-1A
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 July 22, 2021, a psychiatric technician assistant allegedly exposed his genitals in front 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:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely notify the OLES of the incident.
Pre-Disciplinary Assessment	1. Did the hiring authority timely notify the Office of Law Enforcement Support (OLES) of the incident? No. The Office of Protective Services was notified of the incident at 1045 hours and did not report the incident to OLES until 1257 hours.
Department Corrective Action Plan	The OPS provided refresher training to all the OPS supervisors and sworn personnel on the OLES reporting guidelines. The department will reinforce the importance to make sure a priority one reporting requirement are met within the two-hour reporting time frame.

Case Detail	Description
Incident Date	08/07/2021
OLES Case Number	2021-00948-1A
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 7, 2021, a patient was discovered in respiratory distress and stopped breathing. Although life-saving measures were initiated, the patient could not be resuscitated and later died. An autopsy determined the cause of death was a ruptured aneurysm of the left ventricle.
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.

Appendix C: 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 Pre-Disciplinary Phase

Case Detail	Description
Incident Date	10/10/2020
OLES Case Number	2020-01049-1A
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:** Modified Salary Reduction
Incident Summary	On October 10, 2020, a senior psychiatric technician allegedly stomped on a patient's foot. Also, a psychiatric technician allegedly failed to report the patient's report of abuse.
Disposition	The hiring authority sustained the allegation against the psychiatric technician and determined a salary reduction of 5 percent for 12 months was the appropriate penalty. The hiring authority determined there was insufficient evidence

	to sustain the allegation against the senior psychiatric technician. The OLES concurred with the hiring authority's determinations. The psychiatric technician filed an appeal with the State Personnel Board. At the pre-hearing settlement conference, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a 5 percent salary reduction for six months in exchange for withdrawing his appeal. The OLES concurred because the settlement was reasonable.
Investigative Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the investigative process. The draft report did not include a summary of a key witness interview conducted by another investigator.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft report did not include a summary of a key witness interview conducted by another investigator.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	In administrative cases that are monitored, Investigators have been given the direction to discuss their initial case plan with the assigned monitor. Furthermore, send an email to the AIM advising when their interviews will take place in an effort to allow the assigned AIM the opportunity to monitor.

Procedurally Insufficient in the Disciplinary Phase

Case Detail	Description
Incident Date	03/03/2020
OLES Case Number	2020-00219-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	On March 3, 2020, a patient was discovered unresponsive on the bathroom floor. Life-saving measures were administered;

	however, the patient died. A nurse allegedly falsified documentation in the patient's medical record, and was dishonest when interviewed. On July 23, 2020, the nurse was again allegedly dishonest during a second interview.
Disposition	The hiring authority sustained the allegations against the nurse, and determined a dismissal was the appropriate penalty. The OLES concurred. The nurse filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the nurse wherein the department withdrew the disciplinary action against the nurse, and the nurse agreed to resign, and withdraw her appeal. 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:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the disciplinary process. The department did not serve the disciplinary action in a timely manner.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The findings and penalty conference occurred on November 19, 2020; however, the disciplinary action was not served until June 1, 2021, 195 days later.
Department Corrective Action Plan	The facility will further ensure OLES monitored cases remain a priority.

Case Detail	Description
Incident Date	08/24/2020
OLES Case Number	2020-01004-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On August 24, 2020, a psychiatric technician allegedly used a patient as a shield against another patient who was being physically aggressive toward the psychiatric technician.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a salary reduction of 5

	percent for 12 months. The OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a five percent salary reduction for six months. The psychiatric technician agreed to withdraw her appeal. The OLES concurred.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not sufficiently comply with policies and procedures governing the disciplinary process. The hiring authority made findings and penalty determinations on March 11, 2021; however, the psychiatric technician was not served with the disciplinary action until 131 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The hiring authority made the findings and penalty decisions on March 11, 2021; however, the action was not served on the psychiatric technician until July 20, 2021, 131 days later.
Department Corrective Action Plan	The DSH will continue to prioritize all OLES cases to meet the designated timeframes.

Case Detail	Description
Incident Date	09/01/2016
OLES Case Number	2020-01038-2A
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. Sustained 3. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Instruction
Incident Summary	Between September 2016 and March 2018, a psychiatric technician allegedly engaged in an intimate relationship with a patient. On September 28, 2020, the psychiatric

	technician allegedly began communicating via social media with the same patient, who had since been discharged, and failed to notify her supervisor of her communications with the former patient.
Disposition	The hiring authority sustained the allegation that the psychiatric technician communicated with the former patient, but determined there was insufficient evidence to sustain the remaining two allegations. The hiring authority determined a salary reduction of 5 percent for three months was the appropriate penalty. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Prior to State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a letter of instruction in exchange for the psychiatric technician withdrawing her appeal. The OLES concurred because the settlement was reasonable and the likelihood of reoccurrence is low.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Insufficient **Substantive Rating:** Sufficient The department did not comply with policies and procedures governing the disciplinary process. The department attorney did not provide OLES with a draft copy of the disciplinary action before it was served.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? No. The department attorney did not provide OLES with a copy of the draft disciplinary action prior to it being served.
Department Corrective Action Plan	DSH Legal currently has in place a tracking log for all active employment cases for the department. Each attorney is responsible for ensuring the log reflects the current status of all cases assigned to them. DSH Legal will continue to emphasize the importance of keeping the log updated, particularly with those attorneys who are going out on leave.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
Incident Date	03/10/2020
OLES Case Number	2020-00253-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Attempted Suicide
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	On March 10, 2020, a senior psychiatric technician and a psychiatric technician issued a shaving razor to a patient, and allegedly failed to collect and account for the razor. The patient disassembled the razor, and used the blades in an attempt to commit suicide by cutting his forearm.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 5 percent for seven months was the appropriate penalty for the senior psychiatric technician and the psychiatric technician. The OLES concurred. The senior psychiatric technician and psychiatric technician both filed appeals with the State Personnel Board. Prior to an evidentiary hearing, the department entered into a settlement agreement with the senior psychiatric technician wherein the penalty was reduced to a 5 percent salary reduction for five months because the senior psychiatric technician showed remorse and likelihood of recurrence was minimized. The psychiatric technician agreed to withdraw his appeal. The department also entered into a settlement agreement with the psychiatric technician wherein the penalty was modified to an official letter of reprimand based on mitigating information presented. The psychiatric technician agreed to withdraw her appeal. The OLES concurred with the settlements.
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	04/16/2020
OLES Case Number	2020-00432-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	On April 16, 2020, an officer allegedly falsified a report by writing a patient had recanted an allegation of abuse. However, in a recorded interview the patient did not recant the allegation.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determination. The officer filed an appeal with the State Personnel Board. Following an evidentiary hearing, the State Personnel Board upheld the dismissal.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department 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	08/01/2019
OLES Case Number	2020-00455-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** Letter of Reprimand
Incident Summary	Between August 1, 2019, and May 11, 2020, a law enforcement supervisor allegedly engaged in inappropriate financial transactions with subordinate employees. During December 2019, he allegedly brought alcohol onto hospital grounds.
Disposition	The hiring authority sustained the allegation that the law enforcement supervisor brought alcohol onto hospital grounds. The remaining allegations were not sustained. The hiring authority determined a letter of reprimand was the

	appropriate penalty. The OLES concurred. The law enforcement supervisor 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	05/15/2020
OLES Case Number	2020-00504-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Instruction
Incident Summary	On May 15, 2020, a psychiatrist and a psychiatric technician allegedly failed to activate their personal alarm devices and initiate life-saving measures on an unresponsive patient, who was later pronounced dead.
Disposition	The hiring authority sustained the allegations against the psychiatrist and the psychiatric technician, and determined a letter of instruction and a salary reduction of 10 percent for six months, respectively, were the appropriate penalties. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the evidentiary hearing, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to a letter of instruction in exchange for withdrawing her appeal. The OLES concurred because the settlement was reasonable in light of the penalty imposed on the psychiatrist.
Investigative Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Procedural Rating:** Sufficient **Substantive Rating:** Sufficient

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

Case Detail	Description
Incident Date	01/01/2019
OLES Case Number	2020-01048-2CON
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Misuse of state property 3. Other failure of good behavior 4. Dishonesty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	Between January 1, 2019, and October 31, 2020, an officer allegedly associated with a convicted felon and known gang member who was involved in continuing illegal activity. Between September 27, 2020, and September 30, 2020, the officer allegedly provided the convicted felon with a state police radio and two boxes of ammunition. He also allegedly agreed to purchase a firearm for the convicted felon. On October 19, 2020, the officer allegedly possessed illegal narcotics and was dishonest during a criminal investigation. On February 12, 2021, the officer was allegedly dishonest during an administrative interview.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. 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.

Appendix D: 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.

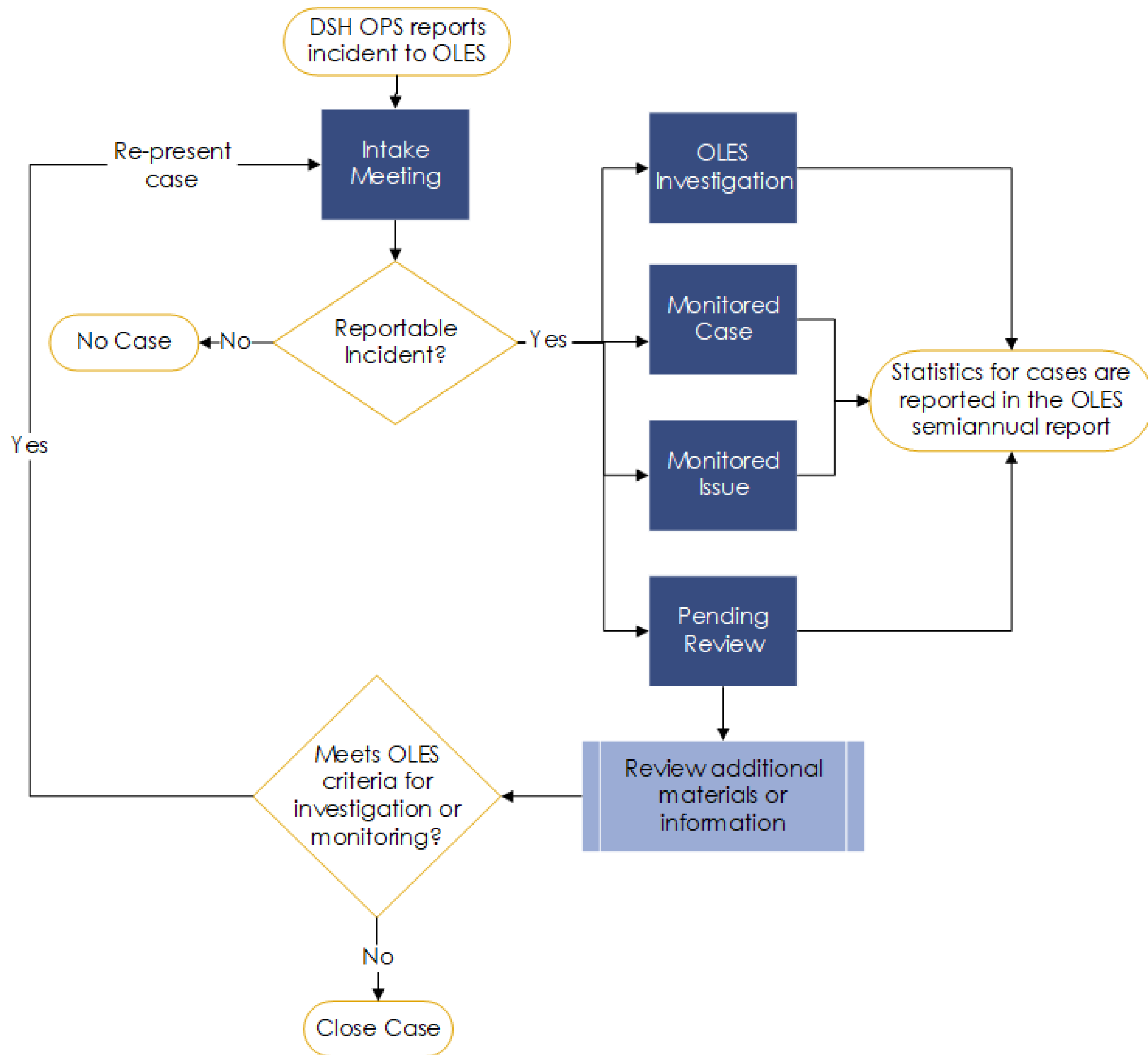
(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:

(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 E: 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 F: 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.

---

[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.