Office of Law Enforcement Support

Semiannual Report

January 1, 2022–June 30, 2022

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

Promoting a safe, secure and therapeutic environment

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

Contents

Introduction

I am pleased to present the thirteenth 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 January 1 through June 30, 2022.

In this report, OLES provides details on 561 reported incidents and the results of completed investigations and monitored cases.

In response to case deficiencies OLES identified while monitoring cases, the DSH provided additional training on the OLES reporting guidelines, required legal admonitions before taking statements and report writing. The DSH also allocated additional staff resources to support supervision of newer investigators and to track the completion of disposition conferences.

During this reporting period, OLES provided formal training on the OLES reporting guidelines and conducted formal facility visits to observe DSH OPS operations. The OLES also opened a monitored issue to address concerns regarding the canine handler selection process, training and program oversight of DSH canine programs. The OLES reopened a monitored issue on the recording of investigatory interviews after discovering that previously reported policy updates were not completed.

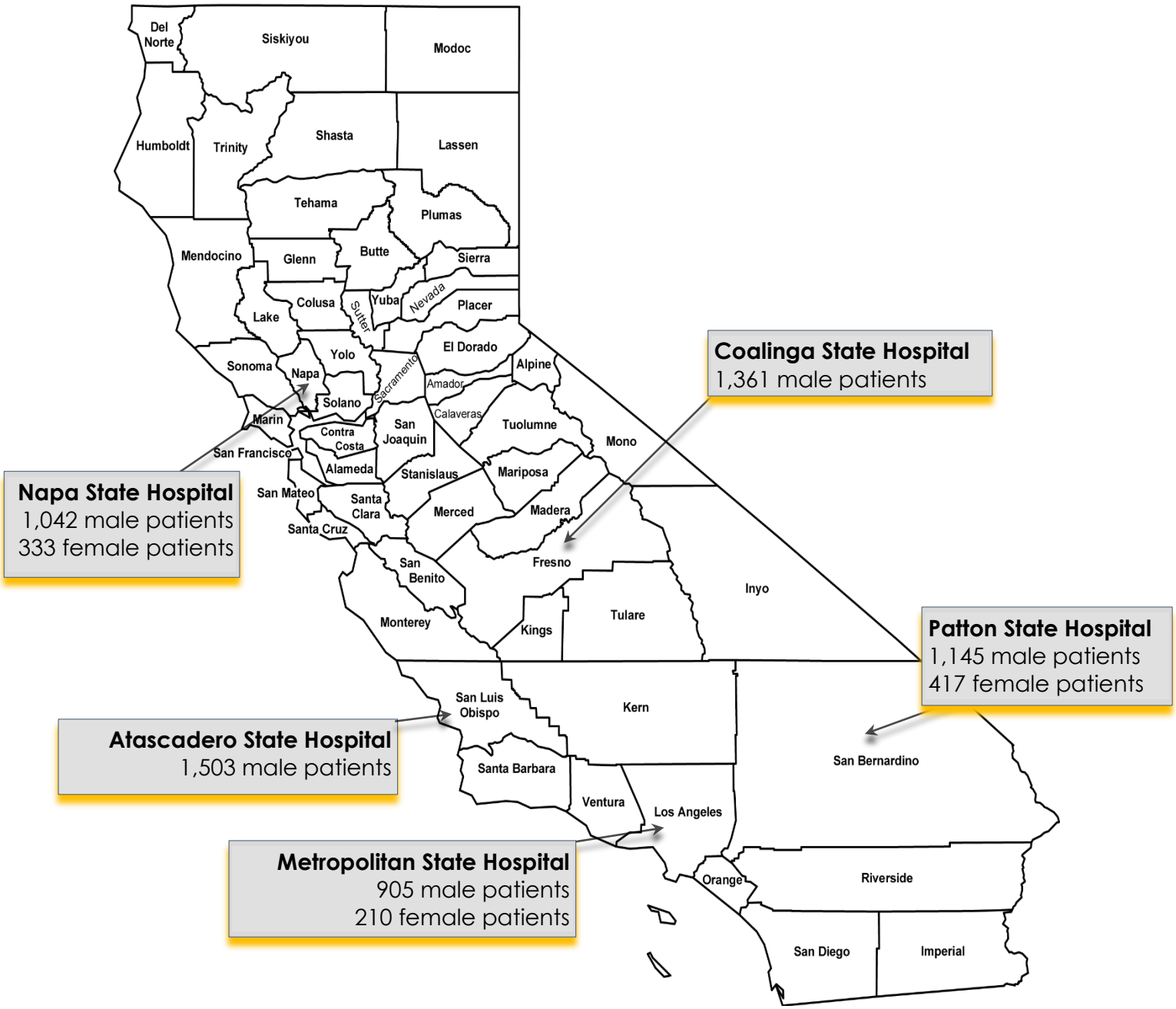
As OLES concludes its seventh year of oversight and monitoring, we remain committed to continuous quality improvement and strengthening accountability at DSH.

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 and Population Served

The OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers reflect the total patients served from January 1 through June 30, 2022, and were provided by the department.



Total Patients Served by Facility

DSH Facility	Number of Male Patients	Number of Female Patients	Total
Atascadero	1,503	0	1,503
Coalinga	1,361	0	1,361
Metropolitan	905	210	1,115
Napa	1,042	333	1,375
Patton	1,145	417	1,562
Total	5,956	960	6,916

Total Patients Served by Commitment Type

Patients are committed to a state hospital by a civil court proceeding according to the Welfare and Institutions Code (WIC) or committed by a criminal court proceeding according to the Penal Code (PC). Commitment types are described below.

Commitment Type	Description
PC 1370 IST	Felony Incompetent to Stand Trial. Effective January 1, 2019, the maximum term for ISTs was reduced from three years to two years, pursuant to SB 1187.
PC 1026 NGI	Not Guilty by Reason of Insanity. Maximum commitment is equal to the longest sentence which could have been imposed for the crime; can be extended at two-year intervals.
PC 2962/ 2964a OMD	Offender with a Mental Disorder. A prisoner who as a result of a severe mental disorder is ordered into treatment by the court as a condition of his parole. Six specific criteria must be met to be certified as an Offender with a Mental Disorder. Can be an Offender with a Mental Disorder for up to three years.
PC 2972 OMD	Prisoner who was paroled as an Offender with a Mental Disorder and parole has ended. Placed on civil commitment where it must be shown that the individual has a severe mental disorder that is not in remission and that, due to this mental disorder, the individual is a substantial danger to others. One year commitment. Renewable annually.
WIC 6316 MDSO	Mentally disordered sex offender.
PC 2684 CDCR	California Department of Corrections and Rehabilitation (CDCR) inmate sent to DSH for psychiatric stabilization with the expectation that they will return to CDCR when they have reached maximum benefit from treatment.
WIC 6602 SVPP	Sexually violent predator probable cause. A prisoner who has been identified as likely to engage in sexually violent predatory criminal behavior upon release and will remain in custody until the completion of the probable cause.
WIC 6604 SVP	Sexually violent predator. Civil commitment for prisoners released from prison who meet criteria under the Sexually Violent Predator Act.
WIC 5358 LPS	Full Conservatorship for Grave Disability. Annual renewal.
WIC 1756 DJJ	Juvenile offender referred by CDCR Division of Juvenile Justice

Commitment Type	Description
	for treatment

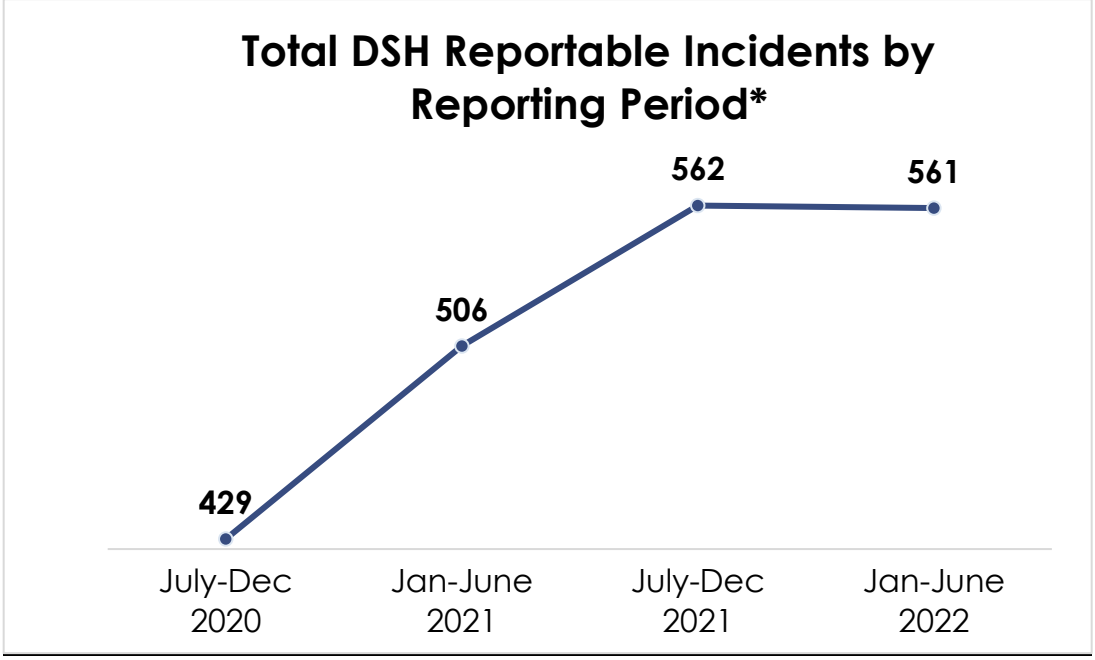
The following table provides the commitment type of patients served during the reporting period.

Commitment Type	Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST	566	0	660	620	476
PC 1026 NGI	167	<11	103	521	524
PC 2962/2964a OMD	450	0	<11	0	122
PC 2972 OMD	105	349	13	***	191
WIC 6316 MDSO	0	<11	0	<11	<11
PC 2684 CDCR	185	35	0	0	18
WIC 6002/6604 SVP	<11	962	0	0	<11
WIC 5358 LPS	***	<11	336	188	226
WIC 1756 DJJ	0	0	<11	0	<11

*Data is de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Executive Summary

During the reporting period of January 1 through June 30, 2022, the Office of Law Enforcement Support (OLES) received and processed 561 reportable incidents[1] from the California Department of State Hospitals (DSH). Reportable incidents include alleged misconduct by state employees, serious offenses between patients, patient deaths and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is a decrease of one incident report compared to the prior reporting period which had 562 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



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

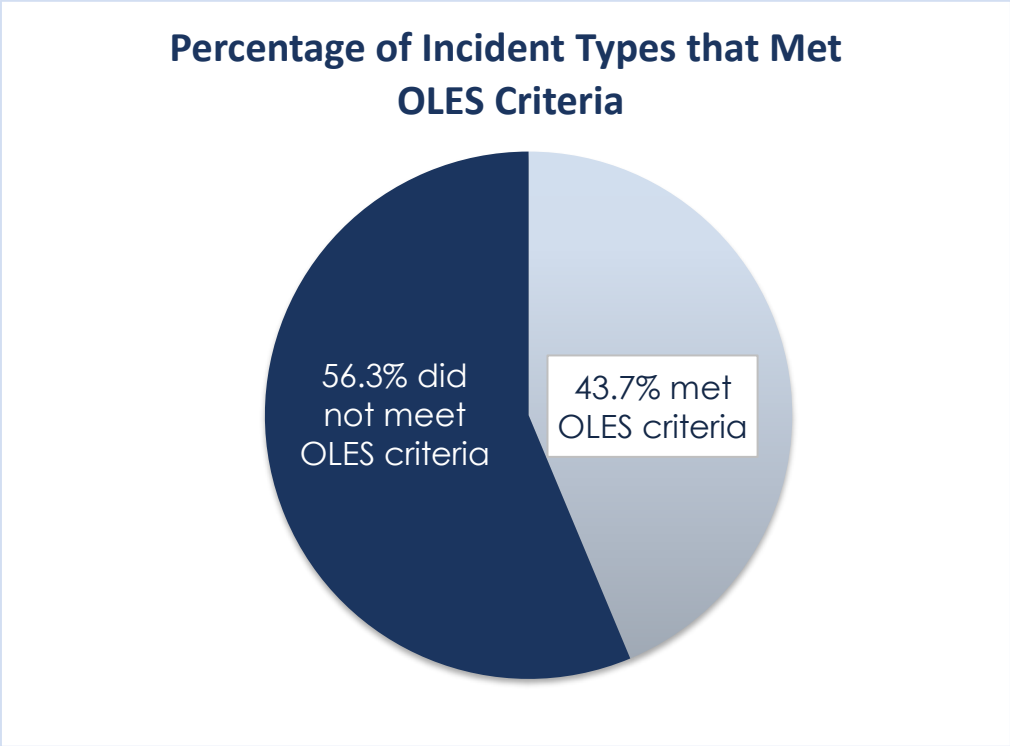
Incident Types Meeting OLES Criteria

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

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

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

investigation, monitoring or consideration for research as a potential departmental systemic issue. From the 561 reported incidents, the OLES identified 54 incidents with two or more incident types. The DSH reported a total of 638 incident types during this reporting period. Two hundred and seventy-nine, or 43.7 percent of the 638 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported by DSH include sexual assault, abuse, head or neck injury and significant interest-drugs and use of force by law enforcement.

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. The OLES received 107 reports of use of force, which accounted for 16.8 percent of all reported incident types by DSH. Two of the 107 use of force reports included an allegation of patient abuse against law enforcement.

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 DSH reported 92 allegations of sexual assault, making sexual assault allegations the second most frequently reported incident type. Allegations of patient abuse was the third most reported incident type, with 84 allegations reported, representing a 1.2 percent decrease when compared to the 85 reported allegations in the prior reporting period. The DSH reported 42 head or neck injury incident types. Reports of head or neck injuries decreased by 10.6 percent when compared to the prior reporting period.

The fifth most frequent incident type was significant interest-drugs, which increased by 320 percent, compared to the prior reporting period. This incident type includes verified drug offenses by patients and allegations of drug trafficking or smuggling against patients or staff. This increase is associated with more reported discoveries from the mail room, positive results from patient drug tests and allegations against staff.

Patient Deaths

The number of patient deaths decreased by 20.6 percent, from 34 deaths to 27 deaths during this reporting period. Ten of the reported death incident types met the OLES criteria for investigation or monitoring. Nineteen of the 27 patient deaths were expected due to existing medical conditions. Eight 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.

Napa State Hospital (NSH) and Patton State Hospital reported the largest number of patient deaths.

Patient Arrests

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

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

During this reporting period, DSH reported eight patient arrests, four less arrests compared to the prior reporting period. The patients were arrested for violations of the statutes listed in the following table.

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

Results of Completed OLES Investigations on DSH Law Enforcement

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

Appendix A provides information on the 22 investigations that OLES completed during this reporting period. These investigations involved allegations against at least 32 sworn staff members. As of June 30, 2022, there were approximately 718 DSH sworn staff.

The OLES submitted 13 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 or sleeping on duty. The OLES completed nine criminal investigations. The OLES referred one criminal case to a district attorney's office. Eight 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 77 monitored administrative cases and 76 monitored criminal cases that, by June 30, 2022, 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 five criminal investigations resulted in referrals to prosecuting agencies.

The OLES monitored 153 pre-disciplinary phase cases; 141 of the pre-disciplinary phase

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

cases are listed in Appendix B and 12 are in Appendix C. The OLES rated 31 of the 153 pre-disciplinary phase cases insufficient. Frequent deficiencies include delayed investigations, inadequate interviews and delays in conducting the findings and penalty conference.

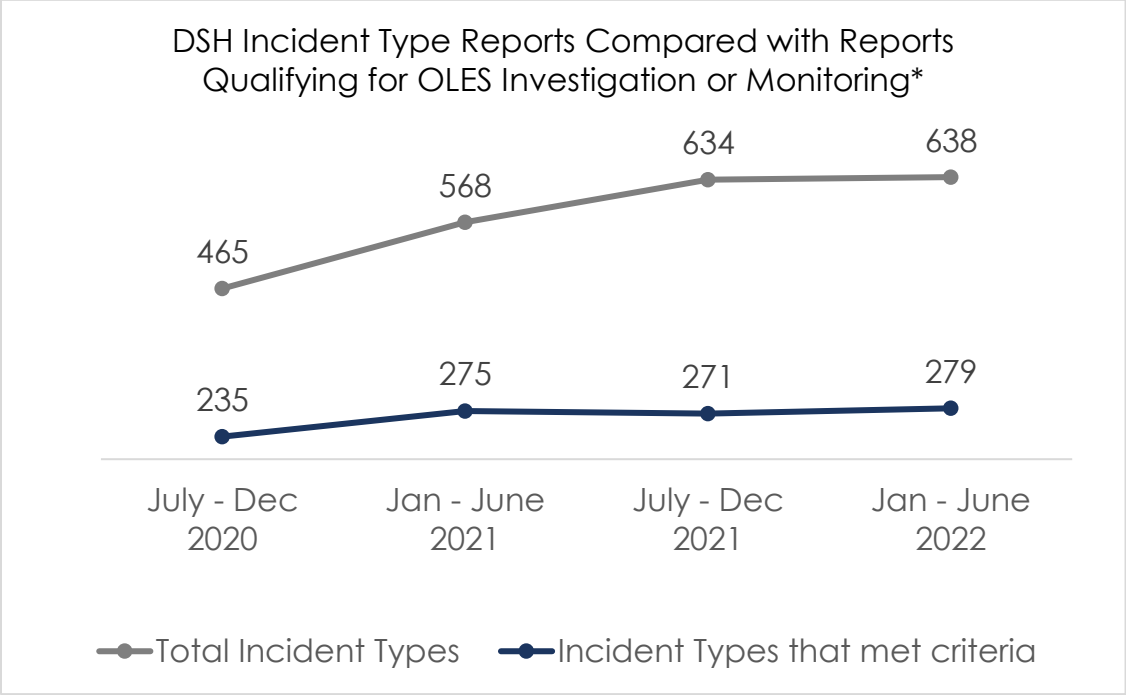
The OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in 12 administrative cases listed in Appendix C. Four of the 12 disciplinary phase cases were rated insufficient due to delays in serving a disciplinary action.

Incidents and Incident Types

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

Increase in Reported Incident Types

The number of DSH incidents reported to OLES from January 1 through June 30, 2022, decreased 0.2 percent, from 562 during the prior reporting period to 561 in this reporting period. From the 561 reported incidents, the OLES identified 638 incident types, as 54 of the incidents featured two or more incident types. Two hundred and seventy-nine of the 638 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, allegations of sexual assault, allegations of abuse, head or neck injury and significant interest-drugs. These five incident type categories accounted for 367 or 57.5 percent of all incident types reported by DSH. Of the 367 incident types, 139 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was use of force by law enforcement. The 107 reports of use of force accounted for 16.8 percent of the reported incident types.

Allegations of sexual assault accounted for 14.4 percent of all incident types reported. The number of sexual assault allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period decreased by 14.9 percent, from 47 during the prior reporting period, to 40 in this reporting period.

Allegations of abuse were the third most frequently reported incident type by DSH, with 84 incident types reported. Allegations of abuse accounted for 13.2 percent of all incident types reported. Of the 84 abuse allegations reported in this period, 80 allegations qualified for investigation, monitoring or consideration of a potential systemic issue. This is a decrease of 4.8 percent or four qualifying reports from the prior reporting period, which had 84 incident types of abuse that met OLES criteria.

While the head or neck injury incident type category remains one of the most frequently reported incident types, reports of head or neck injuries decreased 10.6 percent to 42 incident types.

Verified drug offenses by patients and allegations of drug trafficking or smuggling against patients or staff increased from 10 to 42. This 320 percent increase in reported incident types is associated with more reported discoveries from the mail room, positive results from patient drug tests and allegations against staff. 12 of the 42 incident types involved allegations against staff. The discoveries coincide with OLES's change in the reporting guidelines to distinguish drug-related allegations and crimes by patients or staff as a separate incident type.

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

Most Frequent Incident Types January 1 through June 30, 2022

Incident Type Category	Prior Period Incident Type Total – July 1 through December 31, 2021	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Use of Force	130	107*	-17.7%	2
Sexual Assault	103	92	-10.7%	40
Abuse	85	84	-1.2%	80
Head/Neck Injury	47	42	-10.6%	5
Significant Interest-Drugs	10	42	+320%	12

*Two 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 January 1 - June 30, 2021 (Reported)*	Prior Period January 1 - June 30, 2021 (Meets Criteria)*	Prior Period July 1 - December 31, 2021 (Reported)*	Prior Period July 1 - December 31, 2021 (Meets Criteria)*	Current Period January 1 - June 30, 2022 (Reported)	Current Period January 1 - June 30, 2022 (Meets Criteria)
Abuse	103	96	85	84	84	80
Broken Bone (Known Origin)	19	2	12	2	19	3
Broken Bone (Unknown Origin)	48	45	32	31	37	37
Burn	4	1	7	0	7	0
Death	56	9	34	11	27	10
Genital Injury (Known Origin)	5	1	11	1	6	1
Genital Injury (Unknown Origin)	11	8	10	7	9	5
Head/Neck Injury	53	4	47	9	42	5
Misconduct	24	17	25	23	41	39
Neglect	26	25	25	21	34	27
Non-patient assault/GBI on Patient	0	0	1	1	0	0
OPS Use of Force	-	-	130	6	107**	2
Patient on Patient Assault/GBI	23	1	18	2	10	0
Pregnancy	0	0	0	0	0	0
Sexual Assault	101	45	103	47	92	40
Sexual Assault-OJ* **	27	0	28	0	31	0
Significant Interest-Attack on Staff** **	11	0	12	1	7	0

Incident Categories	Prior Period January 1 - June 30, 2021 (Reported)*	Prior Period January 1 - June 30, 2021 (Meets Criteria)*	Prior Period July 1 - December 31, 2021 (Reported)*	Prior Period July 1 - December 31, 2021 (Meets Criteria)*	Current Period January 1 - June 30, 2022 (Reported)	Current Period January 1 - June 30, 2022 (Meets Criteria)
Significant Interest-Attempted Suicide	2	1	1	1	1	0
Significant Interest-AWOL	6	2	4	2	1	0
Significant Interest-Child Pornography	3	0	1	0	2	0
Significant Interest-Drugs***	-	-	10	5	42	12
Significant Interest-Other****	23	8	11	2	12	2
Significant Interest-Over-Familiarity	10	9	15	15	19	16
Significant Interest-Patient Arrest	13	1	12	0	8	0
Significant Interest-Riot	0	0	0	0	0	0
Total	568	275	634	271	638	279

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

**Two 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 flying over 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

The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

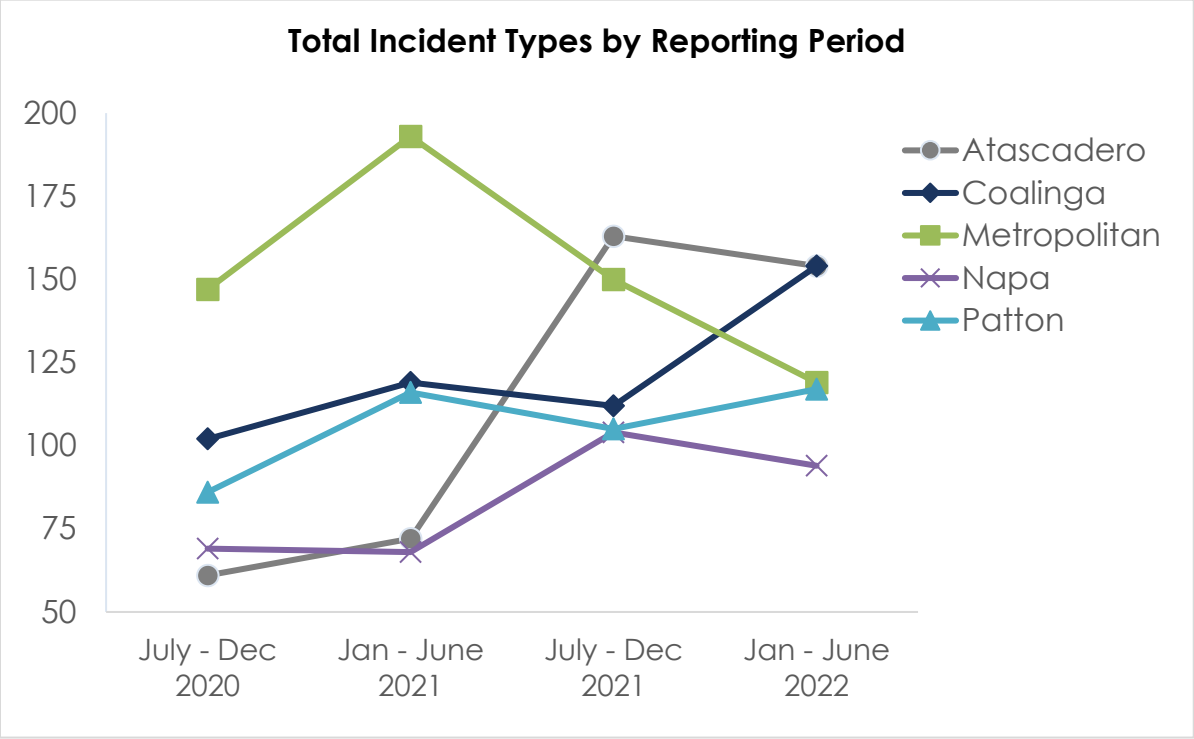
DSH Population and Total Incident Types

DSH Facility	Number of Patients Served*	Total Incident Types
Atascadero	1,503	154
Coalinga	1,361	154
Metropolitan	1,115	119
Napa	1,375	94
Patton	1,562	117
Total	6,916	638

*The department provided population numbers as of June 30, 2022.

Coalinga State Hospital (CSH) and Patton State Hospital (PSH) reported more incident types compared to the prior reporting period. Compared to the prior reporting period, CSH reported an increase in allegations of abuse and drug-related incidents. PSH reported more allegations of sexual assault that occurred outside the jurisdiction of DSH.

The following chart depicts the total number of incident types for this reporting period and the prior three reporting periods.



Sexual Assault Allegations

Like the prior reporting period, sexual assault allegations were the second most frequently reported incident type from January 1 through June 30, 2022. The 92 alleged sexual assault incident types reported in this reporting period accounted for 14.4 percent of all reported incident types from DSH. Forty of the 92 reported incident types of alleged sexual assault, or 43.5 percent, met OLES criteria for investigation, monitoring or research into systemic department issues. There were 31 reported incident types under the sexual assault-OJ category, none of which met OLES criteria for investigation or monitoring.

Of the five DSH facilities, CSH and PSH reported the highest number of sexual assault allegations. The Atascadero State Hospital (ASH) and PSH reported the highest number of incident types under the alleged sexual assault-OJ category. 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 48 incident types, or 52.2 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 30 incident types or 32.6 percent of the 92 alleged sexual assault incident types. There were 12 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 two allegations of sexual assault on a patient by law enforcement personnel during this reporting period. All DSH reports of alleged sexual assaults, including those that allegedly occurred before the patient was in the care of DSH, received by OLES during the reporting period are shown in the following table.

Sexual Assault Allegations Reported January 1 through June 30, 2022

Allegation Type	Total
Patient on Patient	48
Law Enforcement Staff on Patient	2
Non-Law Enforcement Staff on Patient	30
Unknown Person on Patient	12
OJ*	31
Total	123

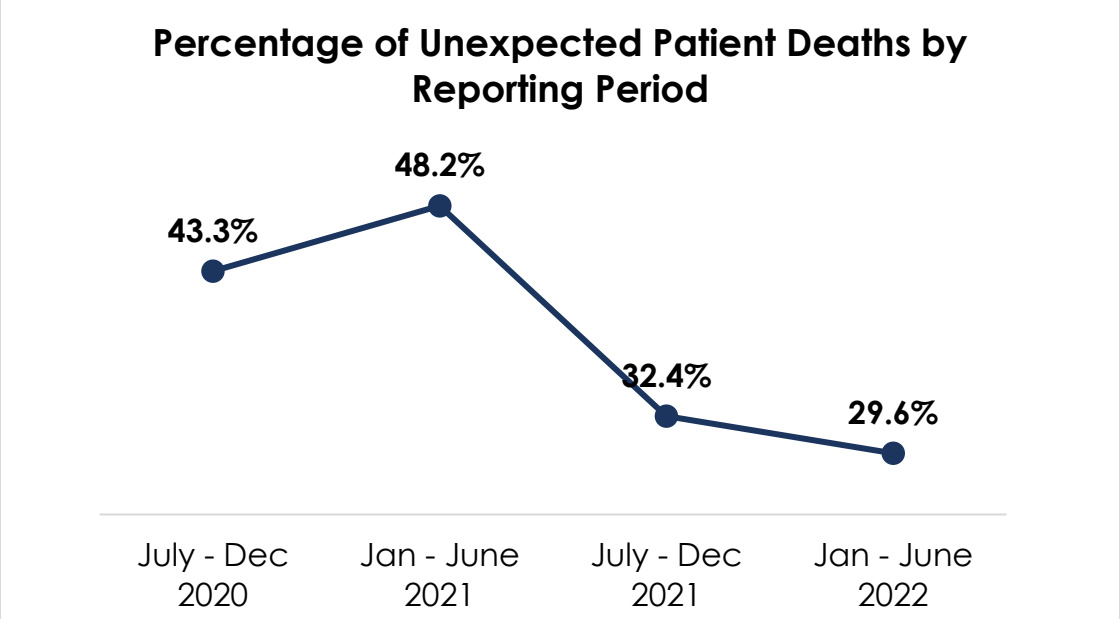
*Sexual Assault-OJ is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH.

Patient Deaths

The DSH reported 27 patient deaths to OLES during this reporting period. This number decreased 20.6 percent from the 34 patient deaths reported in the prior reporting period of July 1 through December 31, 2021.

Nineteen of the patient deaths were classified as "expected" primarily due to underlying health conditions, such as cancer, cardiac or respiratory issues, cerebral issues or renal or liver issues. Eight 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. The OLES monitored 10 of the departmental death investigations.

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



As shown in the following table, cardiac or respiratory issues were the most frequent cause of death amongst patients during this reporting period.

Cause of Patient Deaths

Cause	Total
Cardiac/Respiratory	12
Other	12
Pending Determination	3
Total	27

Reports of Head or Neck Injuries

The DSH reported 42 head or neck injuries during this reporting period. These head or neck injuries were the result of a patient-on-patient altercation, a patient fall or a self-inflicted injury by the patient. Patient-on-patient altercations were the most frequently

reported cause. Of the 42 reported head or neck injuries, 22 of the injuries were due to patient-on-patient altercations.

Reports of Patients Absent without Leave

In this reporting period, DSH reported one incident type under the significant interest-absent without leave (AWOL) category. During a courtyard break, a forensic patient climbed up a tree and jumped from the tree onto the roof of a unit, hitting barbed wire. Officers and the fire department responded to the roof and escorted the patient back to the unit. The patient was subsequently transported to an outside hospital for further evaluation, where it was determined the patient sustained only minor injuries from the fall.

Following this incident, the facility had landscapers trim the trees in the courtyard and assess the trees in the remaining courtyards for landscaping needs.

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.

On April 28, 2022, OLES changed reporting requirements for sexual assault allegations. Sexual assault allegations against staff, law enforcement or unidentified person(s) remained a priority one notification. Patient on patient sexual assault allegations and allegations of sexual assault that occurred before the patient was in the care of DSH became a priority 2 notification. Priority One and Two incident types are listed 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.
Priority 1 Sexual Assault	Any allegation of sexual assault of a patient against staff, law enforcement personnel or unidentified person(s).

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 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.
Priority 2 Sexual Assault	Any allegation of sexual assault between two patients. Any allegation of sexual assault that occurred before the patient was in the care of the department (Outside Jurisdiction).
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 increased in the timely reporting of incident types with 92.4 percent timely reports when compared to the prior reporting period, which had 91.1 percent timely reports.

Seventeen of the 638 reported incident types were excluded from DSH's total incident type count when calculating timeliness. These incident types involved a patient attack on staff or were incidents reported directly to OLES by a patient, family member of a patient, facility staff member or by an outside law enforcement agency. Of the 621 incident types evaluated for timeliness, 574 were reported timely and 47 incident types were not timely. Five of the 47 untimely incident types were unreported and were discovered by OLES when reviewing the DSH facility daily incident logs or incident reports.

Timeliness by Incident Type

The following table provides the percentage of timely notifications by incident type. The table does not include the 17 incident types that were excluded described above.

Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Abuse	77	11	88	87.5%
Broken Bone (Known Origin)	18	1	19	94.7%
Broken Bone (Unknown Origin)	30	7	37	81.1%
Burn	6	1	7	85.7%
Death	27	0	27	100.0%
Genital Injury (Known Origin)	6	0	6	100.0%
Genital Injury (Unknown Origin)	7	0	7	100.0%
Head/Neck	41	1	42	97.6%
Misconduct	31	1	32	96.9%
Neglect	31	3	34	91.2%
OPS Use of Force	104	2	106	98.1%
Patient on Patient Assault/GBI	9	1	10	90.0%
Priority 1: Sexual Assault	80	11	91	87.9%
Priority 2: Sexual Assault	32	1	33	97.0%
Significant Interest – Attempted Suicide	1	0	1	100.0%
Significant Interest – AWOL	1	0	1	100.0%

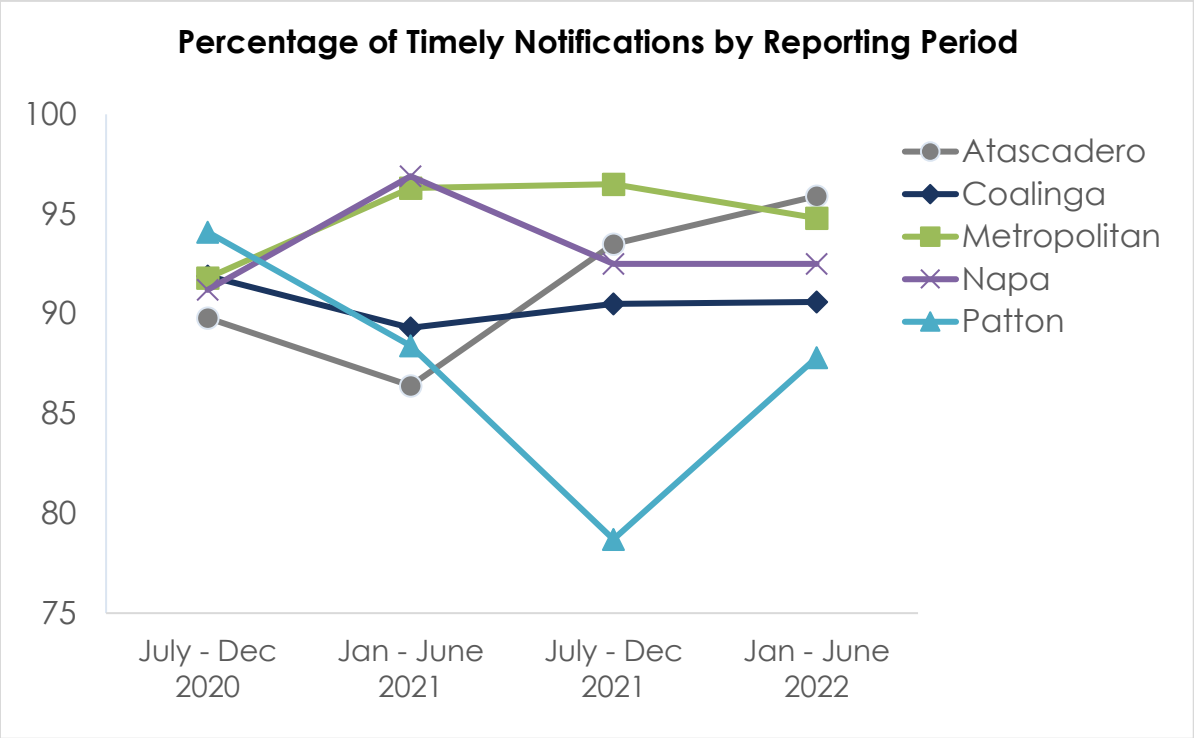
Incident Type	Number of Timely Notifications	Number of Untimely Notifications	Total Reported Incident Types	Percentage of Timely Notifications
Significant Interest – Child Porn	1	1	2	50.0%
Significant Interest – Drugs	37	4	41	90.2%
Significant Interest – Other	9	2	11	81.8%
Significant Interest – Over-Familiarity	18	0	18	100.0%
Significant Interest – Patient Arrest	8	0	8	100.0%
Total	574	47	621	92.4%

The following table compares the percentage of timely notifications by facility. The ASH had the highest percentage of timely notifications at 95.9 percent during this reporting period. The PSH had the lowest percentage of timely notifications at 87.8 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	Atascadero	142	6	6	154	95.9%
2	Metropolitan	110	6	3	119	94.8%
3	Napa	86	7	1	94	92.5%
4	Coalinga	135	14	5	154	90.6%
5	Patton	101	14	2	117	87.8%
	Total	574	47	17	638	92.4%

When compared to the prior reporting period, The ASH and PSH increased in the percentage of timely reports. The CSH and NSH maintained relatively the same percentage of timely reports. The Metropolitan (MSH) had a lower percentage of timely notifications this reporting period compared to the prior reporting period.

The following chart compares the percentage of timely notifications by 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 F. To ensure OLES is independently assessing whether an allegation meets its criteria, OLES requires the departments to broadly report misconduct allegations.

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

For the January 1 through June 30, 2022, reporting period, 336 of the total 707 cases opened for DSH incidents that occurred within DSH's jurisdiction or 47.5 percent were assigned a pending review. The OLES opened cases for 31 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 35 administrative investigations and 7 criminal investigations. The OLES opened 203 monitored criminal cases and 95 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 E).

Cases Opened in the Current Reporting Period

OLES Case Assignments	January 1 – June 30, 2022	Percentage of Opened Cases
Pending Review	336	47.5%
Monitored, Criminal	203	28.7%
Monitored, Administrative	95	13.4
Outside Jurisdiction*	31	4.4
OLES Investigations, Criminal	7	1%
OLES Investigations, Administrative	35	5%
Totals	707	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 E). 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. 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 22 investigations. Nine investigations were criminal cases and 13 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, OLES referred one criminal investigation to a district attorney's office.

All completed OLES investigations into administrative wrongdoing or misconduct are forwarded to facility management for review. In this reporting period, OLES referred 13 administrative cases to DSH 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 OLES determined there was a lack of probable cause.

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

Results of Completed OLES Investigations

Type of Investigation	Total completed January 1 - June 30, 2022	Referred to prosecuting agency	Referred to facility management	Closed without referral
Administrative	13	N/A	13	N/A
Criminal	9	1	N/A	8
Total	22	1	13	8

OLES Monitored Cases

In this report, OLES provides information on 153 completed monitored cases. By the end of the reporting period, 76 monitored criminal cases had either been referred or not referred to a district attorney's office. Five of the 76 criminal cases were referred to a district attorney's office.

There were 77 completed monitored pre-disciplinary administrative cases with allegations that were sustained or not sustained during this reporting period. Nineteen of the 77 cases had sustained allegations. Fifty-eight 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	5
Criminal-Not Referred	71
Total Criminal	76
Administrative-With Sustained Allegations	19
Administrative-Without Sustained Allegations	58
Total Administrative	77
Grand Total	153

Pre-Disciplinary Phase Cases

Of the 153 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 31 cases insufficient. Significant deficiencies found in insufficient cases include, but are not limited to the following.

Deficiency Category	Description
Incident Response	The DSH did not appropriately respond to the incident in 11 cases. Specific deficiencies identified from the 11 cases include: • Incomplete interview by the responding officer or failure to complete all necessary and relevant interviews by the investigator • Failure to provide the required legal admonition prior to taking a statement by the responding officer

Deficiency Category	Description
	• Failure to collect or preserve evidence
Delayed Investigation	The DSH failed to complete investigations within 120 days in 13 pre-disciplinary phase cases. The duration of the delayed investigations ranged from 122 days to 406 days. For the case that took 406 days, the one-year misdemeanor criminal statute of limitations expired prior to the completion of the criminal investigation, thereby preventing a prosecution. There were no significant negative outcomes associated with remaining 12 delayed investigations. However, delayed investigations increase risks of inaccurate recollection, witnesses becoming unavailable or patients being discharged or transferred. In addition, the subject employees may continue to perform poorly throughout the delay.
Lack of Consultation with OLES	The DSH failed to appropriately consult with OLES in six pre-disciplinary phase cases. This includes: • Notifying OLES that the draft investigative report is ready for review • Notifying OLES of scheduled interviews • Consulting with OLES on whether to refer a case to the district attorney's office

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

Disciplinary Phase Cases

The OLES monitored the disciplinary action, *Skelly* hearings, settlements and State Personnel Board proceedings in 12 administrative cases. Four cases were 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 inputs trainings into 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 ensuring the database accurately reflects current compliance rates.

Self-Reported Compliance Rates for Mandated Training

The DSH reported the following percentages for law enforcement compliance with mandated training requirements as of June 30, 2022.

DSH Facility	Percentage of Compliance
Atascadero	97.3
Coalinga	79.2%
Metropolitan	76%
Napa	87%
Patton	81.79%

Methods Used to Track Training

To more efficiently track training compliance, DSH developed a compliance monitor dashboard within the training database that would provide training managers with enhanced visibility for up-to-date information on the training. However, the compliance monitor dashboard is still in the early stages of development and training managers

reported several concerns with the accuracy of the dashboard. For example, the dashboard does not update when courses are entered in the database. In addition, the dashboard only tracks training compliance for the last 365 days, which results in the dashboard excluding pertinent records that may indicate a staff member is still in compliance.

Due to these issues, all training managers continue to use a separate excel spreadsheet to either supplant or supplement the dashboard for tracking training compliance. Each facility independently created its own tracking spreadsheet. While there is no standardized spreadsheet used across the department, all facilities have been able to sufficiently explain tracking methods and provide compliance rates when requested by OLES.

DSH Law Enforcement Training Advisory Committee

To coordinate training efforts across the facilities, the DSH established the Law Enforcement Training Advisory Committee (LETAC). Training lieutenants, training sergeants and training officers from each facility, as well as, academy and staff from DSH OPS headquarters are invited to attend the bimonthly meeting to discuss training topics and changes to training. However, discussions with facility training managers revealed that attendance for the LETAC meeting is not enforced.

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	Total Formal administrative investigations/actions completed*	Adverse action taken (Formal investigations)**	No adverse action taken***	Direct adverse action taken**	Resigned/ retired pending adverse action****
Atascadero	34	5	16	11	2
Coalinga	34	11	9	14	0
Metropolitan	49	1	39	8	1
Napa	60	5	51	3	1
Patton	52	8	33	9	2
Total	229	30	148	45	6

* 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	13	12	1	0
Coalinga	264	89	175	41
Metropolitan	35	0	35	0
Napa	21	0	21	0
Patton	4	3	1	0
Total	337	104	233	41

* 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	9	0
Coalinga	0	0	0	0
Metropolitan	0	0	2	0
Napa	0	0	1	0
Patton	0	0	1	0
Total	0	2	13	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 or not referred*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	333	51	282	94
Coalinga	322	89	233	45
Metropolitan	333	20	313	21
Napa	400	2	398	1
Patton	118	43	75	5
Total	1,506	205	1301	166

* 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, OLES opened one new monitored issue on the DSH canine program and re-opened a previous monitored issue on the recording of investigative interviews. Information on new and long-running monitored issues are provided below.

New Monitored Issue: DSH Canine Program

The DSH's canine program aims to enhance the safety and security for staff, patients, and visitors through combating the introduction of illegal drugs and contraband, which reduces the overall level of criminal activity within the facility. Currently, the DSH OPS maintains nine canine teams. All of DSH's canine teams are certified by either the California Narcotic Canine Association in narcotics or certified by the California Commission on Peace Officer Standards and Training in narcotics, firearms and cell phones. Each canine unit is comprised of a canine handler and a canine officer, which also includes the canine lieutenant as well as the canine sergeant.

During a prior reporting period, the Office of Law Enforcement Support (OLES) received notification regarding the death of a police canine. An officer left the canine in an outside unshaded kennel with a concrete floor at his private residence for approximately three hours. Upon return, the officer discovered the canine was deceased. A subsequent necropsy report revealed the canine was a four-year-old canine in good postmortem and nutritional conditions. However, the report noted the canine had lesions in the heart and lungs, which were highly consistent with abnormally high body temperature as the cause of death. The high temperature for the city where the residence was located was estimated to be between 95 to 100 degrees.

On June 7, 2022, the DSH reported the following facility specific actions in response to the canine death.

- Temporarily modified the program to limit canine deployment to mailroom contraband interdictions under the supervision of another DSH facility's canine sergeant and lieutenant.
- Updated and improved record keeping to appropriately reflect that current canine handlers are certified by the California Narcotic Canine Association and provided weekly training logs to the canine handlers supervisor/Sergeant and to OLES.
- Implemented and documented a process for regular home inspections of canine handler residences with photographic evidence to support passed inspections.

The OLES reviewed the circumstances surrounding the death of the canine and

identified systemic issues requiring immediate attention. Specific areas of concern include the canine handler selection process, training for canine handlers and overall program oversight.

Canine Handler Selection Process

The DSH Canine Procedure Manual indicates that the canine handler is the most important factor relating directly to the success or failure of the canine team and, therefore, it is imperative that a stringent selection process be utilized when selecting a canine handler. The manual also indicated that the prospective canine handler must possess personal qualities such as good judgment and a responsible attitude.

The manual specifies that prior to a prospective canine handler entering the initial training, the prospective handler must successfully complete a departmental training and evaluation session conducted by the canine lieutenant or designee. The evaluation is to determine the prospective canine handler's ability to follow instructions, give clear commands in a calm voice and take charge of the canine. Furthermore, the canine handler must maintain a residence with the necessary space and security to house the canine that is acceptable to the chief of police, with input from the program's lieutenant and sergeant.

The manual states that the final approval of the canine handler will be made by the chief of police based on successful completion and certification from the California Narcotics Canine Association or other agency.

In this case, DSH deviated from the administrative policy which specifies the canine handler selection process.

Training for Canine Handlers

The *DSH Policy 310 Canines* indicates that before assignment in the field, each canine team must be trained and certified to meet current Peace Officer Standards and Training (POST) guidelines or other recognized and approved certification standards. Any canine team failing to graduate or obtain certification must not be deployed in the field for tasks the team is not certified to perform until graduation or certification is achieved. Furthermore, each canine team must thereafter be recertified to a current POST or other recognized and approved certification standards annually.

The facility's canine handler policy indicates that the handler is responsible for caring for the canine, both during duty hours and off-duty hours, and should receive proper training in Canine CPR and First Aid with a refresher course every two years. The policy also requires each handler to have a copy of the Canine Handler's Manual and Handler's Agreement on file with the department.

Facility management denied repeated requests for canine team training over a four-year period. For some canine handlers, training was not provided. The DSH failed to ensure the prospective canine handler had the ability and training to control and care for the canine.

Program Oversight
The DSH Canine Procedure Manual identifies specific responsibilities for the program's lieutenant and sergeant. The lieutenant must ensure each canine team complies with all policies and procedures relating to the program. The sergeant must oversee all areas of the program, including training, assist with the handler selection process and ensure each canine team complies with all OPS policies and procedures relating to the program. The DSH policy states the lieutenant is responsible for ensuring sufficient checks and balances are in place to provide accountability, leadership, direction, and program consistency. The policy also noted that compliance with policy and maintenance of required training and certifications is essential to the canine program's success. Additionally, the policy indicated the sergeant is responsible for ensuring program objectives are met through oversight of training, audits, and report evaluations.

The DSH failed to meet program objectives and did not provide the required training. The DSH permitted canine handlers to deploy assigned canines, despite not having received the mandatory training defined in policy. This practice could have exposed DSH liability, should a canine cause harm to an employee, patient or the public.

Recommendations
On May 23, 2022, OLES issued a monitored issue memorandum to DSH with the following recommendations to ensure compliance with mandatory policies, training, and program oversight.

- Ensure the canine handlers and their assigned canine have received the required training under Department policy and the POST guidelines.
- Conduct inspections of all canine handler residences and properly document each inspection.
- Conduct an executive-level review of all canine program-related policies and procedures.
- Update, if needed, any policies regarding the canine program and ensure understanding and compliance through written documentation with each canine handler and supervisor.
- Review and assess the current primary and collateral responsibilities of the canine program's lieutenant and sergeant to ensure they can provide meaningful supervision of the canine handlers.
- Formalize the canine handler selection process.
- Create an official acquisition/transfer process for canine consistent with best practices to support the canine's good health and overall well-being.
- Require all requests for canine program training to be formalized, and any training received be memorialized through certificates or written documentation maintained in the official personnel file of the canine handlers and supervisors.

Department Response
In addition to the facility specific actions listed at the beginning of the section, the DSH reported the following actions for the department's K-9 programs statewide.

- An executive level review of canine policies and procedures led by DSH's Chief

of Law Enforcement and canine leadership at each DSH facility.

- Updated draft of statewide canine policy and procedure manual, which includes, but not limited to the following procedures.
    - Training documentation requirements
    - Canine leadership and personnel selection process
    - Roles and responsibilities for all levels of canine personnel
    - Procedure for re-assignment/transfer of a canine
    - Checklist and expectations for inspections of canine handler residences
- Verification that home inspections of canine handler residences have occurred systemwide.

The DSH reported to be in the process of finalizing the updated canine policy and procedure manual as well as setting up regular meetings to discuss successes, challenges and continuous improvement opportunities. The OLES will work collaboratively with the department and monitor the department's progress on this issue.

Reopened Monitored Issue: Recording of Investigatory Interviews

On January 4, 2022, OLES re-opened a former monitored issue to address deficiencies in DSH OPS Policy 600, 418 and 601 concerning the recording of investigatory interviews. The OLES recommended DSH update policy to require OPS staff to:

- Record all interviews conducted
- Record staff refusals to be interviewed
    - If there is a refusal, OPS staff also document in the investigative report the setting and circumstances surrounding the refusal to be recorded.

The DSH is in the process of updating the existing recording policies. The OLES will work collaboratively with the department and monitor the department's progress on this issue.

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 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.

On June 6, 2022, the DSH reported that ASH completed supervisory training on extraction. In addition, all DSH command level staff and front-line supervisors will partake in a use of force training facilitated by the DSH Chief of Law Enforcement and subject matter expert on use of force.

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

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 did not include specific timeframes for supervisors and managers to input incidents. The OLES recommended DSH input each reportable incident into Blue Team within 72 hours of discovery of the incident. On February 24, 2022, DSH reported that the procedure manual was updated to include OLES's recommendation.

The DSH also reported that entries for use of force increased substantially and the Chief of Law Enforcement now reviews all use of force reports on Blue Team. 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 physical 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 anytime they use physical techniques on with a patient regardless if their actions are interpreted 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 were opportunities for improvement in its UOF review and reporting process. Since the last update, DSH's Chief of Law Enforcement along with an external law enforcement use of force expert, reviewed DSH's policies and use of force reporting processes to identify opportunities to strengthen DSH's processes. DSH's Chief of Law Enforcement developed training and prepared to deliver the training for DSH command level staff and front-line supervisors, which is expected to be completed during the next reporting period. The use of force subject matter expert reviewed and approved DSH's plan of instruction and scheduled training. The DSH is also making updates to its use of force reporting forms to clarify requirements and details to be reported including that use of therapeutic strategies and interventions by sworn staff must be documented and reported. 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.

On June 1, 2022, DSH shared a draft policy update for Policy Directive 8010, which included a reference to reporting confidential patient information and allegations as required by law to OLES. The DSH also created mandated reporting posters and pocket guides describing OLES reporting requirements for staff distribution.

During the reporting period of January 1 through June 30, 2022, OLES identified 13 incidents in which level of care staff failed to timely report to OPS. The reportable incident types are listed below. The OLES will work collaboratively with the department and monitor the department's progress on this issue.

Incident Type	Delay/Notes
Abuse	7 hours, 53 minutes
Broken Bone (Unknown Origin)	5 hours, 37 minutes
Broken Bone (Unknown Origin)	17 hours, 35 minutes
Broken Bone (Unknown Origin)	Level of care staff did not report this incident to OPS. The OPS discovered the incident after reading a morning report.
Broken Bone (Unknown Origin)	Level of care staff did not report this incident to OPS. The OPS discovered the incident after reading a morning report.
Broken Bone (Unknown Origin)	Level of care staff did not report this incident to OPS. The OPS discovered the incident after reading a Health Services Specialist's report.
Genital Injury (Known Origin)	Level of care staff did not report this

Incident Type	Delay/Notes
	incident to OPS. The OPS discovered the incident after reading a nurse-on-duty log.
Genital Injury (Unknown Origin)	This incident was discovered by OLES only.
Genital Injury (Unknown Origin)	This incident was discovered by OLES only.
Sexual Assault	17 hours, 30 minutes
Sexual Assault	20 hours, 27 minutes
Sexual Assault-Outside Jurisdiction	1 day, 1 hour, 35 minutes
Significant Interest-Drugs	6 days

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2022. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

To protect the anonymity of law enforcement personnel, the OLES refers to an officer, sergeant or investigator as an "officer." The rank of lieutenant or above is referred to as "law enforcement supervisor."

Case Detail	Description
OLES Case Number	2021-00252-1A
Case Type	Investigative
Incident Type	1. Abuse 2. Abuse 3. Abuse 4. Use of Force Review
Incident Summary	Two officers allegedly used excessive force while conducting a pat-down search of a patient.
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
OLES Case Number	2021-00333-1A
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	An officer allegedly used unauthorized force on a patient.
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
OLES Case Number	2021-00348-1C
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly provided false testimony at a civil deposition.
Disposition	The OLES conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office.

Case Detail	Description
OLES Case Number	2021-00456-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer was allegedly insubordinate when he failed to appear at two assigned classes and conduct training.
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
OLES Case Number	2021-00781-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly posted inappropriate comments on a social media website.
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
OLES Case Number	2021-00899-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly improperly shared confidential peace officer information.
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
OLES Case Number	2021-00968-1A
Case Type	Investigative
Incident Type	1. Abuse 2. Use of Force Review
Incident Summary	Two officers allegedly failed to document their use of physical force on a patient. One of the officers allegedly provided false or misleading information when describing the incident.
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
OLES Case Number	2021-00973-1C
Case Type	Investigative
Incident Type	1. Abuse 2. Use of Force Review
Incident Summary	An officer allegedly assaulted a patient.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2021-01080-1C
Case Type	Investigative
Incident Type	1. Abuse 2. Significant Interest - Attack on Staff 3. Use of Force Review
Incident Summary	Officers allegedly used excessive and unnecessary force while restraining a patient.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2021-01284-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly was dishonest and discourteous during a COVID-19 mask audit.
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
OLES Case Number	2021-01322-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer used marijuana on two occasions. The officer allegedly gave false statements during a pre-employment polygraph exam conducted for employment with another state agency.
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
OLES Case Number	2021-01323-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	An officer allegedly threatened and intimidated a patient.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2021-01340-2C
Case Type	Investigative
Incident Type	1. Abuse 2. Use of Force Review
Incident Summary	Several officers allegedly used excessive force while restraining a patient during a court ordered blood-draw.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2021-01377-2A
Case Type	Investigative
Incident Type	1. Abuse 2. Use of Force Review
Incident Summary	An officer allegedly used excessive force on a patient who was in full restraints.
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
OLES Case Number	2021-01429-2C
Case Type	Investigative
Incident Type	1. Broken Bone (Known Origin) 2. Use of Force Review
Incident Summary	Two officers allegedly used excessive force while restraining a patient.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2021-01502-1C
Case Type	Investigative
Incident Type	1. Abuse 2. Assault/GBI 3. Priority 1: Sexual Assault
Incident Summary	An officer allegedly physically and sexually assaulted a patient.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2021-01526-1C
Case Type	Investigative
Incident Type	1. Abuse
Incident Summary	Several officers allegedly physically assaulted a patient.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2022-00063-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly failed to properly secure and safeguard state police equipment, which was stolen from his personal vehicle.
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
OLES Case Number	2022-00125-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	Two officers allegedly failed to document an attempted bribery allegation of a patient by a staff employee.
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
OLES Case Number	2022-00213-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer allegedly released confidential information about a patient.
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
OLES Case Number	2022-00241-1C
Case Type	Investigative
Incident Type	1. Abuse 2. Use of Force Review
Incident Summary	Seven officers allegedly used excessive force while attempting to restrain a combative patient.
Disposition	The OLES conducted an investigation into this allegation. 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
OLES Case Number	2022-00366-1A
Case Type	Investigative
Incident Type	1. Misconduct
Incident Summary	An officer was arrested for allegedly driving while under the influence of alcohol.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition. The OLES monitored the disposition process.

Appendix B: Pre-Disciplinary Cases Monitored by the OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2022, had sustained or not sustained allegations, or a decision whether to refer the case to the district attorney's office. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period.

The OLES rated each case as sufficient or insufficient after assessing the department's performance in conducting the internal investigation. A sufficient case indicates the department complied with policies and procedures governing the pre-disciplinary process. For each case that OLES rated insufficient, OLES identified the deficiencies in the investigative assessment of the case table and listed the department's corrective action plan submitted to OLES.

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
OLES Case Number	2021-00072-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On September 3, 2020, eight staff members allegedly restrained a patient against a psychiatrist's order.
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	**Case Rating:** Insufficient The investigation did not comply with policies and procedures governing the investigative process. The one-year criminal misdemeanor statute of limitations expired prior to the completion of the criminal investigation. The investigation was not completed until 406 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Did the deadline for taking disciplinary action or filing charges expire before the investigation was complete?

	Yes. The one-year misdemeanor criminal statute of limitations expired prior to the completion of the criminal investigation. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 406 days after discovery of the incident.
Department Corrective Action Plan	To avoid further lengthy delays, the OSI Supervisor will immediately notify DSH OPS headquarters of all investigations that exceed 120 days to mitigate any further unnecessary delays.

Case Detail	Description
OLES Case Number	2021-00636-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Broken Bone (Known Origin)
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Referred 2. Referred
Incident Summary	A unit supervisor allegedly tackled a patient who was fighting a second patient. X-rays confirmed the first patient sustained three rib fractures. A psychiatric technician also allegedly taunted, intimidated and made fun of the first patient regarding the incident.
Disposition	The Office of Protective Services conducted an investigation and referred the case to the district attorney's office for review. The OLES concurred with the determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-00990-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly forcefully removed a patient from a wheelchair.
Disposition	The Office of Protective Services conducted an investigation

	and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 122 days after the incident was discovered. Additionally, OPS did not notify the OLES of the subject interview.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The OPS did not notify the OLES of the suspect interview, thereby preventing OLES from providing real-time monitoring 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 122 days after discovery of the incident.
Department Corrective Action Plan	The investigator conducted a suspect interview without notifying the OLES Monitor. The investigator was instructed by the supervisor and mentors that the OLES Monitor is always to be advised to notify the monitor of a victim and/or suspect interview. OPS agrees with the OLES Monitor's assessment that they weren't notified of the suspect interview for real-time monitoring. This issue was addressed in the investigator's probationary evaluation. The case had to be reassigned because the investigation was not complete given the corrections that the supervisor requested weren't made by the assigned investigator prior to the departure to training. This case was submitted to the OLES AIM without final approval from the supervisor who was still requesting corrections. OPS agrees with the assessment of the OLES Monitor that the case wasn't completed until 122 days later. The case had to be reassigned because the corrections that the supervisor requested weren't made. The investigator was provided additional training and guidance on adherence to OLES guidelines. This incident was documented in the investigators' probationary evaluation.

Case Detail	Description
OLES Case Number	2022-00031-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	On January 7, 2022, a senior psychiatric technician allegedly placed his hand on a patient's throat while stabilizing the patient.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Criminal-Not Referred

Case Detail	Description
OLES Case Number	2020-01349-1C
Case Type	Monitored
Incident Types	1. Death 2. Use of Force Review
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A combative patient became unresponsive while in restraints. Emergency life-saving measures were initiated; however, the patient was declared dead. An autopsy determined the cause of death was due to fatal cardiac dysrhythmia/prolonged agitated state with excited delirium/schizophrenia.
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	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-00219-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient fell and struck his head against a wall. The patient became unresponsive. Responding staff initiated life-saving measures; however, the patient was eventually pronounced dead. An autopsy determined the cause of death was Acute Cardiopulmonary Arrest due to Probable Seizure.
Disposition	The Office of Protective Services conducted an investigation, and determined there was no evidence that a crime caused or contributed to the patient's death. The OLES concurred. The Office of Protective Services opened did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-00479-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly intentionally threw a sponge ball at a patient's head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. 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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 243 days after the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 243 days after the incident was discovered.
Department	This will be corrected in the near future as an acting

Corrective Action Plan	supervisor will be added to provide more support to newer or acting investigators to facilitate continued learning and development of less experienced staff, which will aid in the timely completion of investigations.

Case Detail	Description
OLES Case Number	2021-00603-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was discovered nonresponsive in his room. Emergency life-saving measures were performed; however, the patient was declared dead. An autopsy determined the immediate cause of death was a seizure disorder due to blunt trauma and a cerebral aneurysm caused by prior head injuries incurred by the patient outside the facility.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-00650-1C
Case Type	Monitored
Incident Types	1. Pregnancy 2. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	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 Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 190 days from the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence?

	The investigation was not completed until 190 days from the date of discovery.
Department Corrective Action Plan	In an effort to re-tighten existing controls, SSI I and AGPA have reintroduced individual weekly meetings between the Liaison and the Investigators to closely monitor the aging of all cases; reintroduced a structured tier (by age of case) for support and involvement by additional Investigators; re-established OLES monitor monthly check-ins to reveal potential cases of aging concern; re-established production of a weekly report highlighting specific case concerns, and for AGPA to submit extensions, as needed, by the 110 day aging mark.

Case Detail	Description
OLES Case Number	2021-00813-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly harassed and searched a patient without probable cause.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-00874-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly squeezed a patient's shoulder and hit the back of the patient's head.
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's monitoring criteria.
Investigative Assessment	**Case Rating:** Sufficient

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

Case Detail	Description
OLES Case Number	2021-00943-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Three psychiatric technicians allegedly improperly attempted to stabilize a patient against a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-00989-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician 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 did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 260 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 260 days after discovery of the incident.
Department Corrective Action Plan	Five investigators attended the same Investigator Academy, which did not allow these investigators to complete some of their cases in time before departing. There was a large case

	load that was turned in between these supervisors, which were evaluated by the supervisor. Upon discovery of this issue, the Chief of Law Enforcement met with the OSI supervisor. The Investigator was instructed to enhance his communication with his supervisor and the supervisor was counseled on case management and to check his queue for progress of open and closed cases.

Case Detail	Description
OLES Case Number	2021-01009-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Hospital staff witnessed a patient fall and become unresponsive. Staff initiated emergency life-saving measures; however, the patient was pronounced dead. An autopsy determined the cause of death was acute cardiac pulmonary arrest.
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 post-death investigation, which the OLES accepted for monitoring. .
Investigative Assessment	**Case Rating:** Insufficient The department did not to comply with policies and procedures governing the investigative process because unit staff cleaned the scene prior to the arrival of hospital police and investigators.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. Unit staff cleaned the crime scene of the patient's bodily fluids prior to the arrival of hospital police and investigators.
Department Corrective Action Plan	To ensure OPS complies with policies and procedures governing the investigative process, the investigator who interviewed the employee who cleaned the bodily fluids reminded the employee about preserving potential crime scenes until hospital police or investigators have determined no crime has occurred. OPS will also bring up this event with the Program Directors to remind all staff of the preservation of potential crime scenes.

Case Detail	Description
OLES Case Number	2021-01016-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient died while receiving treatment at an outside hospital. The coroner determined the cause of death was due to hypertensive and atherosclerotic cardiovascular disease.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01018-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A senior psychiatric technician allegedly provided illicit narcotics to a patient for further distribution to other patients. The senior psychiatric technician, and a psychiatric technician, also allegedly engaged in sexual activity with the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01022-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was discovered unresponsive in the dayroom. Emergency life-saving measures were initiated by responding staff; however, the patient was declared dead. An autopsy determined the cause of death was fatal cardiac dysrhythmia due to dilated cardiomyopathy.
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	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01029-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A unit supervisor and three psychiatric technicians allegedly choked and scratched a patient while placing the patient in restraints.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01045-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed 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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 244 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 244 days after discovery of the incident.
Department Corrective Action Plan	Five investigators attended the same Investigator Academy, which did not allow these investigators to complete some of their cases in time before departing. There was a large case load that was turned in between these supervisors, which were evaluated by the supervisor. Upon discovery of this issue, the Chief of Law Enforcement met with the OSI supervisor. The Investigator was instructed to enhance his communication with his supervisor and the supervisor was counseled on case management and to check his queue for progress of open and closed cases.

Case Detail	Description
OLES Case Number	2021-01079-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A social worker allegedly hit a patient on the face and 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 due to lack of evidence.

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

Case Detail	Description
OLES Case Number	2021-01097-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin) 2. Head/Neck 3. Significant Interest - Attempted Suicide
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with a fractured neck after jumping off of a dresser.
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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 215 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 215 days after discovery of the incident.
Department Corrective Action Plan	The OPS agrees with the assessment of the OLES Monitor that the case wasn't completed until 215 days later. The issue has been addressed within the investigator's probationary evaluation. The investigator was provided additional training on adherence to OLES guidelines since their return from the Specialized Basic Investigator's Course.

Case Detail	Description
OLES Case Number	2021-01115-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly failed to assist a patient who reported she had been assaulted earlier that day by another 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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01117-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient began choking and staff provided emergency life-saving measures; however, the patient was pronounced dead. The coroner's report listed the cause of death as "Asphyxia, due to aspiration of food."
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	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01127-1C
Case Type	Monitored
Incident Types	1. 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	A senior psychiatric technician and three psychiatric technicians allegedly failed to provide medical care to a patient who had fallen and sustained fractured ribs.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the

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

Case Detail	Description
OLES Case Number	2021-01154-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Abuse 3. Neglect 4. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Three staff members allegedly sexually abused 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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 204 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 204 days after discovery of the incident.
Department Corrective Action Plan	The initial assigned investigator to this investigation was unable to complete work on this case prior to department to the Specialized Basic Investigator's Course on February 11, 2022. As a result, the investigation was reassigned to another investigator on March 11, 2022, and completed on April 20, 2022. OPS recognizes the OLES Monitor's assessment of the investigation being submitted 204 days later. The investigator was advised accordingly, and it was documented in the investigator's probationary evaluation. At the time of this investigation, there was a 12:1 and 13:1 ratio of investigators to supervisor and also the supervisor had the duty of supervising an office technician. Also, at this time, there were 5 new investigators, which require additional coaching and

	training. This coaching/training will be addressed in the near future by adding an acting supervisor in August or September. This will help tremendously with acting investigators that require more supervision because they are learning the job.

Case Detail	Description
OLES Case Number	2021-01155-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly pushed a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01156-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Neglect 3. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Three psychiatric technicians allegedly forcefully moved and attempted to sexually assault 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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 223 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence?

	No. The investigation was not completed until 223 days after discovery of the incident.
Department Corrective Action Plan	Five investigators attended the same Investigator Academy, which did not allow these investigators to complete some of their cases in time before departing. There was a large case load that was turned in between these supervisors, which were evaluated by the supervisor. Upon discovery of this issue, the Chief of Law Enforcement met with the OSI supervisor. The Investigator was instructed to enhance his communication with his supervisor and the supervisor was counseled on case management and to check his queue for progress of open and closed cases.

Case Detail	Description
OLES Case Number	2021-01160-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	A psychiatric technician alleged that a second psychiatric technician meets with a patient in the back stairwell of the unit and provides contraband 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, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01162-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a patient to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective

	Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department complied with all policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01171-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was discovered in respiratory distress. Unit staff responded and provided emergency life-saving measures. However, the patient was declared dead. The coroner's reported listed the cause of death as acute respiratory arrest and acute pulmonary thromboembolism.
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	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01173-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly forcefully removed a patient from the patient's room
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 145 days after discovery of the incident. Additionally, OPS did not include

	OLES in the suspect interview.
Pre-Disciplinary Assessment	1. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The OPS did not include OLES in the suspect interview. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 145 days after discovery of the incident.
Department Corrective Action Plan	The investigator failed to follow instructions given to him by the supervisor and his mentor when he interviewed the suspect without notifying the OLES Monitor. OPS agrees with the OLES Monitor's assessment, and the investigator was advised and the failure to comply was noted in the probationary evaluation. OPS agrees with the OLES Monitor's assessment of time the case took. The investigator has been advised on adherence to OLES case completion guidelines and the supervisor consulted with the OLES monitor regarding a thoroughly investigated case. The investigator has since completed Specialized Investigator's Basic Course and is being evaluated to see if there is any continued improvement needed with how the investigations are conducted.

Case Detail	Description
OLES Case Number	2021-01196-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient several times on 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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01197-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly grabbed, hit and bruised a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01209-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly hit a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01214-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient alleged two registered nurses propositioned her for sex.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01224-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit and kicked a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The investigation was not completed until 244 days after discovery of the incident.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 244 days after discovery of the incident.
Department Corrective Action Plan	The DPS will review controls in place and provide training to all police staff regarding timely reporting for OLES reportable offences (Priority 1 and 2). In addition, on-going informal training will be provided to all officers by shift sergeants during shift briefings pertaining to the timely reporting of OLES reportable offences.

Case Detail	Description
OLES Case Number	2021-01241-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly dropped a patient onto the shower floor and forced the patient across a table.
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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The department improperly characterized the incident as neglect rather than physical abuse.
Pre-Disciplinary Assessment	1. Did the hiring authority properly characterize the nature and scope of the incident during his/her notification to OLES? No. The hiring authority improperly characterized the incident as neglect rather than physical abuse.
Department Corrective Action Plan	The DPS will review controls in place and provide training to all police staff regarding timely reporting for OLES reportable offences (Priority 1 and 2). In addition, on-going informal training will be provided to all officers by shift sergeants during shift briefings pertaining to the timely reporting of OLES reportable offences.

Case Detail	Description
OLES Case Number	2021-01249-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly brushed his body against the shoulder and hip area of a patient as they passed each other in a 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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01251-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Use of Force Review
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly forced a patient to the floor, then repeatedly hit the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01292-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient on 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 Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01308-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A patient reported a doctor allegedly sexually assaulted the patient approximately ten years ago, and that the Office of

	Protective Services allegedly failed to investigate the incident. An investigation into the allegations had been completed in 2014. The patient also reported that four psychiatric technicians allegedly engaged in religious hate crimes when they confiscated or damaged the patient's property.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01363-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly violated the "professional boundary" policy by being alone with a patient in her room. The nurse resigned during the investigation.
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 Special Investigations also opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01366-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	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 did not open an administrative investigation due to lack of evidence.

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

Case Detail	Description
OLES Case Number	2021-01370-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient on 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 Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01385-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly sexually assaulted a patient and struck the patient with a set of keys.
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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01420-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault 2. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychologist was allegedly having inappropriate sexual contact with a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01433-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly failed to assist a wheelchair-bound patient in using the restroom and the patient subsequently fell.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01437-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A nurse allegedly slapped a restrained patient.

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

Case Detail	Description
OLES Case Number	2021-01444-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly sold narcotics to a patient. The psychiatric technician allegedly threatened to harm the patient because the patient allegedly owed money to the psychiatric technician for the drugs.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01447-1C
Case Type	Monitored
Incident Types	1. Head/Neck
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly watched and did not intervene as a patient stood on his bed and fell to the ground three times, resulting in the patient sustaining a head injury.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to

	lack of evidence. The OLES concurred.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigator was not assigned the case until 101 days after the incident and the department did not preserve video evidence of the incident.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The department did not preserve video evidence of the incident. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigator was not assigned the criminal investigation until 101 days after the alleged incident was discovered. Due to this delay, video evidence of the incident was not recoverable.
Department Corrective Action Plan	To correct this deficiency, the Supervising Special Investigator shall ensure the assigned Investigator downloads any available incident video surveillance at the start of the criminal investigation. The Supervising Special Investigator has had a refresher training on Unit 29 Genetec video monitoring system. If there is an incident in which there is surveillance recordings, the Supervising Special Investigator shall make the proper assigning of these cases a priority. This corrective action will ensure footage is obtained before the system's 45-day automatic recording purged and cases are assigned timely and tracked.

Case Detail	Description
OLES Case Number	2021-01460-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a patient into a room and 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 accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient

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

Case Detail	Description
OLES Case Number	2021-01464-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault 2. Priority 1: Sexual Assault
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	A patient alleged that two psychiatric technicians were engaging in sexual activity with patients.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01481-1C
Case Type	Monitored
Incident Types	1. Head/Neck 2. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient with an extensive history of self-harm sustained a head injury which reopened a prior injury and required the reapplication of stitches.
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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The

	investigator was not assigned the case until 94 days after the incident and the department did not preserve video evidence of the incident.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The department did not preserve video evidence of the incident. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigator was not assigned the criminal investigation until 94 days after the alleged incident was discovered. Due to this delay, video evidence of the incident was not recoverable.
Department Corrective Action Plan	In an effort to correct these deficiencies moving forward, the Supervising Special Investigator shall ensure the assigned Investigator downloads any available incident videos surveillance at the start of the criminal investigation. This corrective action will ensure footage is obtained before the system's 45-day automatic recording purge. It should be noted this case was closed criminally at the line level. In the future, the Supervising Special Investigator shall ensure criminal and administrative cases are properly assigned within the RMS system officially. This will ensure there will not be a delay in assignment.

Case Detail	Description
OLES Case Number	2021-01522-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin) 2. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly failed to medically assess a patient with a genital injury.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES did not concur with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The draft and final investigative reports contained an inaccurate legal standard for abuse, the Office of Protective Services did not

	consult with the OLES regarding whether to refer the case to the district attorney's office for prosecution, and the Office of Protective Services did not appropriately determine whether probable cause existed for a referral to the district attorney's office.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report inaccurately stated the legal standard for the alleged violation of the Penal Code. 2. Was the final investigative report thorough and appropriately drafted? No. The final investigative report inaccurately stated the legal standard for the alleged violation of the Penal Code. 3. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution? No. The department did not appropriately determine that probable cause existed, even though the investigation established that the nurse intentionally failed to medically assess a patient. 4. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? No. The department did not consult with the OLES regarding the decision to not refer the case to the district attorney's office for prosecution.
Department Corrective Action Plan	To ensure OPS reporting guidelines are met, the Chief of Law Enforcement met with the Hospital Chiefs of Police. In the discussion it was made clear the untimely reporting was not an acceptable practice. A lieutenant met with the sergeant and educated them on the OLES Reporting Guidelines, OPS Policy 607, and how this incident met the OLES priority 1 criteria to ensure this did not occur again. Reporting guideline cheat sheets were issued to the Officer. Moving forward, the Chief of Hospital Police will work with the Supervising Special Investigator to find practical reasonable solutions, so any assigned OLES AIMs and OSI Investigators feel that potential identifiable issue is appropriately dealt with and is therefore fairly resolved to the benefit of all

	involved. To correct this deficiency, the Supervising Special Investigator shall conduct a briefing in collaboration with the assigned AIM to gain an understanding of the legal standard of abuse from their criminal viewpoint. When there is a disagreement regarding the submittal of cases to the District Attorney's Office to pursue criminal charges, the SSI shall consult the Chief of Hospital and conference with the AIM or Chief of OLES.

Case Detail	Description
OLES Case Number	2021-01547-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01548-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A unit supervisor found an anonymous note alleging a psychologist and a patient were involved in a sexual relationship.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2021-01553-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act 6. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred 6. Not Referred
Incident Summary	Two psychiatric technicians allegedly encouraged a patient to stab two other patients.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00008-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A unit supervisor found an anonymous note that alleged a psychiatric technician and a patient were involved in a sexual relationship.
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	**Case Rating:** Sufficient

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

Case Detail	Description
OLES Case Number	2022-00011-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly confronted a patient about leaving a mess on the unit. The psychiatric technician then allegedly pushed the patient, causing the patient to hit his head against the 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, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00046-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly inappropriately touched a patient while conducting a pat-down search of the patient. Additionally, the senior psychiatric technician allegedly offered to give the patient money if the patient agreed to withdraw his complaint.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00067-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed and bruised 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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00080-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient died while at an outside hospital from respiratory failure due to pneumonia, COVID-19, and chronic obstructive pulmonary disease (COPD).
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00084-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly hit a patient on the back of 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 Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00102-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly inappropriately touched a patient over the patient's clothing while conducting a pat-down search of the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00104-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly inappropriately touched a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00143-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with a fractured toe.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00181-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient with a food tray.
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	**Case Rating:** Sufficient The department complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00205-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Multiple staff members did not comply with a doctor's "Line-of-Sight" observation order of 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. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00208-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly chased and grabbed 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00214-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity 2. Significant Interest - Over-Familiarity 3. Significant Interest - Over-Familiarity 4. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient sent two letters alleging that a psychiatric technician had engaged in an ongoing overly familiar relationship with four 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 opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process because the

	draft investigative report did not contain a reference that the psychiatric technician invoked her constitutional rights and refused to provide a statement to the investigator.
Pre-Disciplinary Assessment	1. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? No. The draft investigative report did not state that the suspect invoked her constitutional rights and refused to provide a statement to the investigator.
Department Corrective Action Plan	To correct this deficiency, the Supervising Special Investigator shall ensure the draft report is complete before advising the assigned AIM the case is ready for review.

Case Detail	Description
OLES Case Number	2022-00222-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly engaged in an overly familiar relationship with a patient. After the patient's discharge, the psychiatric technician allegedly engaged in a sexual relationship with the former patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination because an incomplete investigation precluded a probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The Office of Protective Services repeatedly did not adequately consult with the OLES during the investigation regarding the scheduling of witness interviews, did not interview possible staff witnesses, did not adequately interview the former patient, and refused to interview the psychiatric technician.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator did not interview staff assigned to the housing unit where the former patient resided and where he met the psychiatric technician. 2. Were all of the interviews thorough and appropriately conducted?

	No. The investigator did not adequately question the former patient about his relationship with the psychiatric technician while he was a patient at the hospital and he refused to interview the psychiatric technician. 3. Did OPS appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution? No. Due the insufficient investigation conducted by the department, a probable cause determination was not able to be made which would justify a referral to the district attorney's office. 4. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not notify the OLES of the scheduling of the former patient's interview, thereby preventing the monitor from attending the interview and providing real-time feedback. 5. Was the investigation thorough and appropriately conducted? No. The investigator failed to interview unit staff witnesses, fully interview the former patient and interview the suspect psychiatric technician.
Department Corrective Action Plan	In response to this Insufficient notice, the Chief of Law Enforcement met with the Hospital Chiefs of Police. In the discussion it was made clear that all Supervising Special Investigators (SSI) will brief all OLES monitored cases and maintain consistent communication with the assigned AIM. When there is a disagreement regarding the submittal of cases to the District Attorney's Office to pursue criminal charges, the SSI shall consult the Chief of Police at the Hospital and conference with the AIM or Chief of OLES. In this matter, the Supervising Special Investigator concurred with the criminal Investigator's assertion that this case was not criminal. This case was not submitted for criminal charges. However, in the spirit of cooperative oversight, the Supervising Special Investigator shall confer with the facility assigned Deputy District Attorney, brief the case, and provide the AIM with the opportunity to provide input as to the filing of criminal charges.

Case Detail	Description
OLES Case Number	2022-00226-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient alleged that between three and five years earlier, he was sexually assaulted by a healthcare staff member.
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	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00237-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	On March 2, 2022, a patient was found unresponsive in his room. Life-saving measures were initiated; however, the patient was declared dead. The coroner's report stated the cause of death was bladder cancer.
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	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Detail	Description
OLES Case Number	2022-00267-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient sustained a fractured left foot after allegedly falling in the dayroom.

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

Case Detail	Description
OLES Case Number	2022-00286-2C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	A nurse practitioner allegedly inserted his finger in the patient's rectum and made inappropriate comments during a medical examination of the patient.
Incident Summary	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.
Disposition	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Investigative Assessment	A nurse practitioner allegedly inserted his finger in the patient's rectum and made inappropriate comments during a medical examination of the patient.

Case Detail	Description
OLES Case Number	2022-00345-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An anonymous person submitted a complaint to OLES alleging hospital staff are posting pictures of patients on social media platforms.
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	**Case Rating:** Sufficient

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

Administrative-With Sustained Allegations

Case Detail	Description
OLES Case Number	2020-01148-2A
Case Type	Monitored
Incident Types	1. Head/Neck
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	A nurse allegedly failed to continuously monitor a patient and intervene before the patient threw himself backwards to the ground, sustaining a head injury, and failed to activate a personal alarm during the incident. On February 1, 2021, the nurse was allegedly less than forthcoming during his investigative interview.
Disposition	The hiring authority sustained the allegation that the nurse failed to activate his personal alarm during the incident, but determined there was insufficient evidence to sustain the remaining allegations, and issued the nurse a written counseling memo. After consulting a subject matter expert panel, the OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00200-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment
Findings	1. Sustained
Penalty	**Initial:** Letter of Reprimand **Final:** No Penalty Imposed

Incident Summary	A law enforcement supervisor was allegedly disrespectful and discourteous toward an officer in the presence of other personnel.
Disposition	The hiring authority sustained the allegation and determined a letter of reprimand was the appropriate penalty. The OLES concurred. However, the statute of limitations ran before disciplinary action could be imposed.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The disposition conference was not timely conducted and the statute of limitations expired before disciplinary action could be imposed.
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 delivered to the hiring authority on September 30, 2021; however, the disposition conference was not conducted until November 19, 2021, 50 days later. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The statute of limitations expired before disciplinary action could be imposed.
Department Corrective Action Plan	The Executive Analyst will be trained on how to process the OLES cases with the acting Executive Team member in the Executive Directors absence to ensure the Hiring Authority Review of Investigation Form is completed and sent to the assigned AIM. In addition, a copy of the Hiring Authority Review of Investigation Form will be sent to Employee Relation Office (ERO) to schedule a disposition timely.

Case Detail	Description
OLES Case Number	2021-00360-2A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly kissed a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation; however, the psychiatric technician had resigned during the investigation, thereby precluding

	disciplinary action. The department placed a letter indicating he resigned under unfavorable circumstances in his official personnel file.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00615-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A patient on one-to-one observation swallowed several staples. Five psychiatric technicians allegedly failed to properly supervise the patient. Two registered nurses allegedly failed to properly assess the patient and document their actions in the patient's medical chart.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against one registered nurse and five psychiatric technicians. However, the hiring authority determined that there was sufficient evidence to sustain two allegations against the remaining registered nurse for failing to adequately assess the patient and document the patient's medical chart and determined a letter of expectation and additional training was the appropriate remedy. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01391-1A
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. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician administered medication to a patient. Approximately three hours later, another psychiatric technician allegedly administered a second dose of the same medication. The second dose doubled the amount of medication that was actually prescribed. Both psychiatric technicians immediately reported the error. The patient did not experience any adverse side effects or symptoms as a result of the error.
Disposition	The hiring authority sustained the allegations against both psychiatric technicians and issued corrective action. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00121-1A
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	An officer allegedly did not follow proper security measures when he allowed a staff housekeeper access through an unauthorized gate.
Disposition	The hiring authority sustained the allegation and issued the officer a letter of instruction. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the administrative inquiry process.

Case Detail	Description
OLES Case Number	2022-00275-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Absence without leave
Findings	1. Not Applicable
Penalty	**Initial:** Dismissal

	Final: Resigned In Lieu of Dismissal
Incident Summary	A psychiatric technician assistant was arrested by police from an outside jurisdiction for lewd and lascivious acts with a minor and was held in a local detention facility until March 12, 2022.
Disposition	The hiring authority served the psychiatric technician assistant with an Absent Without Official Leave (AWOL) termination notice. After a due process pre-termination hearing, the department entered into a settlement agreement with the psychiatric technician assistant wherein he agreed to a voluntary resignation. The OLES concurred with the terms of the settlement agreement.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Administrative-Without Sustained Allegations

Case Detail	Description
OLES Case Number	2020-00493-2A
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin)
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	Several level of care staff allegedly forced a disruptive patient onto the floor, jumped on the patient, and grabbed the patient's head and hair. The patient was then placed in restraints. X-rays later confirmed the patient sustained five fractured ribs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2020-00624-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two staff members allegedly tackled, choked, pepper sprayed, and injured 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	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00072-2A
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	Eight staff members allegedly restrained a patient against a psychiatrist's order.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00129-1A
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	The department received an anonymous email, purportedly from a hospital employee, alleging ongoing staff misconduct on a particular unit at a state hospital.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00252-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Abuse 3. Abuse 4. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two officers allegedly used excessive force while conducting a pat-down search of a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00256-2A
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	A psychiatric technician allegedly hit a patient with a restroom door while attempting to prevent the patient from entering a restricted area.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00333-2A
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	An officer allegedly used unauthorized force on a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00492-2A
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	A psychiatric technician allegedly pushed a laundry cart into a patient's leg.
Disposition	The hiring authority determined there was insufficient

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

Case Detail	Description
OLES Case Number	2021-00510-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly hit and threatened a patient. A second psychiatric technician and a nurse also allegedly failed to change the patient's soiled undergarments.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00689-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient reported that a psychiatric technician allegedly brought contraband items to female patients.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient

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

Case Detail	Description
OLES Case Number	2021-00760-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A nurse allegedly kicked a patient's wheelchair to get the patient's attention.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient Overall, the department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00777-1A
Case Type	Monitored
Incident Types	1. Significant Interest - AWOL 2. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two staff members allegedly negligently monitored a "high flight-risk" patient while transporting the patient to an outside hospital. Once at the hospital, the patient ran away from the transportation van and was apprehended shortly thereafter.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigator did not consult with OLES prior to finalizing the investigative plan or prior to completing the investigation. The initial investigative report was not provided to OLES for review prior to closing the investigation. The investigator did not interview the staff who made the decision on how the patient would be transported to the outside medical facility.

	The investigation was not completed until 163 days after the date of discovery.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? No. The investigation was completed without any consultation with OLES. It was only after OLES suggested the investigation be reopened that OPS began consulting with OLES. 2. Did the investigator adequately prepare for all aspects of the investigation? No. The investigator did not interview the staff who made the decision on how the patient was to be transported. 3. Were all of the interviews thorough and appropriately conducted? No. The investigator did not thoroughly investigate why the patient was not transported at a higher level of restraint in light of the fact that he was a pre-determined flight risk along with being a danger to self and to others. None of the witnesses interviewed had the authority to make the transportation decision. 4. 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 department did not notify OLES that the initial draft investigative report was ready for review. 5. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The initial investigation was not completed until 163 days after the date of discovery.
Department Corrective Action Plan	Once it was discovered that this portion of the case was supposed to be monitored, the investigator stayed in contact with the OLES Monitor. This mistake should not happen again as office staff has been instructed to verify and double check with supervisor as to what part of a case would be monitored and which investigation would be a pending review. The OSI department was carrying a heavy caseload including the new investigators. This was a new

	investigator who was being trained by mentors who were carrying a caseload of 20 –25 cases themselves. OPS acknowledges the investigation exceeded the 120 days. OSI will ensure review of each case to determine if it is PR or a monitored investigation. The employee who transposed the case assignment sheet information, is no longer employed by DSH. OSI will continue to train new investigators on procedures required to meet OLES guidelines.

Case Detail	Description
OLES Case Number	2021-00788-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On June 27, 2021, two psychiatric technicians, a nurse, and a psychiatric technician assistant allegedly injured and twisted a patient's arm, while escorting the patient to his room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00899-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An investigator allegedly improperly shared confidential peace officer information.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.

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

Case Detail	Description
OLES Case Number	2021-00905-1A
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	A senior psychiatric technician and a psychiatric technician allegedly hit and kicked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. The responding officer did not conduct a thorough interview of the percipient witness.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not conduct a thorough interview of the percipient employee witness. Many relevant details regarding the incident were not covered, such as whether the employee was assigned to a one-to-one watch, whether she participated in the Therapeutic Strategies and Interventions, what precipitated the incident, where was she during the incident or whether she witnessed the entire incident.
Department Corrective Action Plan	The officer will be sent to a report writing class. In addition, the department is in the process of creating small pocket size booklets that contain important questions to ask during interviews. This will help aid officers in remembering basic interviewing questions to ask during the interviewing process. The officer's watch commander will conduct follow ups with the officer, ensuring the deficiency was corrected.

Case Detail	Description
OLES Case Number	2021-00920-2A
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	A nurse and psychiatric technician allegedly injured a patient when they dragged him by lifting him from under his armpits.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00952-1A
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	A psychiatric technician allegedly pushed and threatened 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00962-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly inappropriately touched a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the pre-disciplinary process. During the interview of the victim patient, the officer made it clear that he did not believe her, told her she had been dishonest in the past and asked her to prove the allegation was true. The victim patient terminated the interview before all relevant questions could be asked.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not properly interview the patient. At the outset of the interview, the officer made it clear to the patient that he did not believe her and that she needed to prove that the incident actually occurred.
Department Corrective Action Plan	The officer was properly counseled on the incident and on how to properly interview alleged sexual assault victims. The officer was counseled on Lexipol Policies 601.2.1 and 601.2.2 which talks about sexual assault investigations and health and safety of the alleged victims whether the allegations appear unfounded or unsubstantiated. The officer was also counseled on not asking alleged victims of sexual assault incidents to prove the allegation as stated in the above policy. Supervision will continue monitoring the officer, making sure the above insufficiency will stay corrected.

Case Detail	Description
OLES Case Number	2021-00964-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly provided false information to his supervisors in order to obtain time off.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was delivered to the hiring authority on December 23, 2021; however, the disposition conference did not take place until March 22, 2022, 89 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 delivered to the hiring authority on December 23, 2021; however, the disposition conference did not take place until March 22, 2022, 89 days later.
Department Corrective Action Plan	Due to the pandemic and staffing impact on the Human Resources Department, the process for service was delayed. Pursuant to Government Code Section 19574, the statute of limitations to take adverse action against an employee is three years; however, DSH-Patton has continued to make every effort to issue adverse actions in an expeditious manner, using the resources available, within the OLES recommended time frames. DSH-Patton will continue to prioritize all OLES cases to meet the designated timeframes. The Human Resources, Labor Relations Department is hiring a Staff Services Analyst to be assigned only the OLES monitored cases to ensure timeliness is met. The anticipated start date for our new analyst is July 1, 2022.

Case Detail	Description
OLES Case Number	2021-00970-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly provided false information during a COVID screening process.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The investigation was delivered to the hiring authority on November 17, 2021; however, the disposition was not completed until February 25, 2022, 99 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 delivered to the hiring authority on November 17, 2021; however, the disposition was not completed until February 25, 2022, 99 days later.
Department Corrective Action Plan	The team members involved will be coached/instructed of the appropriate OLES reporting guidelines to facilitate timely submission to OLES.

Case Detail	Description
OLES Case Number	2021-00974-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On August 12, 2021, a psychiatric technician allegedly hit a patient on the leg.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The

	investigation was not completed until 154 days from the date of discovery. The Hospital Police Department took 74 days to complete the initial investigation.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? No. The investigation was not completed until 154 days after discovery of the incident. The Hospital Police Department took 71 days to complete the initial report.
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 timeframe 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
OLES Case Number	2021-00980-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An anonymous caller reported that a psychiatric technician allegedly was overly familiar with 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	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-00982-1A
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	Staff members allegedly failed to intervene when a patient assaulted a second patient. A psychiatric technician allegedly failed to intervene when the first patient attempted to choke a third 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01009-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Hospital staff witnessed a patient fall and become unresponsive. Staff initiated emergency life-saving measures; however, the patient was pronounced dead. An autopsy determined the cause of death was acute cardiac pulmonary arrest.
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	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01010-1A
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	A staff member allegedly kicked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01040-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Drugs
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On approximately July 26, 2019, two psychiatric technicians allegedly introduced contraband drugs into a state hospital.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01054-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	On September 2, 2021, a psychologist, a rehabilitation therapist, and a psychiatric technician allegedly sedated and sexually assaulted a patient.

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

Case Detail	Description
OLES Case Number	2021-01059-1A
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	A psychiatric technician allegedly hit a patient after being kicked by 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01061-1A
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	A psychiatric technician allegedly sprayed a patient with an aerosol deodorizer.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01062-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity 2. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatrist allegedly provided confidential information to patients.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01064-2A
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	A psychiatric technician allegedly repeatedly hit a patient in 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01071-2A
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	A psychiatric technician allegedly pushed and kicked a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01072-2A
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	A psychiatric technician allegedly pushed a patient into a wheelchair.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01111-1A
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	Three psychiatric technicians, a registered nurse, and a psychiatric technician assistant allegedly repeatedly hit 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01127-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician and three psychiatric technicians allegedly failed to provide medical care to a patient who had fallen and sustained fractured ribs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01125-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly engaged in an inappropriate relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01136-1A
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	A registered nurse allegedly struck a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01139-1A
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	A registered nurse and a psychiatric technician allegedly repeatedly hit 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01165-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient alleged that she had been repeatedly sexually assaulted by hospital staff over the past 16 years.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the initial investigative process. The responding officer did not conduct a thorough preliminary investigation, did not obtain relevant evidence, and did not provide the staff with the legally required Beheler admonition.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not provide the suspect with the legally required Beheler admonition prior to obtaining their statements. The officer did not document in the police report relevant information regarding the patient's psychiatric diagnosis and medical history. 2. Was the incident properly documented? No. The officer's report was notated as being for "informational" purposes, when it should have been a full report based on an allegation of sexual assault by staff. There were numerous relevant details missing from the initial investigation and report.
Department Corrective Action Plan	The officer was counseled regarding proper Beheler admonition of staff members.

Case Detail	Description
OLES Case Number	2021-01175-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two psychiatric technicians were allegedly discovered by a patient engaging in sexual activity. When confronted, one of the psychiatric technicians allegedly brandished a weapon at the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The

	investigator conducted the interviews of both psychiatric technicians without notice to OLES.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? No. The investigator did not notify OLES prior to conducting the interviews of the psychiatric technicians, thereby preventing OLES from providing contemporaneous monitoring of the investigation.
Department Corrective Action Plan	The investigator will in the future check and double check the correct email and confirm with OLES via telephone or confirmed email for a confirmation and response before moving forward with the case.

Case Detail	Description
OLES Case Number	2021-01192-1A
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	A registered nurse allegedly used excessive force while attempting 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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The responding officer conducted short, cursory interviews with the involved parties resulting in an incomplete report and the need to re-interview witnesses.
Pre-Disciplinary Assessment	1. Was the incident properly documented? No. The responding officer's interviews of the involved parties were cursory and incomplete.
Department Corrective Action Plan	The officer will be sent to a report writing class. In addition, we are in the process of creating small pocket size booklets that contain important questions to ask during interviews. This will help aid the officer in remembering basic interviewing questions.

Case Detail	Description
OLES Case Number	2021-01211-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient alleged that, on unspecified dates, she was forced to take drugs and was sexually assaulted by a psychiatric technician.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01217-1A
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	A psychiatric technician allegedly grabbed a patient by the wrists.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01303-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed

Incident Summary	A psychiatrist allegedly forcefully stepped on a patient's back and dislocated the patient's 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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The officer who conducted the criminal interview with the psychiatrist did not provide the psychiatrist with the legally required Beheler admonition.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The officer who conducted the initial interview with the psychiatrist, did not provide the psychiatrist with the legally required Beheler admonition prior to obtaining the psychiatrist's statement.
Department Corrective Action Plan	The officer was counseled on the importance of staff Beheler admonition. The supervisor will continue to monitor the officer, ensuring future adherence.

Case Detail	Description
OLES Case Number	2021-01319-1A
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	A licensed vocational nurse allegedly grabbed a patient by her gown sleeve while assisting her out of bed and twisted the patient's arm.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The responding officer did not provide the licensed vocational nurse with the required Beheler admonition prior to taking her statement. Furthermore, the interview did not address the allegation of physical abuse.
Pre-Disciplinary Assessment	1. Was the incident properly documented? No. The responding officer did not provide the licensed

	vocational nurse with the legally required Beheler admonition prior to taking her statement. The interview was cursory and did not address the allegation of physical abuse.
Department Corrective Action Plan	The officer was verbally counseled on the importance of required Beheler admonition. Furthermore, the officer will be required to attend a report writing class. The supervisor will continue to work with the officer and monitor issues moving forward and assess if further action/coaching is needed.

Case Detail	Description
OLES Case Number	2021-01343-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician and two psychiatric technicians allegedly held a patient down on his bed and hit him in his face multiple times.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01385-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Priority 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 November 15, 2021, a psychiatric technician allegedly sexually assaulted a patient and struck the patient with a set of keys.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures

	governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01512-1A
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	A senior psychiatric technician and another staff member allegedly grabbed and placed a fully clothed patient in the shower.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2021-01544-1A
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	A senior psychiatric technician and a psychiatric technician allegedly bullied and repeatedly 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	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The responding officer did not provide the two suspect employees with the legally required Beheler admonition prior to obtaining their statements.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? No. The responding officer did not provide the suspect employees with the legally required Beheler admonition prior to obtaining their statements.
Department	The officer was counseled on the importance of staff Beheler

Corrective Action Plan	admonition. The supervisor will continue to monitor the officer, ensuring future adherence.

Case Detail	Description
OLES Case Number	2021-01561-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Head/Neck
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two psychiatric technicians allegedly slammed a door on a patient's foot and hit the patient several times.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00020-1A
Case Type	Monitored
Incident Types	1. Abuse 2. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly threw a food tray on the table in front of a patient. The senior psychiatric technician allegedly forced the patient to the ground and attempted to sexually assault the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00057-1A
Case Type	Monitored
Incident Types	1. Head/Neck
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An "at risk for falls" patient was observed with blood on the side of his face from an apparent fall. The patient was unable to articulate how he was injured. He was treated for a laceration above his eyebrow.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00106-1A
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	A psychiatric technician allegedly attempted to hit 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	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00107-1A
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	A patient exhibited an altered mental state and hypoxia, and was transported to an outside hospital. On January 29, 2022, the patient was pronounced dead. The cause of death was due to acute respiratory failure, pneumonia, and congestive heart 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	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00111-1A
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	A patient suffered shortness of breath and was transported to an outside hospital. On January 31, 2022, the patient was pronounced dead. The cause of death was determined to be from acute exacerbation of congestive heart 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	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00171-2A
Case Type	Monitored
Incident Types	1. Neglect 2. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly failed to appropriately respond to and report a patient-on-patient sexual assault.

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

Case Detail	Description
OLES Case Number	2022-00213-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly released confidential information about a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.

Case Detail	Description
OLES Case Number	2022-00250-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A registered nurse allegedly inappropriately touched a patient every time the nurse took the patient's vital signs.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently 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. These cases cover incidents that occurred either during the reporting period or were closed out during the reporting period. Each phase was rated separately.

Investigations and other activities conducted by the departments during the pre-disciplinary phase are rated for sufficiency based on consultations with OLES and investigation activities for timeliness, quality, adequacy and thoroughness of the investigative interviews and reports, among other things.

The disciplinary phase is rated for sufficiency based on timely consultation with OLES during the disciplinary process, and whether the entire disciplinary process was conducted in a timely fashion, 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.

Insufficient in the Disciplinary Phase

Case Detail	Description
OLES Case Number	2020-00216-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Dishonesty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	A psychiatric technician allegedly made overly familiar comments to a patient. A second psychiatric technician allegedly failed to timely report the comments and was dishonest to her supervisors and an investigator. A third psychiatric technician allegedly failed to cooperate during the investigation.
Disposition	The hiring authority found insufficient evidence to sustain the allegation against the first psychiatric technician. The hiring authority sustained the allegations against the second

	psychiatric technician and dismissed her. The second psychiatric technician filed an appeal with the State Personnel Board. Prior to the pre-hearing settlement conference, the psychiatric technician entered into a settlement agreement wherein she agreed to resign in lieu of termination. The hiring authority sustained the allegation against the third psychiatric technician; however, the psychiatric technician had been previously separated for unrelated reasons. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Insufficient The department failed to comply with policies and procedures governing the disciplinary process. The disciplinary action was not served until 257 days after disciplinary determinations were made.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The penalty conference was held on August 5, 2021; however, the disciplinary action was not served until April 19, 2022; 257 days later.
Department Corrective Action Plan	The Human Resources, Labor Relations Department has hired a Staff Services Analyst have primary focus on OLES monitored cases to ensure timeliness is met. Our new analyst began in-office on July 21, 2022.

Case Detail	Description
OLES Case Number	2020-01158-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A nurse was allegedly sleeping while assigned to a one-to-one enhanced patient observation.
Disposition	The hiring authority sustained the allegation and imposed a salary reduction of 10 percent for 18 months. The OLES concurred with the hiring authority's determination. The licensed vocational nurse filed an appeal with the State

	Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the penalty was reduced to a 10 percent salary reduction for nine months and the nurse agreed to withdraw his appeal. The OLES concurred with the settlement as it was not unreasonable.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the pre-disciplinary process. The OLES was not notified when the action was served or when the Skelly hearing was held thereby preventing OLES from fulfilling its monitoring responsibilities. The disciplinary process took 197 days to complete. The OLES was not provided with the draft of the pre-hearing settlement conference statement prior to it being filed with the State Personnel Board.
Disciplinary Assessment Questions	1. Was OLES provided with a draft of the pre-hearing settlement conference statement prior to it being filed? No. The OLES was not provided with a draft of the pre-hearing settlement conference statement prior to it being filed. 2. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? No. The disciplinary officer did not notify OLES when the action had been served or that a Skelly hearing was scheduled, thereby preventing OLES from continuous real-time monitoring. 3. Was the disciplinary phase conducted with due diligence by the department? No. The disposition meeting was completed on May 10, 2021; however, the action was not served until November 22, 2021, 197 days later.
Department Corrective Action Plan	Training was provided to the analyst to ensure she has an appropriate method for tracking OLES-monitored cases and

	will include the OLES monitor in all phases of the disciplinary process in the future. The Human Resources, Labor Relations Department is hiring a Staff Services Analyst to be assigned only the OLES monitored cases to ensure timeliness is met. The anticipated start date for our new analyst is July 1, 2022.

Case Detail	Description
OLES Case Number	2021-00039-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Inexcusable neglect of duty 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A psychiatric technician allegedly attempted to get a family member tested for COVID-19, while knowing testing was reserved for hospital employees only.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations and imposed a 10 percent salary reduction for 24 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 10 percent salary reduction for 15 months. The psychiatric technician agreed to withdraw her appeal. The OLES concurred because the settlement was reasonable.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The initial disposition meeting took place on May 10, 2021; however, the disciplinary action was not served until October 18, 2021, 162 days later.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? No. The initial disposition meeting took place May 10, 2021; however, the disciplinary action was not served until October 18, 2021, 162 days later.

Department Corrective Action Plan	The Human Resources, Labor Relations Department is hiring a Staff Services Analyst to be assigned only the OLES monitored cases to ensure timeliness is met. The anticipated start date for our new analyst is July 1, 2022.

Case Detail	Description
OLES Case Number	2021-00209-3A
Case Type	Monitored
Incident Types	1. Significant Interest - Other 2. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Reprimand
Incident Summary	A psychiatric technician allegedly confronted a patient regarding an allegation the patient made about the psychiatric technician bringing drugs into the facility, resulting in the patient engaging in self-injurious behavior.
Disposition	The hiring authority sustained the allegation and determined a 5 percent salary reduction for two months was the appropriate penalty. The employee did not file an appeal with the State Personnel Board. The department entered into a settlement agreement with the psychiatric technician, reducing the penalty to a letter of reprimand. The OLES concurred.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Insufficient The department did not comply with policies and procedures governing the disciplinary process. The penalty conference was held on September 13, 2021; however, the disciplinary action was not served until February 22, 2022, 162 days later. The department did not notify OLES of the Skelly Hearing.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? No. The discipline officer did not inform the OLES monitor of the employee's Skelly Hearing. 2. Was the disciplinary phase conducted with due diligence

	by the department? No. The penalty conference was held on September 13, 2021; however, the disciplinary action was not served until February 22, 2022, 162 days later.
Department Corrective Action Plan	The department will continue to work on the process of scheduling Skelly hearings and ensuring all parties, including the OLES monitor, are notified prior to the Skelly hearing. Calendar invites will also be sent to all parties to document the notifications. DSH will continue to ensure OLES monitored cases remain a priority.

Sufficient in Both the Pre-Disciplinary Phase and Disciplinary Phase

Case Detail	Description
OLES Case Number	2020-01185-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior 2. Inexcusable neglect of duty 3. Inefficiency
Findings	1. Sustained 2. Not Sustained 3. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	An officer was arrested for allegedly being intoxicated in public and committing an act of domestic violence. The officer allegedly failed to promptly report his arrest to his supervisor.
Disposition	The hiring authority sustained the allegations that the officer was intoxicated in public and failed to promptly report his arrest. The hiring authority found insufficient evidence to sustain the domestic violence allegation. The hiring authority determined the appropriate penalty was a salary reduction of 5 percent for seven months. The department entered into a settlement agreement whereby the department agreed to reduce the salary reduction to six months and the officer agreed not to file an appeal. The OLES concurred with the settlement as it was a minor reduction in penalty and remained within the appropriate disciplinary range for the misconduct.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary	**Case Rating:** Sufficient

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

Case Detail	Description
OLES Case Number	2021-00370-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	An officer was allegedly asleep while on duty.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 5 percent for six months was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**Case Rating:** Sufficient The department complied with the policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
OLES Case Number	2021-00456-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A training officer was allegedly insubordinate when he failed to appear at two assigned classes and conduct training.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of five percent for six months was the appropriate penalty. Following a Skelly hearing, the department entered into a settlement agreement with the officer wherein the department agreed to reduce the salary reduction to 5 percent for three months and the officer agreed not to file an appeal with the State Personnel Board. The OLES concurred as the penalty remained at the same level in the disciplinary matrix and the reduction was not unreasonable.

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

Case Detail	Description
OLES Case Number	2021-00593-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	An officer allegedly slept in a security post while on duty. The officer also allegedly used her personal cell phone while on duty.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of five percent for eight months was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
OLES Case Number	2021-00605-2A
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. Sustained 2. Sustained 3. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly held a restrained patient

	by the neck. Three psychiatric technicians allegedly failed to report the incident.
Disposition	The hiring authority sustained the allegation that the psychiatric technician displayed discourteous treatment when he placed his hand on or around the patient's throat. The hiring authority found insufficient evidence to sustain the allegations that the other three psychiatric technicians failed to report the incident. The hiring authority determined a salary reduction of five percent for 12 months was the appropriate penalty. The OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the hearing, the department withdrew the action. The OLES concurred with the department's decision because the department was unable to produce an expert at hearing who could testify the psychiatric technician's behavior violated departmental policy.
Investigative Assessment	**Case Rating:** Sufficient The department sufficiently complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
OLES Case Number	2021-00687-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A psychiatric technician allegedly fell asleep while assigned to enhanced observation of a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 5 percent salary reduction for 12 months. The OLES concurred 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 5 percent salary reduction for five months. The psychiatric technician agreed to withdraw his appeal. The OLES concurred because the settlement was reasonable.
Investigative	**Case Rating:** Sufficient

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

Case Detail	Description
OLES Case Number	2021-01322-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Dishonesty 2. Other failure of good behavior
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	An officer used marijuana on two occasions. The officer allegedly gave false statements during a pre-employment polygraph exam conducted for employment with another state agency.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. The OLES concurred. However, the officer resigned before disciplinary action could be imposed. The department placed a letter in her official personnel file indicating she resigned pending disciplinary action.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Detail	Description
OLES Case Number	2021-01387-1A
Case Type	Monitored
Incident Types	1. Significant Interest - Over-Familiarity
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A psychiatric technician allegedly engaged in an overly familiar relationship with a patient.

Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and determined the appropriate penalty was dismissal. The OLES concurred with the hiring authority's determination. The employee resigned before disciplinary action could be imposed.
Investigative Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the pre-disciplinary process.
Disciplinary Assessment	**Case Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Appendix D: Monitored Issues

Case Details	Description
OLES Case Number	2019-00430-1MI
Case Type	Monitored Issue
Incident Types	1. Significant Interest - Other
Incident Summary	In March 2019, the OLES discovered that a patient attempted to escape through multiple unsecured doors, gates and locks. The attempted escape was made possible due to a lack of supervision and communication among officers and a lack of adequate control or accountability measures in issuing and inventorying keys. The OLES made several recommendations to ensure a similar incident would not occur in the future.
Disposition	The department implemented numerous measures to ensure a similar incident would not occur in the future and adequately responded to the OLES' concerns.

Appendix E: 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.

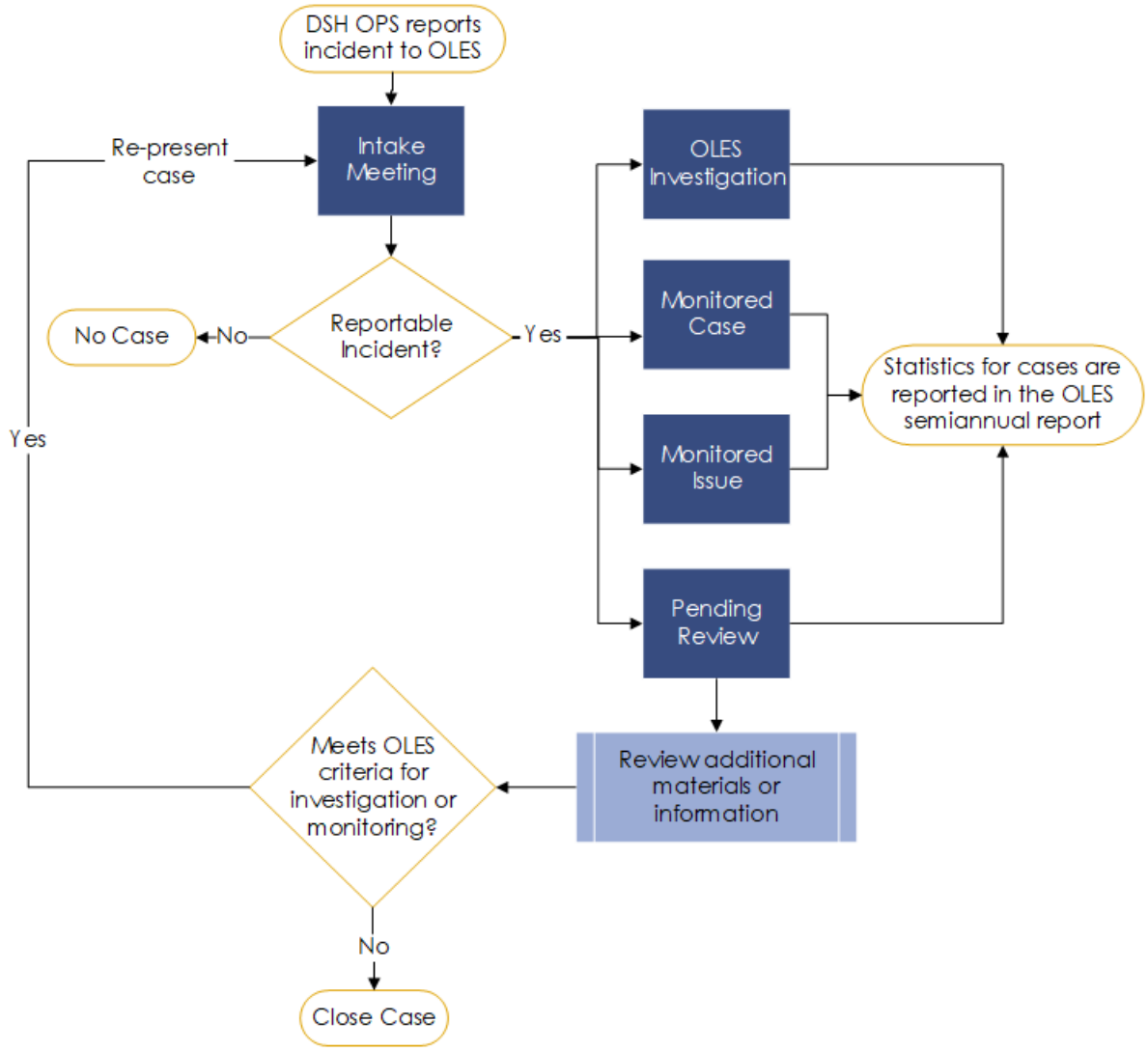
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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 F: 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 G: 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.