Office of Law Enforcement Support

Semiannual Report

January 1, 2024 – June 30, 2024

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 seventeenth 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, 2024.

In this report, the OLES provides details on 628 reported incidents and the results of completed investigations and monitored cases.

OLES provides updates on previous monitored issues regarding the department's handling of audio recordings of investigatory interviews, unsuccessful utilization of the department's early intervention system, use of force reporting and documentation, and ongoing deficiencies in mandated reporting as required by statute Welfare and Institutions Code section 15630, et.al.

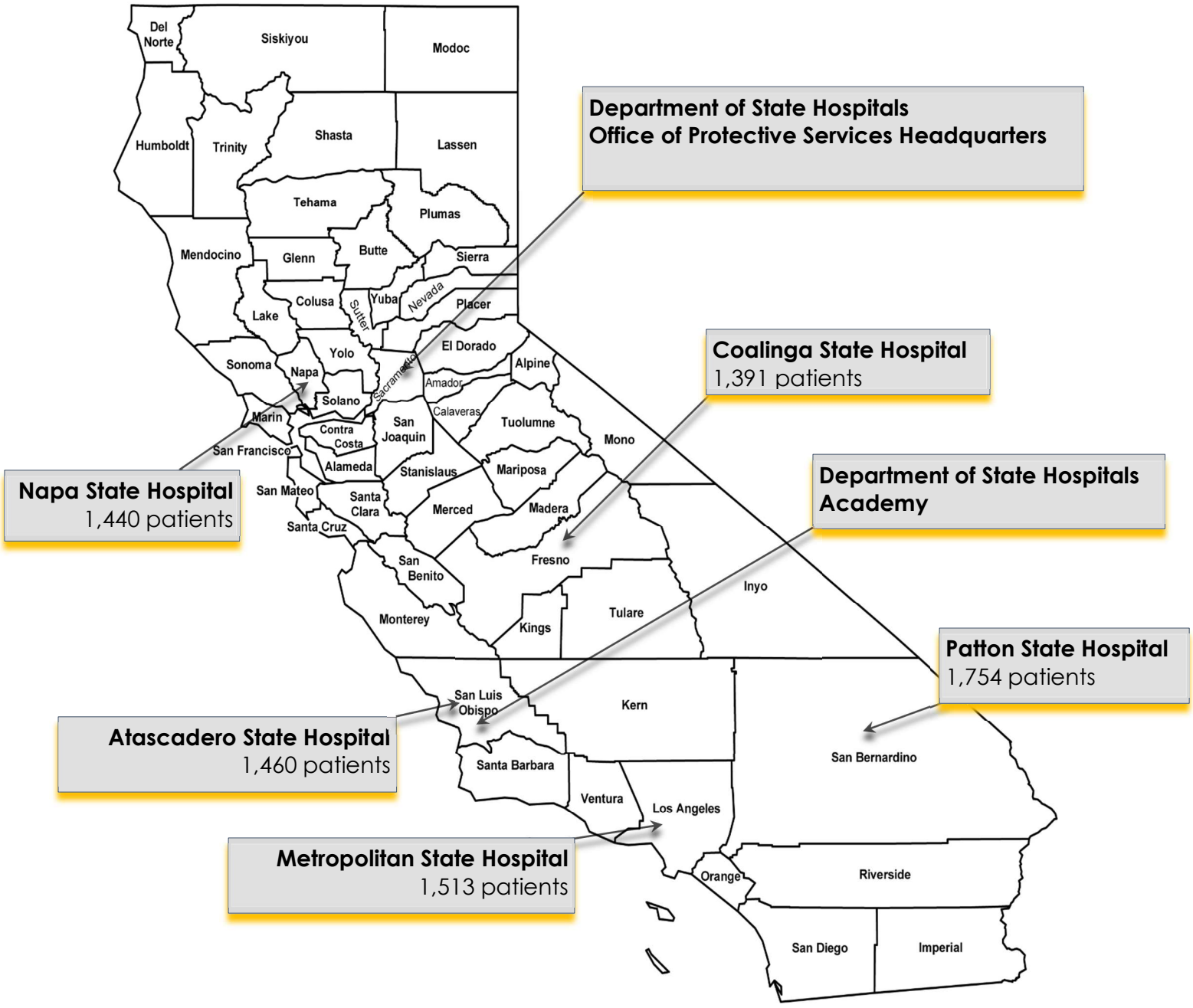
OLES continues to bring attention to an important topic within DSH – Firearms. In an effort to ensure consistency and compliance with state law and best practices, OLES previously raised an issue concerning the recordkeeping of institutional and evidentiary firearms. DSH collaborated with OLES et. seq to inspect and account for all firearms in their control and implement a centralized and uniform firearm record of departmental firearms consistent with state law.

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

OLES provides oversight and conducts investigations for the DSH facilities below. Population numbers reflect the total patients served from January 1 through June 30, 2024, and were provided by the department.



Total Patients Served by Facility January 1, through June 30, 2024

DSH Facility	Total Number of Patients
Atascadero	1,460
Coalinga	1,391
Metropolitan	1,513
Napa	1,440
Patton	1,754
Total	7,558

The total number of patients served by DSH from January 1 through June 30, 2024, decreased 2 percent, from 7,700 during the prior reporting period to 7,558 in this reporting period.

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 (IST). 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 the individual's 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.

Commitment Type	Description
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 their trial to determine if they meet the criteria in the Sexually Violent Predator Act to be committed to DSH as an SVP.
WIC 6604 SVP	Sexually violent predator. Civil commitment for prisoners released from prison who have been determined by a court to meet criteria under the Sexually Violent Predator Act.
WIC 5358 LPS	Full Conservatorship for Grave Disability. Annual renewal.

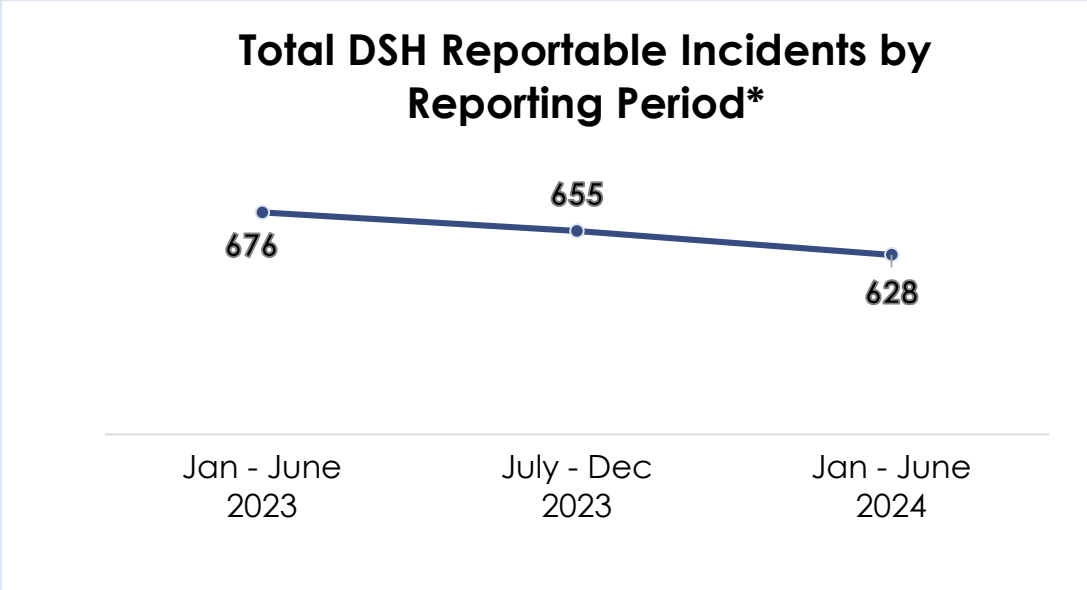
The following table provides the commitment type of patients served during the reporting period.

Commitment Type	Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST	457	0	1,249	730	754
PC 1026 NGI	240	<11	<11	480	543
PC 2962/2964a OMD	412	0	0	0	83
PC 2972 OMD	124	326	<11	***	218
WIC 6316 MDSO	0	<11	0	<11	<11
PC 2684 CDCR	208	***	0	0	***
WIC 6602/6604 SVP	0	973	0	0	0
WIC 5358 LPS	19	11	251	185	143

*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, 2024, the Office of Law Enforcement Support (OLES) received and processed 628 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, use of force (UOF) incidents and other occurrences, per Welfare and Institutions Code sections 4023, 4023.6 and 4427.5. This is a decrease of 27 incident reports compared to the prior reporting period which had 655 incident reports. The following chart compares the total incidents reported during this reporting period to the totals from the prior three reporting periods.



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

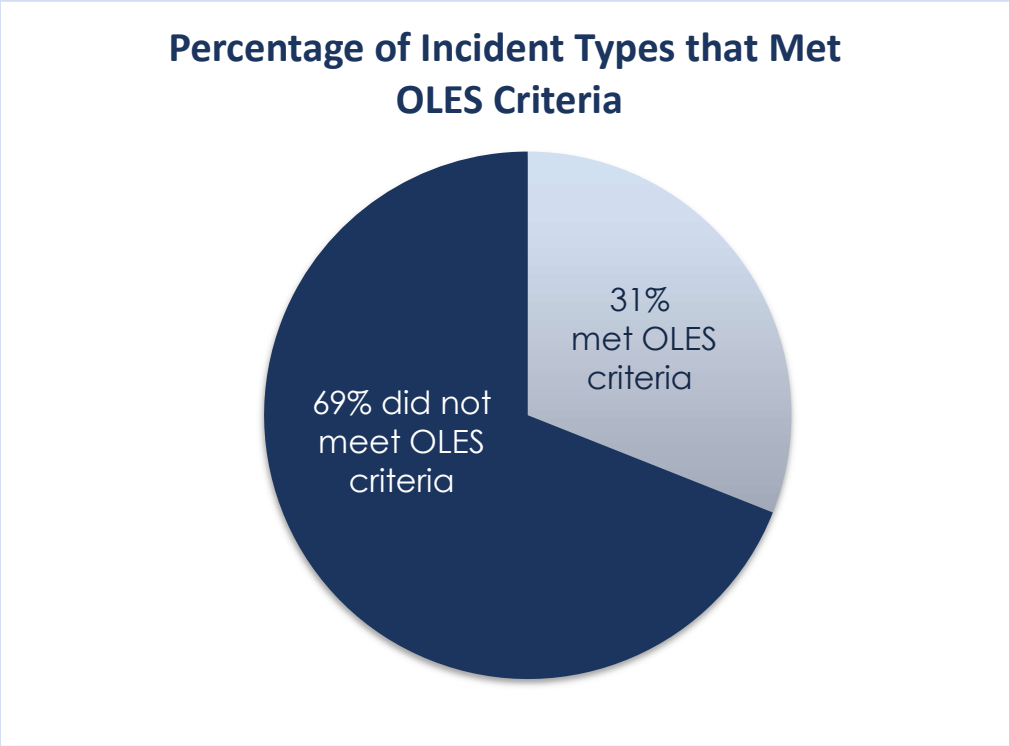
Incident Types Meeting OLES Criteria

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.

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

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

An incident type meeting criteria is an occurrence that OLES determined to meet OLES criteria for investigation, monitoring, or consideration for research as a potential departmental systemic issue. From the 628 reported incidents, OLES identified 13 incidents with two or more incident types. The DSH reported a total of 641 incident types during this reporting period. One hundred ninety-nine, or 31 percent of the 641 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

The most frequent incident types reported by DSH include use of force by law enforcement, allegations of abuse, and allegations of sexual assault.

Law enforcement use of force was the most reported incident type. A use of force report documents an operational incident and does not indicate misconduct or excessive force by an officer. OLES received 115 reports of use of force, which accounted for 18 percent of all reported incident types by DSH. Six of the 115 use of force reports included an allegation of excessive force which are included in the Abuse and Misconduct totals, and all were assigned an OLES investigation.

For reporting purposes, 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 if no resistance is offered by subject to the officer or officers.

Allegations of abuse were the second most reported incident type, with 90 allegations reported, compared to 89 in the prior reporting period.

Allegations of sexual assault were the third most reported incident type, with 80 incidents reported, compared to 83 in the prior reporting period.

The fourth most frequent incident type was broken bone (unknown origin), with 98 reports. This is an increase of 18, compared to the prior reporting period of 80 reports. OLES monitored 94 percent of these incidents.

Patient Deaths

The number of patient deaths increased 18.75 percent, from 32 deaths to 38 deaths during this reporting period. Fifteen of the reported death incident types met OLES criteria for monitoring. Seventeen of the 38 patient deaths were expected due to existing medical conditions. Twenty-one patient deaths were classified as unexpected and received two levels of review by DSH, per department policy.

The largest number of patient deaths were reported from Napa State Hospital (NSH) with 12 deaths and Coalinga State Hospital (CSH) with 11 deaths.

Patient Arrests

OLES works collaboratively with DSH to ensure patients receive the best possible treatment and care at the local jurisdiction holding facility. 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, which was one more arrest compared to the prior reporting period. The patients were arrested for violations of the statutes listed in the following table. Three patients were arrested at CSH, three patients at MSH, one patient at NSH and one patient at PSH.

Statute	Description
Penal Code section 243(d)	Battery with force likely to cause great bodily injury (GBI)
Penal Code section 243.4(a)	Sexual battery
Penal Code section 245 (a)	Assault by means of force likely to cause GBI
Penal Code section 311.11(a)	Possession of child pornography

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 27 investigations that OLES completed during this reporting period. These investigations involved allegations against at least 45 sworn staff members. As of June 30, 2024, there were approximately 732 DSH sworn staff.

OLES submitted all 24 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process. Administrative investigations are initiated in response to alleged policy violations such as excessive force, dishonesty, discourteous treatment, failure to report misconduct or sleeping on duty. OLES completed three criminal investigations. OLES did not refer any criminal cases to a district attorney's office. A summary of the review and decision for each administrative and criminal 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 87 monitored administrative cases and 77 monitored criminal cases that, by June 30, 2024, 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.

Twenty-four pre-disciplinary administrative cases had sustained allegations, no criminal investigations resulted in referrals to prosecuting agencies.

OLES monitored 164 pre-disciplinary phase cases; 155 of the pre-disciplinary phase cases are listed in Appendix B and nine are in Appendix C. OLES rated 17 of the 164 pre-disciplinary phase cases insufficient. Deficiencies found in insufficient cases include, but are not limited to, incomplete interviews by the responding officer, failure to provide the required legal admonishment prior to taking a statement and delayed

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

investigations.

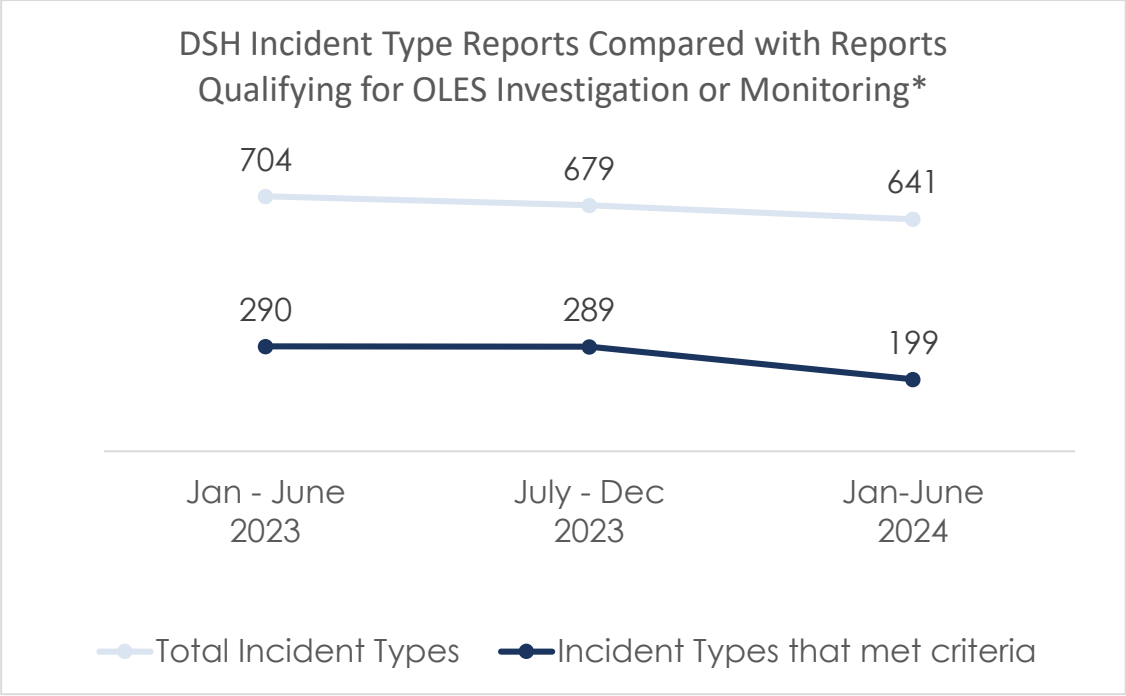
OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in nine administrative cases listed in Appendix C. One of the nine disciplinary phase cases were rated insufficient due to a delay in serving a disciplinary action.

Incidents and Incident Types

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

Decrease in Reported Incident Types

The number of DSH incidents reported to OLES from January 1 through June 30, 2024, decreased 4.1 percent, from 655 during the prior reporting period to 628 in this reporting period. From the 628 reported incidents, OLES identified 641 incident types, as 13 of the incidents featured two or more incident types. One hundred ninety-nine of the 641 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 by law enforcement, allegations of abuse, and sexual assault. These three incident type categories accounted for 282 or 44 percent of all incident types reported by DSH. Of the 282 incident types, 116 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was use of force by law enforcement. The 115 reports of use of force accounted for 17.9 percent of the reported incident types, but down 5.7 percent from the last period's 122 reports. This is the sixth full reporting period of OLES requiring the department to report all use of force by law enforcement.

The DSH's second most frequent report to OLES was allegations of abuse with 90 reports. The number of abuse allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period was 85. The 90 reports of abuse accounted for 14 percent of the reported incident types.

Allegations of sexual assault were the third most frequently reported incident type by DSH, with incident types reported. Allegations of sexual assault accounted for 12 percent of all incident types reported. Of the 77 sexual assault allegations reported in this period, 31 allegations or 40 percent qualified for investigation or monitoring.

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, 2024

Incident Type Category	Prior Period Incident Type Total July 1 through December 31, 2023	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Use of Force*	122	115	-5.72%	0
Abuse	89	90	+1.1%	85
Sexual Assault**	80	77	-3.8%	31

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

**These statistics do not include sexual assaults alleged to have occurred to patients before they were admitted to a state hospital.

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, 2023 (Reported)*	Prior Period January 1 – June 30, 2023 (Meets Criteria)*	Prior Period July 1 - December 31, 2023 (Reported)*	Prior Period July 1 – December 31, 2023 (Meets Criteria)*	Current Period January 1 - June 30, 2024 (Reported)	Current Period January 1 - June 30, 2024 (Meets Criteria)
Abuse	123	117	89	85	90	85
Broken Bone (Known Origin)	27	5	35	3	39	1
Broken Bone (Unknown Origin)	47	43	78	73	63	22
Burn	6	1	6	0	8	1
Death	46	10	32	9	38	15
Genital Injury (Known Origin)	29	3	10	1	6	0
Genital Injury (Unknown Origin)	16	8	12	9	8	1
Head/Neck Injury	44	3	51	3	46	2
Misconduct **	31	31	27	26	21	13
Neglect	29	27	45	36	14	11
Non-patient assault/GBI on Patient	0	0	0	0	0	0
OPS Use of Force***	100	0	122	1	115	0
Patient-on-Patient Assault/GBI	14	3	14	3	4	0
Pregnancy	0	0	0	0	0	0
Sexual Assault	83	27	80	25	77	31

Incident Categories	Prior Period January 1 – June 30, 2023 (Reported)*	Prior Period January 1 – June 30, 2023 (Meets Criteria)*	Prior Period July 1 - December 31, 2023 (Reported)*	Prior Period July 1 – December 31, 2023 (Meets Criteria)*	Current Period January 1 - June 30, 2024 (Reported)	Current Period January 1 - June 30, 2024 (Meets Criteria)
Sexual Assault-Outside Jurisdiction* ***	42	0	21	0	49	0
Attack-on-Staff***	7	0	4	0	5	0
Attempted Suicide	2	0	1	0	1	0
AWOL	3	0	4	0	4	0
Child Sexual Abuse Material	4	1	4	0	5	0
Drugs******	24	3	23	3	25	2
Significant Interest *******	6	4	2	0	0	0
Over-Familiarity	15	12	12	12	15	15
Patient Arrest	13	0	7	0	8	0
Riot	0	0	0	0	0	0
Total	704	290	679	289	641	199

*Numbers in these columns are unadjusted and provided as they were previously published.
**The misconduct statistics include six allegations of excessive force by law enforcement, one head/neck and one over-familiarity, and are included in the total count for these incident type categories.
***The 115 use of force incidents were assigned a pending review. Six of the 115 incidents of use of force included allegations of excessive force and were assigned investigations. These incidents are included in the allegations of abuse meeting criteria.
****These incidents occurred outside the jurisdiction of DSH.
*****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, 2023, reporting periods, 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 incident of significant interest that may draw media attention.

Distribution of Incident Types

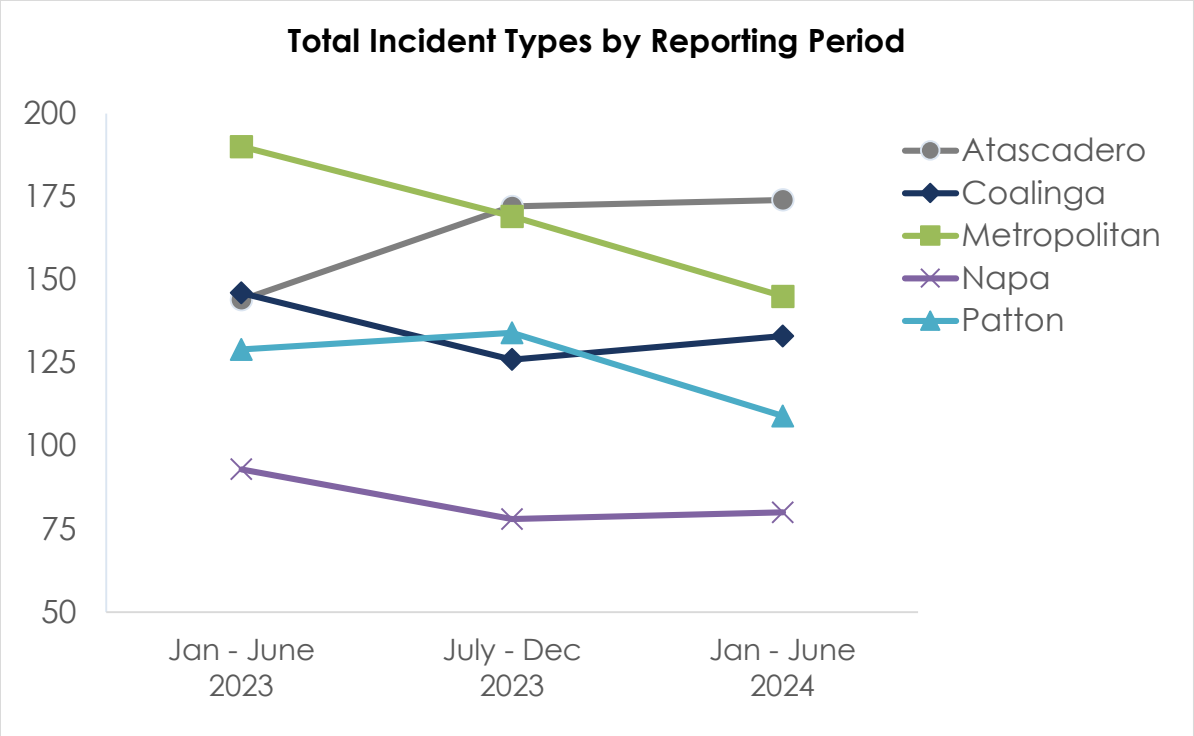
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

DSH Population and Total Incident Types

DSH Facility	Number of Patients Served*	Total Incident Types
Atascadero	1,472	174
Coalinga	1,399	133
Metropolitan	1,584	145
Napa	1,425	80
Patton	1,820	109
Total	7,700	641

*The department provided population served from January 1 through June 30, 2024.

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



Sexual Assault Allegations

During this reporting period, sexual assault allegations were the second most frequently reported incident type from January 1 through June 30, 2024. The 77 alleged sexual assault incident types reported in this reporting period accounted for 12 percent of all reported incident types from DSH. Thirty-one of the 77 reported incident types of alleged sexual assault, or 40.1 percent, met OLES criteria for investigation or monitoring. There were 49 reported incident types under the sexual assault outside jurisdiction 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.

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 39 incident types, or 51 percent of the alleged 77 sexual assault incident types. The second most frequent type of alleged sexual assault involved non-law enforcement staff on a patient, with 28 incident types or 36 percent of the 77 alleged sexual assault incident types. There were 10 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. 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, 2024

Allegation Type	Total
Patient-on-Patient	39
Law Enforcement Staff-on-Patient	0
Non-Law Enforcement Staff-on-Patient	28
Unknown Person-on-Patient	10
Outside Jurisdiction*	49
Total	126

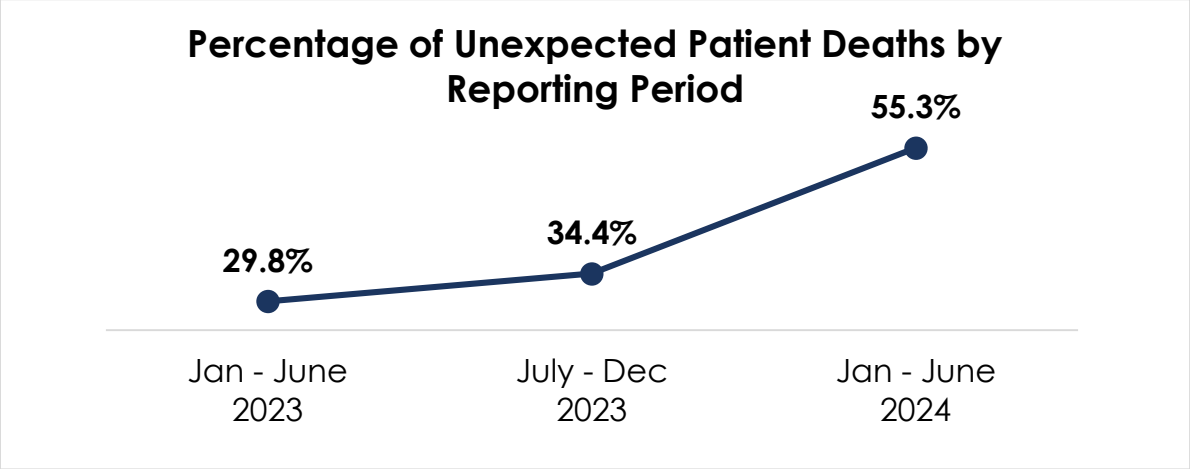
*Sexual assault outside Jurisdiction is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH.

Patient Deaths

The DSH reported 38 patient deaths to OLES during this reporting period. This number increased 18.75 percent from the 32 patient deaths reported in the prior reporting period of June 30 through December 31, 2023. This number decreased from 46 patient deaths in the January 1 through June 30, 2023, reporting period.

Seventeen of the patient deaths were classified as expected primarily due to underlying health conditions, such as cardiac or respiratory issues, and cancer. Twenty-one deaths were classified as unexpected. Each unexpected patient death receives two levels of review within DSH, per department policy. OLES reviewed each unexpected death and monitored the cases that met OLES criteria. OLES monitored ten of the departmental death investigations.

The following chart depicts the percentage of unexpected patient deaths in this reporting period and the two 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	25
Cancer	4
Cerebral	1
Covid-19	1
Pending Coroner's Report	3
Sepsis	2
Other	2
Total	38

As shown in the following table, Napa State Hospital (NSH) had the most patient deaths during this reporting period.

Patient Deaths by Facility

DSH Facility	Total Number of Deaths
Atascadero	2
Coalinga	11
Metropolitan	3
Napa	12
Patton	10
Total	38

Reports of Head or Neck Injuries

The DSH reported 46 head or neck injuries during this reporting period. These head or neck injuries were the result of patient-on-patient altercations, a patient fall or a self-inflicted injury by the patient. Patient-on-patient altercations accounted for 20 of the 46 reported head or neck injuries. Two head or neck injuries allegedly occurred with altercations with staff and law enforcement. Both incidents were either monitored or investigated by OLES.

Reports of Patients Absent Without Leave

A patient is Absent Without Leave (AWOL) when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in police intervention to recover the patient. In this reporting period, DSH reported four AWOL incident types.

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 Priority 1 incident types is 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 2 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 1 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 1 and 2 incident types are listed in the tables below.

Priority 1 Incident Type Descriptions

Incident	Description
ADW	An assault with a deadly weapon (ADW) against a patient by a non-patient.
Assault with GBI	An assault with force likely to produce great bodily injury (GBI) of a patient.
Broken Bone (U)	A broken bone of a patient when the cause of the break is undetermined and was not witnessed by staff.
Deadly Force	Any use of deadly force by staff (including a strike to the head/neck).
Death	Any death of a patient, including a patient that is officially declared brain dead by a physician or other authorized medical professional noting the date and time, or a death that occurs up to 30 days from patient discharge from the facility.
Genital Injury (U)	An injury to the genitals of a patient when the cause of injury is undetermined and was not witnessed by staff.
Physical Abuse	Any report of physical abuse of a patient implicating staff.
Sexual Assault	Any allegation of sexual assault of a patient against staff, law enforcement personnel or unidentified person(s).

Priority 2 Incident Type Descriptions

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.

Incident	Description
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 1 incident type must be reported in accordance with the Priority 1 reporting requirements.
Pregnancy	A patient pregnancy.
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 or any incident which may potentially draw media attention.
AWOL	A patient is AWOL when they have left an assigned area, or the supervision of assigned staff without staff permission, resulting in police intervention to recover the patient.
Attempted Suicide	A patient suicide attempt requiring treatment beyond first aid.
Serious Crimes	The commission of serious crimes by patient(s) or staff.
Drugs	Drug trafficking or smuggling.
Riot	As defined for OLES reporting purposes.
Over-Familiarity	Over-familiarity between staff and patients.

Timeliness of Notifications

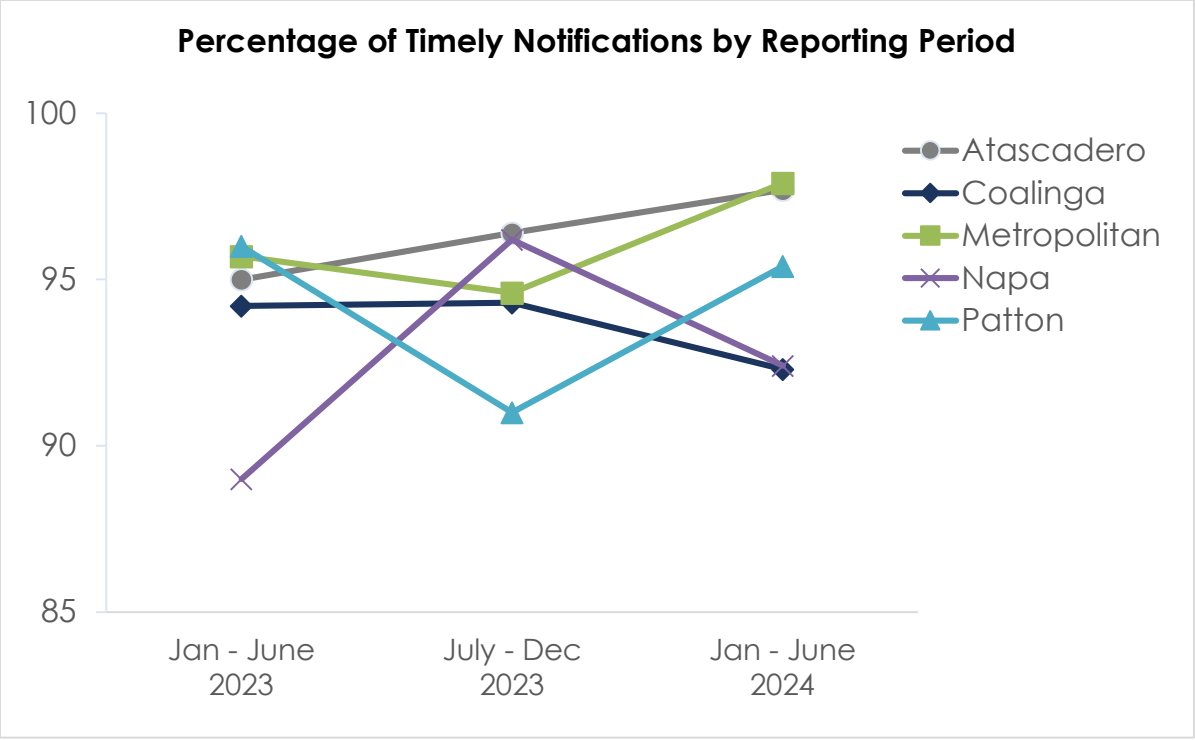
The DSH timely reported incident types 95.6 percent compared to the prior reporting period, which had 94.4 percent timely reports.

Seven of the 641 reported incident types were excluded from DSH's total incident type count when calculating timeliness. These incidents were reported directly to OLES by a patient, family member of a patient, facility staff member or by an outside law enforcement agency. Of the 634 incident types evaluated for timeliness, 606 were reported timely and 28 incident types were not timely.

The following table compares the percentage of timely notifications by facility.

DSH Facility	Total Reported Incident Types	Number of Timely Notifications	Number of Untimely Notifications	Percentage of Timely Notifications
Atascadero	173	169	4	97.7%
Coalinga	130	120	10	92.3%
Metropolitan	143	140	3	97.9%
Napa	79	73	6	92.4%
Patton	109	104	5	95.4%
Total	634	606	28	95.6%

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 E. To ensure OLES is independently assessing whether an allegation meets its criteria, OLES requires the departments to broadly report misconduct allegations.

For incidents that initially do not appear to fit the criteria[4] for OLES involvement, 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, 2024, reporting period, 442 of the total 641 cases opened for DSH incident types that occurred within DSH's jurisdiction or 69 percent were assigned a pending review. OLES opened cases for 49 incidents that may have occurred while the patient was not housed within a DSH facility and assigned those cases a pending review. OLES opened 13 administrative investigations and seven criminal investigations. OLES opened 176 monitored criminal cases and two monitored administrative cases.

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

[4] Welfare and Institutions Code section 4023.6 et. seq. (see Appendix D).

Cases Opened in the Current Reporting Period

OLES Case Assignments	January 1 – June 30, 2024	Percentage of Opened Cases
Pending Review	393	61.3%
Monitored, Criminal	176	27.5%
Monitored, Administrative	2	0.3%
Outside Jurisdiction*	49	7.6%
OLES Investigations, Criminal	7	1.1%
OLES Investigations, Administrative	13	2.0%
Totals	640	100%

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

Completed Investigations and Monitored Cases

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

- Investigate allegations of serious misconduct by DSH law enforcement personnel. These investigations can involve criminal or administrative wrongdoing, or both.
- Monitor investigations conducted by DSH law enforcement into serious misconduct allegations against non-law enforcement staff at the departments. These investigations can involve criminal or administrative wrongdoing, or both.
- Review and assess the quality, timeliness and completion of investigations conducted by the departmental police personnel.
- Monitor the employee discipline process in cases involving staff at DSH.
- Review and assess the appropriateness of disciplinary actions resulting from a case involving an investigation and report the degree to which OLES and the hiring authority agree on the disciplinary actions, including settlements.
- Monitor that the agreed-upon disciplinary actions are imposed and not inappropriately modified. 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 27 investigations. Three investigations were criminal cases and 24 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 did not refer any criminal investigations to a district attorney's office. 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.

All 24 OLES investigations into administrative misconduct were forwarded to facility management for review. If the facility management imposes discipline, OLES monitors and assesses the discipline process to its conclusion. This can include State Personnel Board proceedings and civil litigation, if warranted.

The 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, 2024	Referred to prosecuting agency	Referred to facility management
Administrative	24	N/A	24
Criminal	3	0	N/A
Total	27	0	24

OLES Monitored Cases

In this report OLES provides information on 164 completed monitored cases. Seventy-seven of the 164 cases were criminal cases, none of the 77 cases were referred to a district attorney's office.

There were 87 completed monitored pre-disciplinary administrative cases during this reporting period. Twenty-four of the 87 cases had sustained allegations, sixty-three 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	0
Criminal-Not Referred	77
Total Criminal	77
Administrative-With Sustained Allegations	24
Administrative-Without Sustained Allegations	63
Total Administrative	87
Grand Total	164

Pre-Disciplinary Phase Cases

Of the 164 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 17 cases insufficient. Deficiencies found in insufficient cases include, but are not limited to, incomplete interviews by the responding officer, failure to provide the required legal admonishment prior to taking a statement and delayed investigations. Corrective action plans for deficiencies in pre-disciplinary phase cases are provided in Appendix B.

Disciplinary Phase Cases

OLES monitored the disciplinary action, *Skelly* hearings, settlements, and State Personnel Board proceedings in nine administrative cases. Three cases were insufficient due to delays in serving the disciplinary 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, 2024.

DSH Facility	Percentage of Compliance
Atascadero	98.2%
Coalinga	73.4%
Metropolitan	92.6%
Napa	92%
Patton	95.7%

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 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.

Due to the issues mentioned above, DSH has been working to implement a new Learning Management System (LMS) that will better meet the needs of the department. The initial implementation for OPS will be the DSH Academy. The new LMS system will be utilized for all OPS training needs when all phases are completed and is expected to resolve the issues that have been identified and remove the need for additional tracking.

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 bi-monthly 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, 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 administrative investigations/actions completed*	Adverse action taken**	No adverse action taken***	Direct adverse action taken**	Resigned/ retired pending adverse action****
Atascadero	44	7	29	7	1
Coalinga	35	7	12	15	1
Metropolitan	21	0	12	9	0
Napa	36	0	36	0	0
Patton	70	4	44	20	2
Total	206	18	133	51	4

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

*** No adverse action taken refers to cases in which 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 investigations.

Criminal Cases against Employees

DSH Facilities	Total cases*	Referred to prosecuting agencies**	Not referred***	Rejected by prosecuting agencies****
Atascadero	28	0	28	0
Coalinga	20	0	20	0
Metropolitan	40	1	39	0
Napa	19	0	19	0
Patton	12	12	0	0
Total	119	13	106	0

* 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. This column includes rejected cases that were referred from prior reporting periods. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

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	1	5	0
Coalinga	0	0	0	0
Metropolitan	0	0	0	0
Napa	0	0	1	0
Patton	0	1	0	0
Total	0	2	6	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	405	43	362	81
Coalinga	308	108	200	38
Metropolitan	393	66	327	38
Napa	11	6	8	0
Patton	156	156	0	11
Total	1,273	379	897	168

* 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. The disposition of all criminal cases rejected by prosecuting agencies may not be known at the time of report publishing.

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. Information on new and long-running monitored issues are provided below.

Recordkeeping of Institutional Firearms and Crime/Evidence Firearms

The proper inventorying and storage of institutional and evidentiary firearms is a fundamental and critical responsibility of a law enforcement agency. The failure to do so places law enforcement agencies in serious legal jeopardy. As such, all law enforcement agencies, including the Department of State Hospital's Office of Protective Services (OPS), should have established policies to provide guidance and accountability to law enforcement personnel to avoid loss of and/or damage to such weapons.

OLES conducted a review of DSH recordkeeping of DSH institutional firearms and crime/evidence firearms in February 2023 by comparing firearms inventory information provided by DSH facilities with data obtained from the Automated Firearms System (AFS) maintained by the California Department of Justice, Bureau of Firearms.

The review revealed the following four issues: (1) DSH did not have a policy containing any requirement that OPS staff enter information into AFS for any recovered, found, lost, or seized firearm, or the acquisition of institutional firearms; (2) numerous firearms in the possession of DSH were not recorded in AFS; (3) DSH facilities were in possession of crime guns for long periods of time and had yet to properly destroy or return these firearms in accordance with law; and (4) one DSH facility inappropriately identified, labeled and/or stored seized firearms.

OLES provided specific recommendations to DSH, and because of OLES's review and recommendations, DSH took the following actions:

- All weapons at DSH were physically accounted for and listed in AFS;
- DSH updated two policies to address OLES's concerns regarding the lack of direction to OPS staff regarding the entering of firearm information into AFS;
- DSH ensured each facility properly accounted for and entered into AFS all seized firearms; and
- DSH identified, relabeled, and secured the firearms at one facility that were inappropriately stored in evidence.

DSH has also resolved two previously outstanding issues regarding the standardization of qualification records and a revision to its policy to require the prompt return/destruction of crime/evidence firearms upon completion of an investigation.

OLES will continue to monitor the department's progress and implementation.

Recording of Investigatory Interviews

In 2017, OLES issued a memorandum to the department recommending that OPS staff record investigatory interviews. In response, the department updated its policies and procedures to require recordings. However, in 2020 and 2021, it was noted that OPS staff were not regularly recording interviews. Therefore, in January 2022, OLES reopened this monitored issue to address this concern. In response to OLES recommendations, DSH updated its policy related to the recording of investigatory interviews, purchased additional recorders, and provided training for all OPS sworn staff. Since then, there has been significant improvement in the recording of investigatory interviews. While OLES documented seven instances of unrecorded interviews during this reporting period, the primary problem now appears to be a reluctance on the part of staff witnesses to cooperate with the investigation by expressing an unwillingness to have their statement recorded. OLES recommends that the department continue to work with its OPS and non-sworn staff to increase understanding of the importance of cooperation with the investigatory process and the recording of interviews.

OLES will continue to monitor the department's progress and implementation.

Underutilization of Blue Team/IAPro

In March 2015, OLES provided the Legislature with a report detailing the challenges faced by law enforcement at DSH and recommended adopting an early intervention system (EIS) to monitor incidents and identify potential performance problems. Subsequently, DSH selected the Blue Team/IAPro software for this purpose. 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. Despite completing staff training in 2016, DSH failed to utilize Blue Team/IAPro effectively. Therefore, OLES initiated a monitored issue in July 2017 to assess the implementation and usage of the program as part of OLES's ongoing commitment to addressing the issue. It was found that the data inaccurately reflected reportable incidents, with discrepancies between Blue Team/IAPro and the department's Records Management System (RMS). Furthermore, there was a lack of consistency in ensuring accurate reporting, with no efforts made to question zero-incident reports.

In subsequent reviews conducted in March 2018 and August 2021, OLES reiterated concerns regarding DSH's failure to consistently input reportable incidents into Blue Team/IAPro promptly. However, it is important to acknowledge that OLES recognizes DSH's commitment to improvement, including the additional training provided in December 2020 and updating the procedure manual in February 2022 to include OLES's recommendations. These efforts demonstrate the department's dedication to rectifying past mistakes and improving performance.

Even so, during the most recent audit conducted in February 2024, DSH entered 116

UOF cases into Blue Team/IAPro. However, the review found two cases had been entered twice. The audit also revealed that 16 incidents reported to OLES were not entered into Blue Team/IAPro, and another five incidents were not reported to OLES. These discrepancies highlight a consistent pattern with the department's use of Blue Team/IAPro, underscoring the pressing and urgent need for corrective action.

Despite years of monitoring, additional training, and oversight, the DSH has been unable to fully utilize the Blue Team/IAPro software as intended, as evidenced by a consistent pattern of inaccuracies and omissions in reporting crucial incidents, particularly concerning the category of use of force. OLES has repeatedly identified systemic issues, yet the department has yet to implement lasting changes to resolve these issues. Regardless of repeated reviews, recommendations, and DSH's prior efforts to improve, DSH has not historically demonstrated the commitment to addressing these deficiencies. Immediate and decisive action is required to rectify these shortcomings and ensure the accurate monitoring and reporting of incidents within DSH. Failure to do so jeopardizes the value in monitoring incidents and identifying potential performance problems that could impact the safety and well-being of patients and staff.

Therefore, OLES recommended that DSH implement the following:

1. **Immediate Corrective Action:** DSH must immediately address the inaccuracies and deficiencies in its reporting processes. This includes implementing stricter protocols for incident reporting and ensuring timely and accurate data entry into Blue Team/IAPro.
2. **Enhanced Oversight:** DSH HQ should intensify its monitoring of the DSH facilities' usage of Blue Team/IAPro, conducting regular audits to identify and rectify discrepancies promptly.
3. **Accountability Measures:** DSH leadership, including police chiefs and supervisors, must be held accountable for ensuring compliance with reporting requirements.
4. **Comprehensive Training:** DSH should provide ongoing and comprehensive training to employees responsible for incident reporting, emphasizing the importance of accurate and timely data entry.

In response to OLES's recommendations, DSH developed a three-part plan as follows:

1. DSH will change from the Management centric use of Blue Team to a Supervisor centric use of Blue Team.
2. OPS will oversee the use of Blue Team by the Hospital Police Departments.
3. OPS will receive training through CI-Technologies to use IAPro and Blue Team more effectively for the Department of State Hospitals law enforcement.

According to DSH, training has been developed for supervisors and local administrators. OPS will complete the training for local administrators by October 31, 2024, and for the sergeants by January 31, 2025. OPS headquarters will conduct quarterly audits to ensure all applicable incidents are entered into Blue Team and transferred into IAPro in a timely manner. OLES will continue to monitor the department's usage of Blue Team/IA Pro.

Use of Force Reports, Reviews and Tracking at DSH

In September 2023, the OLES use of force consultant and DSH chiefs and representatives from their command participated in a meeting dedicated to developing an updated use of force policy, with field-level input.

In July 2024, DSH completed its use of force policy update and released it department-wide for review and acknowledgment. Simultaneously, DSH advised that statewide training on the updated policy was forthcoming.

In August 2024, OLES joined the DSH executive and command staff to preview the use of force training video developed by the DSH Academy staff. This video will be disseminated to each facility to train the OPS staff. After the preview, the academy staff engaged in a positive discussion, addressing participants' suggestions for edits to the training.

OLES commends DSH for its significant progress in creating a comprehensive and well-produced training video that aligns with the department's objectives for the updated use of force policy. The video meets the department's training needs and demonstrates a thoughtful approach to ensuring staff are properly equipped with the knowledge and guidelines necessary when considering the use of force. This effort highlights DSH's commitment to continuous improvement and accountability.

OLES will continue to monitor the department's progress and implementation.

Delayed Reporting by Other Mandated Reporters

In December 2021, OLES provided a monitored issue memorandum to DSH after discovering significant delays in required reporting of reportable incidents by level of care staff and social workers (collectively hereinafter as, Other Mandated Reporters) at DSH. OLES reviewed the reportable incidents it received from the department and found that while OPS often made timely notification to OLES, the Other Mandated Reporters did not consistently report these incidents to OPS timely. Additionally, they did not notify OPS despite specific statutory requirements to timely report such incidents both internally and externally. These delays by Other Mandated Reporters ranged from several hours to several days after initial discovery, to no notification at all to external law enforcement.

These delays can often have a negative impact on the investigation of the reportable incidents. Timely notification to appropriate law enforcement is critical, especially for alleged sexual assaults or other potential crimes of violence. For example, 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 or discards their clothing, showers, brushes his/her teeth, or uses the restroom. Additionally, for sexual assaults and other allegations of abuse, delays could undermine investigations in other ways. For example, delays create an opportunity for collusion amongst involved parties, or may cause a patient or victim to fear going forward with reporting 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.

To address this issue, OLES recommended in its original 2021 monitored issue memorandum that DSH implement a statewide policy requiring all mandated reporters to make timely notifications to OPS and/or outside law enforcement agencies as required by law. In 2022, DSH responded by developing language for Policy Directive 8010, which included a reference to reporting confidential patient information and allegations as required by law. The DSH also created and distributed mandated reporting posters and pocket guides to staff outlining the reporting requirements for OPS to make notifications to OLES. OPS also met with level of care staff to review the OLES reporting guidelines. These efforts may have increased awareness of Other Mandated Reporters to make timely notification to OPS. However, continued efforts to ensure thorough knowledge of reporting requirements are needed.

Unfortunately, during the current reporting period of January 1, 2024, through June 30, 2024, there were eight incidents of delayed reporting by Other Mandated Reporters. Additionally, there were some critical deficiencies, including an allegation of sexual assault against a staff member that was not reported to OPS for over two days. The eight incidents are listed below:

Incident Type	Estimated Delayed Reporting to OPS
Broken bone (unknown origin)	5 hours
Sexual assault	2 days, 5 hours, and 30 minutes
Physical abuse	5 hours, 45 minutes
Broken bone (unknown origin)	3 hours
Physical abuse and broken bone	2 hours, 45 minutes
Physical abuse	4 hours, 40 minutes
Genital injury (unknown origin)	1 day, 3 hours
Physical abuse	1 day

Moreover, in the original memorandum to DSH, OLES identified the circumstances under which Other Mandated Reporters are required to provide notification to OPS and an outside law enforcement agency within two hours of discovery. And while DSH facilities have made efforts to reduce Other Mandated Reporters' late notifications to OPS, there is no documentation or information regarding Other Mandated Reporters' compliance with making timely notification to an outside law enforcement agency when required.[5]
OLES renews its recommendations that DSH implement a statewide policy to ensure all

[5] Although OPS often notifies outside law enforcement agencies about these specific reportable incidents as required, the OPS notification may not satisfy the original two-hour reporting requirement the Other Mandated Reporter who first discovered the alleged abuse is obligated to comply with. That is because OPS staff are also mandated reporters. OPS has its own two-hour reporting requirement that is triggered once OPS first discovers the alleged abuse or is first notified of it.

DSH mandated reporters (regardless of classification) are made aware of and comply with their obligations as mandated reporters to timely report possible abuse and neglect to law enforcement within two hours. Additionally, DSH statewide policy should further clarify that timely notification to both OPS *and* outside law enforcement, not just OPS alone, may sometimes be required. Doing so will ensure accurate, thorough investigations are completed without delay or compromise. OLES will continue to work with the department and monitor the department's progress on this issue.

Appendix A: Completed OLES Investigations

The following tables provide information on investigations completed by OLES in the reporting period of January 1 through June 30, 2024. 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, 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 Details	Description
Incident Date	06/06/2022
OLES Case Number	2022-00676-2C
Case Type	Investigative
Incident Types	1. Abuse 2. Use of Force Review
Incident Summary	Several officers allegedly used excessive force while restraining a patient.
Disposition	OLES conducted an investigation. 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 Details	Description
Incident Date	08/01/2022
OLES Case Number	2023-00596-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly created a hostile work environment by the use of inappropriate language.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	04/21/2023
OLES Case Number	2023-00694-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly provided unauthorized items to patients.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/01/2023
OLES Case Number	2023-00824-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer failed to act on another officer's admission of off-duty drug use.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	05/08/2023
OLES Case Number	2023-00825-1A
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	Two law enforcement supervisors and five officers allegedly failed to properly respond to a patient's allegation of excessive force.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	05/30/2023
OLES Case Number	2023-00888-1A
Case Type	Investigative

Incident Types	1. Abuse
Incident Summary	Three officers allegedly used excessive force on a patient, completed inaccurate reports, and conducted an inadequate investigation.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/17/2023
OLES Case Number	2023-00894-1A
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	An officer was allegedly discourteous to a patient.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/09/2023
OLES Case Number	2023-00909-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly had an inappropriate conversation and contact with a hospital visitor.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/27/2023
OLES Case Number	2023-00939-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly did not return facility property in a timely manner.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/04/2023
OLES Case Number	2023-00957-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly made a discourteous remark to a patient.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/05/2023
OLES Case Number	2023-00966-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly engaged in on-duty sexual activity with another employee.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/05/2023
OLES Case Number	2023-00980-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly drove a state vehicle at an unsafe rate of speed.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/23/2023
OLES Case Number	2023-01105-1C

Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	A patient alleged that officers conducted random and unlawful searches of patients and their property.
Disposition	OLES conducted an investigation. 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 Details	Description
Incident Date	07/30/2023
OLES Case Number	2023-01151-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	A supervisor allegedly made a sexually inappropriate comment.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	08/11/2023
OLES Case Number	2023-01161-2C
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	An officer allegedly contaminated a patient's food and toothpaste. A medical professional allegedly instructed a patient to assault another patient.
Disposition	OLES conducted an investigation. 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 Details	Description
Incident Date	06/20/2023
OLES Case Number	2023-01220-1A
Case Type	Investigative

Incident Types	1. Misconduct
Incident Summary	A law enforcement supervisor and an officer allegedly improperly supervised the transportation of a restrained patient.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/19/2017
OLES Case Number	2023-01298-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	A law enforcement supervisor allegedly sexually harassed another law enforcement supervisor.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	09/11/2023
OLES Case Number	2023-01310-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An anonymous complaint alleged that officers were abandoning their assigned posts.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	09/16/2023
OLES Case Number	2023-01339-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer allegedly interfered with hospital staff who were attempting to administer an injection to a patient.
Disposition	The investigation was completed by OLES and submitted to

	the hiring authority for disposition.

Case Details	Description
Incident Date	01/10/2023
OLES Case Number	2023-01480-1A
Case Type	Investigative
Incident Types	1. Confidential
Incident Summary	A fire department supervisor allegedly removed state equipment for personal use.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	10/12/2023
OLES Case Number	2023-01481-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An anonymous complaint alleged that several officers removed weapons and training items from a storage facility.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	10/10/2022
OLES Case Number	2023-01558-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	A law enforcement supervisor allegedly falsely stated his qualifications on a promotional application.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	03/26/2023

OLES Case Number	2024-00010-1A
Case Type	Investigative
Incident Types	1. Misconduct
Incident Summary	An officer was allegedly discourteous towards a hospital employee.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition. OLES monitored the disposition process.

Case Details	Description
Incident Date	01/13/2024
OLES Case Number	2024-00084-1A
Case Type	Investigative
Incident Types	1. Abuse 2. Head/Neck
Incident Summary	An officer allegedly abused a patient.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	01/20/2024
OLES Case Number	2024-00130-1A
Case Type	Investigative
Incident Types	1. Abuse
Incident Summary	Four officers allegedly used excessive force on a patient.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition. OLES monitored the disposition process.

Case Details	Description
Incident Date	02/02/2024
OLES Case Number	2024-00269-1A
Case Type	Investigative

Incident Types	1. Misconduct
Incident Summary	One law enforcement supervisor and one officer allegedly improperly conducted the selection process for two canine handler positions. The law enforcement supervisor also allegedly exhibited a racial bias towards an applicant.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Appendix B: Pre-Disciplinary Cases Monitored by OLES

Appendix B of this report provides information on monitored administrative cases and monitored criminal cases that, by June 30, 2024, 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.

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.

Case Details	Description
Incident Date	03/30/2022
OLES Case Number	2022-00381-2A
Case Type	Monitored
Incident Types	1. Drugs
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician or a pharmacy technician allegedly removed a controlled sleep medication tablet from a medication dispensing machine and replaced it with an over-the-counter sleep medication. The psychiatric technician or the pharmacy technician also allegedly removed six tablets of the over-the-counter sleep medication.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	04/10/2022
OLES Case Number	2022-00386-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was found unresponsive. Level of care staff responded, and initiated life-saving measures. The patient was transported to an outside hospital, where he was later pronounced dead.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/27/2022
OLES Case Number	2022-00869-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Other
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was found unresponsive, and a medical alarm was activated. Although life-saving measures were attempted, the patient later died from hypertensive cardiac disease.

Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a policy violation that contributed to the patient's death. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/07/2022
OLES Case Number	2022-00928-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient became unresponsive in a transport vehicle. The transport officers removed the patient from the vehicle and initiated life-saving measures. Level of care staff and ambulance services responded; however, the patient was pronounced dead.
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; therefore, the case was not referred to the district attorney's office. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/13/2022
OLES Case Number	2022-01269-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A psychiatric technician allegedly engaged in an overly familiar and sexual relationship with a patient.
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 department opened an administrative investigation which OLES did not accept for monitoring because the incident did not meet OLES's monitoring criteria.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The investigation was not completed in a timely manner discovered.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 509 days after the incident was discovered.
Department Corrective Action Plan	This case was completed by the Office of Protective Services headquarters (OPS). The OPS now have a supervising special investigator-1 assigned to OPS. The SSI-1 monitors all cases assigned to all investigators, adds cases, and closes cases. The SSI-1 also reviews investigations at the time these cases are initiated and approves or sends cases back to the investigator for corrections and then approves when corrections are made. The SSI-1 will reassign investigations when needed and review timelines to be sure all cases are completed timely and in accordance with POBAR and OLES guidelines.

Case Details	Description
Incident Date	01/11/2023
OLES Case Number	2023-00061-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was found unresponsive. Level of care staff initiated life-saving measures. The patient was

	transported to the urgent care room; however, the patient was later pronounced dead. The patient had ongoing medical issues which contributed to his death.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/01/2023
OLES Case Number	2023-00171-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A custodian allegedly brought contraband coffee to a patient who in turn sold the coffee to other patients. The custodian allegedly used a patient help her with her custodial duties. Four custodial supervisors allegedly were aware the custodian violated policy and failed to report it.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation the custodian brought contraband coffee to a patient. The hiring authority determined there was sufficient evidence to sustain the allegation the custodian used a patient to assist with custodial duties in violation of policy and determined corrective action was appropriate. The hiring authority determined there was insufficient evidence to sustain the allegations against the four custodian supervisors. OLES

	concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigator did not properly identify all of the subjects and did not provide three of the subjects with their rights to union representation. The initial draft report was not thorough and additional investigation was required. The department did not provide OLES with a copy of the final draft report prior to providing the report to the hiring authority. The investigation was not completed until 429 days after the date of discovery.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not properly identify all subjects during the investigation. 2. Were all of the interviews thorough and appropriately conducted? • No The investigator did not inform the subjects of their rights to union representation. As a result, the investigator had to reinterview three of the subjects. 3. 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 initial draft report was forwarded to OLES. OLES provided feedback which included recommendations for additional investigation, which the investigator completed. OLES was not provided with the second draft report before it was forwarded to the hiring authority. 4. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The initial investigation did not address all of the controlling policies and relevant training. 5. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? • No The investigator did not provide OLES with a copy of

	the final draft report. 6. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 429 days after the date of discovery.
Department Corrective Action Plan	Investigators will evaluate their case file to correctly identify witnesses and subjects. This will allow for using the proper admonishments prior to the interviews. The process has been to furnish the AIM a draft of the report and await any suggestions or comments. The investigators will complete any corrections, and or suggestions made by the AIM. Future correspondence to the AIMS will include a follow up request for review if more than 1 draft is necessary. The investigators will ensure their Statement of Facts address all relevant AD and Training issues. The investigator was working another high priority case, which caused a delay in working this case file. He did request and obtain an extension on this case file. The investigator will schedule interviews in between working priority cases. Due dates will be tracked on the case file and will be noted in an obvious place within the file. This will serve as a noticeable reminder of the due date. The investigators are reminded of meeting the time frame of 120 days in which to complete an investigation, and requesting an extension if the investigation will move beyond the 120 days. A request for an extension will be discussed with the assigned OLES monitor, according to the parameters set out in the issued memorandum, dated 11/13/17 by Chief of Law Enforcement.

Case Details	Description
Incident Date	01/23/2023
OLES Case Number	2023-00183-2A
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 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty 9. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained 7. Not Sustained 8. Not Sustained 9. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly grabbed and twisted a patient's arms. X-rays confirmed the patient sustained a ligament tear in his wrist. The psychiatric technician also allegedly failed to activate his personnel duress alarm. A second psychiatric technician, and a nursing coordinator allegedly failed to report the incident.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/11/2022
OLES Case Number	2023-00187-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	Two officers allegedly failed to accurately report

	damage to a state vehicle.
Disposition	The hiring authority sustained the allegations and issued letters of expectation. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/11/2023
OLES Case Number	2023-00377-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
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	Two psychiatric technicians allegedly forced a patient to shower and then allegedly inappropriately touched the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 130 days after the incident was discovered. The investigation was not assigned to an investigator for approximately 60 days; however, once assigned, the investigator exercised due diligence to complete the investigation.

Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 130 days after the incident was discovered.
Department Corrective Action Plan	Investigators will be reminded of due dates, and to try and contact staff members' supervisors if they do not get timely responses to the scheduling correspondence.

Case Details	Description
Incident Date	03/23/2023
OLES Case Number	2023-00435-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient died unexpectedly from bronchopneumonia with contributing factors of atherosclerotic cardiovascular disease and emphysema, while being continuously monitored by staff.
Disposition	The department determined there was no evidence of staff misconduct; therefore, no allegations were sustained. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The hiring authority made decisions regarding the sufficiency of the investigation and investigatory findings without consulting the monitor.
Pre-Disciplinary Assessment	1. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The hiring authority made decisions regarding the sufficiency of the investigation and the investigative findings without consulting the assigned monitor.

Department Corrective Action Plan	To ensure the hiring authority is aware there is an OLES AIM assigned to a case, OSI will print a blue colored cover sheet indicating the case is monitored by OLES. The cover sheet will include OLES case number and the name of the assigned monitor. The blue sheet will be the first page of the packet that is turned over to the hiring authority. This process will enhance the ability to identify cases monitored by OLES giving the hiring authority the opportunity to make the proper notifications and include the OLES monitor assigned to the case through the sufficiency of the investigation and the findings process. Additionally, mention of OLES AIM presence in interviews without a blue cover sheet (process above) will trigger the Hiring Authority to check with OLES to determine if case is monitored. All OLES AIM and Hiring Authority agreed upon action will be confirmed via email. Hiring authority will create a specific OLES email folder to ensure there is record of consultation.

Case Details	Description
Incident Date	04/12/2023
OLES Case Number	2023-00529-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly grabbed and twisted a patient's arm in an attempt to take a cup of suspected patient-manufactured alcohol out of the patient's hands.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.

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

Case Details	Description
Incident Date	04/16/2023
OLES Case Number	2023-00532-1A
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 forced a patient's head onto the floor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/21/2023
OLES Case Number	2023-00544-2A
Case Type	Monitored
Incident Types	1. Child Sexual Abuse Material 2. Drugs 3. 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	A unit supervisor, and two psychiatric technicians allegedly brought narcotics into the facility for patients' use and distribution.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/20/0202
OLES Case Number	2023-00568-2A
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.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/26/2023
OLES Case Number	2023-00600-1A
Case Type	Monitored
Incident Types	1. Non-Patient Arrest
Allegations	1. Other
Findings	1. Not Sustained

Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A pharmacist was arrested by an outside law enforcement agency for alleged off-duty possession and distribution of illegal pornographic material.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations; however, the pharmacist had already been separated from state service for unrelated reasons. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/21/2023
OLES Case Number	2023-00694-2A
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 provided unauthorized items to patients.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/26/2023
OLES Case Number	2023-00801-1A
Case Type	Monitored

Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained 6. Not Sustained 7. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A senior psychiatric technician allegedly gave a pen to a patient who was on enhanced observation for a history of swallowing pens. Three psychiatric technicians with knowledge of the enhanced observation order allowed the patient to keep the pen, which the patient ultimately swallowed. A registered nurse with knowledge of the enhanced observation order allowed the patient to have a pen in a later incident.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegations against the senior psychiatric technician, the three psychiatric technicians and the registered nurse. Because it was unclear whether patient rights required that the patient have the pen, the hiring authority issued letters of expectation. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/26/2023
OLES Case Number	2023-00804-1A

Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A psychiatric technician assistant allegedly fell asleep while monitoring a patient with a history of harming himself. While the psychiatric technician assistant was allegedly asleep the patient did harm himself.
Disposition	Prior to the completion of the investigation, the psychiatric technician was terminated on an unrelated case. The hiring authority determined there was sufficient evidence to sustain the allegation and issued a letter of dismissal under unfavorable circumstances to be kept in the psychiatric technician assistant's official personnel file. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/01/2023
OLES Case Number	2023-00809-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Known Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An outside medical facility reported that a patient sustained deep tissue injuries near the base of his spine.
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 department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies

	and procedures governing the investigative process. The investigation was not completed until 215 days after the date of discovery.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The facility was notified that this was an OLES monitored investigation on June 22, 2023, but the investigation was not completed until January 23, 2024, 215 days later.
Department Corrective Action Plan	To prevent this issue from occurring again, the OSI Office will implement a better tracking system as it pertains to OLES cases and communicate the change to the assigned Investigator promptly.

Case Details	Description
Incident Date	06/01/2023
OLES Case Number	2023-00822-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Discourteous treatment
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	An officer allegedly was discourteous to staff at an outside medical facility, bringing discredit to the department.
Disposition	The hiring authority sustained the allegation and determined a letter of expectation was the appropriate penalty. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/01/2023
OLES Case Number	2023-00824-2A

Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	An officer allegedly failed to report off-duty drug use. A second officer allegedly failed to report the first officer's admission of off-duty drug use.
Disposition	The hiring authority sustained the allegations and issued training. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/08/2023
OLES Case Number	2023-00825-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	Two law enforcement supervisors and five officers allegedly failed to properly respond to a patient's allegation of excessive force.
Disposition	The hiring authority sustained the allegations for two of the officers and issued letters of expectation and training. The remaining allegations were not sustained. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	06/13/2023
OLES Case Number	2023-00875-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	An officer was allegedly discourteous to a patient.
Disposition	The hiring authority sustained the allegation against the officer and issued a letter of expectation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/17/2023
OLES Case Number	2023-00894-2A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer was allegedly discourteous to a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	06/22/2023
OLES Case Number	2023-00910-1A
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 a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/23/2023
OLES Case Number	2023-00934-1A
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 unit supervisor allegedly hid unit telephones from patients. The unit supervisor also allegedly allowed other patients to hoard the available telephones, enabling these other patients to allegedly extort patients who needed to use the telephones. The unit supervisor allegedly disclosed the first patient's written complaint about telephone availability to other patients.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/05/2023
OLES Case Number	2023-00980-2A
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 drove a state vehicle at an unsafe rate of speed.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 5 percent for 12 months was the appropriate penalty. OLES concurred with the hiring authority's determinations. The officer retired prior to the service of the disciplinary action. A letter was placed in the official personnel file indicating he retired pending disciplinary action.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/10/2023
OLES Case Number	2023-00987-2A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty

Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Several staff members were allegedly asleep and failed to respond to a patient who had fallen in the shower.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/09/2023
OLES Case Number	2023-00988-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly challenged a patient to fight and placed his hands around the patient's neck.
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 department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/09/2023
OLES Case Number	2023-00993-2A
Case Type	Monitored

Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A psychiatric technician allegedly failed to activate an alarm upon finding a patient who had fallen to the ground. A second psychiatric technician allegedly delayed in responding to assist the patient, and a third psychiatric technician allegedly failed to respond altogether.
Disposition	The hiring authority sustained the allegations against the first psychiatric technician for failing to activate his alarm, and determined corrective action was the appropriate penalty. OLES concurred. The hiring authority also sustained all allegations against the other two psychiatric technicians for patient neglect, and failing to activate their alarms; however, no disciplinary action could be taken against those two psychiatric technicians because they had already resigned before completion of the investigation. A letter indicating those two psychiatric technicians resigned under adverse circumstances was placed in each of their official personnel files.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/10/2023
OLES Case Number	2023-00995-1A
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 repeatedly pushed a patient, causing the patient to fall, strike his head and lose consciousness.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/24/2023
OLES Case Number	2023-00997-1A
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 allegedly hit a patient after he was assaulted by the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/11/2023
OLES Case Number	2023-01002-1A

Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin) 2. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly allowed a patient to retain a plastic spoon while on enhanced observation status. A second psychiatric technician observing the patient via a video monitor allegedly failed to see the patient insert the broken spoon into his penis.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/15/2023
OLES Case Number	2023-01020-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient collapsed inside his room. Hospital staff initiated emergency life-saving measures; however, the patient was declared dead. An autopsy determined the patient's death was accidental due to foreign body ingestion with underlying issues of sepsis, peritonitis, and a ruptured small bowel.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime that contributed to the patient's death. OLES concurred.

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

Case Details	Description
Incident Date	07/21/2023
OLES Case Number	2023-01061-1A
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 staff member allegedly hit a restrained patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/23/2023
OLES Case Number	2023-01070-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Discourteous treatment 2. Discourteous treatment
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	Two on-duty officers were allegedly discourteous to each other.
Disposition	The hiring authority sustained the allegations and determined that corrective action was warranted. OLES

	concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The investigation was completed 170 days after the case was initiated.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was completed 170 days after the case was initiated.
Department Corrective Action Plan	This case was assigned to a lieutenant during a period of when the department was experiencing staffing shortages at the lieutenant level. The assigned lieutenant did inform the chief of police, when they were approaching the 120-day mark, that they would need an extension due to these reasons and the extension was granted. To ensure the chief of police is better informed on the progress of the investigations monitored by OLES, a spread sheet will be developed to track the progress of the case, which will require monthly status updates provided to the chief of police. The updates will assist the chief of police in determining if additional resources are available to assist with completing the case within the 120 days as recommended by OLES.

Case Details	Description
Incident Date	07/19/2023
OLES Case Number	2023-01075-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician allegedly pushed a patient to the ground without provocation and did not properly report the fall. A senior psychiatric technician and two

	other psychiatric technicians allegedly did not properly report or document the alleged incident. A registered nurse allegedly failed to timely document his medical assessment of the patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain allegations of failing to report the alleged patient abuse against the three psychiatric technicians, the registered nurse, and the senior psychiatric technician but determined there was insufficient evidence to sustain allegations of patient abuse or neglect. The hiring authority issued letters of warning. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/26/2023
OLES Case Number	2023-01096-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly forced a patient onto a bed.
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 department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigator did not adequately consult or cooperate with the monitor throughout the investigation.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The investigator did send an investigative plan,

	however, did not otherwise consult with OLES after the case was opened and prior to finalizing the investigative plan. 2. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not consult with OLES prior to conducting interviews. Therefore, it is unknown if the investigator was adequately prepared for all aspects of the investigation. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator completed the investigation prior to coordinating with the monitor. The investigator took an unreasonable amount of time to provide interview audio recordings to the monitor.
Department Corrective Action Plan	To prevent this issue from occurring again in terms of collaboration during the investigative process such as coordination with the interviews, the Supervising Special Investigator's will meet with the Investigators to ensure they are communicating effectively and coordinating interviews with the OLES AIM.

Case Details	Description
Incident Date	07/23/2023
OLES Case Number	2023-01111-1C
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 foot.
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 department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2023
OLES Case Number	2023-01144-2A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A nurse was allegedly involved in an overly familiar sexual relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/06/2023
OLES Case Number	2023-01146-2A
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 assistant allegedly pushed a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative	**Overall Rating:** Sufficient

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

Case Details	Description
Incident Date	07/30/2023
OLES Case Number	2023-01151-2A
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	A law enforcement supervisor allegedly made a sexually inappropriate comment.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient Overall, the department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/04/2023
OLES Case Number	2023-01153-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
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	Three officers allegedly vandalized a patient's room

	while conducting a search. One of the officers allegedly harassed the patient by targeting the patient's room for the search, and by yelling profanities at the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against all the officers. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/09/2023
OLES Case Number	2023-01155-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
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 law enforcement supervisor was allegedly discourteous to an officer.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/07/2023
OLES Case Number	2023-01156-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review

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 law enforcement supervisor allegedly yelled at a subordinate and attempted to physically block the subordinate from exiting a room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/21/2023
OLES Case Number	2023-01164-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	A staff member allegedly hit a patient during a physical altercation with the patient. Additionally, two other staff members allegedly hit the same patient as they transferred the patient from his bed to his wheelchair.
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. OLES concurred.

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

Case Details	Description
Incident Date	08/11/2023
OLES Case Number	2023-01172-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient sustained a cervical fracture of an undetermined origin.
Disposition	The hiring authority determined there was no staff misconduct involved. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/03/2023
OLES Case Number	2023-01173-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	Two psychiatric technicians and a nurse allegedly forced a patient against a wall, then forced him onto the floor.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/27/2023
OLES Case Number	2023-01180-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly failed to protect a patient from being attacked by a second patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/15/2023
OLES Case Number	2023-01181-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Two supervisors allegedly forced a patient onto the

	ground and kicked the patient in the genitals.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/18/2023
OLES Case Number	2023-01203-1A
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. Several other staff members allegedly engaged in inappropriate conduct of a sexual nature with the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 157 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 157 days after the incident was discovered.
Department Corrective Action Plan	The investigator will strive to schedule and conduct interviews between high priority cases. He will coordinate with unit supervisors to have subject staff members

	available for interviews, which caused slight delays in this case. He will also ensure to request necessary documents to avoid running into timeliness issues. The investigator will be reminded of due dates on OLES case files.

Case Details	Description
Incident Date	08/19/2023
OLES Case Number	2023-01216-1A
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	A staff member allegedly threatened a patient on two occasions and locked the patient in a room for 20 minutes.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/23/2023
OLES Case Number	2023-01218-1C
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 several healed fractured ribs.
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 department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/20/2023
OLES Case Number	2023-01220-2A
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	A law enforcement supervisor and an officer allegedly improperly supervised the transportation of a restrained patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/01/2023
OLES Case Number	2023-01226-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A licensed vocational nurse, assigned to enhanced observation of a patient, allegedly failed to activate an alarm and intervene when two other patients allegedly assaulted the patient.
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 opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/25/2023
OLES Case Number	2023-01233-1A
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	Six unidentified staff members allegedly abused and choked a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/25/2023
OLES Case Number	2023-01239-1A
Case Type	Monitored

Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A registered nurse allegedly failed to properly supervise a patient on suicide watch; the patient committed suicide.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/29/2023
OLES Case Number	2023-01259-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician allegedly pushed a wheelchair bound patient's neck towards his lap and twisted his hand while the patient was on enhanced observation for medical reasons.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation that the psychiatric technician failed to report the incident and issued a letter of warning, but did not sustain an allegation of physical abuse. OLES concurred with the hiring authority's determinations.
Investigative	**Overall Rating:** Sufficient

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

Case Details	Description
Incident Date	08/31/2023
OLES Case Number	2023-01261-1A
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	Two senior psychiatric technicians, four psychiatric technicians and a registered nurse allegedly ignored a patient's claim that she had two seizures, refused to provide medical treatment, and were asleep in the nurses' station.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/05/2023
OLES Case Number	2023-01274-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed

	Final: No Penalty Imposed
Incident Summary	A licensed vocational nurse allegedly engaged in an overly familiar relationship with a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/05/2023
OLES Case Number	2023-01276-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly repeatedly 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. OLES concurred with the probable cause determination. The department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigator did not adequately consult with OLES. The investigation was not completed until 222 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No OPS did not consult with OLES upon case initiation. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 222 days

	after the incident was discovered.
Department Corrective Action Plan	To prevent this issue from occurring again, the SSI's will meet with the Investigators to ensure they are conferring with the OLES AIM at the initial case assignment stage and prepare an ICP in an expeditious manner to determine the course of the investigation and if any further follow up is required.

Case Details	Description
Incident Date	09/03/2023
OLES Case Number	2023-01277-1C
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was diagnosed with a genital injury.
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 department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/06/2023
OLES Case Number	2023-01279-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Sustained
Incident Summary	A staff member allegedly hit a patient.
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 department will not open an administrative investigation.

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

Case Details	Description
Incident Date	09/06/2023
OLES Case Number	2023-01284-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	An unidentified staff member allegedly assaulted a patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/30/2023
OLES Case Number	2023-01288-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly assaulted a restrained patient.
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 department opened an administrative investigation, which OLES

	accepted for monitoring.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigator did not attempt to interview the suspect after the suspect indicated he wanted to speak to his union representative.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? • No There were no attempts to interview the suspect once he indicated he wanted to speak to his union representative.
Department Corrective Action Plan	The investigator will be instructed on maintaining communication with the monitor throughout the course of the entire investigation. The Supervising Special Investigators will monitor OLES cases and work with investigators to ensure there are no unjustified time gaps in the investigation. This will ensure investigations and reports are timely. The investigators will be instructed to conduct timely follow up on interviews.

Case Details	Description
Incident Date	09/08/2023
OLES Case Number	2023-01289-1C
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 two fractured ribs.
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 department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/09/2023
OLES Case Number	2023-01290-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Unidentified staff members allegedly broke a patient's finger while forcibly extracting the patient from under a bed.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/10/2023
OLES Case Number	2023-01293-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Three unidentified staff members allegedly twisted a patient's arm and pulled the patient's hair. A fourth staff member removed the patient's clothing while she was

	escorted to a seclusion room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/17/2023
OLES Case Number	2023-01299-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A senior psychiatric technician allegedly pulled down their surgical mask and coughed three times towards a nearby patient. The psychiatric technician was also allegedly disrespectful towards the patient by questioning if the patient was actually sick.
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 opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/17/2023
OLES Case Number	2023-01299-2A
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 senior psychiatric technician allegedly pulled down their surgical mask and coughed three times towards a nearby patient. The psychiatric technician was also allegedly disrespectful towards the patient by questioning if the patient was actually sick.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/12/2023
OLES Case Number	2023-01304-1A
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 allegedly repeatedly woke a sleeping patient, over a six-month period, by pressing a button in the nurses' station.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description

Incident Date	09/13/2023
OLES Case Number	2023-01306-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly grabbed a pillowcase, containing personal property, out of a patient's hands.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/11/2023
OLES Case Number	2023-01323-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was diagnosed with a fractured hand.
Disposition	The hiring authority determined there was insufficient evidence of staff misconduct and did not sustain any allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/16/2023
OLES Case Number	2023-01333-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Neglect
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	Unidentified staff members allegedly used excessive force when stabilizing an agitated patient. A psychiatric technician allegedly bruised the patient's arm while escorting the patient. Additionally, unidentified staff members allegedly denied the patient medical treatment.
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 opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/16/2023
OLES Case Number	2023-01333-2A
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 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty

	6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty 9. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained 7. Not Sustained 8. Not Sustained 9. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Staff members allegedly used excessive force while stabilizing an agitated patient and denied the patient medical treatment. A psychiatric technician allegedly bruised the patient's arm while escorting the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/16/2023
OLES Case Number	2023-01335-1C
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 finger.
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 department will not open an administrative investigation.

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

Case Details	Description
Incident Date	09/23/2023
OLES Case Number	2023-01354-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff members discovered a patient unresponsive and initiated emergency life-saving measures; however, the patient died at an outside hospital. An autopsy determined the patient died from atherosclerotic cardiovascular disease.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigatory process. The investigator did not contact OLES for the second subject matter expert interview, thereby preventing the monitor from attending the interview.
Pre-Disciplinary Assessment	1. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator did not contact OLES for the interview of the subject matter expert, thereby preventing the monitor from attending the interview.
Department Corrective Action Plan	The investigators received verbal counseling/instruction about the appropriate investigatory process as it relates to keeping close contact and involvement with OLES for the duration of their monitored investigations.

Case Details	Description
Incident Date	09/22/2023

OLES Case Number	2023-01355-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly entered a sleeping patient's room and sexually assaulted the patient over a three-month period. A second psychiatric technician allegedly hit the patient on the 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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/24/2023
OLES Case Number	2023-01356-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A staff member allegedly entered a seclusion room and kicked a patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/22/2023
OLES Case Number	2023-01358-1A
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, hit and pulled a patient from the dining room.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/22/2023
OLES Case Number	2023-01359-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity 2. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly engaged in efforts to extort money from one patient for the benefit of a second patient.
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. OLES concurred.
Investigative	**Overall Rating:** Sufficient

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

Case Details	Description
Incident Date	09/21/2023
OLES Case Number	2023-01366-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician misplaced his wallet containing a large amount of cash. A patient allegedly found the wallet and hid the money in his room. The patient also allegedly gave some money from the wallet to a second patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred. The Office of Protective Services opened an administrative investigation which OLES is not monitoring as the case no longer meets monitoring criteria.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/20/2023
OLES Case Number	2023-01373-1C
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. OLES concurred with

	the probable cause determination. The department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/26/2023
OLES Case Number	2023-01376-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Sustained 4. Sustained 5. Not Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician allegedly dispensed the wrong medication to a patient. Two other psychiatric technicians allegedly failed to properly monitor the medication line, allowing the patient to receive and consume the wrong medication.
Disposition	The hiring authority determined there was sufficient evidence to sustain two of the three allegations against the first psychiatric technician and issued a letter of warning. The hiring authority determined there was insufficient evidence to sustain the allegations against the other two psychiatric technicians. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/25/2023
OLES Case Number	2023-01393-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was diagnosed with a foot fracture. The cause of the injury was undetermined.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/01/2023
OLES Case Number	2023-01395-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly repeatedly 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. 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	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process The investigation was not completed until 125 days after the

	incident was discovered and all relevant witnesses were not interviewed.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not interview relevant witnesses. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 125 days after the incident was discovered.
Department Corrective Action Plan	The Investigator will be trained and counseled on the importance of locating all possible witnesses in their investigation and thoroughly reviewing all associated reports and documentation. The Office of special Investigations has implemented a procedure where the Supervising Investigator will notify OLES AIM when the report is completed and entered in the report management system.

Case Details	Description
Incident Date	10/03/2023
OLES Case Number	2023-01396-1A
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Unfounded 2. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly demanded sexual acts from a patient in exchange for not making false allegations against the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/04/2023
OLES Case Number	2023-01409-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was diagnosed with a fractured skull after jumping from his bed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	05/14/2023
OLES Case Number	2023-01410-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A unit supervisor allegedly ignored a patient's safety concerns; the patient was later allegedly attacked by another patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.

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

Case Details	Description
Incident Date	10/07/2023
OLES Case Number	2023-01431-1C
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. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/09/2023
OLES Case Number	2023-01433-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	Two officers were allegedly less than alert in a patient housing unit.
Disposition	The hiring authority did not sustain any of the allegations against the officers; however, the hiring authority

	determined documented training was appropriate. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/12/2023
OLES Case Number	2023-01442-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician and a psychiatric technician assistant allegedly dragged a patient on the floor.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/07/2023
OLES Case Number	2023-01456-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed a patient's arm and forced the patient from the nurses' station.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/14/2023
OLES Case Number	2023-01457-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pushed a patient and pulled the patient's beard.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/16/2023
OLES Case Number	2023-01462-1C
Case Type	Monitored
Incident Types	1. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Multiple staff members allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of

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

Case Details	Description
Incident Date	10/14/2023
OLES Case Number	2023-01469-1A
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 assaulted a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/20/2023
OLES Case Number	2023-01477-1A
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 grabbed and twisted a patient's arms and repeatedly forced the patient's head against a wall.
Disposition	The hiring authority found insufficient evidence to sustain

	the allegations. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/15/2023
OLES Case Number	2023-01479-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
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	An off-duty officer allegedly was involved in an act of domestic violence.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/25/2023
OLES Case Number	2023-01501-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff members allegedly grabbed a patient's throat during a containment procedure.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/28/2023
OLES Case Number	2023-01526-1A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained 7. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician and a psychiatric technician allegedly repeatedly hit a restrained patient. A second psychiatric technician, a health services specialist, and two unidentified staff members allegedly witnessed, but did not intervene, nor report the patient abuse. A psychiatrist allegedly was told by the patient about the patient abuse but did not report it.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.

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

Case Details	Description
Incident Date	10/24/2023
OLES Case Number	2023-01530-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Two nurses and a psychiatric technician allegedly medically neglected a patient, leading to the amputation of his toe.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/01/2023
OLES Case Number	2023-01537-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly assaulted a patient and incorrectly positioned a spit mask on the

	patient's face.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/02/2023
OLES Case Number	2023-01542-1C
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 femur after an apparent fall.
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.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/04/2023
OLES Case Number	2023-01545-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient experienced physical discomfort and while

	being assessed by level of care staff, became unresponsive and a medical alarm was activated. Although life-saving measures were attempted, the patient later died. An autopsy determined the patient died from hypertensive atherosclerotic cardiovascular disease.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime that contributed to the patient's death. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/06/2023
OLES Case Number	2023-01547-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Level of care staff found a patient on the floor after the patient had apparently fallen. The patient was conscious and repeatedly declined to be transported to an outside hospital for further medical evaluation. Seven hours later, the patient agreed to be transported to an outside hospital for further medical evaluation. The patient was later pronounced dead at the outside hospital. Coroner noted the manner of death accidental and the cause of death as: closed head injury with cerebral hematoma due to fall to floor striking head.
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. OLES concurred. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	11/04/2023
OLES Case Number	2023-01549-1A
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 on the face and head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/10/2022
OLES Case Number	2023-01558-2A
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	A law enforcement supervisor allegedly falsely stated his qualifications on a promotional application.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient Overall, the department sufficiently complied with

	policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/04/2023
OLES Case Number	2023-01559-1C
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 foot after allegedly falling in his room.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process because hospital police did not preserve video of the patient's alleged fall.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No A video of the patient's alleged fall was not preserved by hospital police.
Department Corrective Action Plan	Inform all officers to notify their sergeants when recording is deemed available for review. Inform all sergeants to notify a Lieutenant or an Investigator about the incident, which may have been captured on video, so the video can be downloaded and viewed for possible evidentiary purposes. If the video is determined to have evidentiary value, the video will be submitted to evidence.

Case Details	Description
Incident Date	11/07/2023
OLES Case Number	2023-01561-1C

Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient died from liver cancer in the hospital's medical unit.
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. However, potential policy violations were identified; therefore: the department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/07/2023
OLES Case Number	2023-01561-2A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	A registered nurse allegedly failed to provide adequate treatment to a terminal cancer patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. However, the hiring authority ordered counseling and training for the registered nurse and training for the medical unit. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description

Incident Date	11/03/2023
OLES Case Number	2023-01567-1C
Case Type	Monitored
Incident Types	1. Significant Interest - Other
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly stole prescription medication from the medication room.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigatory process. The investigator provided the employee with an incorrect legal admonition.
Pre-Disciplinary Assessment	1. Were all of the interviews thorough and appropriately conducted? • No The investigator provided the employee with an incorrect legal admonition.
Department Corrective Action Plan	In this case, the investigator gave the wrong admonishment to the suspect. OLES monitor advised the investigator who acknowledged the error. The investigator will be provided with documented training and a counseling memorandum to address the error.

Case Details	Description
Incident Date	10/30/2023
OLES Case Number	2023-01570-1A
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:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A social worker allegedly did not complete an incident report within two hours of observing a patient hit himself repeatedly in the face.
Disposition	The hiring authority sustained the allegation and determined a letter of expectation was the appropriate penalty. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/11/2023
OLES Case Number	2023-01573-2C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was transferred to an outside medical facility for intensive care treatment, suffered a cardiac arrest, and died. An autopsy determined that the patient died of arteriosclerotic cardiovascular disease.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime that contributed to the patient's death. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/14/2023
OLES Case Number	2023-01583-1C
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 psychiatric technician allegedly inappropriately touched a patient while placing the patient in a seclusion room.
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 opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/14/2023
OLES Case Number	2023-01604-1C
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. OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/16/2023
OLES Case Number	2023-01605-1C

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 shoulder.
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 administration investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/10/2023
OLES Case Number	2023-01607-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient was diagnosed with a compression fracture of several vertebrae.
Disposition	The hiring authority determined there was no staff misconduct. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/11/2023
OLES Case Number	2023-01608-1A
Case Type	Monitored

Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient slipped and fell, while alone in a restroom, and fractured a finger.
Disposition	The hiring authority determined there was no evidence of staff misconduct. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/20/2023
OLES Case Number	2023-01640-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Two unidentified staff members allegedly entered a sleeping patient's room and tried to forcibly open the patient's mouth.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/23/2023

OLES Case Number	2023-01645-1C
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 displaced right femur and a hip fracture.
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.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 171 days from 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 171 days from the date of discovery.
Department Corrective Action Plan	The investigator will be instructed on the importance of maintaining continuous communication with the monitor throughout the course of the entire investigation and if an extension is needed, request it prior to the 120th day. The Supervising Special Investigators will monitor OLES cases and work with investigators to ensure there are no unjustified time gaps in the investigation. This will ensure investigations and reports are timely.

Case Details	Description
Incident Date	11/19/2023
OLES Case Number	2023-01648-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A psychiatric technician allegedly attempted to hit a patient. The psychiatric technician also allegedly made inappropriate comments to the patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/01/2022
OLES Case Number	2023-01651-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Abuse 3. Priority 1: Sexual Assault
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	An unidentified person allegedly poured urine on a patient. A staff member allegedly inappropriately touched the patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/25/2023
OLES Case Number	2023-01663-1C

Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly asked a patient to see her breasts.
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	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/03/2023
OLES Case Number	2023-01678-1C
Case Type	Monitored
Incident Types	1. Assault/GBI 2. Broken Bone (Known Origin) 3. Head/Neck 4. Neglect
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A patient struck a second patient's head multiple times with a mop handle. The second patient sustained nasal and sinus fractures, and multiple lacerations to his face and head. Unit staff allegedly failed to properly supervise the dayroom where the incident occurred, and also allegedly failed to ensure the supply closet was secured.
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. OLES concurred.

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

Case Details	Description
Incident Date	12/01/2023
OLES Case Number	2023-01707-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly dropped a patient on a mattress in the seclusion room and pressed on the patient's chest.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/08/2023
OLES Case Number	2023-01709-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A licensed vocational nurse allegedly failed to provide adequate supervision to a patient who swallowed two batteries.
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 department

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

Case Details	Description
Incident Date	12/13/2023
OLES Case Number	2023-01739-1C
Case Type	Monitored
Incident Types	1. Abuse 2. Priority 1: Sexual Assault
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff members allegedly sexually assaulted a patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/14/2023
OLES Case Number	2023-01741-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Staff members allegedly forced a patient against a wall and onto the ground.
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 department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/15/2023
OLES Case Number	2023-01749-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff members allegedly assaulted and denied a patient water.
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 department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The Office of Protective Services failed to consult with the assigned OLES monitor during the criminal investigation or provide a copy of the draft investigative report, thereby preventing the monitor from providing real-time feedback.
Pre-Disciplinary Assessment	1. Upon completion of the investigation, was a draft copy of the investigative report forwarded to OLES to allow for feedback before it was forwarded to the hiring authority or prosecuting agency? • No OPS did not provide a draft copy of the investigative report to the OLES monitor. 2. Did OPS cooperate with and provide continued real-time consultation with OLES? • No OPS did not consult with the assigned OLES monitor

	during the criminal investigation.
Department Corrective Action Plan	Moving forward, the Supervising Special Investigator will ensure an additional case number is drawn when a patient makes a separate abuse or neglect allegation at the line level. This will ensure the allegations are properly addressed and a separate template is generated based on the allegations. This requirement will be discussed with command and supervisory staff.

Case Details	Description
Incident Date	12/16/2023
OLES Case Number	2023-01750-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient'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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/19/2023
OLES Case Number	2023-01753-1C
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 several older and healed foot and toe fractures.
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 department will not open an administrative investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/21/2023
OLES Case Number	2023-01755-1C
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. OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/25/2023
OLES Case Number	2023-01760-1A
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient fractured a rib while allegedly doing backflips in his room.
Disposition	The hiring authority determined there was insufficient

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

Case Details	Description
Incident Date	12/26/2023
OLES Case Number	2023-01767-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician was allegedly involved in an overly familiar relationship with a patient.
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 department opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/28/2023
OLES Case Number	2023-01788-1A
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	An unidentified staff member allegedly had inappropriate sexual contacts with a patient. A therapist allegedly did not report the allegation.

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

Case Details	Description
Incident Date	01/01/2024
OLES Case Number	2024-00003-1A
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	An unidentified person allegedly sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	03/26/2023
OLES Case Number	2024-00010-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Discourteous treatment
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer was allegedly discourteous towards a hospital employee.

Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/22/2023
OLES Case Number	2024-00045-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A psychiatric technician allegedly dispensed the wrong medication to a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a letter of warning. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/01/2023
OLES Case Number	2024-00052-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred

Incident Summary	Three psychiatric technicians and a psychiatric technician assistant allegedly pushed a patient to the floor during a room search. One of the psychiatric technicians allegedly threatened to hit the patient. The three psychiatric technicians and the psychiatric technician assistant allegedly searched the patient's storage areas and stole his personal property.
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 department opened an administrative investigation which OLES did not accept for monitoring because the incident did not meet OLES monitoring criteria.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/13/2024
OLES Case Number	2024-00084-2A
Case Type	Monitored
Incident Types	1. Abuse 2. Head/Neck
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly abused a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/17/2024

OLES Case Number	2024-00088-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician, two registered nurses, and a fourth unidentified staff member allegedly forced a patient to the floor, injuring his nose.
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 department indicated it will open an administrative investigation; OLES will accept for monitoring.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 159 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The report was not completed until 159 days after the incident was discovered.
Department Corrective Action Plan	To prevent this issue from occurring again, the Supervising Special Investigator's will implement a tracking system to prioritize OLES cases and ensure they are reviewed and approved in an expeditious manner to meet deadlines. The SSI's will also track case progress and meet with Investigators regularly to monitor deadlines.

Case Details	Description
Incident Date	01/21/2024
OLES Case Number	2024-00099-1C
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. OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/23/2024
OLES Case Number	2024-00114-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly grabbed a patient by the neck.
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 department did not open an administrative investigation. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/24/2024
OLES Case Number	2024-00115-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly repeatedly hit a

	patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 153 days after the incident was discovered.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 153 days after the incident was discovered.
Department Corrective Action Plan	To prevent this issue from occurring again, the Supervising Special Investigator's will implement a tracking system to prioritize OLES cases and ensure they are reviewed and approved in an expeditious manner to meet deadlines. The SSI's will also track case progress and meet with Investigators regularly to monitor deadlines.

Case Details	Description
Incident Date	01/20/2024
OLES Case Number	2024-00130-2A
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	Four officers allegedly used excessive force on a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	01/30/2024
OLES Case Number	2024-00181-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant argued with a patient who was laying on a gurney and forced the patient's head onto the gurney.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/31/2024
OLES Case Number	2024-00183-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly initiated an unwarranted restraint of a patient.
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 opened an administrative investigation, which OLES accepted for monitoring.
Investigative	**Overall Rating:** Sufficient

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

Case Details	Description
Incident Date	02/08/2024
OLES Case Number	2024-00234-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A staff member allegedly choked a patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/05/2024
OLES Case Number	2024-00236-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Staff members allegedly grabbed and injured a patient's arm while placing him in restraints.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the investigative process.

Case Details	Description
Incident Date	02/08/2024
OLES Case Number	2024-00243-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was transported to an outside hospital where he died from natural causes.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime that contributed to the patient's death. The coroner found the death was natural with the immediate cause being cardiac arrest.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/02/2024
OLES Case Number	2024-00269-2A
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	One law enforcement supervisor and one officer allegedly improperly conducted the selection process for two canine handler positions. The law enforcement supervisor also allegedly exhibited a racial bias towards an applicant.
Disposition	The hiring authority found insufficient evidence to sustain the allegations. OLES concurred with the hiring authority's

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

Case Details	Description
Incident Date	02/25/2024
OLES Case Number	2024-00316-1C
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A doctor allegedly hit a patient.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/27/2024
OLES Case Number	2024-00318-1C
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient transported to an outside medical facility for non-life threatening treatment unexpectedly became unresponsive the next day. Hospital staff initiated emergency life-saving measures; however, the patient was declared dead. The cause of death was cardiopulmonary arrest.
Disposition	The Office of Protective Services conducted the required

	post-death investigation, and determined there was no evidence that a crime caused or contributed to the patient's death. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	04/03/2024
OLES Case Number	2024-00545-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Four nurses, four psychiatric technicians, and a senior psychiatric technician allegedly failed to respond to and document a patient who allegedly had a seizure while in full bed restraints.
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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative 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.

Case Details	Description
Incident Date	09/14/2021
OLES Case Number	2021-01112-1A
Case Type	Monitored
Incident Types	1. Neglect 2. Neglect
Allegations	1. Absence without leave 2. Absence without leave 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty 7. Inexcusable neglect of duty 8. Inexcusable neglect of duty 9. Inexcusable neglect of duty 10. Inexcusable neglect of duty 11. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained

	3. Sustained 4. Not Sustained 5. Sustained 6. Not Sustained 7. Sustained 8. Not Sustained 9. Sustained 10. Not Sustained 11. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A senior psychiatric technician allegedly drank alcohol during his shift, brought alcohol on grounds, failed to accurately report his own and other staffs' attendance, falsified medical records, made inappropriate statements to subordinates, failed to properly document incidents, and left his post prior to the end of his shift. A second senior psychiatric technician allegedly drank alcohol at an off-grounds establishment during his shift. A registered nurse allegedly refused to accept one-to-one assignments from the first senior psychiatric technician, failed to timely report alleged staff misconduct, and left a patient she was assigned to observe, unattended. A second registered nurse allegedly left her post prior to the end of her shift on multiple occasions. A third registered nurse allegedly left his post prior to the end of his shift on multiple occasions. A fourth registered nurse allegedly drank alcohol at an off-grounds establishment during his shift and allegedly left his post prior to the end of his shift on multiple occasions. A clinical social worker allegedly left her post prior to the end of her shift on multiple occasions. A psychiatric technician allegedly slept during a one-to-one patient observation and left his post prior to the end of his shift. A second psychiatric technician allegedly drank alcohol at an off-grounds establishment during his shift. A third psychiatric technician allegedly drank alcohol at an off-grounds establishment during his shift. A fourth psychiatric technician allegedly failed to timely report to work and left her post prior to the end of her shift on multiple occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the two senior psychiatric technicians, three of the four registered nurses,

	the clinical social worker, and three of the four psychiatric technicians. The hiring authority determined there was sufficient evidence to sustain all of the allegations against the first registered nurse and the fourth psychiatric technician. The registered nurse resigned prior to the end of the investigation; therefore, disciplinary action was not taken. The hiring authority determined a salary reduction of five percent for 12 months was the appropriate penalty for the fourth psychiatric technician. The psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 559 days from 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 559 days from the date of discovery.
Disciplinary Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the disciplinary process. The hiring authority made disciplinary determinations without consulting OLES. The disciplinary action was not served on the psychiatric technician until 281 days after disciplinary determinations were made.
Disciplinary Assessment Questions	1. Did the hiring authority consult with OLES and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision? • No OLES was not made aware of the meeting and was not consulted. 2. Did the department attorney or human resources personnel provide to the hiring authority and OLES written confirmation of penalty discussion? • No The human resources personnel did not provide OLES with written confirmation of the penalty discussions. 3. Did the hiring authority 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 hiring authority did not consult with OLES regarding disciplinary determinations. 4. Was the disciplinary phase conducted with due diligence by the department? • No The department did not serve the psychiatric technician with the disciplinary action until 281 days after disciplinary determinations were made.
Department Corrective Action Plan	Office of Special Investigations and the Hospital Police Department have outlined requirements to all sworn staff with processing OLES monitored reports to ensure reports are completed thoroughly and in a timely manner. This investigation was complex due to the multiple allegations made requiring extensive investigation into documents, while interviewing over 48 involved parties. All investigators worked closely with the AIM and continued to provide updated OLES extensions as needed, but recognized the timeframe exceeded the standard timeframe.

Case Details	Description
Incident Date	01/13/2022
OLES Case Number	2022-00054-2A
Case Type	Monitored
Incident Types	1. Drugs 2. Over-Familiarity
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained 3. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A psychiatric technician was allegedly overly familiar with a patient and brought contraband into the secure treatment area.
Disposition	The hiring authority sustained the allegations and issued a salary reduction of 10 percent for 13 months. OLES concurred with the hiring authority's determinations. The

	psychiatric technician did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	08/23/2022
OLES Case Number	2022-01013-3A
Case Type	Monitored
Incident Types	1. Abuse
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Suspension **Final:** Counseling
Incident Summary	An officer allegedly used unnecessary force on a patient and omitted material information in his report. A second officer allegedly failed to properly document the force he witnessed, and a third officer allegedly made inappropriate changes to the first officer's report.
Disposition	The hiring authority sustained the allegations and determined a penalty of a 24-working-day suspension was the appropriate penalty for the first officer. The second and third officers were provided with training. OLES concurred with the hiring authority's determinations. The first officer filed an appeal with the State Personnel Board. Prior to hearing, the department withdrew the action and issued a letter of counseling and training. OLES concurred due to evidentiary concerns raised prior to the hearing.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures

	governing the disciplinary process.

Case Details	Description
Incident Date	10/17/2022
OLES Case Number	2022-01276-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A psychiatric technician failed to report another psychiatric technician's overly familiar sexual relationship with a former patient.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 5 percent for nine months was the appropriate penalty. OLES concurred. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the pre-hearing settlement conference, the department entered into a settlement agreement with the psychiatric technician, wherein the penalty was reduced to 5 percent salary reduction for three months. OLES concurred.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 253 days from the date of discovery, the department did not provide copies of the draft or final investigative reports to the monitor, and the hiring authority inadvertently made decisions regarding the sufficiency of the investigation and investigatory findings without consulting the monitor.
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 department did not provide copies of the draft or final investigative reports to the monitor, and hiring authority did not consult with the monitor regarding the sufficiency of the investigation and the investigatory

	findings until after the decisions were made because he was unaware that the case was monitored by OLES. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 253 days after the incident was discovered.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.
Department Corrective Action Plan	The OPS now have a supervising special investigator-1 assigned to OPS. The SSI-1 monitors all cases assigned to all investigators. The SSI-1 adds cases and closes cases. The SSI-1 reviews investigations at the time these cases were initiated. The SSI-1 approves or sends cases back to the investigator for corrections and then approves when corrections are made. The SSI-1 can reassign investigations when needed. The SSI-1 reviews timelines to be sure all cases are completed timely and in accordance with POBAR and OLES guidelines. The SSI-1 for OPS will document all cases in a spreadsheet which will include the identified AIM for the case. OPS will be sure to include the OLES AIM in all discussions and decisions regarding the cases.

Case Details	Description
Incident Date	04/22/2023
OLES Case Number	2023-00676-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Reprimand
Incident Summary	An officer allegedly drove a department vehicle at an excessive rate of speed on multiple occasions.
Disposition	The hiring authority sustained the allegation and determined the appropriate penalty was a salary reduction of 5 percent for six months. OLES concurred

	with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Prior to an evidentiary hearing, the department entered into a settlement agreement with the officer wherein the department agreed to reduce the penalty to a letter of reprimand. OLES concurred with the settlement as the officer agreed to GPS monitoring to ensure the misconduct does not reoccur.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	06/06/2023
OLES Case Number	2023-00837-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Reprimand
Incident Summary	An officer allegedly changed information in another officer's written report without their knowledge.
Disposition	The hiring authority sustained the allegation and determined the appropriate penalty was 5 percent for six months. OLES concurred with the hiring authority's determinations. Following a *Skelly* hearing, the hiring authority reduced the penalty to a letter of reprimand and training. OLES concurred with the reduction in penalty based on new mitigating information learned at the *Skelly* hearing.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary	**Overall Rating:** Sufficient

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

Case Details	Description
Incident Date	07/05/2023
OLES Case Number	2023-00961-2A
Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	An officer was allegedly intoxicated while on-duty. A second officer allegedly failed to timely report his belief that the first officer was intoxicated.
Disposition	The hiring authority sustained the allegation that the second officer failed to timely report his belief that an officer was intoxicated while on-duty and determined a salary reduction of 5 percent for 12 months was the appropriate penalty. The hiring authority found insufficient evidence to sustain the allegation against the first officer. OLES concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	07/06/2023
OLES Case Number	2023-00972-1A
Case Type	Monitored

Incident Types	1. 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. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	A psychiatric technician was allegedly overly familiar with a patient, providing the patient with a soft drink and soliciting the patient for oral sex. The psychiatric technician was allegedly uncooperative with investigators in scheduling his interview.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations of providing the patient with a soft drink and soliciting the patient for oral sex. However, the hiring authority determined there was sufficient evidence to sustain the allegation of failure to cooperate during the course of the investigation. The hiring authority determined dismissal was the appropriate penalty. OLES concurred with the hiring authority's determination. However, the psychiatric technician resigned before disciplinary action could be imposed. A letter indicating the psychiatric technician resigned under unfavorable circumstances was placed in his official personnel file.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedures governing the disciplinary process.

Case Details	Description
Incident Date	08/02/2023
OLES Case Number	2023-01121-2A

Case Type	Monitored
Incident Types	1. Misconduct
Allegations	1. Other failure of good behavior 2. Dishonesty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	An officer allegedly sent harassing messages and made a harassing phone call to a member of the public. The officer was allegedly dishonest during the investigation.
Disposition	The hiring authority sustained the allegations and determined dismissal was the appropriate penalty. OLES concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the disciplinary process.

Appendix D: Statutes

California Welfare and Institutions Code 4023.6 et seq.

4023.6.

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

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

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

4023.7.

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

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

4023.8.

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

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

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

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

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

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

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

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

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

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

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

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

(4) The reports required by paragraph (1) shall be posted on the Office of Law Enforcement Support's Internet Web site and otherwise

made available to the public upon their release to the Governor and the Legislature.

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

California Welfare and Institutions Code 4427.5

4427.5.

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

(A) A death.

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

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

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

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

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

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

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

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

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

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

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

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

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

California Welfare and Institutions Code 4023

4023

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

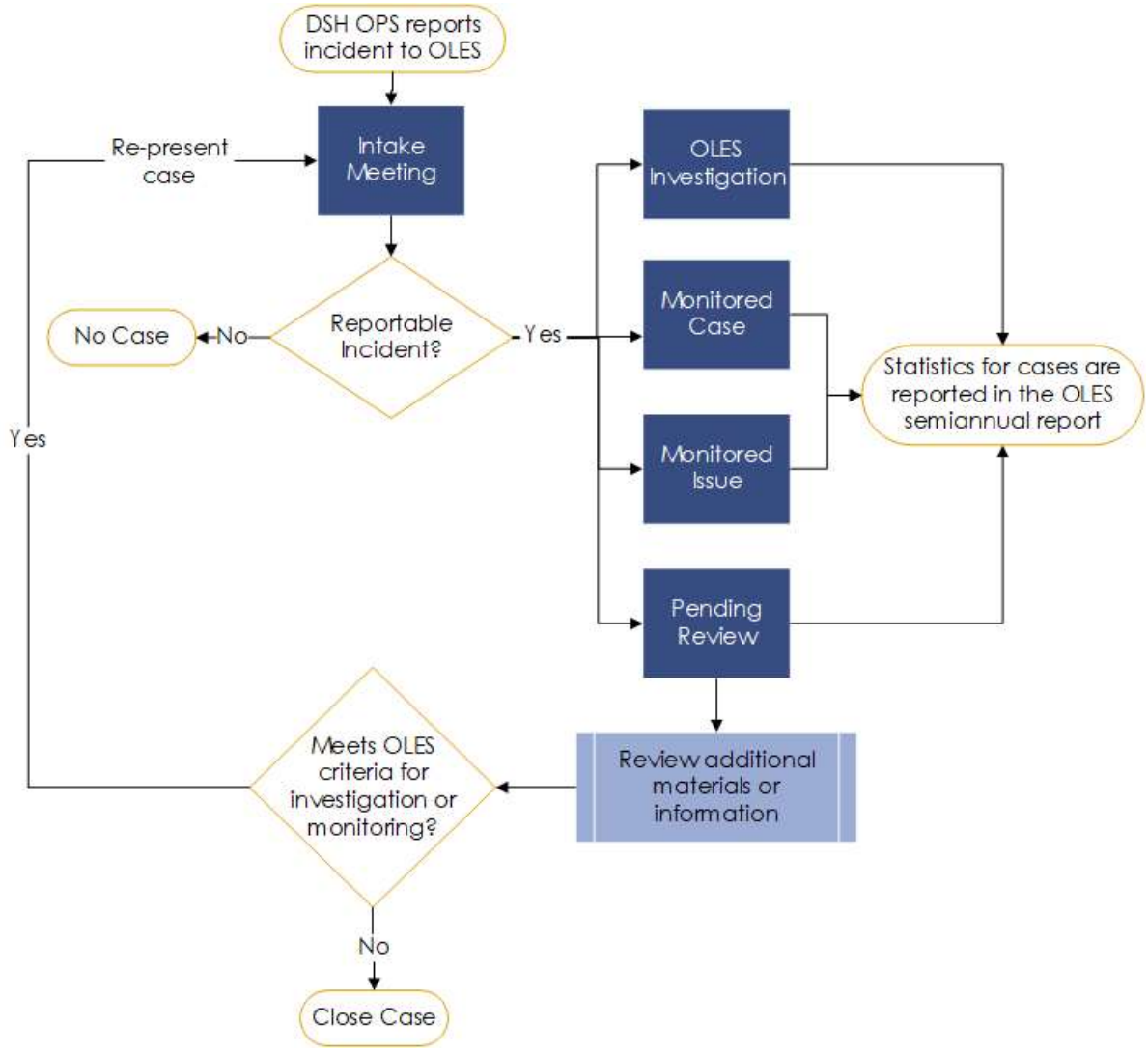
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

California Welfare and Institutions Code 15610.63 (Physical Abuse)

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

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

Appendix E: OLES Intake Flow Chart



Outline Description

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

Appendix F: Guidelines for OLES Processes

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

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

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

1. Department notifies OLES of an incident that meets OLES reporting criteria.
2. 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

[6] The best practice is to have an employment law attorney from the department involved from the outset to guide investigators, assist with interviews and gathering of evidence, and to give advice and counsel to the facility management (also known as the hiring authority) where the employee who is the subject of the incident works.

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

45 Days

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

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

60 Days

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

State employees subject to discipline have a due process right to have the matter reviewed in a *Skelly* hearing by an uninvolved supervisor who, in turn, makes a recommendation to the hiring authority, that is, whether to reconsider discipline, modify the discipline, or proceed with the action as preliminarily noticed to the employee[7]. It is recommended that the *Skelly* due process meeting be completed within 30 days.

30 Days

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

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

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

Conclusion

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